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MICHAEL B. BROWN RECORDER

Return To: Hodges & Davis, P.C.

8700 Broadway, Merrillville, IN 46410

SWORN STATEMENT & NOTICE OF INTENTION TO HOLD HOSPITAL LIEN

TO:

Henry L Harris

Patient:

Henry L Harris

2249 Waite St Gary, IN 46404

Recorder of Lake County, Indiana Lake County Government Center 2293 North Main Street Crown Point, Indiana 46307

Attorney: Ken Nunn

104 S. Franklin Rd. Bloomington, IN 47404

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:

1. The patient was admitted to the hospital on October 07, 2014
and was discharged from the hospital on October 07, 2014

2. The amount due for hospital care, treatment or maintenance during the above hospitalization is __Two Thousand One Hundred Eighty-Nine and 25/100

(\$\frac{2,189.25}{}\$

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 insurance, and credits for all payments, contractual adjustments, write-offs, and any

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

THE METHODIST HOSPITALS, INC.

Angle Djukich

County

STATE OF INDIANA

COUNTY OF LAKE

Angie 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.

ibed and sworn to before me, a Notary Public

(2)

Z, 2014.

My Commission Expires:

Notary Public A Resident of __ Lake

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:

DEBRA A ROSE Notary Public - Seal State of Indiana Lake County My Commission Expires Apr 23, 2022 Earle F. Hites, Attorney at Law 8700 Broadway, Merrillville, IN 46410

AMOUNT S. CASH_ _CHARGE CHECK#

OVERAGE COPY_

NON-COM CLERK

233815