

2013 052476

2013 JUL 17 PM 12:58

MICHAEL B. BROWN  
RECORDER

**SWORN STATEMENT & NOTICE OF INTENTION TO HOLD HOSPITAL LIEN**

TO: NOLAN PARR JR.

NOLAN PARR JR. PT.#1000388754

ATTORNEY:

5401 MARY ANN LN.

MERRILLVILLE, IN 46410

Recorder of Lake County, Indiana  
Lake County Government Center  
2293 North Main Street  
Crown Point, Indiana 46307

Indiana Department of Insurance  
311 West Washington Street  
Suite 300  
Indianapolis, IN 46204

You are hereby notified that The Community Healthcare Systems d/b/a St. Mary Medical Center whose address is 1500 S Lake Park Ave, Hobart, Indiana 46342, 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 06/12/2013 and discharged from the hospital on 06/12/2013
2. The amount due for hospital care during the above time period \$11,680.58  
ELEVEN THOUSAND SIX HUNDRED EIGHTY AND 58/100 DOLLARS
3. To the best of the Hospital's knowledge, the patient or the patient's legal representative claims that the following named individuals and/or entities are liable for damages arising from the patient's illness or injury causing the hospital stay:

**HARTFORD INSURANCE**  
PO BOX 13264  
LEXINGTON, KY 40512  
CL#YOOAL89070

This lien is being filed pursuant to the Hospital Lien Law, I.C. 32-33-4 in the Office of the Recorder of the County in which the hospital is located, within one hundred eighty (180) days after the patient was discharged from the hospital. The undersigned individual executing this instrument, having been duly sworn upon his/her oath, under the penalties of perjury hereby states that 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.

STATE OF INDIANA)  
COUNTY OF LAKE ) SS:

ALISON ADAMS, being the collection clerk for the above named, St Mary Medical Center, being duly sworn upon his/her oath, says that the facts stated in the foregoing are true and correct. I affirm under the penalties of perjury, that I have taken Reasonable care to redact each Social Security number in this document, unless requested by law.

Alison Adams  
ALISON ADAMS, PFS Support

Subscribed and sworn to before me a Notary Public this

10<sup>TH</sup> Day of JULY 20 13

My Commission Expires: 02/14/17  
Residing in Lake County, Indiana

Lisa E. Ward  
LISA E. WARD, Notary Public

This instrument was prepared by ALISON ADAMS

AMOUNT \$ 11  
CASH \_\_\_\_\_ CHARGE \_\_\_\_\_  
CHECK# 0531040  
OVERAGE \_\_\_\_\_  
COPY \_\_\_\_\_  
NON-CONF \_\_\_\_\_  
DEPUTY 8