STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2015 023301

2015 APR 17 PM 1: 11

100967397

238657

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:  | Janice Morris                             |   |  |                   |
|--|---|---|--|-------------------|
| Patient:   | Janice Morris                             | Attorney:                                     |  |                   |
|  | 4910 Oak Ave                              | <del></del>                                   |  | <del></del>       |
|  | Hammond, IN 46327                         | _   |  |                   |
| D  | Tale Country Talian                       | Tadia   | na Danautmant of Tra                           |                   |
|  | Lake County, Indiana<br>Government Center |   | ana Department of Insu<br>V. Washington Street | irance            |
| 2293 North   |   |   | e 300  |                   |
|  | , Indiana 46307                           |   | anapolis, Indiana 4620                         | 04                |
|  |   |   |  |                   |
|  |   | hat THE METHODIST HOS                         |  |                   |
| 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: |   |   |  |                   |
| nospicai ca.   |   | Document                                      | 10   |                   |
| 1.   |   | itted to the hospital                         |  | 2015              |
|  | charged from the hos                      | oital on March 25                             | 2015   | -d                |
| 2. The amount due for hospital care, treatment or maintenance during the above hospitalization is Seventeen Thousand Two Hundred Ninety-Four and 50/100                |   |   |  |                   |
|  | 17,294.50                                 | ) Dollars. This amo                           | ount is subject to r                           | eduction for any  |
| benefits to  | which the patient                         | is entitled under the                         | Cterms of any contra                           | ct, health plan,  |
|  |   | its for all payments,                         | contractual adjustme                           | ents, write-offs, |
| and any oth  |   |   |  | + 1 + 1 -         |
| 3.   |   | Hospital's knowledge,<br>at the following nam |  |                   |
| liable for   | damages arising fro                       | om the patient's ill                          | lness or injury caus                           | ing the hospital  |
| stay:  | damages arriving rise                     | The critical States                           |  |                   |
| -  |   |   |  |                   |
|  |   | pursuant to the Hospi                         |  |                   |
|  |   | the County in which t<br>discharged from the  |  |                   |
| executing t  | this instrument, har                      | ring been duly sworn                          | upon oath, under t                             | the penalties of  |
| perjury, he  | reby states that the                      | e Hospital intends to                         | hold the Hospital I                            | ien as described  |
| above and t  | hat the facts and m                       | natters set forth in                          | the foregoing statem                           | ent are true and  |
| correct.   |   |   |  |                   |
|  |   | THE METHOD.                                   | IST HOSPITALS, INC.                            |                   |
|  |   | (1) BY:ANA.                                   | (mare Sprice U                                 | ch_               |
| STATE OF IN  | DIANA )                                   |   | Angle Djukich                                  |                   |
| COUNTRY OF T   | ) ss:                                     |   |  | •                 |
| COUNTY OF L  | AKE )                                     |   |  |                   |
| I A  | ngie Djukich                              |   | g a Patient Represe                            |                   |
| Methodist Hospitals, Inc., being duly sworn upon oath, says that the facts stated in the   |   |   |  |                   |
| foregoing a  | re true and correct.                      | (0)   | Charin Nuch                                    | (Ab)              |
|  |   | (2)   | Angle Dinkiles                                 |                   |
| 1 Subsc  | ribed and sworn to b                      | efore me, a Notary Pul                        | olic, this day                                 | y of              |
| MD//   | , 2015.                                   | Do le   | 200 01/1/21                                    | _                 |
|  |   | _ lllll                                       | ROY RY   |                   |
| My Commissi  | on Expires:                               | A Resident                                    | _  | Public County     |
| Hovil  | 23 2022                                   | A Resident                                    | OI Dake  | country           |
| 1/01//-  | 9/10                                      |   |  |                   |
| I affirm,  | under the penalties                       | for perjury, that I                           | have taken reasonabl                           | e care to redact  |
| each social  | security number in                        | this document, unless                         | required by law.                               |                   |
| This Instru  | ment Prepared By:                         |   |  |                   |
|  |   | Earle F. Hites, Atto                          |  |                   |
|  | A ROSE                                    | 8700 Broadway, Merri                          | llville, IN 46410                              |                   |
| •  | ublic - Seal<br>f Indiana                 | 11 - 11-                                      |  |                   |
| Lake (   | County                                    | AMOUNT \$                                     |  |                   |
| My Commission Expires Apr 23, 2022  CASH CHARGE  CHECK # 202444  |   |   |  |                   |
| OVERAGE  |   |   |  |                   |
|  |   | COPY  |  |                   |

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