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When recorded, please return this document to:

Kearny Chiropractic, LLC.

DBA Bell West Chiropractic

16846 W Bell Rd. Suite 112

Phone: (623) 556-2335 Fax: (623) 556-9382

NOTICE OF CLAIM OF MEDICAL HEALTHCARE PROVIDER **LIEN PURSUANT TO A.R.S. 33-931 ET SEQ**

Name / Address of claimant: **Kearny Chiropractic, LLC.**
DBA Bell West Chiropractic
16846 W. Bell Rd, Suite 112, Surprise, AZ 85374

Patient Name and Address: Alexis Bastin
27215 N 230th Ave
Wittmann, AZ 85361

Date of Injury: 10/06/2025

County where injuries were sustained: Maricopa

Date of Initial Treatment: 10/15/2025

Date of Final Treatment: Still Treating

Amount due for care of patient: \$280.00 Partial to Date **(Contact claimant above for final balance at settlement)**

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

Insurance Company (s): Commonwealth Casualty Insurance
2500 N 24th St
Phoenix, AZ 85008
Claim No. CAZ-0069934

Pursuant to A.R.S. 33-931 the above named Claimant, personally or through its authorized agent, hereby claims a lien upon any and all claims of liability or indemnity, except health insurance, for damages to said patient on account of injuries giving rise to such claim and which necessitated the health care services provided by the Claimant. Claimant hereby claims a lien in an amount to its customary charges for all health care services rendered to each patient in excess of \$250.00 as provided under A.R.S. 33-931. Claimant hereby demands that its name be placed on any and all settlement checks issued by the person, firm, corporation or insurance carrier liable for the patient's damages. Any hold harmless agreement that the attorney for the patient may provide does not release such person, form, corporation or insurance carrier from their financial responsibility for all amounts due under this lien.

I, Kimberly Bartlema, being sworn upon my oath depose and that (1) I am an authorized agent of the Claimant; (2) I have made this Notice of Claim of Medical Healthcare Provider Lien in good faith; and (3) The facts herein stated are true and correct to the best of my knowledge.

By: Kimberly Bartlema 11/20/25 Date for Kearny Chiropractic, LLC – DBA Bell West Chiropractic

Subscribed and sworn to before me, the undersigned notary public,

This 10th Day of November, 2025.

Notary Public: FE Faigal
My Commission Expires: 1-12-2026

