STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2014 008348

2014 FEB 12 PM 1:30

MICHAEL B. BROWN
RECORDER

100676051

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

SWORN STATEMENT & NOTICE OF INTENTION TO HOLD HOSPITAL LIEN

TO: DORIAN JONES
Patient: DORIAN JONES
730 HANLEY ST
GARY, IN. 46406

Attorney: _____

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

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 December 5 2013 and was discharged from the hospital on December 31 2013

2. The amount due for hospital care, treatment or maintenance during the above hospitalization is One thousand three hundred forty three and 00/100 ($ 1343.00). 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 insurance, and credits for all payments, contractual adjustments, write-offs, and any other benefit.

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:

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.

(1) BY: _____
DIAN HALL

STATE OF INDIANA)
) ss:
COUNTY OF LAKE)

I DIAN HALL , 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) _____
DIAN HALL

Subscribed and sworn to before me, a Notary Public, this 27TH day of January, 2014.

My Commission Expires:
March 24, 2019

_____ Notary Public
A Resident of Lake County

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

This Instrument Prepared By:

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

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

AMOUNT $ 11-
CASH CHARGE
CHECK # 19436
OVERAGE
COPY
NON-COM
CLERK LN

224524

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