

# Unofficial Document

**WHEN RECORDED, RETURN TO:**

Goudarz Vassigh, D.C.  
4425 N. 24<sup>th</sup> Street Suite 125  
Phoenix, AZ 85016  
602-956-8222

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**NOTICE & CLAIM OF MEDICAL LIEN**

**Health Care Provider/Claimant**  
Goudarz Vassigh, D.C.  
4425 N. 24<sup>th</sup> Street, Ste. 125  
Phoenix, AZ 85016

**Name of Patient:** Richard Dominguez

**DATE OF INJURY:** 10/31/2025

**ADDRESS OF PATIENT:** 112 E. ST.  
CATHERINE AVONDALE, AZ 85042

**County/State:** Maricopa County, AZ.

**DATE OF SERVICE FROM:** 11/04/2025

**Date of Service To:** Currently Receiving  
Care

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

**1st PARTY: PROGRESSIVE INS.**  
**ADDRESS: P.O. BOX 94739**  
**CLEVELAND, OH. 44101-4739**  
**ATTORNEY: JOEL BLACK LAW OFFICE**  
**4949 W. INDIAN SCHOOL RD. PHOENIX**  
**AZ. 85031**

**3<sup>RD</sup> PARTY: PROGRESSIVE INS.**

**ADDRESS: P.O. BOX 94739 CLEVELAND, OH.**  
**44101-4739**

**CLAIM NO: 25-327866634**

**CLAIM NO: 25-484565914**

**PHONE NO: 602-277-1393**

**PHONE NO: 800-444-4487**

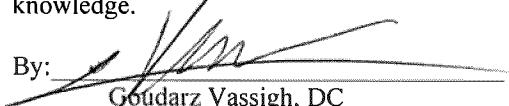
**INSURED: KIMBERLY NUNEZ**

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 occurring to said patient on her/his behalf by legal representatives, assignee or heirs on account of injuries giving rise to such cause of action, and which, necessitated medical care and treatment for which claimant rendered such care at the rate customarily charges for such services which exceed \$250.00 as provided under A.R.S. 33-931 (b) the sum of which is due and payable as indicated above.

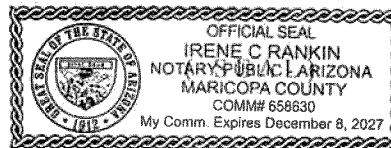
STATE OF ARIZONA  
COUNTY OF MARICOPA

I Goudarz Vassigh, D.C., being sworn upon oath, depose and say: I am named Claimant or authorized agent of Claimant. I have made this notice of medical lien in good faith; the facts are true and correct to the best of my knowledge.

By:

  
Goudarz Vassigh, DC  
Back-Health Chiropractic, L.L.C.

Subscribed and sworn to before me, the undersigned Notary Public, this 5<sup>th</sup> day of November, 2025,  
My commission expires: December 8, 2027.



  
(Notary Signature)