THOMAS HOSPITAL Plaintiff VS. LAURA FAIR Defendant	I I I I	IN THE CIRCUIT COURT OF BALDWIN COUNTY, ALABAMA AT LAW CASE NO. 9564

1.

The Plaintiff claims of the Defendant the sum of SEVEN HUNDRED SEVENTY and 75/100 DOLLARS ($770.75) due from her by account on the 29th day of April, 1970, which sum of money with the interest thereon, is still unpaid.

2.

The Plaintiff claims of the Defendant the sum of SEVEN HUNDRED SEVENTY and 75/100 DOLLARS ($770.75) due from her by account on, to-wit, April 29, 1970, which sum of money with the interest thereon, is still unpaid. An itemized statement of the account sued on, verified by the affidavit of a competent witness, is attached hereto as Exhibits "A" and "B" and made a part hereof.

WILTERS, BRANTLEY & NESBIT

BY: Phyllis S. Nesbit
Attorney for Plaintiff

FILED

NOV 19 1970

ALICE J. DUCK CLERK REGISTER

STATEMENT OF ACCOUNT

Creditor Thomas Hospital

Debtor Mrs. Laura Fair Address 700 Middle St. Fairhope, Ala.

Employment ~~Beasley Nursing Home~~ Address Fairhope Ala.

Professional Services Rendered On Account $ 770.75

Merchandise, Goods, Sold and Delivered On Account $ _____

Date of Last Charge 9 16 67

Date of Last Payment 4-29-70

SWORN STATEMENT OF CLAIM

STATE OF ALABAMA

COUNTY OF MOBILE

I hereby certify that the above account is just and correct and that all proper credits have been given and that the balance as indicated above is due and payable.

X Claud Clark

Claud Clark Jr. Administrator

Affiant

Sworn and subscribed to before me this

2nd day of Sept 1970.

VOL 65 PAGE 785

Notary Public

SUMMONS AND COMPLAINT

THE STATE OF ALABAMA
BALDWIN COUNTY

Circuit Court, Baldwin County

No.....

.....TERM, 19.....

TO ANY SHERIFF OF THE STATE OF ALABAMA:

You Are Hereby Commanded to Summon LAURA FAIR

to appear and plead, answer or demur, within thirty days from the service hereof, to the complaint filed in the Circuit Court of Baldwin County, State of Alabama, at Bay Minette against.....

LAURA FAIR ... Defendant.....

by THOMAS HOSPITAL

....., Plaintiff.....

Witness my hand this 19 day of Nov., 19 70

Alice J. Mack, Clerk

11-23-70

No. 9564 Page.....

THE STATE OF ALABAMA
BALDWIN COUNTY

CIRCUIT COURT

Thomas Hospital

.....

Plaintiffs

vs.

Laura Fair 928-8981

700 Middle St. Defendants

SUMMONS AND COMPLAINT

FILED

Filed ..... 19.....

NOV 19 1970

..... Clerk

ALICE J. BUCK CLERK REGISTER

WILTERS, BRANTLEY & NESBIT

BY: .....

Plaintiff's Attorney

.....

Defendant's Attorney

Defendant lives at

700 Middle St. Fairhope, Ala.

Recieved In Office

Nov. 19 19 70

Taylor Wilkins Sheriff

I have executed this summons

this 23 - Nov. 19 70

by leaving a copy with

Laura Fair

Sheriff claims 70 miles @

Ten Cents per mile Total $ 7.00

TAYLOR WILKINS, Sheriff

BY W. Crook

DEPUTY SHERIFF

....., Sheriff

W. Crook Deputy Sheriff

Moore Printing Co. - Bay Minette, Ala.

CASE NO.

THOMAS HOSPITAL 137

FAIRHOPE, ALABAMA

PATIENT'S NAME (23-36) LAST	(FIRST)	(MIDDLE)	HOME ADDRESS	PHONE
Fair	Louise			

SEX	RACE	AGE	DATE OF BIRTH (37-41)	SWMD	EMPLOYER	ADDRESS

INSURED BY	CONTRACT OR POLICY NO. (2-10)	TYPE	INS. ASSIGNED	TYPE OF CASE (1) MED. (2) SURG. (3) O. (4) ACCID.

