

# Unofficial 20. Document

When recorded return to:

*American Chiropractic Center, Inc.  
8417 E. McDowell Road, Suite 102  
Scottsdale, AZ. 85257*

Li:  
Ho:

## NOTICE AND CLAIM OF MEDICAL CARE LIEN

**Effective date:**  
10/24/2025

**County and State**  
Maricopa County, Arizona

**Licensed Health Care Provider**

American Chiropractic Center, Inc.  
Lynn Genet, D.C.  
Vincent Amoia, D.C.  
8417 E McDowell Rd., Ste. 102  
Scottsdale, AZ 85257

**Patient**

Mortimer O'Connor  
8232 E Edgemont  
Scottsdale, AZ 85257

**First Treatment Date:**  
10/27/2025

**Last Treatment Date:**  
Still treating

**Amount Due for Patient Care:**  
\$1050.00 (still treating)

**County in which injuries  
Were sustained:**  
Maricopa County, Arizona

**Date on which medical treatments were provided:**  
10/27/2025 (still treating)

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 as follows:

(3rd Party)

State Farm  
ATTN: Claims Department  
P.O. Box 106171  
Atlanta, GA 30348  
Claim #: 03-92C3-43S

(Patient)

Mortimer O'Connor  
8232 E Edgemont  
Scottsdale, AZ 85257

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.

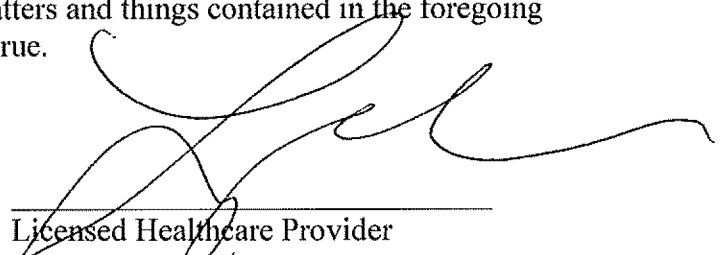
WITNESSETH, I am the Licensed Health Care Provider, Executive Officer or Agent of the Health Care Provider named in the foregoing Notice and Claim of Medical Care Lien, and that I am the authorized person to act on behalf of said Health Care Provider, and makes this Notice Claim of Medical Lien for and on behalf of said Health Care Provider being there unto duly authorized; that the matters and things contained in the foregoing Notice and Claim of Medical Care Lien are true.

STATE OF ARIZONA )

: Ss

COUNTY OF MARICOPA )

SUBSCRIBED AND SWORN this date:

  
\_\_\_\_\_  
Licensed Healthcare Provider

11/66/2025

My Commission expires:

  
\_\_\_\_\_  
Notary Public

