

# Unofficial 20. Document

When recorded mail to:

Name: LifeQuest Physical Medicine & Rehab  
Address: 4049 E. Williams Field Rd.  
Suite 101  
City/State/Zip: Gilbert, AZ 85295

JM  
Ho:

this area reserved for county recorder

***CAPTION HEADING:***

**DO NOT REMOVE**

**This is part of the official document.**

LifeQuest Physical Medicine & Rehab  
 4049 E. Williams Field Rd., Suite 101  
 Gilbert, AZ 85295  
 480-597-9497

**NOTICE AND CLAIM OF MEDICAL LIEN** *Please amend lien 20220643785*

STATE OF ARIZONA

COUNTY OF Maricopa

NAME OF CLAIMANT: LifeQuest Physical Medicine & Rehab

ADDRESS OF CLAIMANT: 4049 E Williams Field Rd STE 101

Gilbert, AZ 85295

NAME OF OFFICER OR AUTHORIZED AGENT: Bryce Bisching, D.C.

NAME OF PATIENT: James McCarthy

DATE OF PATIENT'S INJURY: 06/21/2022

DATE OF PATIENT'S FIRST TREATMENT: 08/02/2022

DATE OF PATIENT'S FULL RELEASE: TBD

AMOUNT DUE FOR CARE AND TREATMENT TO DATE: \$711.33

STATE AND COUNTY IN WHICH INJURIES OCCURRED: Maricopa/AZ

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

NAME	ADDRESS
James McCarthy	2144 E. Junction St., Grand Junction, AZ 85119
Farhang & Medcoff	100 S. Church Ave. #100, Tucson, AZ 85701

Check made out to LifeQuest Physical Medicine and Rehab only and mailed to Doctor's address pursuant to the laws of the State of Arizona and/or the common laws holdings in such cases, the about named Claimant personally, or through its authorized agent, does hereby claim a lien upon any and all causes of action, suits, claims, counterclaims or demands for damages accruing to said patient on his/her behalf by a legal representative, assignees or heirs, on account of injuries giving rise to such causes of action and which is due and payable as indicated above.

STATE OF ARIZONA COUNTY OF Maricopa

I, Bryce Bisching being first duly sworn upon oath, deposes and says that I am the person herein named as claimant for the authorized agent of such claimant, that I have made this Notice and Claim of Medical Lien in good faith, and that the facts therein stated are true and correct to the best of my knowledge, information and belief.

*(Signature)*  
 (Claimant or Agent)

Subscribed and sworn before me, the undersigned Notary Public,

This 23 day of October, 2025

By Andria Taylor

My commission expires 6-10-29

*(Signature)*  
 Notary Public

