Arizona MedLien
Solutions to Secure/Recover Personal Injury Settlements

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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:
Andrea Gutierrez, 1086 East Appaloosa Road, Gilbert, Arizona 85296

DATE ON WHICH INJURIES WERE SUSTAINED:
8/22/25

COUNTY AND STATE WHERE THE TREATMENT FACILITY IS LOCATED:
Maricopa County, Arizona

NAME AND ADDRESS OF TREATMENT FACILITY AND/OR HEALTH CARE PROVIDER:
Better Chiropractic, Brennan Bates, D.C., 2470 South Val Vista Drive, Suite #104, Gilbert, Arizona 85295
(480) 802-0692 • (480) 726-6934/fax

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

AMOUNT DUE TO DATE FOR SERVICES RENDERED:
$6,000.00; **the amount listed does not reflect the final balance due**, contact the provider for the FINAL AMOUNT DUE!

TO THE BEST OF THE CLAIMANTS' 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:

Andrea Gutierrez, 1086 East Appaloosa Road, Gilbert, Arizona 85296
Root Insurance, Adjustor: Kayce Coleman, Columbus, Ohio 43215, CL#M6XTHLAZ

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.

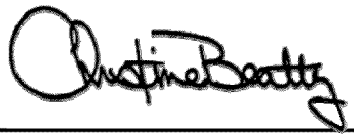
The above-named health care provider maintains and operates or provides health care services at the address stated herein and has been duly licensed by this state or its political subdivisions. Pursuant to **A.R.S. §§33-931& 33-932 et. Seq.**, an **EQUITABLE LIEN; FINANCIAL DIRECTIVE and PROMISE TO PAY 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

11/5/2025 2:27 PM

X 

Christine Beatty - Authorized Agent

Electronically Signed

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.

Signed Copy on File at Providers Office

Better Chiropractic

Please read the following very carefully as it concerns your financial responsibility and reimbursement to the Health Care or Service Provider from whom you are about to receive services and you fully understand.

I Andrea Gutierrez *[patient name]* the undersigned patient does hereby give written authorization for **Better Chiropractic** to receive payment/reimbursement for billed charges from the settlement proceeds that have been established with a Healthcare Provider Lien (recorded or not) and this signed Agreement to serve as my Financial Directive and Promise to Pay along with all favorable state statutes that apply. I give my permission for **Better Chiropractic** and/or their agent to record and serve *Notice and Claim of Health Care Provider Lien and my Financial Directive* for disbursement/reimbursement of the settlement funds upon all parties that are liable, including myself for damages arising from the accident which occurred on 8/22/25 [*date*]. Additionally, any subsequent claims arising from this accident in exchange for providing the necessary medical care without requiring payment in full for services received while awaiting my claim(s) to settle. I understand that by doing so I agree and will abide by the terms and conditions of this Agreement with **Better Chiropractic**. Without any delays, **Better Chiropractic** will expect prompt payment of the entire amount due (no reductions accepted) on my account as a priority from all settlement/claims or financial compensation(s) regardless of how many liable payers are involved. This will include any payment(s) from past, present, or future related or non-related settlements, compromises, judgments verdicts, or damages.

I agree to be legally bound and guarantee to fully reimburse **Better Chiropractic** from whom I have received care and treatment. Once **Better Chiropractic** has been fully compensated, regardless of having a recorded lien, the remaining settlement can then be distributed. I release any legal representative or anyone associated with my claim the authority to challenge the validity or amount due to **Better Chiropractic**, whether a lien has been recorded or not. This Agreement confirms that I have given my written consent and authorization for **Better Chiropractic** to be fully reimbursed without dispute or delay. I knowingly waive any and all state statutes, or state or federal laws that would interfere, delay or dismiss **Better Chiropractic** from being fully compensated *(customary charges)*. I also understand once this Agreement is signed it is irrevocable and cannot be rescinded or amended.

I understand and agree that I am responsible for all charges associated with my care. Primary payment is to be received from the settlement, whether a lien was recorded or not, regardless of the insurance companies' reimbursement, settlement, or compromise. It is the policy of **Better Chiropractic** to establish a lien. I do not have the option to utilize my health insurance as full payment for services, but authorize **Better Chiropractic** to balance bill my health insurance until my claim settles.

I agree to be responsible for but not limited to, all administrative expenses associated with processing my claim, including recording and serving notice upon all liable parties, insurance companies, and government, state, or federal entities from which I am or will be receiving payment(s). Legal costs & fees, collections costs & fees incurred if necessary to collect any unpaid amount due.

I Andrea Gutierrez *[patient name]*, authorize all automobile insurance companies, liable insurance companies, health insurance companies, or attorneys to fully disclose information requested by **Better Chiropractic** pertaining to my personal injury accident promptly.

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.

Arizona MedLien

Solutions to Secure/Recover Personal Injury Settlements

PRACTICE NAME: **Better Chiropractic**

HEALTH CARE PROVIDER: **Brennan Bates, D.C.**

UNITED STATES POSTAL SERVICE® **Certificate of Mailing**

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

Andrea Gutierrez
1086 East Appaloosa Road
Gilbert, Arizona 85296

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

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

Root Insurance
80 East Rich Street, #500
Columbus, Ohio 43215

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

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