DAR-LIENS, INC.
7633 E. Acoma #102
Scottsdale, Arizona 85260

Arizona Certified Legal Document Preparer
Certificate Number 80906
Designated Principal - Dale Shephard

20 11 mo

NOTICE AND CLAIM OF HEALTH CARE PROVIDER LIEN

DATE LIEN PREPARED: NOVEMBER 3, 2025 **COUNTY:** MARICOPA **STATE:** ARIZONA

CLAIMANT LICENSED HEALTH CARE PROVIDER:

GILBERT PHYSICAL MEDICINE
ALISA WASSERMAN, D.C.
725 W. ELLIOT ROAD #115
GILBERT, ARIZONA 85233

EXECUTIVE OFFICER OR AGENT OF LICENSED HEALTH CARE PROVIDER:

Susan C. Beyette

PATIENT INFORMATION - NAME, ADDRESS AND ZIP CODE AS SAME APPEAR ON THE RECORDS OF CLAIMANT HEALTH CARE PROVIDER.

WHITNEY JURJEVICH
2473 S. HIGLEY ROAD #104-414
GILBERT, ARIZONA 85295

DATE OF PATIENT'S FIRST CARE/TREATMENT SEPTEMBER 15, 2025

DATE OF PATIENT'S LAST CARE/TREATMENT (IF COMPLETE) OCTOBER 23, 2025 (NOT YET COMPLETE)

DATES ON WHICH ON-GOING MEDICAL CARE/ TREATMENT WERE PROVIDED (MONTH AND DAY) SEPTEMBER 15 - OCTOBER 23, 2025 (STILL TREATING)

AMOUNT CLAIMED DUE FOR CARE / TREATMENT OF PATIENT	COUNTY IN WHICH INJURIES WERE SUSTAINED
$5,855.00	COCONINO

TO THE BEST OF CLAIMANT'S KNOWLEDGE, THE NAMES AND ADDRESSES OF ALL PERSONS, FIRMS OR CORPORATIONS AND THE INSURANCE CARRIERS FOR SUCH PERSONS, FIRMS OR CORPORATIONS CLAIMED BY THE ABOVE NAMED PATIENT, OR HIS/HER LEGAL REPRESENTATIVE TO BE LIABLE FOR DAMAGES ARE:

NAME	ADDRESS
MIDWEST FAMILY MUTUAL (800) 225-5636 CLAIM #00423839 ATTN: ANGIE STAFIERI	P.O. BOX 3939 URBANDALE, IOWA 50323
STATE FARM INSURANCE (844) 292-8615 CLAIM #0390M243T ATTN: CLAIMS DEPT.	P.O. BOX 106171 ATLANTA, GEORGIA 30348

THE ABOVE NAMED CLAIMANTS, IN ACCORDANCE WITH ARIZONA REVISED STATUES 33-931 THROUGH 33-934, DO HEARBY CLAIM A LIEN UPON ANY AND ALL CAUSES OF ACTION, SUITS, CLAIMS, COUNTER CLAIMS OR DEMANDS ACCRUING TO THE ABOVE NAMED PATIENT OR TO THE LEGAL REPRESENTATIVE OF SUCH PATIENT, AS A RESULT OF INJURIES GIVING RISE TO SUCH CAUSES OF ACTION AND WHICH MADE NECESSARY HIS/HER TREATMENT FOR THE CUSTOMARY CHARGES FOR HEALTH CARE TREATMENT OF THE ABOVE NAMED PATIENT IN THE SUM HEREIN ABOVE CLAIMED TO BE DUE.

SUSAN C. BEYETTE (LIMITED AGENT) BEING DULY SWORN, UPON OATH DEPOSES AND SAYS THAT HE/SHE IS THE LICENSED HEALTH CARE PROVIDER, EXECUTIVE OFFICER OR AGENT OF THE HEALTH CARE PROVIDER NAMED IN THE PRECEDING NOTICE AND CLAIM OF HEALTH CARE PROVIDER LIEN, THAT HE/SHE IS AUTHORIZED TO ACT ON BEHALF OF SAID HEALTH CARE PROVIDER, THAT HE/SHE DID WITHIN FIVE (5) DAYS AFTER THE RECORDING OF SAID NOTICE AND CLAIM OF HEALTH CARE PROVIDER LIEN AND ON THIS _____ DAY OF _____, 2025 DID SEND BY CERTIFIED MAIL OR FIRST CLASS, COPIES THEREOF TO EACH PERSON, FIRM OR CORPORATION AND THE INSURANCE CARRIER OF SUCH PERSONS, FIRM OR CORPORATIONS CLAIMED IN THE SAID NOTICE AND CLAIM OF HEALTH CARE PROVIDER LIEN TO BE LIABLE FOR DAMAGES, AT THE ADDRESSES GIVEN IN THE PRECEDING STATEMENT.

STATE OF: **ARIZONA** } SS **VERIFICATION OF AUTHORIZED AGENT**

COUNTY OF: **MARICOPA** **AND AFFIDAVIT OF PROOF OF SERVICE**

_____

LICENSED HEALTH CARE PROVIDER,
EXECUTIVE OFFICER OR AGENT THEREOF.

SUBSCRIBED AND SWORN TO BEFORE A NOTARY PUBLIC
ON THIS 3rd DAY OF NOVEMBER, 2025.

_____

NOTARY PUBLIC

DALE SHEPHARD
Notary Public - Arizona
Maricopa County
My Commission Expires
November 26,2026
Commission # 638211