

Unofficial Document

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When recorded mail to:

*Spooner Physical Therapy
9097 E Desert Cove, #110
Scottsdale, AZ 85260*

NOTICE AND CLAIM OF MEDICAL LIEN
AMENDED LIEN NOTICE 2025-0590347

Name and address of Claimant/Licensed Health Care Provider:

**Spooner Physical Therapy
PO Box 4570
Scottsdale, AZ 85261-4570**

Name of Patient: **Michelle West—01/24/1993**

Date of Injury: 08/27/2025

County & State where injury occurred: Maricopa County, AZ

Dates of services received by patient: 09/30/2025 through pending

Amount due for care of patient: pending

To the best of claimant's knowledge, the names & address of all persons, firms, or corporations & insurance carriers of said persons, firms or corporations claimed by the above patient, or by his legal representative, to be liable for damages are as follows:

**Michelle West, 25447 North 40th Lane, Phoenix, AZ 85083
Farmers, PO Box 268994, Oklahoma City, OK 73126- CL #: 0389H407N**

Pursuant to A.R.S. 33-931, the above named claimant, personally or through its authorized agent, does hereby claim a lien upon any & all actions, suits, claims, counter claims or demands for damages accruing to said patient on his behalf by a legal representative, assignee or heirs on account of injuries giving rise to such cause of action, & which necessitated medical care & treatment for which claimant rendered such care at the rate customarily charged for such services which exceed \$250.00 as provided under A.R.S. 33-931(B), the sum of which is due & payable as indicated above.

STATE OF ARIZONA)
) SS.
COUNTY OF MARICOPA)

I, Angelica Garcia, being sworn upon oath, deposes' & says: (1) I am named as claimant or authorized agent of claimant, (2) I have made this Notice & Claim of Medical Lien in good faith, (3) the facts herein stated are true & correct to the best of my knowledge.

By: Angelica Garcia

For: **Spooner Physical Therapy**

My Commission Expires: 08/31/2026

SUBSCRIBED AND SWORN to before me,
the undersigned Notary Public, this
22nd day of October 2025.

