When recorded mail to:

Name: _____

Address: _____

_____

City/State/Zip: _____

_____

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dr

this area reserved for county recorder

CAPTION HEADING:

DO NOT REMOVE

This is part of the official document.

NOTICE AND CLAIM OF MEDICAL LIEN (ARS 33-931 et seq.)
RECORD WITHIN 30 DAYS OF FIRST TREATMENT
MAIL WITHIN 5 DAYS AFTER RECORDING (those listed below **and the patient**)

Casey M. Johnston
Associate Doctors
Desert Springs Chiropractic
904 N McQueen Rd Ste 103
Gilbert, AZ 85233
480-668-1199

Treatment Dates 11/6/2025- Still Currently Treating
Cost of Treatment Due
Treatment is: continuing / terminated (circle one)
I verify the statements made herein are true based upon information and belief

Name of Executive Officer or Agent

PATIENT'S NAME/ADDRESS (**as it appears in medical records**) Darney Levin
1901 W. Madison St. Phoenix, AZ 85009
DATE OF PATIENT=S INJURY: 10/24/2025

To the best of claimant=s knowledge, the names and addresses of all persons, firms, corporations and insurance carriers claimed by the above named patient, or by his legal representative, to be liable for injuries for which health care was received, are: (ie. **Responsible driver, Liability Insurance Carrier, etc.**)

NAME	ADDRESS
State Farm Claim # 03-9209-48U	PO Box 106169 Atlanta, GA 30348
Rafi Law Group (attorney)	4701 N. 24th St Building C Phx, AZ 85016

I hereby give the above noted Medical Provider a lien against any and all proceeds of any settlement, judgment, verdict or otherwise regarding this accident. This document is to also act as a direct assignment of my rights and benefits to the extent medical services are provided to me by this Medical Provider. I fully understand that I remain directly and fully responsible to the Medical Provider for all bills submitted for services rendered to me, or supplies provided for me, and that this agreement is solely for the Medical Provider=s additional protection and in consideration of the Medical Provider awaiting payment. **I understand my Medical Provider has elected not to bill any health insurance, and I am in agreement with this. Should my Medical Provider bill my health insurance, I understand and agree that this is solely as a courtesy to me and I agree (independently and as a third party beneficiary) my Medical Provider is not to be bound by any agreement limiting their collection of total charges; and waive any rights to the contrary.** Further, I understand that payment is not contingent on any settlement, judgment or verdict. I further understand and agree that this Lien is irrevocable either by myself or any representative of mine, and I direct any attorney representing me to honor this lien. I also give Power of Attorney to the above noted Medical Provider for the limited purpose of endorsing, signing, or otherwise executing, any and all checks for payment of my bills. I understand that for the further protection of the Medical Provider, a lien may be recorded with the County Recorder=s office. I agree to pay, in addition to all other billed items, a fee not to exceed $75.00 to reimburse the Medical Provider for their costs incurred in recording this lien. Should a dispute arise hereunder, the prevailing party is entitled to their reasonable attorney=s fees, costs, and expenses incurred therein; both pre/post litigation. A copy of this agreement is to be considered as valid as the original.

PATIENT'S SIGNATURE _____ DATE: 11.13.25