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

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WHEN RECORDED RETURN TO:

TINA HORNE
VHC-II, LLC
610 E BASELINE ROAD
TEMPE, AZ 85283

CAPTION HEADING: 20251006RAMIREZ-3-1-1--SURGERY MEDICAL LIEN

This document is being recorded for the 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
610 E BASELINE ROAD
TEMPE, AZ 85283

Notice and Claim of Medical Lien:

Name and Address of Claimant:
VIRTUOUS HEALTH CENTERS
610 E BASELINE ROAD
TEMPE, AZ 85283

Name and Agent of Healthcare Provider:
VIRTUOUS HEALTH CENTERS
610 E BASELINE ROAD
TEMPE, AZ 85283

Name of Patient: GLENDA RAMIREZ | MRN 1421 | DOB: 02/04/1985
Date(s) of Service/Date of First Treatment: 10/06/2025
Current Amount Claimed: $175,826.00 – VHC-II, LLC (SURGICAL FACILITY)
Current Amount Claimed: $5,706.00 – VIRTUOUS ANESTHESIA, LLC
Current Amount Claimed: $16,000.00 – VIRTUOUS MEDICAL ASSOCIATES, LLC

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:

Patient Name/Address	***Insurance/At Fault***	***Attorney Representation***
GLENDA RAMIREZ	N/A	HARRIS INJURY LAW
5158 W CAMPO BELLA DRIVE		1136 E CAMPBELL AVENUE
GLENDALE, AZ 85308		PHOENIX, AZ 85014

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)
) VERIFICATION OF AUTHORIZED AGENT
COUNTY OF MARICOPA)

Signature of licensed healthcare provider Executive Officer or Assigned Authorized Agent

Tina Horne
Printed Name of Signee

Signature

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

Notary Public: Karli Merrill

KARLI MERRILL
Notary Public - Arizona
Maricopa County
Commission # 5836[illegible]
My Comm. Expires Mar [illegible], 2029

virtuous
HEALTH CENTERS
11811 N. Tatum Blvd. Ste.#3031
Phoenix, Arizona 85028
Phone: 602-753-4133 Fax: 602-666-0251

Patient Medical Lien

Patient name: Glenda Ramirez **Date of Surgery:** 10/6/25

Patient date of birth: 02-04-1985

Attorney/Law Office name and contact number: Jason Harris Injury Law

Law Office contact(s):

Law Office address: 1136 E Campbell Ave, Phoenix AZ 85014

I do herby authorize **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 **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 **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 **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 **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, **VIRTUOUS HEALTH CENTERS, ET AL.** will not await payment but may declare the entire balance due and payable at the time of service.

Glenda Ramirez
Printed Name of Patient

7205
Patient Social Security Number or Driver's License Number
(last 4 numbers ONLY of social security number)

Patient Signature

10/4/25
Date of signature

Witness Printed Name

Alyssa Camacho 10/6/25
Witness Signature and date