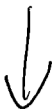


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MICHAEL B. BROWN  
RECORDER

101041989



Return To: Hodges & Davis, P.C.  
8700 Broadway, Merrillville, IN 46410

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

TO: Monique Muhammad  
Patient: Monique Muhammad  
1216 W 112th Pl  
Chicago, IL 60643

Attorney: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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 August 12, 2015 and was discharged from the hospital on August 12, 2015.

2. The amount due for hospital care, treatment or maintenance during the above hospitalization is One Thousand Forty Three and 50/100 (\$ 1,043.50) 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 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.



(1) \_\_\_\_\_  
Angie Djukich  
Angie Djukich

STATE OF INDIANA )  
                                  ) ss:  
COUNTY OF LAKE )

I, 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.

(2) \_\_\_\_\_  
Angie Djukich

August Subscribed and sworn to before me, a Notary Public, this 25<sup>th</sup> day of \_\_\_\_\_, 2015.

My Commission Expires: April 23, 2022

\_\_\_\_\_  
Notary Public  
A Resident of Lake County

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 \$ 11-  
CASH \_\_\_\_\_ CHARGE \_\_\_\_\_  
CHECK # 20489  
OVERAGE \_\_\_\_\_  
COPY \_\_\_\_\_  
NON-COM \_\_\_\_\_  
CLERK CV

242821