

# Unofficial Document

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When recorded mail to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City/State/Zip: \_\_\_\_\_  
\_\_\_\_\_

.....  
this area reserved for county recorder

## CAPTION HEADING:

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DO NOT REMOVE

This is part of the official document.

**NOTICE AND CLAIM OF MEDICAL LIEN (ARS 33-931 et seq.)****RECORD WITHIN 30 DAYS OF FIRST TREATMENT****MAIL WITHIN 5 DAYS AFTER RECORDING (those listed below and the patient)**

**Spinefit PLLC**  
**4921 E. Bell Rd.**  
**Ste107**  
**Scottsdale, AZ 85254.**  
**480-907-6877**

Treatment Dates Nov 19 2025  
Cost of Treatment Due 363  
(must exceed \$250 per ARS § 33-931(C))  
Treatment is: continuing terminated (circle one)

Name of Executive Officer or Agent  
**Dane B. Kohl**

I verify the statements made herein are true based upon information and belief \_\_\_\_\_

PATIENT'S NAME/ADDRESS (as it appears in medical records) Matt Duffy  
3202 W Fielding Dr Phoenix 85053

DATE OF PATIENT'S INJURY: 11/06/25

To the best of claimant's knowledge, the names and addresses of all persons, firms, corporations and insurance carriers claimed by the above named patient, or by his legal representative, to be liable for injuries for which health care was received, are: (ie. **Responsible driver, Liability Insurance Carrier, etc.**)

NAME Johny Sorenson ADDRESS 950 W 21st St #226

I hereby grant SpineFit PLLC (the "Medical Provider") a lien against any and all proceeds of any third-party settlement, judgment, or verdict arising from the above-referenced injury, pursuant to ARS § 33-931 et seq. This lien applies solely to claims of liability or indemnity and does not extend to health insurance proceeds, underinsured motorist (UIM) coverage, or uninsured motorist (UM) coverage as defined in ARS § 20-259.01. This document also serves as a direct assignment of my rights and benefits to the extent medical services are provided by the Medical Provider.

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**Statutory Lien Terms:**

- This lien is subject to the exemption of one-third (1/3) of any third-party judgment, settlement, or award, as required by ARS § 33-931(E)(1).
- The Medical Provider may record this lien with the Maricopa County Recorder's Office within 30 days of first treatment, per ARS § 33-932(A), and mail copies to me and the liable parties listed above within 5 days of recording, per ARS § 33-932(C).
- I understand that the Medical Provider must compromise this lien fairly and equitably, per ARS § 33-937, based on factors such as injury severity and settlement amount.

**Consensual Agreement Terms:**

- I fully understand that I remain directly and fully responsible to the Medical Provider for all bills submitted for services or supplies provided to me, independent of any settlement, judgment, or verdict. This consensual agreement is for the Medical Provider's additional protection and in consideration of awaiting payment, per ARS § 33-931(F).
- The Medical Provider has elected not to bill my health insurance, and I agree to this election in writing, per ARS § 33-931(E)(3)(d). If the Medical Provider bills my health insurance as a courtesy, I agree (independently and as a third-party beneficiary) that the Medical Provider is not bound by any agreement limiting collection of total charges and waive any rights to the contrary.
- I grant the Medical Provider a limited Power of Attorney to endorse, sign, or otherwise execute any checks for payment of my bills related to this injury.
- I direct any attorney representing me to honor this lien and agreement. This consensual agreement is irrevocable by me or my representatives, except as required by law for the statutory lien portion.

**Additional Terms:**

- I agree to reimburse the Medical Provider a fee not to exceed \$75.00 for costs incurred in recording this lien, if applicable.
- Should a dispute arise under this agreement, the prevailing party is entitled to reasonable attorney's fees, costs, and expenses incurred, both pre- and post-litigation.
- A copy of this agreement is as valid as the original.

PATIENT'S SIGNATURE Matt Duffy

DATE: 11/21/25