

# NOT AN OFFICIAL DOCUMENT

GINA PIMENTEL  
RECORDER

2024-019896

STATE OF INDIANA  
LAKE COUNTY  
RECORDED AS PRESENTED

12:27 PM 2024 Jul 28

102520193

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

SWORN STATEMENT & NOTICE OF INTENTION TO HOLD HOSPITAL LIEN

TO: Tracy B Brown  
Patient: Tracy B Brown  
2077 Harrison Street  
Gary, IN 46407

Attorney: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 maintenance of the above listed patient as follows:

1. The patient was admitted to the hospital on June 27, 2024 and was discharged from the hospital on June 28, 2024
2. The amount due for hospital care, treatment or maintenance during the above hospitalization is Three Thousand One Hundred eighty-nine dollars 50/100 (\$ 3,189.50 ) Dollars. This amount is subject to reduction for any benefits to which the patient is entitled under the terms of any contract, health plan, or medical insurance, and credits for all payments, contractual adjustments, 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 stay:

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.

THE METHODIST HOSPITALS, INC.

(1) BY: Thomas E Tadros

STATE OF INDIANA )  
                                  ) ss:  
COUNTY OF LAKE )

I Thomas E Tadros, 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.

(2) Thomas E Tadros

Subscribed and sworn to before me, a Notary Public, this 8th day of July, 2024.

My Commission Expires:

March 24, 2027

Riva Stone  
Notary Public  
Resident of Aaru County  
My Commission No: 090624702

I affirm, under the penalties for perjury, that I have taken ~~reasonable care to~~ <sup>My Commission Expires Mar 24, 2027</sup> redact each social security number in this document, unless required by law.

This Instrument Prepared By: Laura B. Frost

AMOUNT 25- Laura B. Frost, Attorney at Law  
8700 Broadway, Merrillville, IN 46410

CASH CHARGE  
CHECK # 29207  
OVERAGE  
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CLERK LF

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