

DAR-LIENS, INC.  
7633 E. Acorna #102  
Scottsdale, Arizona 85260

Arizona Certified Legal Document Preparer  
Certificate Number 80906  
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# Unofficial Document

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## NOTICE AND CLAIM OF HEALTH CARE PROVIDER LIEN

DATE LIEN PREPARED: NOVEMBER 20, 2025 COUNTY: MARICOPA STATE: ARIZONA

### CLAIMANT LICENSED HEALTH CARE PROVIDER:

STRENGTH TRAINING, INC.  
dba/STI THERAPY DIVISION  
17233 N. HOLMES BLVD. #1650  
PHOENIX, ARIZONA 85053

### EXECUTIVE OFFICER OR AGENT OF LICENSED HEALTH CARE PROVIDER:

Susan C. Beyette

### PATIENT INFORMATION - NAME, ADDRESS AND ZIP CODE AS SAME APPEAR ON THE RECORDS OF CLAIMANT HEALTH CARE PROVIDER.

AMBERLEAH GENTRY (#60993)  
3350 S. COLE DRIVE  
GILBERT, ARIZONA 85297

DATE OF PATIENT'S FIRST CARE/TREATMENT NOVEMBER 5, 2025

DATE OF PATIENT'S LAST CARE/TREATMENT (IF COMPLETE) NOVEMBER 7, 2025 (NOT YET COMPLETE)

DATES ON WHICH ON-GOING MEDICAL CARE/  
TREATMENT WERE PROVIDED (MONTH AND DAY) NOVEMBER 5 - 7, 2025 (STILL TREATING)

AMOUNT CLAIMED DUE FOR CARE / TREATMENT OF PATIENT \$500.00 (ACCRUING)	COUNTY IN WHICH INJURIES WERE SUSTAINED NEW MEXICO
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TO THE BEST OF CLAIMANT'S KNOWLEDGE, THE NAMES AND ADDRESSES OF ALL PERSONS, FIRMS OR  
CORPORATIONS AND THE INSURANCE CARRIERS FOR SUCH PERSONS, FIRMS OR CORPORATIONS  
CLAIMED BY THE ABOVE NAMED PATIENT, OR HIS/HER LEGAL REPRESENTATIVE TO BE LIABLE FOR  
DAMAGES ARE:

NAME

ADDRESS

STATE FARM INSURANCE  
(844) 292-8615  
CLAIM #0485W605C  
ATTN: RUFUS SULLIVAN

P.O. BOX 106170  
ATLANTA, GEORGIA 30348

THE ABOVE NAMED CLAIMANTS, IN ACCORDANCE WITH ARIZONA REVISED STATUES 33-931 THROUGH 33-934, DO HEARBY CLAIM A LIEN UPON ANY AND ALL CAUSES OF ACTION, SUITS, CLAIMS, COUNTER CLAIMS OR DEMANDS ACCRUING TO THE ABOVE NAMED PATIENT OR TO THE LEGAL REPRESENTATIVE OF SUCH PATIENT, AS A RESULT OF INJURIES GIVING RISE TO SUCH CAUSES OF ACTION AND WHICH MADE NECESSARY HIS/HER TREATMENT FOR THE CUSTOMARY CHARGES FOR HEALTH CARE TREATMENT OF THE ABOVE NAMED PATIENT IN THE SUM HEREIN ABOVE CLAIMED TO BE DUE.

**SUSAN C. BEYETTE (LIMITED AGENT)** BEING 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 PRECEDING NOTICE AND CLAIM OF HEALTH CARE PROVIDER LIEN, THAT HE/SHE IS AUTHORIZED TO ACT ON BEHALF OF SAID HEALTH CARE PROVIDER, THAT HE/SHE DID WITHIN FIVE (5) DAYS AFTER THE RECORDING OF SAID NOTICE AND CLAIM OF HEALTH CARE PROVIDER LIEN AND ON THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 2025 DID SEND BY CERTIFIED MAIL OR FIRST CLASS, COPIES THEREOF TO EACH PERSON, FIRM OR CORPORATION AND THE INSURANCE CARRIER OF SUCH PERSONS, FIRM OR CORPORATIONS CLAIMED IN THE SAID NOTICE AND CLAIM OF HEALTH CARE PROVIDER LIEN TO BE LIABLE FOR DAMAGES, AT THE ADDRESSES GIVEN IN THE PRECEDING STATEMENT.

STATE OF: ARIZONA

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COUNTY OF: MARICOPA

**VERIFICATION OF AUTHORIZED AGENT  
AND AFFIDAVIT OF PROOF OF SERVICE**

LICENSED HEALTH CARE PROVIDER,  
EXECUTIVE OFFICER OR AGENT THEREOF.

Unofficial Document

SUBSCRIBED AND SWORN TO BEFORE A NOTARY PUBLIC  
ON THIS 20<sup>th</sup> DAY OF NOVEMBER, 2025.



DALE SHEPHARD  
NOTARY PUBLIC

