

MARICOPA COUNTY RECORDERS OFFICE
MAIN DOWNTOWN OFFICE
301 W JEFFERSON ST #200
PHOENIX, AZ 85003

Unofficial 20. Document

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Pr.

WHEN RECORDED RETURN TO:

TINA HORNE
ARIZONA CENTER FOR SURGICAL EXCELLENCE
3329 E BELL ROAD STE A1-A5
PHOENIX, AZ 85032

CAPTION HEADING: 20251003AMIN-3-1-1--SURGERY MEDICAL LIEN

**This document is being recorded for the sole
purpose of recording a medical lien**

DO NOT REMOVE

THIS IS PART OF THE OFFICIAL DOCUMENT



MARICOPA COUNTY RECORDERS OFFICE
MAIN DOWNTOWN OFFICE
301 W JEFFERSON ST #200
PHOENIX, AZ 85003

WHEN RECORDED RETURN TO:

TINA HORNE, INTERIM RCM MANAGER
3329 E BELL ROAD SUITE A2-A5
PHOENIX, AZ 85032

Notice and Claim of Medical Lien:

Name and Address of Claimant:

Arizona Center For Surgical Excellence
3329 E Bell Road Suite A2-A5
Phoenix, AZ 85032

Name and Agent of Healthcare Provider:

Arizona Center for Surgical Excellence
3329 E Bell Road Suite A2-A5
Phoenix, AZ 85032

Name of Patient: NASIR AMIN | MRN 558 | DOB: 10/10/1990

Date(s) of Service/Date of First Treatment: 10/03/2025

Current Amount Claimed: \$51,166.00

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

Unofficial Document		
<u>Patient Name/Address</u>	<u>Insurance/At Fault</u>	<u>Attorney Representation</u>
NASIR AMIN		RAJ LAW PLLC
1808 N 32 ND ST APT# 203		5050 N 40 TH ST SUITE 220
PHOENIX, AZ 85008		PHOENIX, AZ 85018

The above named claimants, in accordance with Arizona Revised Statutes §33-931 through §33.934, do hereby claim a lien upon any and all causes of action, suits, claims, counterclaims, or demands accruing to the patient named above or to the legal representative of such a patient, as a result of injuries giving rise to causes of action and which made necessary his/her treatment for the customary charges for healthcare treatment of the above named injured patient in the sum herein above claims to be.

STATE OF ARIZONA)
)
COUNTY OF MARICOPA)

VERIFICATION OF AUTHORIZED AGENT

Signature of licensed healthcare provider Executive Officer or Assigned Authorized Agent

Tina Horne

Printed Name of Signee

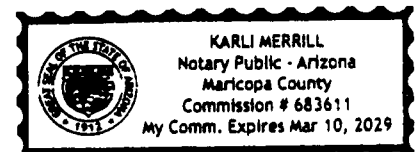
[Signature]

Signature

Subscribed and Sworn to before a Notary Public on this 23 Day of October, 2025

Notary Public

Karli Merrill



Shoulder

3329 E. Bell Rd. A1-A5
Phoenix, AZ. 85329
Phone: 602-753-4133 Fax:
602-666-0251

VIRTUOUS
HEALTH CENTERS

610 E. Baseline Rd. Ste. 106
Tempe, AZ. 85283
Phone 602-753-4133 Fax
602-666-0251

Patient Medical Lien

Patient name:

Date of Surgery: 10-3-2025

AMIN, NASIR

DOB: 10-10-1990

DOB: 10/10/1990 (34) DOS: 10/03/2025

Attorney/Law Office name and contact number: Law RAJ

Sex: Male MRN: 558

Physician: SCHULTZ, BRENT

Law Office contact(s): 480 300 4840

Law Office address: 5050 N. 40th St #200 Phx AZ 85018

I do hereby authorize **ARIZONA CENTER FOR SURGICAL EXCELLENCE/VIRTUOUS HEALTH CENTERS, ET AL.** to furnish my attorney named above with a full report of my examination, diagnosis, treatment, prognosis, etc. with regard to the incident in which I was recently injured.

I further authorize and direct my attorney to pay directly to **ARIZONA CENTER FOR SURGICAL EXCELLENCE/VIRTUOUS HEALTH CENTERS, ET AL** such sums as may be due and owing for medical services rendered to both me by reason of this incident and by reason of any other bills that are due and to withhold such sums from any settlement judgement or verdict as may be necessary to adequately protect and fully compensate said surgery facility.

I hereby further give Lien on my case to **ARIZONA CENTER FOR SURGICAL EXCELLENCE/VIRTUOUS HEALTH CENTERS, ET AL** against any and all proceeds of my settlement, judgement, or verdict which may be recovered or paid as the result of the injuries for which I have been treated.

I fully understand that I am directly and fully responsible to said surgery center for all medical bills submitted by **ARIZONA CENTER FOR SURGICAL EXCELLENCE/VIRTUOUS HEALTH CENTERS, ET AL** for services rendered me and that this agreement is made solely for said surgery center's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any recovery made by me. I hereby agree to waive the defense of Statute of Limitations as it pertains to any claim filed against me beyond three years (or other statutory) after services are rendered. I agree to promptly notify **ARIZONA CENTER FOR SURGICAL EXCELLENCE/VIRTUOUS HEALTH CENTERS, ET AL** of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

I have been advised that if my attorney does not wish to cooperate in protecting the surgery center's interest by signing this document, **ARIZONA CENTER FOR SURGICAL EXCELLENCE/VIRTUOUS HEALTH CENTERS, ET AL** will not await payment but may declare the entire balance due and payable at the time of service.

Printed Name of Patient

Date

Patient Signature

Witness Printed Name

Witness Signature