* I was told by my guardin officer to be checked out, to take advantage of the free medica service now I am getting billed. I do not have a job or income to pay for this bill.

CITY OF RIALTO
LIABILITY CLAIM FOR DAMAGES TO PERSON OR PROPERTY

CITY CLERK'S DATE STAMP
CITY OF RIALTO
2026 JUL 23 PM 3:39
RECEIVED
CITY CLERK

1. Claims for death, injury to person, or to personal property must be filed not later than six (6) months after the occurrence (Gov. Code §911.2).
2. Claims for damages to real property must be filed not later than one (1) year after the occurrence (Gov. Code §911.2).
3. READ ENTIRE CLAIM FOR BEFORE FILING
4. ATTACH SEPARATE SHEETS, IF NECESSARY, TO GIVE FULL DETAILS

RETURN TO:
Rialto City Clerk's Office
Mail: 150 S. Palm Ave., Rialto, CA 92376
Address: 290 W. Rialto Ave., Rialto, CA 92376

CLAIMANT INFORMATION:

Yasmin Lopez Araujo (Higareda)
FULL NAME

DATE OF BIRTH

HOME ADDRESS INCLUDING CITY, STATE & ZIP

HOME TELEPHONE NO.

( ) N/A
BUSINESS TELEPHONE NO.

BUSINESS ADDRESS INCLUDING CITY, STATE & ZIP

N/A

ADDRESS AT WHICH CLAIMANT DESIRES TO RECEIVE NOTICES OR COMMUNICATIONS REGARDING THIS CLAIM (if different from home address provided above):

1. WHEN DID DAMAGE OR INJURY OCCUR? DATE: 07.01.2026 TIME: 12:20 ☒ AM ☐ PM

2. PLACE OF ACCIDENT (OCCURRENCE) BE SPECIFIC – *Describe fully and (if applicable) locate on diagram on reverse side of this sheet. Where appropriate, give street names and addresses, measurements and landmarks.*

Injuries occurred at my home.

3. HOW DID DAMAGE OR INJURY OCCUR?

I was assulted by my partner.

4. WERE POLICE AT THE SCENE? ☐ YES ☒ NO **WERE PARAMEDICS AT THE SCENE?** ☐ YES ☒ NO

5. WHAT PARTICULAR ACT OR OMISSION DO YOU CLAIM CAUSED THE INJURY OR DAMAGES? *Give the name of the city/town employee causing the injury or damage, if known.*

When I got taken into custody, the detention center sent me to the hospital. I declined medical assistences because I do not have medical insurance

6. GIVE TOTAL AMOUNT OF CLAIM *Include estimate of amount of any prospective injury or damage* $

HOW WAS THE ABOVE AMOUNT COMPUTED? *Be specific, list doctor bills, repair estimates, etc.* ***Please attach 2 estimates.***

DAMAGES INCURRED TO DATE:

Item/Date: 07.01.2026 Amount: $ 323.00

Item/Date: N/A Amount: $ N/A

TOTAL AMOUNT CLAIMED AS OF PRESENTATION OF THIS CLAIM: $ 323.

ESTIMATED PROSPECTIVE DAMAGES, AS FAR AS KNOWN:

Item/Date: 07.01.26 Amount: $ 323.00

Item/Date: 07.01.26 Amount: $ 323.00

TOTAL ESTIMATED AMOUNT PROSPECTIVE DAMAGES: $ 323.00

7. WITNESSES TO DAMAGE OR INJURY *List all persons known to have information (attach additional pages, if necessary)*

NAME: N/A
ADDRESS: N/A
N/A
TELEPHONE: ( ) N/A

NAME: N/A
ADDRESS: N/A
TELEPHONE: ( ) N/A

8. IF INJURED, PROVIDE NAME, CONTACT INFORMATION AND DATE/TIME DOCTOR(S) OR HOSPITAL(S) VISITED:

NAME: Arrowhead Radiology
ADDRESS: P.O Box 15888
TELEPHONE: (877) 247-2143
DATE: 07.01.26 TIME: 12:20 ☑ AM ☐ PM

