When Recorded Mail To:

URGENT CHIROPRACTIC CARE
1641 W. Glendale Avenue, STE A
Phoenix, AZ 85021

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Official Records of _____ County, Arizona. _____

County Recorder# _____ or Docket (Book)# _____, Page _____

Date _____ Time _____

NOTICE AND CLAIM OF MEDICAL LIEN

Name and address of Claimant/Licensed Health Care Provider: Urgent Chiropractic Care
1641 w Glendale Ave Ste #A phoenix, AZ 85021
Name of Officer or Authorized Agent, if corporation: Maria Herrada Hernandez
Name and address of patient: Breana Rugnao
2046 N 51st Dr phoenix, AZ 85035
Date of patient's injury: 10.18.25
County and State were injury occurred: Maricopa Arizona
Dates of services received by patient: 10.20.25 through treatment ongoing
Amount due for care of patient: $720.00 - treatment ongoing

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

NAME	ADDRESS
Liberty Mutual	P.O. Box 7214
Clm #6100-280-50	London, KY 40742

Pursuant to A.R.S. 33-931, the above named claimant, personally or through its authorized agent, does hereby claim a lien upon any and all actions, suits, claims, counterclaims or demands for damages accruing to said patient on his/her behalf by a legal representative, assignee or heirs on account of injuries giving rise to such cause of action, and which necessitated his or her medical care and treatment for which claimant rendered medical care at the rate customarily charged for such services which exceed $250.00 as provided in A.R.S. 33-931 (b), the sum of which is due and payable as indicated above.

ANGELINA CASTILLO
NOTARY PUBLIC - STATE OF ARIZONA
MARICOPA COUNTY
COMM. # 677350
COMMISSION EXPIRES
11-30-2028

STATE OF ARIZONA
COUNTY OF Maricopa

I, Maria Herrada Hernandez being first duly sworn upon oath, deposes and says: (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 herein stated are true and correct to the best of my knowledge, information and belief.

Claimant or Agent: Maria Herrada Hernandez
SUBSCRIBED AND SWORN to before me, the undersigned Notary Public this 4 day of November 20 25, by Maria Herrada Hernandez
MY COMMISSION EXPIRES: 11-30-2028 NOTARY PUBLIC Angel Castillo