

Unofficial Document

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NOTICE AND CLAIM OF MEDICAL LIEN

Name and address of Claimant/Licensed Health Care Provider:

**Spooner Physical Therapy
PO Box 4570
Scottsdale, AZ 85261-4570**

Name of Patient: Noah Bushell—10/24/2005

Date of Injury: 09/04/2025

County & State where injury occurred: **Maricopa County, AZ**

Dates of services received by patient: **10/23/2025 through pending**

Amount due for care of patient: **pending**

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

Noah Bushell, 249 E Aster Dr., Chandler, AZ 85286

Progressive, PO Box 94670, Cleveland, OH 44101, CL #: 25-295905348

Doran Justice Law Firm, 3550 N. Central Ave., Suite 1006, Phoenix, AZ 85012

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

STATE OF ARIZONA)
) SS.
COUNTY OF MARICOPA)

I, Angelica Garcia, being sworn upon oath, deposes' & says: (1) I am named as claimant or authorized agent of claimant, (2) I have made this Notice & Claim of Medical Lien in good faith, (3) the facts herein stated are true & correct to the best of my knowledge.

By: Angelica Garcia

For: **Spooner Physical Therapy**

My Commission Expires: 07/10/2026

SUBSCRIBED AND SWEARNED before me,
the undersigned Notary Public, this
4th day of November, 2025.

