STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

2017 019827

2017 MAR 28 PM 1: 12

MICHAEL B. BROWN RECORDER

#101339435

Return To:

Hodges & Davis, P.C.

8700 Broadway, Merrillville, IN 46410

SWORN STATEMENT & NOTICE OF INTENTION TO HOLD HOSPITAL LIEN

| TO: | EZANDRA BROWN | | |
|--|---|---|--|
| Patient: | EZANDRA BROWN | Attorney: | |
| | 304 FAYETTE STREET | | |
| | GARY, IN 46403 | _ _ | |
| Lake County 2293 North 1 | | | na Department of Insurance . Washington Street 300 |
| Crown Point | , Indiana 46307 | India | napolis, 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 FEBRUARY 27, 2017 | | | |
| 1. | charged from the hospi | | |
| 2. | The amount due for to | spiral care, treatmen | nt or maintenance during the |
| | talization is TONE THO | USAND EIGHT HUNDRED | FIFTEEN 72/100 |
| (\$ 1, | 815.79) Dollar | s. This amount is s | subject to reduction for any benefits |
| | | | mydentract, health plan, or medical |
| other benefi | it. | | al adjustments, write-offs, and any |
| 3. | To the best of the Hor | the following name | the patient or the patient's and/or entities are |
| | | | ness or injury causing the hospital |
| stay: | | | and the same of th |
| the Office (90)days af executing tperjury, he | of the Recorder of the ter the patient was dichis instrument, having reby states that the schat the facts and matter than the facts are matter than | e County in which the ischarged from the Hang been willy sworn Hospital intends to term set forth in the THE METHODIS | al Lien Law, I.C. Section 32-33-4 in e Hospital is located, within ninety ospital. The undersigned individual upon oath, under the penalties of hold the Hospital Lien as described the foregoing statement are true and ST HOSPITALS, INC. |
| I MELISSA VASQUEZ , 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. | | | |
| M.M. | ribed and sworn to before, 2017. | ore me, a Notary Pub | n. store |
| My Commission | on Expires: | | Notary Public |
| 100 (| 124, 2019 | A Resident o | of <i>Dull</i> 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: | | | |
| | (/ ~ 8' | arle F. Hites, Attor 700 Broadway, Merril | |
| 0 | MOUNT \$CHARGECHECK #Z/5.39 ENORY | | Official Seal LISA M. STONE Resident of Lake County, IN My commission expires March 24, 2019 |

260655

OVERAGE___ COPY____ NON-COM__ CLERK____