STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

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MICHAEL S. BROWN RECORDER

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Hodges & Davis, P.C.

8700 Broadway, Merrillville, IN 46410

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

TO: Samuel A Moore Samuel A Moore Attorney: Corti Aleksy Castaneda Patient: 759 Kentucky St 180 N LaSalle St. #2910 Gary, IN 46402 Chicago, IL 60601 Indiana Department of Insurance Recorder of Lake County, Indiana Lake County Government Center 311 W. Washington Street 2293 North Main Street Suite 300 Indianapolis, Indiana 46204 Crown Point, Indiana 46307 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 and was discharged from the hospital on October 22 , 2014 October 22 , 2. The amount due for hospital care, treatment or maintenance during the above hospitalization is <a href="Twelve Thousand Five Hundred Forty-One">Twelve Thousand Five Hundred Forty-One</a>
(\$ 12,541.00

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. 3. 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 stav: 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. ngu Hudich Angie Dyukich STATE OF INDIANA SS: COUNTY OF LAKE , being a <u>Patient Representative</u> for The Angie Djukich Methodist Hospitals, Inc., being duly sworn upon oath says that the facts stated in the foregoing are true and correct. (2) Argie Subscribed and sworn to before me, a Notary Public, thi UNDET . 2014 10 Wem Det, 2014. W Notary Public My Commission Expires: Lake A Resident of anch 20,2019

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:

AMOUNT \$

CHECK#

Earle F. Hites, Attorney at Law 8700 Broadway, Merrillville, IN 46410

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Official Seal
LISA M. STONE
Resident of Lake County, IN
My commission expires
March 24, 2019

OVERAGE
COPY
NON-COM
CLERK

234201