SUBSCRIBER OR RESPONSIBLE PARTY (12-14)	ADDRESS	PHONE	OCCUPATION

DATE ADMITTED (15-18)	HOUR	DATE OF DISC. (19-22)	HOUR	ADMIT. OFFICER	PRIOR. ADM.	ATTENDING PHYSICIAN(S) AND ADDRESS

FINAL DIAGNOSIS AND SURGICAL PROCEDURE

DATE	ROOM	P-SP-W	RATE	DAYS

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE ABOVE NAMED HOSPITAL AND MY PHYSICIAN(S) TO RELEASE TO MY INSURORS FULL INFORMATION (INCLUDING COPIES OF RECORDS) RELATIVE TO THIS HOSPITALIZATION, A COPY SHALL BE AS VALID AS THE ORIGINAL

DATE _____ SIGNATURE (PARENT IF MINOR) _____

ASSIGNMENT OF INSURANCE BENEFITS: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED HOSPITAL BENEFITS PAYABLE UNDER THE TERMS OF MY POLICY FOR THIS PERIOD OF HOSPITALIZATION. (L. T.)

DATE 8-6-75 POLICY HOLDER

OPERATING ROOM 1. DELIVERY ROOM 2. ANESTHESIA 3.
I.V. SOLUTIONS 4. TRAYS-CATH.-ETC. 5. DRESSINGS-CASTS 6.

X-RAY	LAB.	DRUGS	ROOM-BOARD NURSERY NURSING-SER. COT	MISCELLANEOUS AMOUNT	MISCELLANEOUS CODE	TOTAL CHARGES OR DESCRIPTION	PAYMENTS 7. ALLOWANCES 8.	DATE	BALANCE	OLD BALANCE PICK-UP
							3 00	9-8-68	803 75	806 75
							3 00	9-24-68	800 75	803 75
							3 00	10-9-68	797 75	800 75
							3 00	10-24-68	794 75	797 75
							3 00	11-10-68	791 75	794 75
							3 00	12-19-68	788 75	791 75
							3 00	2-7-69	785 75	788 75
							3 00	3-28-69	782 75	785 75
							3 00	5-24-69	779 75	782 75
							3 00	7-22-69	776 75	779 75
							3 00	11-22-69	773 75	776 75
							3 00	4-29-70	770 75	773 75

MERCH. ADJ. SVC. 8-25-70

TRANS-AMERICAN COLLECTIONS, INC.
[illegible] CENTER, TOWANDA PLAZA
[illegible]INGTON, ILLINOIS 61701 8-20-68

TOTAL CHARGES

BLUE CROSS-INS. COVERAGE

DUE FROM PATIENT

LESS PATIENT PAYMENTS

BAL. DUE FROM PATIENT

LEDGER COPY

NEW BORN; LIVING ( ) YES ( ) NO: CASE NO.

BIRTH DATE _____ SEX _____ NAME _____

PAYMENT SHOULD BE MADE TO( ) HOSP. ( ) SUBSCRIBER

SIGNED _____ DATE _____

HOSPITAL OFFICER

BURROUGHS CORPORATION
TODD DIVISION – R

MISCELLANEOUS CODE	EXPLANATION	
2. OXYGEN	1. MISCELLANEOUS	1. MISCELLANEOUS
3. EKG-EEG-BMR	DIAPER SERVICE .11	W & G SUCTION .18
4. EMERGENCY ROOM	BIRTH CERTIFICATE .12	CROUPAIRE .19
5. TRANSFUSIONS	BABY FORMULA .13	BENNET. POS. PRESSURE .20
6. TELEPHONE	BABY PICTURE .14	VISITOR MEALS .21
7. PHYSICAL THERAPY	CIRCUMCISION .15	REFUNDS .22
	SHOCK THERAPY .16	.23
	ORTHOPEDIC EQUIP. .17	.24

