

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

20140109000009530 1/1 \$14.00
Shelby Cnty Judge of Probate, AL
01/09/2014 03:40:00 PM FILED/CERT

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: **Rebecca Jehlik**
Address: **480 Highway 469**
Columbiana, AL 35147
Admit Date: **December 17, 2013**
Discharge Date: **December 17, 2013**
Amount Due: **\$1,223.00**

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:

State Farm - 01383D456
P. O. Box 106145
Atlanta, GA

State Farm Insurance - 01383D456
P.O. Box 106147
Atlanta, GA

Shelby Baptist Medical Center

BY: _____

Agent

STATE OF MISSISSIPPI
COUNTY OF ALCORN

The foregoing statement was acknowledged and verified before me this Monday, January 6, 2014, 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 2014, by the duly authorized Shelby Baptist Medica

MY COMMISSION EXPIRES: _____



NOTARY PUBLIC

Prepared by:
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Corinth, MS 38834