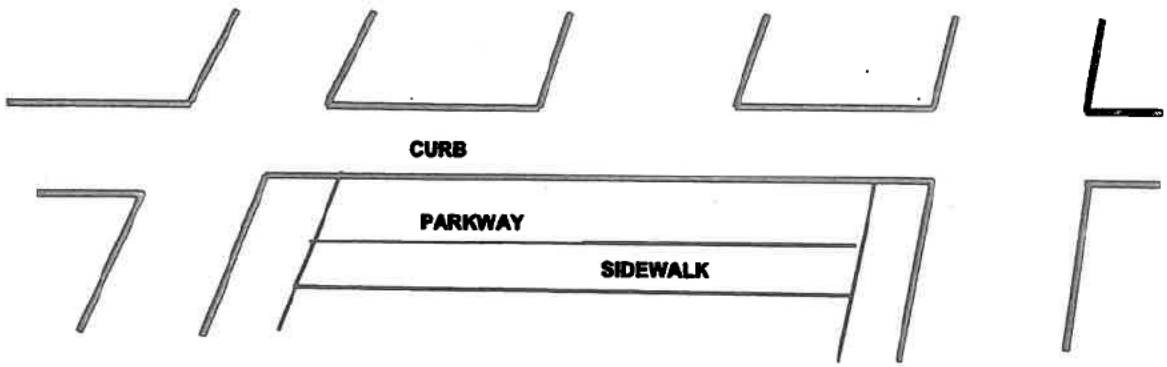
NAME: N/A
ADDRESS: N/A
N/A
TELEPHONE: ( ) N/A
DATE: N/A TIME: ☐ AM ☐ PM

9. PLEASE READ THE FOLLOWING CAREFULLY:

For all vehicle accident claims, place on the following diagram, the names of streets, including NORTH, EAST, SOUTH AND WEST directions. Indicate place of accident by "X" and by showing house numbers or distances to street corners.

If a city/town vehicle was involved, designate by letter "A" location of the City/Town vehicle when you first saw it, and by "B" location of yourself or your vehicle when you first saw City/Town vehicle; location of City/Town vehicle at time of accident by "A-1" and location of yourself or your vehicle at the time of the accident by "B-1" and the point of impact by "X".

⇨ ***NOTE: IF THE DIAGRAM BELOW DOES NOT FIT THE SITUATION, PLEASE ATTACH A PROPER DIAGRAM SIGNED BY THE CLAIMANT.***



I HAVE READ THE FOREGOING CLAIM AND KNOW THE CONTENTS THEREOF; AND CERTIFY THAT THE SAME IS TRUE OF MY OWN KNOWLEDGE EXCEPT AS TO THOSE MATTERS WHICH ARE HEREIN STATED UPON MY INFORMATION AND BELIEF; AND AS TO THOSE MATTERS I BELIEVE THEM TO BE TRUE.

I CERTIFY (OR DECLARE) UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT.

SIGNATURE OF CLAIMANT OR AGENT

Yasmin Lopez Arroyo
TYPE OR PRINT NAME

07.23.2026
DATE

Self
RELATIONSHIP TO CLAIMANT

NOTE: PRESENTATION OF A FALSE CLAIM IS A FELONY (CA PENAL CODE 72)
RETURN CLAIM TO: RIALTO CITY CLERK'S OFFICE – 150 S. PALM AVE., RIALTO, CA 92376

FACILITY : 34 **SAN BERNARDINO COUNTY SHERIFF'S DEPARTMENT**

WEST VALLEY D.C **RECEIPT FOR CLOTHING**

BOOKING NUMBER : INTAKE DATE : **07/02/2026** TIME : **0447**

NAME (LAST, FIRST, MID) : **LOPEZ HIGAREDA,YASMIN** ID : **OFA**

TUB NUMBER : **2229**

Article	Color	Description	Article	Color	Description
DRESS			TOP	RED	SHIRT
SKIRT			PANTS	BLUE	PANTS
COAT			SHOES	BLK	SHOES
UNDER W	MULTI	UNDERWEAR	PURSE		2229

COMMENTS :

INTAKE OFFICER : **A DEAN** BOOKING OFFICER : **A DEAN**

RECEIVING OFFICER : **A CUETO**

INVENTORY OF CLOTHING WAS WITNESSED AND VERIFIED BY ME.

