STATE OF INDIAR LAKE COUNTY FILED FOR RECORD

2014 MAY -5 PM 1: 15

MICHAEL B. BROWN RECORDER

201255154

Return To:

Hodges & Davis, P.C.

8700 Broadway, Merrillville, IN 46410

SWORN STATEMENT & NOTICE OF INTENTION TO HOLD HOSPITAL LIEN

TO: David Venema David Venema Patient: Attorney: Polansky Cichon 8206 Meadow Ln 180 N Stetson Ave #5250 Munster, IN 46321 IL 60601 Chicago, Recorder of Lake County, Indiana Indiana Department of Insurance Lake County Government Center 311 W. Washington Street 2293 North Main Street Suite 300 Crown Point, Indiana 46307 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 Februar and was discharged from the hospital on February 15 , 2014on February 15 , 2014 The amount due for hospital care, treatment or maintenance during the 2. above hospitalization is One Thousand Three Hundred Fifty-Nine and 25/100 (\$ 1,359.25) 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. ngle Bulkh Applie Djuklich STATE OF INDIANA ss: COUNTY OF LAKE Djukich being a <u>Patient Representative</u> for The Angie Methodist Hospitals, Inc., being duly sworn upon oath, says that the facts stated in the foregoing are true and correct. (2)Mall A Subscribed and sworn to before me, a Notary Public ___, 2014. USO MISTONE. My Commission Expires: Notary Public A Resident of _ Jach 24, 2019

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

AMOUNT \$______CHARGE____CHECK #_______CHECK #______COPY______NON-COM_____CLERK________



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