2015 072862

2015 OCT 28 PM 1:01

MICHAEL B. BROWN RECORDER

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TO:

614520



Return To:

Michael Fry

Hodges & Davis, P.C.

8700 Broadway, Merrillville, IN 46410

SWORN STATEMENT & NOTICE OF INTENTION TO HOLD HOSPITAL LIEN

Patient: Michael 1	Fry	Attorney:		
1033 Bent	ton			
Gary, IN	46403		***************************************	
Recorder of Lake Coun-	tv, Indiana	Indiana Departme	nt of Insurance	
Lake County Governmen		311 W. Washington Street		
2293 North Main Street		Suite 300		
Crown Point, Indiana 46307		Indianapolis, In	diana 46204	
Crown Forne, indiana	10307	indianapoiis, in	.ulana 40204	
IN 46402, intends to hospital care, treatme	hold a Hospital Lie ent or maintenance of	en for all reasonable irme epye le sted pati		
1. The patier and was discharged from	nt was admitted to thom the hospital on	october 06 A 2015	06 , 2015	
2. The amount above hospitalization	is Fourteen thousand	treatment or mains to be the property of	enance during the	
(\$ 14,460.58	the Ipakie S	outfinis Ramount des sub-	ject to reduction for any	
			any contract, health plan,	
			l adjustments, write-offs,	
and any other benefit		paymends, constacta	adjustments, write orrs,	
		knowledge, the patient	or the patient(e	
legal representative	claims that the fo	llowing named individ	duals and/or entities are	
			jury causing the hospital	
	rising from the pa	ctent's itimess or in	jury dausing the hospital	
stay:				
This Lien is he	ing filed ourguent t	o the Hognital Lien La	w, I.C. Section 32-33-4 in	
the Office of the Boa	order of the County	in which the Marrital	is located, within ninety	
(00) days after the	tions will discharge	IN WHICH the Hospital	The undersigned individual	
(90)days after the pa	clent was discharged	rpom the Hospital.	rne undersigned individual	
executing this instru	iment, naving been	duly sworn upon oath,	, under the penalties of	
perjury, nereby state	s that the Hospital	intends to hold the H	Mospital Lien as described	
above and that the fa	acts and matters set	forth in the foregoing	ng statement are true and	
correct.				
	E	THE METHODIST HOSPITAL	S, INC.	
	100	WOIANALLINE	S. Alinataka	
	(1)	WOLAND WOLLD WOLLD	Hut lch	
STATE OF INDIANA		Angie ¶ju	kich	
COLINERY OF TAXES) ss:			
COUNTY OF LAKE)			
T Benedia Distrib	-1-			
I Angie Djuki	.cn	, being a Patient	Representative for The	
Methodist Hospitals,	inc., being duly swo	rn upon oath,/says tha	t the facts stated in the	
foregoing are true and		II	N/ 0/41	
	(2)	Ungul_	HUX Ch	
		Ang aj e Djul	kich	
Ac/ Subscribed and s	sworn to before me, a	Notary Public, this _	13 May of	
<u>UCteber</u> , 2015.		\mathcal{A}		
		Dugg Misto.	NC	
My Commission Expires:			Notary Public	
Maria 24 24	10.	A Resident of Lake	County	
March DV 20	<u> </u>			
I affirm, under the peach social security n	penalties for perjur number in this docume	, y, that I have taken nt, unless required by	reasonable care to redact law.	
Mhia Instanta	3			
This Instrument Prepar				
,		ites, Attorney at Law		
1 100	/- 8700 Broad	way, Merrillville, IN	46410	
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CASHCHAR CHECK# 26	137T		Official Seal	
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