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Notice and Claim of Medical Care
H-5 Law Forms 9-88, 12-90

Effective Date: 10-20-2025	**County, State: Maricopa, Arizona**
Licensed Health Care Provider: **Patti Lehew, D.C., P.C.** • **9812 N 7th Street, Suite 7** • **PHOENIX AZ 85020** •	**Patient (Name, Address and Zip code):** **TORY WEEKS** **18820 N 33RD AVE** **PHOENIX, AZ 85027**

Licensed Health Care Provider Executive Officer or Agent of Health Care Provider:
Patti Lehew, D.C., P.C.
9812 N. 7th Street, Suite 7
Phoenix, AZ 85020-1763

First Treatment Date: 10/06/2025	**Last Treatment Date:** **Treatment Continues**
Amount Due For Patient Care: Partial Liens **$690.00- Continues to increase**	**County in which injuries were sustained:** **Maricopa**

Date(s) of which medical care and treatment were provided are 10/06/2025 to present. Patient continues to receive treatment and care.

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:

LIBERTY MUTUAL
P.O. BOX 5014
SCRANTON, PA 18505

CLM# 060208358

The above-named claimants pursuant to the laws of the State of Arizona do hereby claim a lien upon any and all causes of action, 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 here in 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 to act on behalf of the said Health Care Provider and makes this Notice and Claim of Medical Lien for and on behalf of said Health Care Provider being thereunto duly authorized; that the matters and things contained in the foregoing Notice and Claim of Medical Care Lien are true.

STATE OF ARIZONA)
County of Maricopa)ss

Licensed Health Care Provider, Executive Officer or Agent

SUBSCRIBED AND SWORN this date: 10·20·25

June 6, 2027
Notary Expiration Date

Notary Public

ALANNA BERNACCHI
Notary Public - Arizona
Maricopa County
Commission # 648203
My Comm. Expires Jun 6, 2027

(Continued on Reverse Side)