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Return To:

Hodges & Davis, P.C. 8700 Broadway, Merrillville, IN 46410

Official Seal LISA M. STONE Resident of Lake County, IN My commission expires March 24, 2019

(SEAL)

SWORN STATEMENT & NOTICE OF INTENTION TO HOLD HOSPITAL LIEN

TO:	HAZEL HUGHES		
Patient:	HAZEL HUGHES	Attorney:	
	8981 NOBLE ST		
	MERRILLVILLE, IN	46410	
			
	Lake County, India	_	na Department of Insurance
	Government Center		. Washington Street
	Main Street	Suite	
Crown Point	, Indiana 46307	India	napolis, Indiana 46204
You a	are hereby notified	that THE METHODIST HOSE	PITALS, INC., 600 Grant Street, Gary,
IN 46402, :	intends to hold a B	Hospital Lien for all :	reasonable and necessary charges for
hospital ca	re, treatment or ma	intenance of the above	listed patient as follows:
1.	The patient was ad	mitted to the hospital	To ATHER 22
	charged from the ho	spital on July 7,	on June 23, 2011
2.	The amount due for	hospital care treatme	nt or maintenance during the
above hospi	talization is Two	Thousand One	The stance during the
(<u>\$ 2,00</u>	1.00) Dolla	he Lake County Rec	corder!
3.	To the best of the	Hospital's knowledge,	the patient or the patient's
legal repre	esentative claims t	that the following name	ed individuals and/or entities are
flable for	damages arising fr	com the patient's ill	ness or injury causing the hospital
stay:			
This	Lien is being filed	nursuant to the Hospit	al Lien Law, I.C. Section 32-33-4 in
rue orrree	or the Recorder of	the County in which	the Hospital is located within one
nundred and	r ergnty (180) days	larter the patient was	discharged from the Hognital who
undersigned	individual executi	ng this instrument, hav	ing been duly gworn upon oath under
the penalti	es or perjury, her	eby states that the Ho	spital intends to hold the Wornital
rien as de	scribed above and	that the facts and π	matters set forth in the foregoing
statement a	re true and correct	The service of the	
		THE METHODI:	ST HOSPITALS, INC.
		(1) BY:	1 Jal
STATE OF IN	DIANA)	DIAN	
) ss:	E SEAL PLANT	IABU
COUNTY OF L	AKE)	VOIANA TITLE	
		- Committee	
I_DIA		, being a	Patient Representative for The
Methodist H	ospitals, Inc., bei	ng duly sworn upon oath	n, says that the facts stated in the
roregoring a	re true and correct.		\mathcal{L}_{n}
		$(2) \qquad \qquad$	
Subsc:	ribed and sworn to h	DIAN F before me, a Notary Publ	
(Clean	/ , 2011.	•	
		Tuba	m. Stone
My Commissio	on Expires:		M. Stone Notary Public County
munch	24,2019	A Resident o	of Many County
I affirm. u	inder the nemalties	for porium that I had	
each social	security number in	this document, unless r	ave taken reasonable care to redact
		uniess i	equired by law.
This Instrum	ment Prepared By:		
		Earle F. Hites, Attorn	
		8700 Broadway, Merrill	ville, IN 46410
	. 1		

195306

AMOUNT \$_

OVERAGE. COPY_

NON-COM_

CLERK_

CASH___ CHECK #_ CHARGE 17496

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