

# Unofficial Document

WHEN RECORDED MAIL TO:

AZ REGENERATIVE MEDICINE LLC  
16620 N 40<sup>TH</sup> STREET SUITE G2  
PHOENIX, AZ 85032

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dr.

## NOTICE AND CLAIM OF PHYSICIAN LIEN

### CALIMANT INFORMATION:

Name of claimant licensed health care provider: Jeffrey W. Frost D.C., P.M.M.T.P.

Name of licensed health care provider, executive officer or agent of health care provider: Jeffrey W. Frost D.C., P.M.M.T.P.

Address of Licensed health care provider, executive officer or agent of health care provider: 16620 N 40<sup>TH</sup> Street Suite G2  
Phoenix, AZ 85032

### Patient Information:

Name of Patient: Roberto Manaca

Address of Patient: 2706 E Villa Maria Dr Phoenix, AZ 85032

Date of patient's first treatment: 9/16/2024 Date of patient's last treatment: 11/15/2024

The date(s) of which medical care and treatment were provided are: 9/16/24 - 11/15/2024

Amount due to date for care of patient: \$10215.00. County in which injuries were sustained: Maricopa

To the best of claimant's knowledge, the names and the 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 the damages are as follows:

### NAME

Roberto Manaca

### ADDRESS

2706 E Villa Maria Drive

Phoenix, AZ 85032

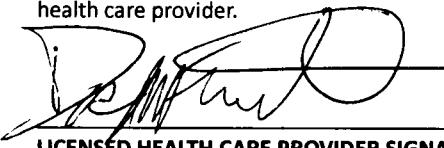
Progressive Insurance

PO Box 94541

claim # 24-327778743

Cleveland, OH 44101

The above named claimants pursuant to the laws of the state of Arizona do hereby claim a lien upon any and all causes of action, suits, claims, counter claims, or demands, accruing to the patient named herein, or to the legal representative of such patient, on 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 herein above claimed to be due. The name and the address of the patient as herein before set forth are as the same appear on the records of the licensed health care provider.



LICENSED HEALTH CARE PROVIDER SIGNATURE

Notary:

Date:

Les Friedl

11-13-2025

