

2014 017468

2014 MAR 26 AM 11:22

MICHAEL B. BROWN

SWORN STATEMENT & NOTICE OF INTENTION TO HOLD HOSPITAL LIEN

TO: **DAVID MARSHALL**

DAVID MARSHALL PT.#100049973
1000509267
6938 SCHNEIDER AVE
HAMMOND, IN 46323

ATTORNEY:

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 Community Healthcare Systems d/b/a St. Mary Medical Center whose address is 1500 S Lake Park Ave, Hobart, Indiana 46342, 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 01/04/2014, 01/24/2014 and discharged from the hospital on 01/04/2014, 01/24/2014
- The amount due for hospital care during the above time period \$14,981.47
FOURTEEN THOUSAND NINE HUNDRED EIGHT ONE AND 47/100 DOLLARS
- 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:

ALLSTATE INSURANCE COMPANY
PO BOX 2874
CLINTON, IA 52733
CL#912280693

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, St Mary Medical Center, 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 18TH Day of MARCH 20 14

My Commission Expires: 02/14/17
Residing in Lake County, Indiana

Lisa E. Ward
LISA E. WARD, Notary Public

This instrument was prepared by ALISON ADAMS

AMOUNT \$ 11-
CASH _____ CHARGE _____
CHECK# 057181
OVERAGE _____
COPY _____
NON-CONF _____
DEPUTY SS