STATE OF INDIA....LAKE COUNTY FILED FOR RECORD

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MICHAEL B. BROWN RECORDER

Acct#201134603

Return To:

Hodges & Davis, P.C.

8700 Broadway, Merrillville, IN 46410

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

TO:

Morgan M Gil: William Brosch

Patient:

6725 Madison Street IN 46410 Merrillville,

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

Attorney: Marshall P Whalley 8915 Broadway

Merrillville, IN 46410

Indiana Department of Insurance 311 W. Washington Street Suite 300 Indianapolis, Indiana 46204

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 patient as follows:

1. The patient was admitted to the hospital on November 07 and was discharged from the hospital on November 07 . 2013 .

2. The amount due for hospital care, treatment or maintenance during the above hospitalization is Five hundred ninety three & 00/100 (\$ 593.00 ) Dollars. This amount is subject to reduction for any benefits to which the patient is entitled under the terms of any contract, health plan, or medical and credits for all payments, contractual adjustments, write-offs, and any insurance, other benefit.

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 patient's illness or injury causing the hospital liable for damages arising from the stay:

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 ninety (90)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.

> THE METHODIST HOSPITALS, INC. NANCY FARRIES

STATE OF INDIANA

ss:

)

COUNTY OF LAKE

NANCY FARRIES being a Patient Representative for The Methodist Hospitals, Inc., being duly sworn upon oath, says that the facts stated in the foregoing are true and correct. (2)

NANCY

Subscribed and sworn to before me, a Notary Public, this  ${\mathcal{A}}{\mathcal{I}}$ outmber, 2013.

My Commission Expires:

Notary\_Public

A Resident of

1anch 24,2019

I affirm, under the penalties for perjury, that I have taken reasonable care to redact each social security number in this occument, unless required by law.

This Instrument Prepared By:

Earle F. Hites, Attorney at Law 8700 Broadway, Merrillville, IN 46410

CASH. CHECK #. **OVERAGE** 

COPY\_

NON-COM\_

AMOUNT \$.

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

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