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MICHAEL B. BROWN RECORDER

201900162

TO:

Return To:

Ashley Liebig

Patient: Ashley Liebig

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

SWORN STATEMENT & NOTICE OF INTENTION TO HOLD HOSPITAL LIEN

Attorney:

| 334 S Boo Rd #202 | |
|--|--|
| Chesteron, IN 46304 | |
| 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 METI IN 46402, intends to hold a Hospital Lien hospital care, treatment or maintenance of | HODIST HOSPITALS, INC., 600 Grant Street, Gary, for all reasonable and necessary charges for the above listed patient as follows: |
| 1. The patient was admitted to the and was discharged from the hospital on A | trospital on August 25 , 2015 |
| 2. The amount due for hospital car above hospitalization is Two Thousand Six | er treatment or maintenance during the Hundred Winety-Nine |
| (\$ 2,699.00 This to which the patient is entitled under the insurance, and credits for allegaments other benefit. 3. To the best of the Hospital's k | mount is subject to reduction for any benefits terms of any contract, health plan, or medical write-offs, and any nowledge, the patient or the patient's owing named individuals and/or entities are |
| liable for damages arising from the pat stay: | ient's illness or injury causing the hospital |
| the Office of the Recorder of the County i (90) days after the patient was discharged executing this instrument, having been d perjury, hereby states that the Hospital above and that the facts and matters second correct. | the Hospital Lien Law, I.C. Section 32-33-4 in n which the Hospital is located, within ninety from the Hospital. The undersigned individual uly sworn upon oath, under the penalties of items to hold the Hospital Lien as described forth in the foregoing statement are true and HE METHODIST HOSPITALS INC. |
| STATE OF INDIANA) | WEAL MAN Apple Djukich Apple Djukich |
| COUNTY OF LAKE) ss: | |
| I Angie Djukich | , being a Patient Representative for The |
| Methodist Hospitals, Inc., being duly sworn foregoing are true and correct. (2) | upon oath, says that the facts stated in the |
| Subscribed and sworn to before me, a september, 2015. | Notary Public, this day of |
| My Commission Expires: | Notary Public |
| March 24,2019 | Resident of Lake County |
| , | , that I have taken reasonable care to redact t, unless required by law. |
| This Instrument Prepared By: Earle F. Hi | tes, Attorney at Law |
| | ay, Merrillville, IN 46410 |
| CASHCHARGE_CHECK#20527_E OVERAGE_COPY_NON-COMA | Official Seal LISA M. STONE Resident of Lake County, IN My commission expires March 24, 2019 |
| Contraction of the Contraction o | |