◇ OR - REPRESENTS A CREDIT CANCELLING A PREVIOUS CHARGE

8355-2-B

CASE NO. 12682 | THOMAS HOSPITAL | 137 | FAIRHOPE, ALABAMA

PATIENT'S NAME (23-36) LAST	(FIRST)	(MIDDLE)	HOME ADDRESS	PHONE
Fair	Laura		General Delivery 700 Middle St. Fairhope	

SEX	RACE	AGE	DATE OF BIRTH (37-41)	SSNO	EMPLOYER	ADDRESS
		55				

INSURED BY	CONTRACT OR POLICY NO. (2-10)	TYPE	INS. ASSIGNED	TYPE OF CASE (1) MED. (2) SURG. (3) O. (4) ACCID.
None				

SUBSCRIBER OR RESPONSIBLE PARTY (12-14)	ADDRESS	PHONE	OCCUPATION

DATE ADMITTED (15-18)	HOUR	DATE OF DISC. (19-22)	HOUR	ADMIT. OFFICER	PRIOR ADM.	ATTENDING PHYSICIAN(S) AND ADDRESS

FINAL DIAGNOSIS AND SURGICAL PROCEDURE

DATE	ROOM	P-SP-W	RATE	DAYS

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE ABOVE NAMED HOSPITAL AND MY PHYSICIAN(S) TO RELEASE TO MY INSURORS FULL INFORMATION (INCLUDING COPIES OF RECORDS) RELATIVE TO THIS HOSPITALIZATION. A COPY SHALL BE AS VALID AS THE ORIGINAL

DATE _____ SIGNATURE (PARENT IF MINOR) _____

ASSIGNMENT OF INSURANCE BENEFITS: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED HOSPITAL BENEFITS PAYABLE UNDER THE TERMS OF MY POLICY FOR THIS PERIOD OF HOSPITALIZATION. (L. T.)

DATE Bal. 594.10 POLICY HOLDER _____

OPERATING ROOM 1. DELIVERY ROOM 2. ANESTHESIA 3. | I.V. SOLUTIONS 4. TRAYS-CATH.-ETC. 5. DRESSINGS-CASTS 6. | PAYMENTS 7. ALLOWANCES 8.

X-RAY	LAB.	DRUGS	ROOM-BOARD NURSERY NURSING-SER. COT	MISCELLANEOUS AMOUNT	MISCELLANEOUS CODE	TOTAL CHARGES OR DESCRIPTION	PAYMENTS	ALLOWANCES	DATE	BALANCE
	8 00	14 70	17 00			39 70	100 00		7-5-67	533 80
1 75	9 00	8 00	9 55			17 00			45 30	9-6-67	579 10
42 00			2 00 / 1 00			17 00			62 00	9-7-67	641 10
			1 00			17 00			18 00	9-8-67	659 10
	8 00	1 00	17 00			26 00			9-9-67	685 10
	4 00	3 25	17 00			24 25			9-10-67	709 35
		3 00	17 00			20 00			9-11-67	729 35
		3 00	17 00			20 00			9-12-67	749 35
	4 00	2 40	17 00			23 40			9-13-67	772 75
	8 00	2 40	17 00			27 40			9-14-67	800 15
		2 40	17 00			19 40			9-15-67	819 55
		2 20	O/C			2 20			9-16-67	821 75
								20 00	10-27-67	801 75
	5 00					5 00			3-6-68	806 75
51.00	156.50	211.00	446.00			921.75			TOTAL CHARGES	

LISTED—CR. INFO. BULL. DATE 2-20-68

#[illegible] (Over)

TRANS-AMERICAN COLLECTIONS, INC.
COMPUTER CENTER, TOWANDA PLAZA
BLOOMINGTON, ILLINOIS 61701

AUG 20 1968

I Agree to Pay $25.00 per month beginning 10-26-67
Laura Fair

OLD BALANCE
PICK-UP

BLUE CROSS-HHS. COVERAGE

DUE FROM PATIENT

LESS PATIENT PAYMENTS

BAL. DUE FROM PATIENT

LEDGER COPY

NEW BORN: LIVING ( ) YES ( ) NO: CASE NO.

