

# Unofficial Document

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WHEN RECORDED, MAIL TO:

DR. LAURIE DODIE  
3920 E. Indian School Road Ste. #16  
Phoenix, AZ 85018

## NOTICE AND CLAIM OF MEDICAL LIEN:

Name & Address of Claimant/Licensed Health Care Provider:

Dr Laurie Dodie 3920 E. Indian School Road Ste. #16 Phoenix, AZ 85018

Name & Address of Patient: Serenity Stlp 3640 W. Wahalla Lane Glendale

Date of Injury: 10/20/12 AZ 85308

County & State where Injury Occurred: Maricopa County, Arizona State

Dates of services received by patient: 10/22/2012 - still treating

Amount due for care of patient: \$5,000 to date and on going

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

NAME	ADDRESS
State Farm Clm# 0391W810V	Box 106171 Atlanta, GA 30348-6171

Pursuant to ARS 33-931, the above named claimant, personally or through its authorized agent, does hereby claim a lien upon any & all actions, suits, claims, counterclaims 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 as provided under ARS 33-931 (B), the sum of which is due & payable as indicated above.

STATE OF ARIZONA

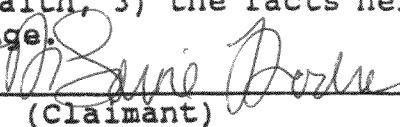
County of Maricopa

I, Laurie Dodie, D.C., 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.

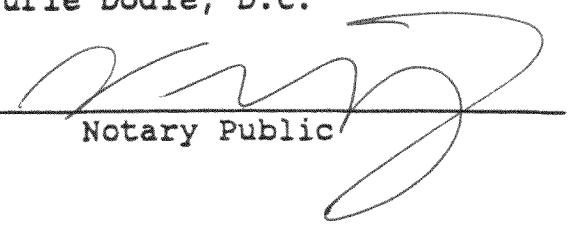
BY: Dr. Laurie Dodie

FOR:

  
(Claimant)

SUBSCRIBED AND SWORN to before me the undersigned Notary Public, this 17 day of November, 20 25 by Laurie Dodie, D.C.

My Commission Expires:

  
Notary Public

