When Recorded Mail To:
Dr. Brian Wright
633 E. Ray Road, Suite 110
Gilbert, AZ 85296
Clinic# 480.222.6059

NOTICE AND CLAIM OF MEDICAL LIEN STATE OF ARIZONA

County of Maricopa
Name of Claimant: **Wright Chiropractic LLC, dba Arizona Sun Chiropractic & Rehab**
Address of Claimant: 633 E. Ray Road, Suite 110 Gilbert, AZ 85296
Name of Officer or Authorized Agent: **Brian Wright**
Name of Patient: **Chloe Eskey**
Patient's Address: 1133 W Page Ave Gilbert, AZ 85233
Date of Patient Injury: **10/27/2025**
Date of Patient's First Treatment: **11/05/2025**
Date of Patient's Full Release: Patient Has Ongoing Treatment.
Amount Due for care and treatment: **$1,575.00** Approximate Dollar Amount: **$10,000**
County/State in which Injuries/Illness Occurred: **Maricopa, Arizona**

To the best of the claimant's knowledge, the names and addresses of all persons, firms, corporation, and insurance carriers claimed by the above named patient or by his legal representative to be liable for damages are as follows:

NAME	ADDRESS
State Farm	**P.O. 106170**
Adj: Angelina Charlson	**Atlanta, GA 30348**
Claim #: 0392M820S	

Check made out to Arizona Sun Chiropractic & Rehab only and mailed to Doctor's address pursuant to the Laws of the State of Arizona, and or the common law holdings in such cases, the above named Claimant personally, or through its authorized agent, does hereby claim a lien upon any and all causes of action, suits, claims, counterclaims or demands for damages accruing to said patient, on his (her) behalf by a legal representative, assignees or heirs, on account of injuries giving rise to such cause of action and which necessitated his or her medical care and treatment, for which claimant rendered medical care at the rate customarily charged for such services, the sum of which is due and payable as indicated above.

STATE OF ARIZONA
COUNTY OF: MARICOPA

I, **Brian Wright** being first duly sworn upon oath, deposes and says: (1) That I am the person herein named as claimant (or the authorized agent of such claimant): (2) that I have made this Notice and Claim of Medical Lien in good faith; and (3) that the facts therein stated are true and correct to the best of my knowledge, information and belief.

VERONICA CARLSON
Notary Public - Arizona
Pinal County
Commission # 658997
My Commission Expires 11/29/2027

Claimant or Agent

SUBSCRIBED AND SWORN to before me, the undersigned Notary Public, this 18 day of NOVEMBER 2025

My Commission Expires: 11.29.2027

Notary Public