

Unofficial Document

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WHEN RECORDED RETURN TO:

T & C WELLNESS INC, DBA
MOUNTAINSIDE CHIROPRACTIC
1170 N. ESTRELLA PKWY #A106
GOODYEAR, AZ 85338

NOTICE AND CLAIM OF HEALTHCARE PROVIDER LIEN

NAME OF CLAIMANT: T & C WELLNESS, DBA
MOUNTAINSIDE
CHIROPRACTIC, INC.

ADDRESS OF CLAIMANT: JOHN GARFIELD, DC
1170 N. ESTRELLA PKWY #A106
GOODYEAR, AZ 85338

FULL NAME OF PATIENT: Baltazar Andrade

ADDRESS OF PATIENT: 19342 W San Juan Ave
Litchfield Park, AZ 85340

PATIENT'S DATE OF BIRTH 12/15/1964

PATIENT'S PHONE NO.: 623-221-7646

DATE OF LOSS: 11/04/2025

INITIAL EXAM DATE: 11/24/2025

DATE OF DISCHARGE: (still treating)

AMOUNT DUE FOR CARE: (total dollar amount
unknown until discharge)

COUNTY IN WHICH THE
INJURY WAS SUSTAINED: Maricopa

Pursuant to A.R.S. §33-932, this lien is being recorded with the Maricopa County Recorder's Office within thirty days after the patient has received any services relating to the injuries.

(PROVIDERS AND TOTALS ARE SUPPLEMENTED AT CLOSE OF TREATMENT)

Baltazar Andrade

To the best of the claimant's knowledge the names and addresses of all persons, firms or corporations and the insurance carriers of the 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:

NAME	ADDRESS
Insurance: <u>State Farm Insurance</u>	<u>P.O. Box 106171</u>
Adjuster's Name: <u>Derek 480-856-1860</u>	<u>Atlanta, GA. 30348</u>
Claim# <u>03-92P0-06B</u>	Phone # <u>844-292-8615</u>
Policy No.: _____	_____
Insurance Company: _____	_____
Adjuster's Name: _____	_____
Claim No: _____	Phone #: _____
Policy No: _____	_____
Insurance Company: _____	_____
Adjuster's Name: _____	_____
Claim No.: _____	Phone No.: _____
Policy No.: _____	Insured: _____
Attorney Name _____	_____
Phone No _____	_____
Fax No: _____	_____
Email: _____	_____

Pursuant to A.R.S. §33-932, copies of the foregoing were sent via first class mail within five days after recording the forgoing claim of lien to the patient, as well as all persons, firms or corporations and their insurance carriers claimed by the patient or their representative to be liable

for damages arising from the injuries for which the patient received health care. This is an attempt to collect a debt. Any information gathered shall be used for such purpose.

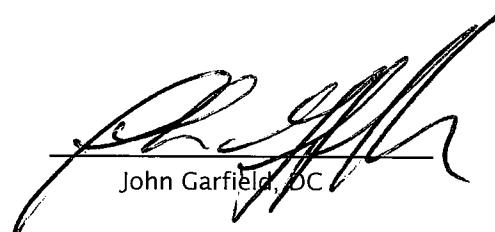
LIEN RE: Baltazar Andrade

The provider, JOHN GARFIELD, DC, 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 or her treatment, for its customary charges for chiropractic care and treatment of the named injured patient in the sum hereinabove claimed to be due. The name and address of the patient hereinabove set forth are as the same appearing on the records of the provider.

STATE OF ARIZONA)
)ss.
County of Maricopa)

JOHN GARFIELD, DC, being first duly sworn, upon oath and says:

That he is the Provider of T & C WELLNESS, DBA MOUNTAINSIDE CHIROPRACTIC, INC., and makes this Notice and Claim of Lien for and on behalf of the said facility, being thereunto duly authorized; that the matters and things contained in the foregoing notice and claim of lien are true.



John Garfield, DC

Subscribed and sworn to me this 24th day of November 2025




Ryan Michelle
Notary Public

My Commission Expires: 12/20/26