



Solutions to Secure/Recover Personal Injury Settlements

Unofficial 20. Document

Fr.
Pr.

Questions Contact Provider

NOTICE AND CLAIM OF HEALTH CARE PROVIDER LIEN

FINANCIAL DIRECTIVE and PROMISE TO PAY. REIMBURSEMENT OF SETTLEMENT MONIES TO HEALTH CARE PROVIDER PER SIGNED AGREEMENT BY PATIENT/CLAIMANT

NAME AND ADDRESS OF PATIENT:

Danika Fromong, 3527 East Calistoga Drive, Gilbert, Arizona 85297

DATE ON WHICH INJURIES WERE SUSTAINED:

10/14/25

COUNTY AND STATE WHERE THE TREATMENT FACILITY IS LOCATED:

Maricopa County, Arizona

NAME AND ADDRESS OF TREATMENT FACILITY AND/OR HEALTH CARE PROVIDER:

**Mesa Family Chiropractic, Sam Pourian, B.S., M.S., D.C., 1059 East Broadway Road, Mesa, Arizona 85204
(480) 833-8003**

NAME AND ADDRESS OF AUTHORIZED AGENT FOR HEALTH CARE PROVIDER:

Arizona MedLien
2550 East Rose Garden Lane, #71093
Phoenix, Arizona 85050

DATE(S) OF SERVICES RENDERED:

10/28/25 – 10/31/25, liable payer(s) must contact the provider for dates of service. Treatment ongoing-balance accruing.

AMOUNT DUE TO DATE FOR SERVICES RENDERED:

\$1,420.00; **the amount listed does not reflect the final balance due, contact the provider for the FINAL AMOUNT DUE!**

TO THE BEST OF THE CLAIMANT'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 FOR REIMBURSEMENT** (PATIENT HAS SIGNED A FINANCIAL DIRECTIVE/REIMBURSEMENT TO HEALTHCARE PROVIDER FOR PAYMENT FROM ANY SETTLEMENT – see the second page) BY THE INJURED PERSON OR THEIR LEGAL REPRESENTATIVE TO BE LIABLE FOR ALL DAMAGES ARISING FROM THE INJURIES FOR WHICH HEALTH CARE HAS BEEN RECEIVED:

Danika Fromong, 3527 East Calistoga Drive, Gilbert, Arizona 85297
Western Agricultural Insurance Company, Adjuster: Tony Burkhart, 5400 University Avenue, West Des Moines, Iowa 50266, PL#000000008239723, CL#PA0021251146
AARP Hartford Insurance, Adjuster: Jason Durfey, 729 East Buckingham Court, Gilbert, Arizona 85297, PL#55100515804, CL#Y4UAL30729

The Healthcare Provider 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 of the above-named Healthcare Providers bills for treatment of the claimant.

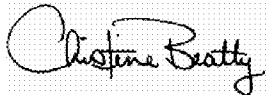
The above-named health care provider maintains and operates or provides health care services at the address stated herein and has been duly licensed by this state or its political subdivisions. Pursuant to A.R.S. §§33-931& 33-932 et. Seq., an **EQUITABLE LIEN; FINANCIAL DIRECTIVE and PROMISE TO PAY FROM SETTLEMENT** consummated between the named patient and health care provider (signed Agreement on file at the provider's address), said health care provider is entitled and expects to be fully reimbursed for charges on all services rendered. Notice is hereby given of a claim (lien) against any money from any insurance policy (except health care insurance) including any causes of action, suits, settlements, judgments, verdicts, counterclaims, or damages payable to the injured person indicated or to their legal representative, for the customary charges (indicated in this Agreement) 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.

VERIFICATION OF AUTHORIZED AGENT'S MAILING(S) OF RECORDED DOCUMENT

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

AUTHORIZED AGENT FOR HEALTH CARE PROVIDER

10/31/2025 2:15 PM

X 

Christine Beatty - Aut. Unofficial Document

Signed by: arizonamedlien@gmail.com

ACKNOWLEDGEMENT OF RECEIPT: HEALTHCARE PROVIDER LIEN AND FINANCIAL DIRECTIVE and PROMISE TO PAY/REIMBURSE HEALTH CARE PROVIDER PER SIGNED AGREEMENT BY PATIENT ON FILE AT PROVIDERS OFFICE.

UNLESS RETURNED WITHIN 10 DAYS OF MAILING DATE TO PROVIDER WITH PROOF OF DELIVERY DISPUTING ANY PORTION OF THIS DOCUMENT/AGREEMENT IT WILL BE CONSIDERED VALID AND PAYABLE (FULL PROVIDERS CHARGES) FROM ANY AND ALL SETTLEMENT PROCEEDS BY THE LIABLE PARTY(S) AND/OR PATIENT.

