



# Unofficial Document

Maricopa County Recorder<sup>20</sup>

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When recorded mail to:

VERVE WELLNESS CENTER  
VERVE MEDICAL GROUP, LLC  
VERVE CHIROPRACTIC AND ASSOCIATES, LLC  
AKA – VERVE CHIROPRACTIC GROUP  
4824 E Baseline Road Ste 140  
Mesa, Az 85206

## NOTICE OF CLAIMS OF MEDICAL LIEN

Name of Claimant/Address

Name of Patient: Maria L Mendoza

Verve Wellness Center  
Verve Medical Group, LLC  
Verve Chiropractic and Assoc.  
4824 E Baseline Road Ste 140  
Mesa, AZ 85209  
480.969.4040

Date of Accident: 10/01/2025 First Visit: 10/23/2025

Amount due Claimant: \$ \_\_\_\_\_ (partial to date / full balance)

State and County in which injuries or illness occurred: ARIZONA / MARICOPA COUNTY

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

Name of 3<sup>rd</sup> Party  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medpay Insurance  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Attorney Name  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Claim #: \_\_\_\_\_  
Adjustor: \_\_\_\_\_

Claim #: \_\_\_\_\_  
Adjustor: \_\_\_\_\_

Telephone: \_\_\_\_\_  
Paralegal: \_\_\_\_\_

Pursuant to A.R.S. 33-931, the above named claimant, personally or through it authorized agent, does hereby CLAIM A LIEN upon any and all actions, suits, claims and counterclaims or demands for damages accruing to said patient on his/her behalf by a legal representative, assignee or heirs on account of injuries giving a rise to such cause of action, and which necessitated his/her medical care and treatment for which claimant rendered medical care at the rate customarily charged 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.

Being of legal age and duly sworn, depose and say that the above mentioned persons were served with the foregoing notice of Physician's Lien in good faith by certified mail at their address, herein stated facts are true and correct to the best of my knowledge, information and belief.

Christina Key

BILLING ACCOUNTS MANAGER – PRINT NAME

Christina Key

SIGNATURE OF ACCOUNTS MANAGER