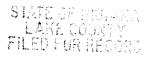
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MICHAEL B. BROWN RECORDER

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Return To:

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

SWORN STATEMENT & NOTICE OF INTENTION TO HOLD HOSPITAL LIEN

Attorney:

TO: Josephine Baker Patient: Josephine Baker 211 Westwind DR #E Michigan City, IN 46360

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 maintepance of the above listed patient as follows:

1. The patient was admitted to the hospital on November 21 , 2015 and was discharged from the hospital on <u>November 21</u> , 2015 2. The amount due for hospital care, treatment or maintenance during the above hospitalization is <u>one Thousand Eighty Four</u> (\$ 1,084.00 to which the patient is entitled under the terms of any contract, health plan, or medical insurance, and credits for **the pagests, Outputy Records** istments, 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. correct. THE METHODIST ADSPITALS / INC. Angie Djukich (1) Angi STATE OF INDIANA) ss: COUNTY OF LAKE I Angie Djukich , being a <u>Patient Representative</u> for The Methodist Hospitals, Inc., being duly sworn upon oath, gays that the facts stated in the foregoing are true and correct. (2) <u>Angle Afue WW</u> Angle Djukith Subscribed and sworn to before me, a Notary Public, this <u>14</u>TM day of <u>December</u>, 2015. A Resident of Lake - Lun Mistere My Commission Expires: County March 24,2019 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:

Earle F.	Hites,	Attorney	at La	aw		
3700 Broa	adway,	Merrillvil	le, 1	IN 4	6410	

LISA M. STONE Resident of Lake County If:

My commission expires March 24, 2019

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AMOUNT S____

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