When recorded, mail to:

Name: Arizona Life Chiropractic Center, LLC

Address: 4150 W Peoria Ave Suite 134

City/State/Zip Code: Phoenix, AZ 85029

Space above this line for Recorder's use

NOTICE AND CLAIM OF MEDICAL LIEN

NAME OF CLAIMANT: Arizona Life Chiropractic Center, LLC

ADDRESS OF CLAIMANT: 4150 W Peoria Ave Suite 134 Phoenix, AZ 85029

NAME OF OFFICER OR AUTHORIZED AGENT, IF CORPORATION: Dennis L. Cathcart, D.C.

NAME OF PATIENT: Flor Arvizu

DATE OF PATIENT'S INJURY OR ILLNESS: 11/3/2025

DATE OF PATIENT'S FIRST TREATMENT: 11/6/2025

DATE OF PATIENT'S FULL RELEASE: Still Treating

AMOUNT DUE CLAIMANT FOR CARE AND TREATMENT OF PATIENT: $ 2,200.00 Still Treating

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

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 damages are as follows:

NAME	ADDRESS
American Family Insurance	6000 American Parkway Madison WI 53783
Adj: Rob Land 608-722-2834	Claim # 01009388148
Rafi Law Group	2235 N 35th Ave #100 Phoenix AZ 85009
Atty: Gabriel Anderson	623-207-1555
Flor Arvizu	1817 S 16th Dr Phoenix AZ 85007

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 a 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 the 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.

Dennis L Cathcart D.C.

Claimant or Agent

By _____

OFFICIAL SEAL
DARLA F REED
NOTARY PUBLIC - ARIZONA
MARICOPA COUNTY
COMM# 623876
My Comm. Expires March 13, 2026

STATE OF ARIZONA)
) ss.
COUNTY OF Maricopa)

I, Dennis L. Cathcart, DC, being first duly sworn upon oath, depose and say: (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.

Claimant or Agent

On this _____ day of _____, 20 ____ , before me, the undersigned Notary Public, personally appeared, Dennis L. Cathcart, DC _____,

To me known to be the individual (s) described in and who executed the foregoing instrument and acknowledged that he (she) (they) executed the same for the purposes therein contained.

My Commission Expires _____

OFFICIAL SEAL
DARLA F REED
NOTARY PUBLIC - ARIZONA
MARICOPA COUNTY
COMM# 623876
My Comm. Expires March 13, 2026

Notary Public