TO:

LAKE COUNTY FILED FOR RECORD

2006 008941

2006 FEB -3 PM 1: 12

Acct 612167460

MICHAEL A. BROWN RECORDER

Return To:

Willie D. Boyd

Hodges & Davis, P.C.

 $870\bar{0}$ Broadway, Merrillville, IN 46410

SWORN STATEMENT & NOTICE OF INTENTION TO HOLD HOSPITAL LIEN

Patient: Willie D. Boyd	Attorney:
525 N Vanderburg St.	
Gary, IN 46403	
	- 11 D Lucate of Theymongo
Recorder of Lake County, Indiana	Indiana Department of Insurance
Lake County Government Center	311 W. Washington Street
2293 North Main Street	Suite 300
Crown Point, Indiana 46307	Indianapolis, Indiana 46204
	TOO TOO TOO TOO TOO Crant
You are hereby notified that	THE METHODIST HOSPITALS, INC., 600 Grant
Street, Gary, IN 46402, intends to hold a Hospital Lien for all reasonable and	
necessary charges for hospital care, treatment or maintenance of the above listed	
natient as follows:	
This Docume	nt is the property of
1. The patient was admitted to the hospital on December 24, 2005	
and was discharged from the hospital on December 29 , 2005 .	
2. The amount due for hospital care, treatment or maintenance during the above hospitalization is Twelve Thousand Eight Hundred Fifty Five and 50/10	
above hospitalization is Twelve Thous	sand Eight Hundred Filey Five and 30710
(\$ 12,855.50) Dollars.	's knowledge, the patient or the patient's
3. To the best of the Hospital	following named individuals and/or entities
legal representative claims that the	the patient's illness or injury causing the
	the pattern a fillness of injury same
hospital stay:	
	on the same of the
mbig lion is being filed pursuan	t to the Hospital Lien Law, I.C. Section 32-
This Lien is being filed pursuant to the Hospital Lien Law, I.C. Section 32-33-4 in the Office of the Recorder of the County in which the Hospital is	
located, within one hundred and eighty (180) days after the patient was	
discharged from the Hospital. The undersigned individual executing this	
instrument, having been duly sworn upon oath, under the penalties of perjury,	
hereby states that the Hospital intends to hold the Hospital Lien as described	
above and that the facts and matters set forth in the foregoing statement are	
true and correct.	
true and correct.	
	THE METHODIST HOSPITALS, INC.
	Λ
(1)	BY: Ungue Querch
STATE OF INDIANA)	Angle Djukich
) ss:	ů V
COUNTY OF LAKE)	
Angie Djukich, being	a Patient Representative for The Methodist
Hospitals, Inc., being duly sworn up	oon oath, says that the facts stated in the
foregoing are true and correct.	
	Charin Durbink
(2)	This Didish
and the second of the second o	ne a Notary Public, this day of
Subscribed and sworn to before m	ne, a Notary Public, this _/ day of
<u>January</u> , 2006	Luxa Stone
	Notary Public
My Commission Expires:	A Resident of Lake County
March 7/12011	
This Instrument Prepared By: Clyde D. Compton, Attorney at Law 8700 Broadway, Merrillville, IN 46410	
This Instrument Prepared By: Clyde D. Compton, Attorney at Law 8700 Broadway, Merrillville, IN 46410	
8700 Broadway, Merrill Ville, IN 46410	
	Official Seal
	LISA STONE
1117527	(≈(SEAL) Resident of Lake County, I My commission expires
142532	March 24, 2011

Prescribed by the State Board of Accounts (2005)

County form 170

Declaration

This form is to be signed by the preparer of a document and recorded with each document in accordance with IC 36-2-7.5-5(a).

I, the undersigned preparer of the attached document, in accordance with IC 36-2-7.5, do hereby affirm under the penalties of perjury:

- 1. I have reviewed the attached document for the purpose of identifying and, to the extent permitted by law, redacting all Social Security number(s) in attached document.

 This Document is the property of
- 2. I have redacted, to the extent permitted by law, each Social Security number in the attached document.

I, undersigned, affirm under the penalties of perjury, that the foregoing declarations are true.

Signature of Declarant

Angie Djukich
Printed Name of Declarant