ARRESTEE SIGNATURE (X) _____

CLOTHING RETURNED

RECEIVED BY (X) _____

RELEASED BY (X) _____ DATE : _____

I HEREBY AUTHORIZE THE RELEASE OF MY CLOTHING.

TO : _____ RELATIONSHIP : _____

INMATE SIGNATURE (X) _____ DATE : _____

RECEIVED BY (X) _____

RELEASED BY (X) _____ DATE : _____

ARROWHEAD RADIOLOGY MEDICAL

OPI-1000

□

Amount Due:
$323.00

Statement Summary

Account Name:	ARAUJO YASMIN LOPEZ
Account Number:	
Statement Date	07/15/2026
Due Date:	Upon Receipt
Total Charges:	$323.00
Total Insurance Payment:	$0.00
Total Insurance Adjustments:	$0.00
Total Patient Payments:	$0.00
Total Patient Adjustments:	$0.00
Amount Due:	**$323.00**

Visit Us Online

Visit us at: https://www.peryourhealth.com
To update your insurance, address,
view account, or message our billing office.
ID: 4455*7131539.1
Access Key: R5FP8U

NOTE: Please enter the website address exactly as displayed including https://

REQUEST FOR PAYMENT

Billing Questions?

Please Call:
(877) 331-3729
9:00AM-3:00PM PST MON-FRI

Para asistencia en Espanol
llame al numero arriba.

Payment Options

Pay Online
https://www.peryourhealth.com
ID: 4455*7131539.1
Access Key: R5FP8U

Pay By Phone
To make a payment over the phone,
please call us at: (877) 247-2143
Enter Account Number: 4455*7131539.1

Pay By Mail
Please detach and return the bottom portion of this statement with your payment.

MAIL PROCESSING CENTER
Dept OPI001
PO Box 600
Oaks, PA 19456-0600
Do Not Remit Payment to this Address

1 of 3

Return Service Requested

For help with billing questions,
please call: (877) 331-3729
Hours: 9:00AM-3:00PM PST MON-FRI

ADDRESSEE:

ARAUJO YASMIN LOPEZ

0002 000084

Account Number:

Due Date:	Upon Receipt
Amount Due:	$323.00
Amount Paid:	$_____

We accept credit card payments over the phone or online.

MAKE CHECKS PAYABLE AND REMIT TO:

ARROWHEAD RADIOLOGY MEDICAL
PO BOX 1888
GREENVILLE TX 75403

44559529484498000000007131539001000000323003

Date	Service Description (Qty)	Provider	Charges & Debits	Adjustments	Payments & Credits	Patient Balance
	Patient Name: ARAUJO YASMIN LOPEZ **Account Number:** Referring Physician: SCOTT A MEEKER MD Site of Service: ARROWHEAD REG MED CTR ER					
07/01/26	72100 LUMBOSACRAL SPINE LTD, 2 OR 3		$31.00			
07/01/26	72125 CT CERVICAL SPINE WITHOUT CON		$168.00			
07/01/26	70450 CT HEAD WITHOUT CONTRAST		$124.00			
	You Owe					$323.00

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

☐

Change of Address

Name (Last, First, Middle Initial)

Address

City State ZIP

Telephone

Note:

Please be aware that the above summary represents Radiology services from your medical provider. You will receive a separate statement for services provided by the hospital.

Primary Insurance Updates

Primary Insured Name

Primary Insurance Name Effective Date

Primary Insurance Street Address

City State ZIP Telephone

Employer Name Group Number

Subscriber ID # Policyholder's Date of Birth

Secondary Insurance Updates

Secondary Insured Name

Secondary Insurance Name Effective Date

Secondary Insurance Street Address

City State ZIP Telephone

Employer Name Group Number

Subscriber ID # Policyholder's Date of Birth