

2013 089129

2013 DEC -4 AM 9:45

MICHAEL B. BROWN  
RECORDER

**SWORN STATEMENT & NOTICE OF INTENTION TO HOLD HOSPITAL LIEN**  
**AMENDED 2013 031175**

TO: TIMOTHY D. CLELAND

TIMOTHY D. CLELAND PT.#3000434538

ATTORNEY:

68 SHORE DRIVE

PORTAGE, IN 46368

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 Munster Medical Document Foundation d/b/a The Community Hospital whose address is 901 MacArthur Blvd., Munster, Indiana 46321, 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 04/08/2013 and discharged from the hospital on 04/09/2013
2. The amount due for hospital care during the above time period \$2,259.99  
TWO THOUSAND TWO HUNDRED FIFTY NINE AND 99/100 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:

STATE FARM INSURANCE  
PO BOX 661011  
DALLAS, TX 75266  
CL#14-206Q033

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, The Community Hospital, being duly sworn upon his/her oath, says that the facts stated in the foregoing are true and correct. I affirm under the penalties for 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 5<sup>TH</sup> Day of NOVEMBER 20 13

My Commission Expires: 08/15/14  
Residing in Lake County, Indiana

Gayle Brumley  
GAYLE BRUMLEY, Notary Public

This instrument was prepared by ALISON ADAMS

AMOUNT \$ 11  
CASH \_\_\_\_\_ CHARGE \_\_\_\_\_  
CHECK # 055383  
OVERAGE \_\_\_\_\_  
COPY \_\_\_\_\_  
NON-COM \_\_\_\_\_  
CLERK \_\_\_\_\_