WHEN RECORDED MAIL TO :

EMERGENCY CHIROPRACTIC, P.C.
2040 E. BELL RD., #140
PHOENIX, AZ 85022

STATE OF : AZ COUNTY OF : MARICOPA

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NOTICE AND CLAIM OF PHYSICIAN LIEN

Name of claimant licensed health care provider **EMERGENCY CHIROPRACTIC, P.C.** Name/address of licensed health care provider executive officer/agent of the health care provider **TAMMY LANE, 2040 E. Bell Rd., #140, Phoenix, AZ 85022**.

NAME OF PATIENT : ALEXANDER, DYNISHA
ADDRESS OF PATIENT : 3017 4TH AVE, LOS ANGELES, CA 90018
DATE OF FIRST TREATMENT : 11/04/2025
DATE OF LAST TREATMENT : ONGOING
AMOUNT DUE TO DATE FOR CARE : $ 1,697.00 * **For final lien balance, please call: 602-268-4600**

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

ALEXANDER, DYNISHA
3017 4TH AVE
LOS ANGELES, CA 90018

GEICO
PO BOX 509119
SAN DIEGO, CA 92150
CLM # 0652235470101032

The above-named claimants pursuant to the Laws of the State of Arizona do hereby claim a lien upon any and all causes of actions, suits, claims, counterclaims, or demands accruing to the patient named herein, or to 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 the customary charges for health care and treatment of the above-named injured patient in the sum herein above claimed to be due. The name and address of the patient as herein before set forth are as the same appear on the records of the Licensed Health Care Provider.

Licensed Health Care Provider, Executive Officer or Agent thereof (F)

State of : ARIZONA)
) § VERIFICATION OF AUTHORIZED AGENT
County of : MARICOPA)

TAMMY LANE, being first duly sworn, upon oath deposes and says :
That he/she is the Licensed Health Care Provider, Executive Officer or Agent of the Health Care Provider named in the foregoing Notice and Claim of Medical Care Lien and that he/she is authorized to act on behalf of said Health Care Provider and makes this Notice and Claim for and on behalf of said Health Care Provider; that he/she within five (5) days after the recording of said Notice and Claim of Uniform Medical Care Lien mail a copy thereof, postage prepaid, to each person, firm, or corporation and the insurance Carrier of each person, firm or corporation claimed in said Notice and Claim of Medical Lien to be liable for damages, at the address given to the foregoing statement.

Licensed Health Care Provider, Executive Officer or Agent thereof (F)

Subscribed and sworn to before this 19th day of November, 2025.

Notary Public

Notary Seal :

JEN CONNOR
Notary Public - State of Arizona
MARICOPA COUNTY
Commission # 670897
Expires July 23, 2028