ADVANCED HOLISTIC HEALTH CENTER
PATRICIA L SUMMERS, D.C.
106 S KYRENE ROAD, SUITE 1
CHANDLER, AZ 85226
480-458-6000

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NOTICE AND CLAIM OF HEALTHCARE PROVIDER LIEN

DATE LIEN PREPARED: 10/30/2025 COUNTY: MARICOPA STATE: ARIZONA

Licensed Healthcare Provider: **Advanced Holistic Health Center, Patricia L Summers, D.C.**

Patient Name: **Burkhart, Paige** Date of Accident: 10/22/2025

Date of Patient's First Care/Treatment: 10/29/2025 **Treatment is ongoing – balance accruing**

Amount for Services Rendered: $490 **ACCURING** contact provider for **FINAL AMOUNT DUE**

To the best of claimant's knowledge, the names and addresses of all persons, firms or corporations and their insurance carriers INCLUDING the claimants own first party insurance policy being claimed for reimbursement (patient has signed a Financial Directive/Reimbursement to Advanced Holistic Health Center for payment form any settlement *see 2nd page*) by the injured person or their legal representative to be liable for ALL damages arising from the injuries for which healthcare has been received.

NAME	ADDRESS
Burkhart, Paige	1100 N Priest Drive #1134 Chandler, AZ 85226
Progressive CLAIM#25-359802764	**a154187@progressive.com**

Recoverable Signature

X Julia Raygoza

Julia Raygoza
Authorized Agenet
Signed by: f92615ed-f4ef-4eee-b8bd-d1ff50f39db8

Advanced Holistic Health Center must be placed on any & all settlement checks issued by any liable party(ies) and/or insurance company(ies) including first party insurance companies whose policy holder(s) have Med-Pay, UIM/UM and PIP. Any hold harmless agreement that the attorney and/or patient or patient representative signs does not indemnify the named responsible party(ies) and/or insurance company(ies) from their legal and financial responsibilities for **Advanced Holistic Health Center** bills for treatment received.

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Chandler, AZ
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PATIENT FINANCIAL AGREEMENT

(Equitable Lien/Benefit Assignment Contract and Indemnification Agreement)

Please read the following very carefully as it concerns your financial responsibility to the Health Care or Service Provider from whom you are about to receive services.

I Paige Burkhart **[patient printed name]**, the undersigned Patient hereby agrees to establish a Lien/Assignment of benefits or claims in favor of **Advanced Holistic Center** by this contract and pursuant to any state statues that apply in the state where I reside and/or am receiving treatment. I give my permission for **Advanced Holistic Center** and/or their agent, to file, record and serve notice of a copy of recorded copy of a *Notice and Claim of Statutory Health Care Provider Lien Equitable Lien/Benefit Assignment Contract and Indemnification Agreement* upon all parties who may be liable, including me for damages arising from the accident which occurred on 10/22/25 **[date]** and any subsequent claims arising from this accident for which I am receiving health care services. I understand that by doing so I am willingly signing a contract with the above-named health care or service provider. **I am authorizing direct payment(s) to Advanced Holistic Center from any and all proceeds regardless of which insurance policy makes payment, settlement, compromise, judgement verdict or damages** to which I may be entitled and paid in connection with the settlement of claims or litigation arising from this accident, in such sums necessary **to fully compensate the health care or service provider from whom I have received care**. The Lien/Assignment created by this Equitable Lien Contract and Indemnification Agreement shall have priority over any subsequent liens or assignments of my interests in claims arising from this accident.

In exchange for providing the necessary medical care without requiring payment in full at the time services are received, I agree that I am responsible for all charges associated with my care, regardless of the insurance companies' reimbursement, settlement or compromise. Charges for which I agree to be responsible for include all administrative expenses associated with processing my claim, including recording and/or serving the notice of this Lien/Assignment upon all liable parties and/or their insurance companies.

I Paige Burkhart **[patient printed name]**, *authorize my auto insurance company, any liable insurance company or attorney's office to release any information requested by* **Advanced Holistic Center** *pertaining to my personal injury accident.*

Also included will be any collection charges or legal costs and fees incurred while attempting to collect any missing accident information and/or medical bills related to this claim should such measures become necessary.

Patient's Signature Paige Burkhart Date 10.29.25

[If patient is a minor print minor's name here]