

NOTICE OF HOSPITAL LIEN UNIVERSITY OF ALABAMA HOSPITAL

JT Ste 720, 619 19th ST. S., Birmingham, AL 35249-6510 1-888-309-8435 or 934-6405

STATE OF ALABAMA SHELBY COUNTY

Notice is hereby given, as provided by the laws of the State of Alabama that UNIVERSITY OF ALABAMA HOSPITAL whose address is, JT 720, 619 19th ST. S., Birmingham, AL 35249-6510, which operates a hospital of the same name, at the same address, claims a lien for the reasonable charges of hospital care, treatment and maintenance received by: Brandon Atchison of 164 Clear Springs Way Lot 7, Shelby, AL 35143, against all causes of action, suits, claims, counter claims and demands accruing to the said Parent or Guardian of Brandon Atchison or his/hers legal representative, and against all judgments, settlements and settlement agreements entered into by virtue thereof and on account of such injuries giving rise to such causes of action, suits, claims, counter claims, demands, judgments, settlements or settlement agreements and which necessitated such hospital care. 064820242.2104

nount Claimed:	\$30,961.01	Date of Admission:	04/13/2012	
te of Injury:	04/13/2012	Date of Discharge:	04/14/2012	
tive of such per	-	•	-	.'s
Name: State Farm Insurance		Name:		
P.O.Box 106151	İ			
Atlanta GA 303	48	Address:		
		Name:		
		Address:		
personally apperorized representatement of lie	eared, Thomas Elmetative for the claims on, and that the same before me this	a Notary Public in and faces who being by me first durant, and as such has personal eare true and correct. April 1998 April 1998 Ary Public Tary Public	ly sworn, doth depose and say that she knowledge of the facts set forth in the	he/he
	s and addresses tive of such per e, as follows: State Farm Insurp.O.Box 10615 Atlanta GA 303 Personally appears or ized representatement of lie	UNIVERSITY OF By: Duly Authorized Reported representative for the claims statement of lien, and that the same d and sworn to before me this Note.	Date of Discharge: s and addresses of all persons, firms or corporations claimed by tive of such person, to be liable for damages arising from such e, as follows: State Farm Insurance	Date of Discharge: 04/14/2012 s and addresses of all persons, firms or corporations claimed by such injured person, or the legal tive of such person, to be liable for damages arising from such injuries are, to the best of the claimant e, as follows: State Farm Insurance Name: P.O.Box 106151 Atlanta GA 30348 Address: UNIVERSITY OF ALMAMA HOSPITAL By: Duly Authorized Representative, UAB/PFS Address: Hospital Lien Prepared by:Colundra JT 720, 619 19th Street South Birmingham, AL 35249 A Notary Public in and for the County of Jefferson, State of personally appeared, Thomas Elmes who being by me first duly sworn, doth depose and say that she norized representative for the claimant, and as such has personal knowledge of the facts set forth in the statement of lien, and that the same are true and correct. d and sworn to before me this day of, 2012.

BONDED THRU NOTARY PUBLIC UNDERWRITERS