

# Unofficial Document

When Recorded Mail To:

URGENT CHIROPRACTIC CARE  
1641 W. Glendale Avenue, STE A  
Phoenix, AZ 85021

SR

HO

Official Records of \_\_\_\_\_ County, Arizona \_\_\_\_\_

County Recorder# \_\_\_\_\_ or Docket (Book)# \_\_\_\_\_, Page \_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_

## NOTICE AND CLAIM OF MEDICAL LIEN

Name and address of Claimant/Licensed Health Care Provider: Urgent Chiropractic Care  
1641 W Glendale Ave Ste #A Phoenix, AZ 85021

Name of Officer or Authorized Agent, if corporation: Maria Hernandez

Name and address of patient: Sonya Romero  
7347 N 127th Dr Glendale, AZ 85307

Date of patient's injury: 10/26/25

County and State where injury occurred: Maricopa Arizona

Dates of services received by patient: 10/28/25 through treatment ongoing

Amount due for care of patient: \$465.00 - treatment ongoing

To the best of Claimant's knowledge, the names and addresses of all persons, firms or corporations and insurance carriers of said persons, firms or corporations claimed by the above patient, or by his or her legal representative, to be liable for damages are as follows.

### NAME

USAA Insurance

### ADDRESS

P.O. Box 26001

Claim #000684668-800

Daphne, AL 36526

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

STATE OF ARIZONA

COUNTY OF Maricopa

I, Maria Hernandez, being first duly sworn upon oath, deposes and says: (1) that I am the person herein named as claimant (or the authorized agent of such claimant), (2) that I have made this Notice and Claim of Medical Lien in good faith and (3) that the facts herein stated are true and correct to the best of my knowledge, information and belief.

Claimant or Agent: Maria Hernandez

SUBSCRIBED AND SWORN to before me, the undersigned Notary Public this 4 day of November 2025, by Maria Hernandez

MY COMMISSION EXPIRES: 11/30/2028 NOTARY PUBLIC Angel Castillo