The Healthcare Provider 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 of the above-named Healthcare Providers bills for treatment of the claimant.

Mesa Family Chiropractic
1059 East Broadway Road, Mesa, Arizona 85204

PATIENT AGREEMENT/CONTRACT AND FINANCIAL DIRECTIVE

This patient agreement/contract and financial directive hereinafter referred to as ("Agreement") is entered into on this 28th [day] of October [month] 2025 [year], between the undersigned patient, hereinafter referred to as ("Patient,") and **Mesa Family Chiropractic**, hereinafter referred to as the ("Provider.")

1. Authorization for Direct Payment

I, Danika Fromong [patient printed name], the undersigned patient, do hereby provide explicit written authorization for Provider to be duly compensated, encompassing their customary fees incurred in exchange for patients' medical treatment of injuries sustained from the accident on 10/14/25 [date]. This executed Agreement serves as binding, in alignment with all pertinent and favorable state statutes.

2. Opt-Out and Direct Reimbursement

Patient assuredly opts out of **A.R.S. §20-259.01** and authorizes Provider to secure direct indemnity from Med-Pay, and UIM/UM coverages from patient's auto policy, if available. Patient understands our practice policy will not accept any health insurance when treating personal injury patients, solidifying this Agreement with Provider.

3. Healthcare Provider Lien and Financial Directive

Patient acknowledges that a recorded Healthcare Provider Lien shall serve as Patients Agreement, and is irrevocable. Patient also promises to pay Providers customary fees, in conjunction with Agreement and all applicable favorable state statutes.

4. Recording and Serving Notice of Lien

Provider's agent will record and serve Notice and Claim of Health Care Provider Lien, along with the Agreement against the total settlement amount. The recorded lien will be provided to all liable parties, including the Patient, for accruing or completed treatment charges arising from the accident. Unofficial Document

5. Payment Priority and Conditions

Patient commits to diligently comply with the stipulations outlined in this Agreement, guaranteeing that Provider receives timely payment as a foremost priority from all settlement, or other financial compensations, including direct payment from patient. No reductions unless explicitly sanctioned by the Provider.

6. Guarantee of Compensation

Patient unequivocally pledges the full settlement of the entire outstanding amount on their account with the Provider. The patient explicitly instructs any legal representative linked to their claim to refrain from impeding the payment owed to the Provider.

7. Waiver of State Statutes and Laws

Patient consciously waives any state statutes, or federal laws that would interfere, delay, or dismiss Provider from receiving customary fees and charges. Patient knowingly signs this Agreement which is irrevocable.

8. Responsibility for Charges and Administrative Expenses

Patient acknowledges responsibility for all charges associated with their care. Prompt payment to Provider is required, regardless of settlement or insurance reimbursement. Patient accepts and agrees they are responsible for all administrative, legal, and collection costs & fees for their care from Provider.

9. Authorization for Information Disclosure

I, Danika Fromong [patient printed name], authorize any reputed liable entities or attorney's to fully disclose without delay any information requested by Provider regarding my personal injury case.

The Healthcare Provider 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 of the above-named Healthcare Providers bills for treatment of the claimant.



Solutions to Secure/Recover Personal Injury Settlements

PRACTICE NAME:

Mesa Family Chiropractic

HEALTH CARE PROVIDER:

Sam Pourian, B.S., M.S., D.C.

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may be used for domestic and international mail.

From: **Arizona MedLien**
2250 East Rose Garden Lane, #71093
Phoenix, Arizona 85050

Danika Fromong
 3527 East Calistoga Drive
 Gilbert, Arizona 85297

PS Form 3817, April 2007 PSN 7530-02-000-9065



This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may be used for domestic and international mail.

From: **Arizona MedLien**
2250 East Rose Garden Lane, #71093
Phoenix, Arizona 85050

AARP Hartford Insurance
 729 East Buckingham Court
 Gilbert, Arizona 85297

PS Form 3817, April 2007 PSN 7530-02-000-9065

Unofficial Document



This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may be used for domestic and international mail.

From: **Arizona MedLien**
2250 East Rose Garden Lane, #71093
Phoenix, Arizona 85050

Western Agricultural Insurance Company
 5400 University Avenue
 West Des Moines, Iowa 50266

PS Form 3817, April 2007 PSN 7530-02-000-9065

The Healthcare Provider 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 of the above-named Healthcare Providers bills for treatment of the claimant.