STATE OF INDIA:

LAKE COUNTY
FILED FOR RECORD

2014 009255

2014 FEB 18 PM 1: 17

MICHAEL B. BROWN RECORDER

201242238

Ashley Taylor

NON-COM_

TO:

Return To: Hodges & Davis, P.C. 8700 Broadway, Merrillville, IN 46410 SWORN STATEMENT & NOTICE OF INTENTION TO HOLD HOSPITAL LIEN

Patient:	Ashley Taylor	Attorney:	
	67 N Wisconsin		
	Hobart, IN 46342	 -	
Recorder of	f Lake County, Indiana	Indian	a Department of Insurance
	Government Center		Washington Street
	Main Street	Suite	
Crown Point	, Indiana 46307	Indian	apolis, Indiana 46204
You a	are hereby notified th	nat THE METHODIST HOSP	ITALS, INC., 600 Grant Street, Gary,
IN 46402,	intends to hold a Ho	spital Lien for all r	easonable and necessary charges for
		Document 1	isted patient as follows:
1. and was dis	The patient was admi scharged from the hosp	tted to the hospital cital on <u>February 03</u>	n February 03 , 2014
2.	The amount due for h	ospital care, treatmen	t or maintenance during the
above hospi	talization is One Th	ousand Seven Hundred T	hirty-Three and 25/100
(\$ 1,	,733.25) Doll:	ars. This amount is s	ubject to reduction for any benefits
to which th	ne patient <mark>is entitle</mark> c	d under the terms of a	ny contract, health plan, or medical
insurance,	and credits for all	payments, contractua	l adjustments, write-offs, and any
other benef 3.		osnital/s knowledge t	he patient or the patient's
	esentative claims that	at the following name	d individuals and/or entities are
liable for	damages arising from	n the patient's illn	ess or injury causing the hospital
stay:	J I		out and any outstand the mospitul
This	Lien is heing filed r	virgiant to the Wornit	al Lien Law, I.C. Section 32-33-4 in
the Office	of the Recorder of the	he County in which the	e Hospital is located, within ninety
(90) days af	ter the patient was	discharged from the Ho	spital. The undersigned individual
executing t	this instrument, have	ing been duly sworn	upon oath, under the penalties of
perjury, he	ereby states that the	Hospital intends to	hold the Hospital Lien as described
	that the facts and ma	atters set forth in th	ne foregoing statement are true and
correct.			
		THE METHODIS	HOSPITALS, INC.
		(1) BY:	ingle Gul wh
STATE OF IN			Andie Djuklch
COUNTY OF L) ss: AKE)		_ 0
	·		
	ngie Djukich	, 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.			
zorogozny a	re true and correct.	$(2) \qquad \qquad C$	(maio Mila (M)
			Angie Divkich ic, this /// day of
		fore me, a Notary Publ	ic, this day of
Per Muay			. 1
V My Commissi	on Expires:	-W19 1	Notary Public
_	_	A Resident o	<u>-</u>
Manch o	04,2019		
I affirm, u	under the penalties f	or perjury, that I ha	ve taken reasonable care to redact
each social	security number in the	nis document, unless re	equired by law.
This Instru	ment Prepared By:	2	
		Earle F. Hites, Attorne	
***	OUNT 0 - //-	3700 Broadway, Merrilly	ville, IN 46410
	OUNT \$		
	6H0HANGE ECK #		
	FRAGE		Official Seal LISA M. STONE
)PY		((SEAL)) Resident of take County In (
	ON-COM		My commission expires March 24, 2019