

# Unofficial 20. Document

**WHEN RECORDED, HOLD FOR PICK UP**

Name: Collision Chiropractors LLC.

Address: 3602 W. Thomas Rd., #4

City/State/Zip: Phoenix, AZ 85019

DA:

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## NOTICE AND CLAIM OF MEDICAL LIEN

NAME OF CLAIMANT: **COLLISION CHIROPRACTORS LLC.**

ADDRESS OF CLAIMANT: **3602 W. THOMAS RD #4 PHOENIX, AZ 85019**

NAME OF OFFICER OR AUTHORIZED AGENT, IF CORPORATION: **Mike Papamatheakis DC**

NAME OF PATIENT: **Danna Arana Berrelleza**

DATE OF PATIENT'S INJURY OF ILLNESS: **3/21/2025**

DATE OF PATIENT'S FIRST TREATMENT: **3/25/2025**

DATE OF PATIENT'S BIRTH: **2/7/2011**

☒ With treatment ongoing. ☐ Treatment complete.

AMOUNT DUE FOR CARE AND TREATMENT OF PATIENT: **\$600.00**☒ w/ accruing bal.

STATE AND COUNTY IN WHICH INJURED OR ILLNESS OCCURRED: **Arizona, Maricopa**

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

NAME	ADDRESS
Danna Arana Berrelleza	7 E 6h Avenue Mesa AZ, 85120

AND ANY AND ALL PARTIES RESPONSIBLE, BUT NOT MENTIONED ABOVE.

Pursuant to A.R.S §33-931, the above named claimant, personally or through its authorized agent, does hereby Claim A Lien upon any and all actions, suits, claims, counterclaims or demands for damages accruing to said patient on his/her behalf by legal representative, assignee 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 rate customarily charged for such services which exceed \$250.00, as provided under A.R.S. § 33-931(B), the sum of which is due and payable as indicated above.

By: Mike Papamatheakis DC - Claimant/ Agent

STATE OF ARIZONA )  
 )ss.  
COUNTY OF MARICOPA )

I Mike Papamatheakis, being first duly sworn upon oath, depose and say: (1) That I am the person herein named as claimant (or authorized agent of such claimant) ; (2) That I have made this Notice 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.

*[Handwritten signature]*

**Mike Papamatheakis – Claimant/ Agent**