

Unofficial Document

When recorded mail to:

Name: LifeQuest Physical Medicine & Rehab
Address: 4049 E. Williams Field Rd. _____
Suite 101
City/State/Zip. Gilbert, AZ 85295

JM
HO:

this area reserved for county recorder

CAPTION HEADING:

DO NOT REMOVE

This is part of the official document.

LifeQuest Physical Medicine & Rehab
 4049 E. Williams Field Rd., Suite 101
 Gilbert, AZ 85295
 480-597-9497

NOTICE AND CLAIM OF MEDICAL LIEN Please amend lien 20220643785

STATE OF ARIZONA

COUNTY OF Maricopa

NAME OF CLAIMANT: LifeQuest Physical Medicine & Rehab

ADDRESS OF CLAIMANT: 4049 E Williams Field Rd STE 101

Gilbert, AZ 85295

NAME OF OFFICER OR AUTHORIZED AGENT: Bryce Bisching, D.C.

NAME OF PATIENT: James McCarthy

DATE OF PATIENT'S INJURY: 06/21/2022

DATE OF PATIENT'S FIRST TREATMENT: 08/02/2022

DATE OF PATIENT'S FULL RELEASE: TBD

AMOUNT DUE FOR CARE AND TREATMENT TO DATE: \$711.33

STATE AND COUNTY IN WHICH INJURIES OCCURRED: Maricopa/AZ

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

NAME	ADDRESS
<u>James McCarthy</u>	<u>2144 E. Junction St., Grand Junction, AZ 85119</u>
<u>Farhang & Medcoff</u>	<u>100 S. Church Ave. #100, Tucson, AZ 85701</u>

Check made out to LifeQuest Physical Medicine and Rehab only and mailed to Doctor's address pursuant to the laws of the State of Arizona and/or the common laws holdings in such cases, the about named Claimant personally, or through its authorized agent, does hereby claim a lien upon any and all causes of action, suits, claims, counterclaims or demands for damages accruing to said patient on his/her behalf by a legal representative, assignees or heirs, on account of injuries giving rise to such causes of action and which is due and payable as indicated above.

STATE OF ARIZONA COUNTY OF Maricopa

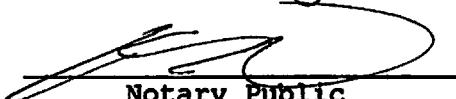
I, Bryce Bisching being first duly sworn upon oath, deposes and says that I am the person herein named as claimant for the authorized agent of such claimant, that I have made this Notice and Claim of Medical Lien in good faith, and that the facts therein stated are true and correct to the best of my knowledge, information and belief.

(Claimant or Agent)

Subscribed and sworn before me, the undersigned Notary Public,
 This 23 day of October, 2025

By Andria Taylor

My commission expires 6-10-29


 Notary Public

