AIM
ATHLETIC INSTITUTE OF MEDICINE
9475 East Ironwood Square Drive #100
Scottsdale, AZ 85258
480-778-1400 • 480-778-0400 Fax

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NOTICE AND CLAIM OF STATUTORY HEALTH CARE PROVIDER LIEN

DIRECT PAYMENT TO HEALTHCARE PROVIDER

NAME AND ADDRESS OF PATIENT:
Travis Rawlings, 4818 E Winchcomb Dr., Scottsdale AZ 85254

NAME AND LOCATION OF HEALTH CARE PROVIDER:
Athletic Institute of Medicine 9475 E. Ironwood Square Drive #100 Scottsdale, AZ 85258
(480) 778-1400 (480) 778-0400/Fax

NAME AND ADDRESS OF AUTHORIZED AGENT FOR HEALTH CARE PROVIDER:

Thomas J. Wall M.D. 9475 E. Ironwood Square Drive #100 Scottsdale, AZ 85258

DATE(S) ON WHICH SERVICES WERE RECEIVED:

10/30/2025 and continuing

AMOUNT CLAIMED DUE TO DATE FOR HEALTH CARE SERVICES RENDERED:

$1,000.00, plus still accruing as treatment continues.

TO THE BEST OF THE CLAIMANT'S KNOWLEDGE, THE NAMES AND ADDRESSES OF ALL PERSONS, FIRMS OR CORPORATIONS AND **THEIR INSURANCE CARRIERS BEING CLAIMED** BY THE INJURED PERSON OR THEIR LEGAL REPRESENTATIVE TO BE LIABLE FOR ALL DAMAGES ARISING FROM THE INJURIES FOR WHICH HEALTH CARE HAS BEEN RECEIVED:

NAME OF INSURANCE COMPANIES ADDRESS: Not on File

NAME OF INDIVIDUAL ADDRESS: Not on File

Copy to: Michael Nysather 15232 N 59th Ave. Glendale, AZ 85306

The health care provider named above must be paid separately from the patient. Contact the health care provider for its balance. Any hold harmless agreement that the attorney and/or patient or patient representative signs does not indemnify the named responsible party(ies) and/or insurance company(ies) from their legal and financial responsibilities for all the above named Healthcare Providers bills for treatment of the claimant.

The above-named health care provider maintains and operates or provides health care services at the address stated herein and has been duly licensed by this state or its political subdivisions. Notice is hereby given of a claim (lien) against any and all causes of actions, suits, settlements, judgements, verdicts, counterclaims, or damages payable to the patient indicated or to their legal representative, for the customary charges (indicated in this document) in connection with care and treatment of the injured person on account of said injuries which gave rise to such claims and necessitated services for medical care and treatment.

VERIFICATION OF AUTHORIZED AGENT AND CERTIFICATE OF SERVICE

Thomas J. Wall, being first duly sworn, upon oath deposes and states as follows:

1.) That he is the authorized agent of health care provider named in the foregoing notice and claim of statutory health care provider lien, and that he is authorized to act on behalf of said health care provider and makes this notice of claim statutory health care provider lien for and on behalf of said health care provider in good faith being thereunto duly authorized.
2.) That the statements contained herein are factual, true and correct to the best of his knowledge, information and belief.
3.) That within five days of recording this notice and claim of statutory health care provider lien, copies of same were served by Delivery Confirmation U.S. Mail, postage prepaid upon the above-named injured person and upon each person, firm or corporation claimed to liable for damages and their respective insurance carriers at the indicated address(es) in the foregoing.

I declare under penalty of perjury that foregoing is true and correct. Signed on the 30th day of October, 2025.

AUTHORIZED AGENT FOR HEALTH CARE PROVIDER

SUBSCRIBED AND SWORN to before me this 10/30/25

Notary Public

Notary Public State of Arizona
Maricopa County
Michelle Mahurin
My Commission Expires 9/16/2026
Commission Number 637350