

TO: Shelby County Probate Office
P.O. Box 825
Columbiana, AL 35051

NOTICE OF HOSPITAL LIEN

Under the provisions of Title 35, Chapter 11, Division 15, Code of Alabama, 1975, notice is hereby given that Health Care Authority of the Baptist Health Foundation, Inc., whose address is 1000 1st Street North Alabaster, AL 35007, claims a lien for all reasonable charges for hospital care, treatment and maintenance necessitated by injuries received by:

Patient's Name: **Tonya Cummings**
Address: **Po Box 732**
Columbiana, AL 35051

Admit Date: **August 27, 2013**
Discharge Date: **August 27, 2013**
Amount Due: **\$2,378.00**

To the best of the claimant's knowledge, the names and addresses of all persons, firms or corporations claimed by said injured person, or legal representative of said person, to be liable for damages arising from such injuries are as follows:

Progressive - 131739970
2100 Riverchase Center, Suite 110
Birmingham, AL

Shelby Baptist Medical Center

BY: _____

[Signature]
Agent

STATE OF MISSISSIPPI
COUNTY OF ALCORN

The foregoing statement was acknowledged and verified before me this Wednesday, October 2, 2013, by the duly authorized Hospital of the above named health care provider for and on behalf of said hospital.

The foregoing statement was acknowledged and verified before me this 2013, by the duly authorized Shelby Baptist Medical

[Signature]
NOTARY PUBLIC

MY COMMISSION EXPIRES: _____




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Shelby Cnty Judge of Probate, AL
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