When recorded mail to:
Name: Rehabilitation Chiropractic Care
Address: 6638 E Baseline Rd #103
City/State/Zip: Mesa, AZ 85206

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LIEN ON PERSONAL INJURY RECOVERY

Christopher Scott Vincent ("patient") does hereby authorize Rehabilitation Chiropractic Care, PC located at 6638 E Baseline Rd #103, Mesa, AZ 85206 to assert a lien upon any and all rights of action, suite, claims, counterclaims and demands which arise out of the automobile accident on 9/16/25 (date)

In connection, the patient understands and acknowledges the following criteria:

1. Rehabilitation Chiropractic Care, P.C., to the end of perfecting its lien and copying with the statute governing it, gives this notice and information.

   a. The name of the injured person is: Scott Vincent
   b. The address of the injured person is: 1858 E. Lafayette Ave. gilbert. Az, 85298
   c. Treatment start date 9/26/25
   d. Location of the accident: N. 38 Ave & Bell Rd. Glendale, Az.
   e. Name of the insurance company: _____
   f. Claim Number: _____
   g. The Name of the Treating Provider is: Med. lien
   h. The amount due for chiropractic services is the total sum for all services and/or products received and any further services pertaining to the stated incident above.

If applicable:
Name of Attorney(s): Jacob Flemming
Address of Attorney(s): _____

Patient, Insurance Company and Attorney understands and acknowledges in the event of this claim being settled without the reimbursement of the full medical bills, that Rehabilitation Chiropractic Care, P.C. shall have full rights to prosecute the creditor's claim for the full amount plus late fee(s) of 15% compounded monthly. Patient understands that bankruptcy will not release him/her from this debt.

In the event of default in full payment, the patient insurance company and attorney agree to pay all reasonable costs of collection involving attorney's fees, court costs, and collection service fee(s).

I authorize and direct all insurance companies, attorneys, etc. to make direct payment to Rehabilitation Chiropractic Care, P.C. for all monies due my account. If assignment is prohibited, I direct all payers required to make checks payable to me, to mail said payments to Rehabilitation Chiropractic Care, P.C.. Patients selecting this payment option gives Rehabilitation Chiropractic Care, P.C. permission to endorse their name to checks payable to either or both parties, by way of a limited power of attorney.

Date: _____ Physician Signature: _____

Date: 9/26/25 Patient Signature: C. S. Vincent