Questions Contact Facility and/or Provider(s)

Sobel Family Medicine
Sobel Spine and Sports
4550 E. Bell Road, Ste. 114
Phoenix, AZ 85032
602) 996-6668
Fax#(602)494-0926

OC
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LIEN-MEDICAL

NOTICE AND CLAIM OF STATUTORY HEALTHCARE PROVIDER LIEN/ASSIGNMENT

DIRECT PAYMENT TO HEALTHCARE FACILITY AND/OR PROVIDER(s)
PATIENT SIGNED A CONTRACT AND ASSIGNMENT OF SETTLEMENT AND/OR BENEFITS

AGREEMENT BY PATIENT GRANTING PROVIDER(S) A LIEN AND PROMISING TO PAY PROVIDER(S) FOR MEDICAL SERVICES

NAME AND ADDRESS OF PATIENT:
Chrystal Ognissanti 37818 N 18th St Phoenix, AZ 85086

DATE ON WHICH INJURLES WERE SUSTAINED:
09/30/2025

COUNTY AND STATE WHERE TREATMENT FACILITY IS LOCATED:
Maricopa County, Arizona

NAME AND ADDRESS OF TREATMENT FACILITY AND/OR HEALTH CARE PROVIDER
Sobel Family Medicine & Physical Therapy, Sobel Spine and Sports, Bruce DeMartino, D.C., 4550 East Bell Road, Suite #114 Phoenix, Arizona 85032 (602) 996-6668 • (602) 494-0926/fax

DATE(S) OF SERVICES RENDERED:
10/18/2025, Treatment ongoing-balance accruing.

AMOU NT DUE TO DATE FOR SERVICES RENDERED:
$592.00: the amount listed does not reflect the final balance due, contact provider for this information.

TO THE BEST OF THE TREATMENT FACILITY AND/OR PROVIDER(s) KNOWLEDGE. THE NAMES AND ADDRESSES OF ALL PERSONS. FIRMS OR CORPORATIONS AND **THEIR INSURANCE CARRIERS INCLUDING THE CLAIMANTS OWN FIRST PARTY INSURANCE POLICY BEING CLAIMED (PATIENT HAS ASSIGNED BENEFITS TO HEALTHCARE PROVIDER - *see second page)*** BY THE INJURED PERSON OR THEIR LEGAL REPRESENTATIVE TO BE LIABLE FOR ALL DAMAGES ARISING FROM THE INJURIES FOR WHICH HEALTHCARE HAS BEEN RECEIVED:

NAME OF PATIENT, INSRANCE COMPANIES, ADDRESS, CLAIM OR POLICY NUMBER:
(Individuals who are at fault, patient, and/or patient's own insurance policy (i.e. Med-pay, UIM/UM, PIP) are listed as being responsible for payment until the healthcare facility and/or provider(s) fees has been settled to the facility and/or provider(s) satisfaction)

Chrystal Ognissanti 37818 N 18th St Phoenix, AZ 85086
Geico Po Box 509119 San Diego, CA 92150 Claim# 88566664170000001 Insured: Carter Petersen

The Healthcare Facility and/or Provider(s) named above must be placed on any and all settlement checks issued by the above named liable party(ies) and/or insurance company(ies) (including first party insurance companies whose policy holder(s) have Med-Pay, UIM/UM and PIP – see second page). Any hold harmless agreement that the attorney and/or patient or patient representative signs does not indemnify the named responsible party(ies) and/or insurance company(ies) from their legal and financial responsibilities for all the above-named Healthcare Facility and/or Provider(s) bills for treatment of the claimant.

The above-named healthcare facility and/or provider(s) maintains and operates or provides health care services at the address stated herein and has been duly licensed by this state or its political subdivisions. Pursuant to A.RS. §§33-931& 33-932 et. Seq. an Equitable Lien Contract and Assignment of Benefits Contract consummated between the named patient and healthcare facility and/or provider(s) (contract on file at the provider's address), said healthcare facility and/or provider(s) is entitled to be fully compensated on charges for services rendered. Notice is hereby given of a claim (lien) against any and all money from any insurance policy (except health care insurance) including any and all causes of action, suits, claims, counter-claims, settlements, judgements, verdicts, or damages payable to the injured person indicated or to their legal representative, for the customary charges (indicated in this document) in connection with care and treatment or transportation of the injured person on account of said injuries which gave rise to such claims and necessitated services for medical care and treatment.

That within five business days after the recording of this notice and claim of statutory healthcare provider lien, copies of same were served by U.S. Mail postage paid upon the above named injured person and upon each person, firm, insurance company, or corporation claimed to be liable for damages and their respective insurance carriers at the indicated address(es) in the foregoing instrument.

I declare under penalty of perjury that the foregoing is true and correct. Signed on the __28___ day of _____October_____, 2025.

Victoria Ventura

Victoria Ventura, Billing Clerk, based upon information and belief, the content herein is true
Sobel Family Medicine, Sobel Spine & Sports
Electronically Signed
10/28/2025