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WHEN RECORDED, MAIL TO:
Marie M. Cipollo, D.C.
DBA: Islands Chiropractic & Massage
1447 W. Elliot Rd., Suite 103
Gilbert, AZ 85233
Tel: 480.545.4580
Fax: 480.892.4640
islandschiro@gmail.com

NOTICE AND CLAIM OF MEDICAL LIEN

Claimant: Dr. Marie Cipollo
Agent: Dr. Marie Cipollo
Patient: Ruben Sierra
Date of Loss: 09-17-2025
Date of first treatment: 09-19-2025
Current amount due claimant:$3143.00 & continuing

Address: 1447 W. Elliot Rd., #103, Gilbert, AZ 85233
Address: 1447 W. Elliot Rd., #103, Gilbert, AZ 85233
Address: 2324 E. Rawhide St., Gilbert, AZ 85296
County in which injury was sustained: Maricopa
Is treatment ongoing?: YES
Are there additional cost accruing: YES

To the best of claimant's knowledge, the names and addresses of all persons, firms or corporations and the insurance carriers of said persons, firms or corporations claimed by the above named patient, or by his/her legal representative, to be liable for damages are as follows:

3rd Party Ins. & Address: Sedgwick Claims Management P.O.Box 14459 Lexington Kentucky 40512
Claim #: 258031460
Ins. Adjuster:
Contact Info: Phone # 248-649-2100

Other Ins. & Address:Liberty Mutual P.O. Box 5014 Scranton, PA 18505
Claim #060133428:
Ins. Adjuster: Myrna Pacheco
Contact Info: Phone # 1-800-225-2467

(PROVIDERS AND TOTALS TO BE SUPPLEMENTED AT CLOSE OF TREATMENT)

The above named claimant pursuant to the laws of the State of Arizona in such cases made and provided, does hereby claim a lien upon any and all causes of action, suits, claims, counterclaims or demands for damages accruing to the patient named herein, or the legal representative of such patient, on account of injuries giving rise to such causes of action and which necessitated his/her health care and its customary charges for treatment of the above named injured patient in the sum hereinabove claimed to be due. The name and address of the patient as hereinbefore set forth are as the same appearing on the records of the provider.

Dated: 10-15-25

Marie M. Cipollo, D.C.
Claimant/Agent
Marie M Cipollo DC
Signature

I, **Daniel J. Carlow, D.C., P.C.**, being first duly sworn upon oath, depose and say: (1) That I am the person herein named as claimant (or the authorized agent of such claimant); (2) That I have made this Notice and Claim of Medical Lien in good faith; and (3) That the facts therein stated are true and correct to the best of my knowledge, information and belief.

Daniel J Carlow DC
Signature