

DAR-LENS, INC.
7633 E. Acorn #102
Scottsdale, Arizona 85260

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NOTICE AND CLAIM OF HEALTH CARE PROVIDER LIEN

DATE LIEN PREPARED: NOVEMBER 12, 2025

COUNTY: MARICOPA STATE: ARIZONA

CLAIMANT LICENSED HEALTH CARE PROVIDER:

SHEA CHIROPRACTIC CLINIC
ROBERT D. LARSON, D.C.
3241 E. SHEA BLVD. #4
PHOENIX, ARIZONA 85028

EXECUTIVE OFFICER OR AGENT OF LICENSED HEALTH CARE PROVIDER:

Susan C. Beyette

PATIENT INFORMATION - NAME, ADDRESS AND ZIP CODE AS SAME APPEAR ON THE RECORDS OF CLAIMANT HEALTH CARE PROVIDER.

JOANNA ALLAN
38150 N. 7th AVENUE
PHOENIX, ARIZONA 85086

DATE OF PATIENT'S FIRST CARE/TREATMENT JULY 31, 2025

DATE OF PATIENT'S LAST CARE/TREATMENT (IF COMPLETE) SEPTEMBER 2, 2025 (NOT YET COMPLETE)

DATES ON WHICH ON-GOING MEDICAL CARE/
TREATMENT WERE PROVIDED (MONTH AND DAY) JULY 31 - SEPTEMBER 2, 2025 (STILL TREATING)

AMOUNT CLAIMED DUE FOR CARE /
TREATMENT OF PATIENT \$2,935.00

COUNTY IN WHICH INJURIES
WERE SUSTAINED MARICOPA

TO THE BEST OF CLAIMANT'S KNOWLEDGE, THE NAMES AND ADDRESSES OF ALL PERSONS, FIRMS OR
CORPORATIONS AND THE INSURANCE CARRIERS FOR SUCH PERSONS, FIRMS OR CORPORATIONS
CLAIMED BY THE ABOVE NAMED PATIENT, OR HIS/HER LEGAL REPRESENTATIVE TO BE LIABLE FOR
DAMAGES ARE:

NAME

ADDRESS

STATE FARM INSURANCE
(480) 856-1172
CLAIM #0387Z432K
ATTN: CLAIMS DEPT.

P.O. BOX 106171
ATLANTA, GEORGIA 30348

THE ABOVE NAMED CLAIMANTS, IN ACCORDANCE WITH ARIZONA REVISED STATUTES 33-931 THROUGH 33-934, DO HEARBY CLAIM A LIEN UPON ANY AND ALL CAUSES OF ACTION, SUITS, CLAIMS, COUNTER CLAIMS OR DEMANDS ACCRUING TO THE ABOVE NAMED PATIENT OR TO THE LEGAL REPRESENTATIVE OF SUCH PATIENT, AS A RESULT OF INJURIES GIVING RISE TO SUCH CAUSES OF ACTION AND WHICH MADE NECESSARY HIS/HER TREATMENT FOR THE CUSTOMARY CHARGES FOR HEALTH CARE TREATMENT OF THE ABOVE NAMED PATIENT IN THE SUM HEREIN ABOVE CLAIMED TO BE DUE.

SUSAN C. BEYETTE (LIMITED AGENT) BEING 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 PRECEDING NOTICE AND CLAIM OF HEALTH CARE PROVIDER LIEN, THAT HE/SHE IS AUTHORIZED TO ACT ON BEHALF OF SAID HEALTH CARE PROVIDER, THAT HE/SHE DID WITHIN FIVE (5) DAYS AFTER THE RECORDING OF SAID NOTICE AND CLAIM OF HEALTH CARE PROVIDER LIEN AND ON THIS _____ DAY OF _____, 2025 DID SEND BY CERTIFIED MAIL OR FIRST CLASS, COPIES THEREOF TO EACH PERSON, FIRM OR CORPORATION AND THE INSURANCE CARRIER OF SUCH PERSONS, FIRM OR CORPORATIONS CLAIMED IN THE SAID NOTICE AND CLAIM OF HEALTH CARE PROVIDER LIEN TO BE LIABLE FOR DAMAGES, AT THE ADDRESSES GIVEN IN THE PRECEDING STATEMENT.

STATE OF: ARIZONA

COUNTY OF: MARICOPA

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VERIFICATION OF AUTHORIZED AGENT
AND AFFIDAVIT OF PROOF OF SERVICE

[Signature]

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LICENSED HEALTH CARE PROVIDER,
EXECUTIVE OFFICER OR AGENT THEREOF.

SUBSCRIBED AND SWORN TO BEFORE A NOTARY PUBLIC
ON THIS 12th DAY OF NOVEMBER, 2025.

[Signature]
NOTARY PUBLIC

