STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

2014 067131

2014 OCT 22 PM 2: 21

201527994

TO:

138372

MICHAEL B. BROWN RECORDER

Return To:

David Altomere

Hodges & Davis, P.C.

8700 Broadway, Merrillville, IN 46410

SWORN STATEMENT & NOTICE OF INTENTION TO HOLD HOSPITAL LIEN

Patient: David Altomere	Attorney:
7118 Broadway Suite 2C	
Merrillville, IN 46410	
Recorder of Lake County, Indiana	Indiana Department of Insurance
Lake County Government Center 2293 North Main Street	311 W. Washington Street
Crown Point, Indiana 46307	Suite 300
	Indianapolis, Indiana 46204
IN 40402, Intends to hold a Hospital Lie	ETHODIST HOSPITALS, INC., 600 Grant Street, Gary, en for all reasonable and necessary charges for
hospital care, treatment or maintenance	The cove listed patient as follows:
1. The patient was admitted to and was discharged from the hospital on	ne hospital on September 18, 2014
2. The amount due for hospital cabove hospitalization is Three Thousand	res theatment error in fenance during the
$(\frac{1}{2} - \frac{3}{2} \frac{10.25}{0.25})$ Dollars Kings	amount is subject to reduction for any honofite
to which the patient is entitled under th	e terms of any contract health plan or modical
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
liable for damages arising from the	llowing named individuals and/or entities are
stay:	tient's illness or injury causing the hospital
This Lien is being filed pursuant to	o the Hospital Lien Law, I.C. Section 32-33-4 in
the Office of the Regorder of the County	in which the Hospital is located, within pinety
executing this instrument having he	from the Hospital. The undersigned individual
perjury, hereby states that the Wornital	duly sworn upon oath, under the penalties of
above and that the facts and matters got	intends to hold the Hospital Lien as described forth in the foregoing statement are true and
correct.	first the loregoing statement are true and
	THE METHODIST HOSPITALS, INC.
(1)	WOIAN A STATE OF THE STATE OF T
STATE OF INDIANA	Angie Djukich
) ss:	
COUNTY OF LAKE)	
IAngie_Djukich	hoing a Datitut D
Methodist Hospitals, Inc., being duly swo	, being a <u>Patient Representative</u> for The rn upon oath, says that the facts stated in the
foregoing are true and correct.	that the facts stated in the
(2)	Unque Stusich
Subscribed and grown to before	Angze Djukach
Subscribed and sworn to before me, a cfober, 2014.	Notary Public, this day of
	_ Sing M. Stone
My Commission Expires:	Notary Public
March 24, 2019	A Resident of <u>Lake</u> County
I affirm, under the penalties for perjury each social security number in this decumen	y, that I have taken reasonable care to redact nt, unless required by law.
This Instrument Prepared By:	5
11 .<	ites, Attorney at Law
	way, Merrillville, IN 46410
CASHCHARGE	
CHECK #	Official Seal
COPYE	LISA M. STONE (SEAL) Resident of Lake County, IN
NON-COM.	My commission expires March 24, 2019
CLERK CLERK	