

# Unofficial Document

WHEN RECORDED MAIL TO:

SOUTHWEST SPINE AND REHAB  
2919 S ELLSWORTH ROAD, STE 102  
MESA, AZ 85212

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HO:

## NOTICE OF MEDICAL LIEN

CLAIMANT LICENSED HEALTHCARE PROVIDER:

SOUTHWEST SPINE AND REHAB  
SCOTT TAYLOR, DC  
2919 S ELLSWORTH ROAD, STE 102  
MESA, AZ 85212

EXECUTIVE OFFICER OR AGENT OF HEALTHCARE PROVIDER: Dr. Scott Taylor, DC (LIMITED AGENT)

NAME OF PATIENT: Bethany Taylor

ADDRESS OF PATIENT: 8725 E. Lakeview Ave., Mesa, AZ 85209

DATE OF PATIENT'S FIRST CARE/TREATMENT: 11/3/25

DATE OF PATIENT'S LAST CARE/TREATMENT: TBD ( STILL TREATING/  TREATMENT COMPLETE)

AMOUNT DUE TO DATE FOR MEDICAL CARE: \$ TBD

COUNTY WHICH MEDICAL CARE PERFORMED: Maricopa

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

Bethany Taylor

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8725 E. Lakeview Ave

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Mesa, AZ 85209

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Progressive

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300 N. Commons Blvd

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Mayfield Village, OH 44143

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 CLAIMED TO BE DUE.

STATE OF ARIZONA

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) ss. VERIFICATION OF AUTHORIZED AGENT

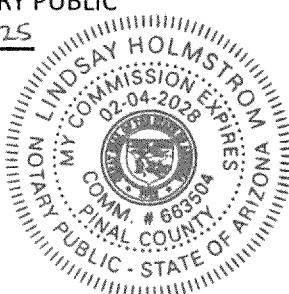
COUNTY OF MARICOPA

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SIGNATURE OF LICENSED HEALTHCARE PROVIDER EXECUTIVE OFFICER OR AGENT THEREOF: \_\_\_\_\_

SUBSCRIBED AND SWEARN TO BEFORE A NOTARY PUBLIC  
ON THIS 18 DAY OF November, 2025

LH  
NOTARY PUBLIC



MY COMMISSION EXPIRES: 2/4/2028