Valley Chiropractic and Wellness Center
Dr. Samuel D Sickmeyer D.C.
18001 N. 79th Ave B45
Glendale, AZ 85308

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By signing below, I acknowledge that I have read the Financial Information Form and understand the policies and my responsibilities. I also authorize Samuel D. Sickmeyer, D.C., to release medical records and information to my insurance company(s) in order to assist me in recovering my costs for care, and it also authorized and directs the insurance company(s) and/or the attorney(s) to pay benefits directly to Dr. Samuel D. Sickmeyer. This also authorizes Dr. Samuel D. Sickmeyer to release records and information, and to consult with other individuals or health care providers as necessary to ensure that I receive the best health care possible or to recover my costs. I understand that I am responsible for any amount not covered for any reason, as well as any fees associated with collecting that balance. I understand that charges not paid within 90 days or arranged to be paid through other payment plans may be subject to a monthly finance charge of 10%, or as allowed by law, and that pertinent information may be released to a collection agency or credit bureau to accomplish that collection. I also understand that a copy of this form is just as valid as the original.

Fill out this section if you are here for an auto injury claim.

This form also gives notice that I am authorizing a Lien to be executed in accordance with AZ 98-06 when appropriate by Samuel D. Sickmeyer, DC to secure payment or services rendered to me. I acknowledge that I have or am about to receive treatment for injuries or conditions as described in my patient history and other places, and am authorizing Samuel D Sickmeyer, DC to claim a lien upon those individual(s) responsible for causing these injuries or conditions, and any other person liable for the injury or condition or obligated to compensate me on account of these injuries or conditions. These services were or will be rendered on dates set out in the billing statements, or as provided below:

Date of Claim/Injury/Accident: 9/27/25 **Claim #:** 03-90Z6-78Z

Liability Insurance Carrier: Statefarm Phone: _____

Fax: _____

Legal Representation: Amara Edblad Phone: (623) 471-8881

Office Name: Amara & Associate Fax: (623) 471-8881

I also attest to the fact that I have read all of the above and understand it, and agree to its provisions, I hereby authorize Samuel D. Sickmeyer, DC to supply the information above when appropriate, and have it appropriately recorded on my behalf.

_____ 10-23-25
PATIENT SIGNATURE (or RESPONSIBLE PARTY) DATE

_____
PRINTED NAME OF PATIENT (or RESPONSIBLE PARTY)

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Lien

The "health care service provider" (hereinafter Provider) and the Patient have elected not to use any coverage potentially available under a health insurance or similar medical benefit plan for payment, in whole or part, for medical services rendered as a necessary medical care for injuries sustained in the underlying accident. Provider is relying upon patient's representation that the portion of settlements, awards, or judgments available to Provider as payment, arising from the accident causing the injuries that were treated, are sufficient to pay all of health care service provider's customary charges for accident related treatment. Where not contrary to law, and where any lien will not be obviated: Patient understands and agrees that Provider may elect to abandon/void this agreement should patient's representations appear not true or appear not to be coming to their fruition. Provider shall not be held responsible/liable for any lack of insurance coverage, or other damages, that may result to patient by delays in billing, or any other reason. Patient agrees to be responsible for payment of any unpaid customary charges; where not prohibited by law.

Date of loss: 9/27/25

Patient or legal representative (Printed)

Provider (or authorized agent)

Patient gives the "health care service provider" (hereinafter Provider) a consensual lien for customary charges of health care services provided, diagnostic testing, equipment, and all other associated health care related items - against any payments, settlements, judgments, awards (regardless of their source) – arising from the accident which in Provider's opinion caused the personal injury(ies) treated. This consensual lien extends to monies owed to the Provider by the Patient for any other reason. Patient understands and agrees that regardless of providing this consensual lien, that Patient remains responsible for payment of all monies owed, or customary charges for services as services are received. Patient directs all persons, firms, corporations, or insurers paying any monies for the reasons noted herein – to give priority to this consensual lien where permitted by law; to remit payment directly to the Provider for the amount claimed as owed, payable solely in the name of the Provider, and mailed/issued directly to the Provider as directed by the Provider.

Date of loss: 9/27/25

Patient or legal representative (Printed)

Patient or legal representative (Signature)

Provider (or authorized agent)