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MICHAEL B. BROWN RECORDER

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TO:

Arnie Hosea -Redmond

## Return To: Hodges & Davis, P.C. 8700 Broadway, Merrillville, IN 46410 SWORN STATEMENT & NOTICE OF INTENTION TO HOLD HOSPITAL LIEN

Patient:	Arnie Hosea-Redmon	Attorney:	
	1726 Aspen Dr	<del></del>	
	Crown Point, IN 46	<del>-</del> <del>-</del> <del>-</del>	
Recorder of	Lake County, Indiana	ı Indiana	a Department of Insurance
Lake County	Government Center	311 W.	Washington Street
2293 North	Main Street	Suite 3	300
Crown Point	, Indiana 46307	Indiana	apolis, Indiana 46204
You a	re hereby notified th	hat THE METHODIST HOSDI	TALS, INC., 600 Grant Street, Gary,
			asonable and necessary charges for
			sted patient as follows:
	/	Document 1	S
1.	The patient was admi	tted to the hospital or	1 May 30 , 2016
and was dis	charged from the hose	wital on May 30	or maintenance during the
2.	The amount due for h	lospital care, treatment	or maintenance during the
above hospi	talization is lours	hoveand Eights Hilbered o	perty by 100
( <u>3</u> 4,	801.49	e Lake County Reco	bject to reduction for any benefits y contract, health plan, or medical
incurrence	e pattent 19 entitle	a under the terms of an	y contract, health plan, or medical
other benef		. payments, contractual	adjustments, write-offs, and any
3.		Jaspital/s knowledge th	ne patient or the patient's
	esentative claims the	at the following named	individuals and/or entities are
			ess or injury causing the hospital
stay:	damages allsing ito	n the patient's IIIn	ess of injury causing the hospital
beay.			
This	Lien is being filed	pursuant to the Hospita	1 Lien Law, I.C. Section 32-33-4 in
			Hospital is located, within ninety
			spital. The undersigned individual
			upon oath, under the penalties of
			old the Hospital Lien as described
above and t	that the facts and m	atters set forth in th	e foregoing statement are true and
correct.			s relations are state and
		THE METHODIST	ADSPITALS, INC.
		THE PARTY OF THE P	
		(1) BY ANTON	ingle spill les
STATE OF IN	,		Angie Djukich
COLINER OF L	) SS:		
COUNTY OF L	AKE )		
I An	gie Djukich	. heina	a Patient Representative for The
			says that the facts stated in the
	re true and correct.	, and show apon such,	/// char one races scarca in one
3 3		(2)	(Amare Blook (Ch)
			Angre Djukich
	ribed and sworn to be	efore me, a Notary Publi	.c, this 1000 day of
_ Kunl	, 2016.	-05	100 Clause
		_ Sung	m. Stone
My Commissi	on Expires:		Notary Public
March	Jul Jaice	A Resident of	Lake County
	24, 2019		
I affirm, u	under the penalties	for periury, that I ha	ve taken reasonable care to redact
each social	security number in t	this document, unless re	equired by law.
			Addition of lan.
This Instru	ment Prepared By:	25	
		Earle F. Hites, Attorne	
	1/-	8700 Broadway, Merrilly	ville, IN 46410
AMOUNT	\$		
CASH	CHARGE		grant to make more him and the most to make the most to make the most to make the most to make the most of the most
CHECK	20775 F		Official Seal
OVERAG	iE		LISA M. STONE  [SEAL] A Resident of Lake County, IN
COPY_			My commission expires
NONCO	284		March 24, 2019