

# Unofficial Document

## **MEDICAL LIEN NOTIFICATION AND CLAIM FORM**

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**Claimant/Licensed Health Care Provider Information:**

**Name and Address of Claimant/Licensed Health Care Provider:**

SUN RADIOLOGY

16222 N. 59th Ave Suite C-150, Glendale, AZ 85306

Phone: 623-815-8200

Officer or Authorized Agent of Health Care Provider: **SUN RADIOLOGY**

**Claim Information:**

To the best of the claimant's knowledge, the names and addresses of the persons, firms, or corporations, and insurance carriers claimed to be liable for damages are as follows:

Date of Lien Prepared: 12/01/2025

## County: Maricopa

State: AZ

## Patient Information:

**Patient: MIGUEL MONTES**

**DOB: 03/11/1959**

**Address: 8940 W SHAW BUTTE DR. PEORIA AZ 85345**

## Law Firm Information

Law Firm Name: SOUTHWEST INJURY SPECIALIST

**Firm Address: 301 E BETHANY HOME RD STE A-125, PHOENIX AZ 85012**

**Firm Phone Number:** 602-922-9955

**Date of Injury:**

**Date of Service Patients First Visit: 11/18/2025 - Present - Treating Continuing**

Date of Full Release of Care: Ongoing

Amount Due Claimant for Care/Treatment: \$ 4,000.00 & ACCRUING:

County and State in Which Injury or Illness Occurred: Maricopa County, AZ

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Date: 11-18-2025

Patient Signature: Miguel mortez

Date: \_\_\_\_\_

Agent Signature: Mark Lee

The undersigned being witness does hereby agree to observe all the terms of the above and agree to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor named above.

Date: 11-18-2025

Attorney Signature: \_\_\_\_\_

Unofficial Document

Please date, sign and return one copy to doctor's office

Keep one copy for your records

**FAX # 623-815-8299**

**Medical Lien Details:**

Pursuant to A.R.S. 33-931 through A.R.S. 33-934, the above-named Claimant hereby claims a lien upon any and all causes of action, suits, claims, counterclaims, or demands for damages accruing to the above-named patient or to the legal representative, assignee, or heirs of such patient. This is a result of injuries giving rise to such causes of action that necessitated his/her treatment for the customary charges for health care treatment of the named patient in the sum herein above claimed to be due.