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SAINT MARGARET HOSPITAL
OF HAMMOND

SWORN STATEMENT AND NOTICE OF INTENTION TO HOLD HOSPITAL LIEN

DECEMBER 6 ,19 84.

TO: MR. STEVEN MATTES

ADDRESS: 1728 STANTON AVENUE

WHITING, IN , 46394

You are hereby notified that Saint Margaret Hospital (hereinafter called "CLAIMANT") whose address is 5412 Hohman Avenue, Hammond, Indiana, 46320, intends to hold a Hospital Lien for all reasonable and necessary charges for hospital care, treatment, or maintenance of the above-listed patient as follows:

1. The patient was admitted to the hospital on OCTOBER 02 , 19 84, and discharged from the hospital on OCTOBER 08 ,19 84 .
2. The amount due for hospital care during the above time period is FIVE THOUSAND THIRTY-FOUR and EIGHTY-FIVE CENTS Dollars ($ 5034.85).
3. To the best of Claimant's knowledge the following names and addresses are those claimed by the patient or his legal representative to be liable for damages arising from the illness or injury causing the hospital stay:

(a) ALLSTATE INSURANCE COMPANY - DISTRICT CLAIM OFFICE
9131 BROADWAY - P.O. BOX 10249 MERRILLVILLE, IN 46410

(b) ____________________

(c) ____________________

STATE OF INDIANA/S.S. NO.
LAKE COUNTY
FILED FOR RECORD
DEC 14 2 43 PM '84
WILLIAM [illegible] JR
RECORDER

This lien is being filed pursuant to the Hospital Lien Law, I.C. 32-8-26 in the Office of the Recorder of Lake County in which the Claimant is located, within ninety (90) days after the patient was discharged from the hospital. The undersigned Claimant intends to hold a Hospital Lien as described above and that the facts and matters set forth in the foregoing statement are true and correct.

Nancy M. Sprinkles
(Signature)

NANCY M. SPRINKLES, CREDIT REP.
(Printed)

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Before me, a Notary Public in and for said County and State, personally eppeared NANCY M. SPRINKLES , who acknowledged the execution of the foregoing Sworn Statement and Notice of Intention to Hold Hospital Lien, and who, having been duly sworn, under the penalties of perjury, stated that the facts and matters therein set forth are true and correct.

Witness my hand and Notarial Seal this 6th day of DECEMBER ,19 84 .

My Commission Expires

Signature Terry L. Johnson

Printed TERRY L. JOHNSON
Notary Public

~~Terry L. Johnson, Notary Public~~
Lake County, Indiana
Commission expiration date 4/14/87
Residing in Lake County, Indiana

SMH 1460
8/84

SAINT MARGARET HOSPITAL OF HAMMOND

PATIENT STATEMENT OF ACCOUNT

5412 HOHMAN AVENUE
HAMMOND, INDIANA 46320
PHONES (219) 933-2051 (312) 891-9305

PATIENT'S NAME	ACCOUNT NO.	ADMISSION DATE	DISCHARGE DATE	STATEMENT DATE
MATTES, STEVEN	00015591201-7	10/02/84	10/08/84	10/15/84

PLEASE REFER TO ACCOUNT NUMBER ON ALL REMITTANCES, CORRESPONDENCE AND INQUIRIES

L.B. JOHNSON PHONE 4229

BILL TO:

STEVEN MATTES
1726 STANTON
WHITING IN 46394

REMIT TO:

SAINT MARGARET HOSPITAL
ATTN. PATIENT ACCOUNTING
5412 HOHMAN AVENUE
HAMMOND, INDIANA 46320

MAKE CHECKS PAYABLE TO SAINT MARGARET HOSPITAL

KEY BENEFITS ADM. C01 C

IMPORTANT: PLEASE DETACH & RETURN THE TOP PORTION OF THIS STATEMENT WITH YOUR REMITTANCE TO ASSURE PROPER CREDIT

PATIENT'S NAME	ACCOUNT NO.	STATEMENT DATE	PAGE NO.
MATTES, STEVEN	00015591201-7	10/15/84	SM01

INSURANCE PORTION IS COMPUTED ACCORDING TO THE INFORMATION SUPPLIED BY YOUR INSURANCE CARRIER

SERVICE DATE	REF. NO.	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	AMOUNT DUE FROM GUARANTOR
		SUMMARY OF CHARGES			
		ROOM CHARGES			
	001	ICU			
		1 DAY AT 581.00	581.00	581.00	
	001	SEMI-PRIVATE			
		5 DAYS AT 213.00	1,065.00	1,065.00	
		ANCILLARY CHARGES			
	002	EMERGENCY ROOM	93.50	93.50	
	004	PHYSICIAN FEE/ER	445.00	445.00	
	005	RECOVERY ROOM	251.00	251.00	
	010	LABORATORY	101.45	101.45	
	020	RADIOLOGY	804.30	804.30	
	031	ANESTHESIA SUPPLIES	146.00	146.00	
	035	SPECIAL EQUIPMENT	52.00	52.00	
	040	DRUGS	236.40	236.40	
	042	DRUGS-SEDATIVE	42.75	42.75	
	050	OPERATING ROOM	842.00	842.00	
	063	IV SOLUTIONS	73.75	73.75	
	070	CENTRAL SUPPLY	124.70	124.70	
	073	SURGICAL SUPPLIES	163.30	163.30	
	092	CARDIOPULMONARY THERAPY	12.70	12.70	

THIS STATEMENT FOLLOWING DISCHARGE IS NOT ALWAYS COMPLETE. IF ADDITIONAL CHARGES ARE RECEIVED AFTER YOUR DISCHARGE, THEY WILL BE INCLUDED ON A SUPPLEMENTAL BILLING MAILED TO YOU.

X-RAY, LABORATORY AND ANESTHESIA CHARGES DO NOT INCLUDE THE PROFESSIONAL FEES OF THE RADIOLOGIST, PATHOLOGIST, OR ANESTHESIOLOGIST. YOU WILL RECEIVE A SEPARATE BILL FOR THESE SERVICES.

SAINT MARGARET HOSPITAL OF HAMMOND
5412 HOHMAN AVENUE
HAMMOND, INDIANA 46320
PHONES (219) 933-2051 (312) 891-9305

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MATTES, STEVEN	00015591201-7	10/15/84	SMC 2

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SERVICE DATE	REF. NO.	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	AMOUNT DUE FROM GUARANTOR
	092	TOTAL ANCILLARY	3,388.85	3,388.35	
		PATIENT PAYMENT	14.00-		14.00-
		TOTAL CHARGES & ESTIMATED INS.	5,020.85	5,034.85	
		BALANCE DUE FROM GUARANTOR			14.00-

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