

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

2014 016123

2014 MAR 19 PM 12:39

MICHAEL B. BROWN  
RECORDER

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

#100719218

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

TO: MARINO, LISA  
Patient: MARINO, LISA  
2036 W RIDGE RD  
GARY, IN 46408

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:

- The patient was admitted to the hospital on February 16, 2014 and was discharged from the hospital on February 16, 2014.
- The amount due for hospital care, treatment or maintenance during the above hospitalization is Two thousand three hundred fifty three and 25/100 (\$ 2,353.25 ) 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 insurance, and credits for all payments, contractual adjustments, write-offs, and any 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 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: Yolanda R Simpson  
Yolanda R Simpson

STATE OF INDIANA )  
) ss:  
COUNTY OF LAKE )

I Yolanda R Simpson, 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) Yolanda R Simpson  
Yolanda R Simpson

Subscribed and sworn to before me, a Notary Public, this 20<sup>th</sup> day of February, 2014.

My Commission Expires:  
March 24, 2019

Lisa M. Stone  
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: [Signature]  
Earle F. Hites, Attorney at Law  
8700 Broadway, Merrillville, IN 46410

AMOUNT \$ 11-  
CASH \_\_\_\_\_ CHARGE \_\_\_\_\_  
CHECK # 19516  
OVERAGE \_\_\_\_\_  
COPY \_\_\_\_\_  
NON-COM \_\_\_\_\_  
CLERK [Signature]



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