

# Unofficial Document

The Instrument was Recorded at the Request of:

KOENKE CHIROPRACTIC  
3514 NORTH POWER ROAD  
SUITE 110  
MESA, AZ 85215  
(480) 830-7288

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The Record Official is Directed to Return this Instrument or a  
Copy to the Above Person(s).

## NOTICE and CLAIM of MEDICAL CARE LIEN

Effective Date: 10/10/25	County and State: MARICOPA, AZ
Licensed Health Care Provider (Name, Address, Zip Code)  KYLE KOENKE D.C. 3514 NORTH POWER ROAD SUITE 110 MESA, AZ 85215	Patient (Name, Address, Zip Code)  KATHERYNE MITCHELL 6506 E. PALM ST. MESA, AZ 85215
Licensed Health Care Provider, Executive Officer or Agent of Health Care Provider (Name, Address, Zip Code)  KYLE KOENKE D.C. 3514 NORTH POWER ROAD SUITE 110 MESA, AZ 85215	First Treatment Date: 10/10/25  Last Treatment Date: STILL TREATING
Initial Amount Due for Patient Care: \$ 1000.00	County in Which Injuries Were Sustained: MARICOPA

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

1. CLEAR COVER INSURANCE COMPANY, P.O. BOX 2871, CLINTON, IA 52733, CLAIM# 25ATAZ167573067.
2. KATHERYNE MITCHELL, 6506 E. PALM ST., MESA, AZ 85215.

The above-named Claimant(s), pursuant to the laws of the state of Arizona, do hereby claim a lien upon any and all causes of action, suits to the legal representative of such patient, on a account of injuries giving rise to such causes of action and which necessitated his or her treatment, for the customary charges for health care and treatment of the above-named injured patient in the sum hereinabove claimed to be due. The name and address of the patient as herein before set forth are the same as appear on the records of the Licensed Health Care Provider.

WITNESSETH I am the Licensed Health Care Provider, Executive Officer, or Agent of the Health Care Provider named in the forgoing Notice and Claim of Medical Care Lien and that I am authorized to act on behalf of the said Health Care Provider and make this Notice and Claim of Medical Lien for and on behalf of the said Health Care Provider being thereunto duly authorized; that the matters and things contained in the foregoing Notice and Claim of Medical Care Lien are true.

STATE OF ARIZONA  
County of Maricopa

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*Melissa Quinlan*

Licensed Health Care Provider,  
Executive Officer or Agent  
Melissa Quinlan, Office Manager

This instrument was acknowledged before me this 21<sup>st</sup> day of  
Oct 2025, by Melissa Quinlan  
In witness whereof I herewith set my hand and official seal.

Bruno Idriss NOTARY PUBLIC.

11/04/2025  
Notary Expiration Date

