

# Unofficial Document

WHEN RECORDED MAIL TO :

EMERGENCY CHIROPRACTIC, P.C.  
2040 E. BELL RD., #140  
PHOENIX, AZ 85022

11:  
HO:

STATE OF : AZ COUNTY OF : MARICOPA

## NOTICE AND CLAIM OF PHYSICIAN LIEN

Name of claimant licensed health care provider **EMERGENCY CHIROPRACTIC, P.C.** Name/address of licensed health care provider executive officer/agent of the health care provider **TAMMY LANE, 2040 E. Bell Rd., #140, Phoenix, AZ 85022.**

NAME OF PATIENT : DOMINGUEZ DE TORRES, ELVIRA

ADDRESS OF PATIENT : 8539 W COLLEGE DR, PHOENIX, AZ 85033

DATE OF FIRST TREATMENT : 11/11/2025

DATE OF LAST TREATMENT : ONGOING

AMOUNT DUE TO DATE FOR CARE : \$ 1,891.90 \* For final lien balance, please call: 623-848-0800

To the best of claimant's knowledge the names and addresses 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 damages are :

DOMINGUEZ DE TORRES, ELVIRA  
8539 W COLLEGE DR  
PHOENIX, AZ 85033

STATE FARM  
PO BOX 106171  
ATLANTA, GA 30348  
CLM # 0329H127W

The above-named claimants pursuant to the Laws of the State of Arizona do hereby claim a lien upon any and all causes of actions, suits, claims, counterclaims, 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 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, Executive Officer or Agent thereof (D)

State of : ARIZONA )  
County of : MARICOPA ) § VERIFICATION OF AUTHORIZED AGENT

**TAMMY LANE**, being first 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 foregoing Notice and Claim of Medical Care Lien and that he/she is authorized to act on behalf of said Health Care Provider and makes this Notice and Claim for and on behalf of said Health Care Provider; that he/she within five (5) days after the recording of said Notice and Claim of Uniform Medical Care Lien mail a copy thereof, postage prepaid, to each person, firm, or corporation and the insurance Carrier of each person, firm or corporation claimed in said Notice and Claim of Medical Lien to be liable for damages, at the address given to the foregoing statement.

Licensed Health Care Provider, Executive Officer or Agent thereof (D)

Subscribed and sworn to before this 14th day of November, 2005.

Notary Public

Notary Seal :

