

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

NOTICE OF HOSPITAL LIEN

Under the provisions of Alabama Code 1975, § 35-11-370 et seq., 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: **Jesus Medina**
Address: **500 Pope Drive**
Columbiana, AL 35124

Admit Date: **January 3, 2014**
Discharge Date: **January 3, 2014**
Amount Due: **\$1,360.00**

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 Insurance - 013Q14247
Auto Claims Central P O Box 106145
Atlanta, GA

Shelby Baptist Medical Center

BY: _____

[Signature]
Agent

STATE OF MISSISSIPPI
COUNTY OF ALCORN

The foregoing statement was acknowledged and verified before me this Monday, February 10, 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 Medical

[Signature]

NOTARY PUBLIC

MY COMMISSION EXPIRES: _____



Prepared By:

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P.O Box 1465
Corinth, MS 38834