BIRTH DATE _____ SEX _____ NAME _____

PAYMENT SHOULD BE MADE TO ( ) HOSP. ( ) SUBSCRIBER

SIGNED _____ DATE _____

HOSPITAL OFFICER

BURROUGHS CORPORATION TODD DIVISION — R

MISCELLANEOUS CODE	EXPLANATION	
2. OXYGEN	1. MISCELLANEOUS	1. MISCELLANEOUS
3. EKG-EEG-BMR	DIAPER SERVICE .11	W & G SUCTION .18
4. EMERGENCY ROOM	BIRTH CERTIFICATE .12	CROUPAIRE .19
5. TRANSFUSIONS	BABY FORMULA .13	BENNET. POS. PRESSURE .20
6. TELEPHONE	BABY PICTURE .14	VISITOR MEALS .21
7. PHYSICAL THERAPY	CIRCUMCISION .15	REFUNDS .22
	SHOCK THERAPY .16	.23
	ORTHOPEDIC EQUIP. .17	.24

◇ OR - REPRESENTS A CREDIT CANCELLING A PREVIOUS CHARGE

8355-2-0

CASE NO. 12682

THOMAS HOSPITAL - 137 - FAIRHOPE, ALABAMA

PATIENT'S NAME (23-36) LAST	(FIRST)	(MIDDLE)	HOME ADDRESS	PHONE
Fair	Laura		General Delivery 700 Middle St. Fairhope	8-8981

SEX	RACE	AGE	DATE OF BIRTH (37-42)	MARRIED	EMPLOYER	ADDRESS
F	C	55		M	Patient: Beasley Nursing Home Spouse: Receives old age pension	

INSURED BY	CONTRACT OR POLICY NO. (2-10)	TYPE	INS. ASSIGNED	TYPE OF CASE (1) MED. (2) SURG. (3) O.	% ACCID.
None ~~Independent Life and Accident~~					

SUBSCRIBER OR RESPONSIBLE PARTY (12-14)	ADDRESS	PHONE	OCCUPATION
Clarence Fair			

DATE ADMITTED (15-18)	HOUR	DATE OF DISC. (19-22)	HOUR	ADMIT. OFFICER	PRIOR. ADM.	ATTENDING PHYSICIAN(S) AND ADDRESS
8-22-67	5:20 pm			ar		T. H. Yancey, M.D.

FINAL DIAGNOSIS AND SURGICAL PROCEDURE

DATE	ROOM	P-SP-W	RATE	DAYS
8-22-67	300	p	20.00	

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE ABOVE NAMED HOSPITAL AND MY PHYSICIAN(S) TO RELEASE TO MY INSURORS FULL INFORMATION (INCLUDING COPIES OF RECORDS) RELATIVE TO THIS HOSPITALIZATION. A COPY SHALL BE AS VALID AS THE ORIGINAL

DATE _____ SIGNATURE (PARENT IF MINOR) _____

ASSIGNMENT OF INSURANCE BENEFITS: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED HOSPITAL BENEFITS PAYABLE UNDER THE TERMS OF MY POLICY FOR THIS PERIOD OF HOSPITALIZATION. (L. T.)

DATE _____ POLICY HOLDER _____

OPERATING ROOM 1. DELIVERY ROOM 2. ANESTHESIA 3. | I.V. SOLUTIONS 4. TRAYS-CATH.-ETC. 5. DRESSINGS-CASTS 6. | 7. PAYMENTS ALLOWANCES 8.

X-RAY	LAB.	DRUGS	ROOM-BOARD NURSERY NURSING-SER. COT	MISCELLANEOUS AMOUNT	MISCELLANEOUS CODE	TOTAL CHARGES OR DESCRIPTION	DATE	BALANCE	OLD BALANCE PICK-UP
	13 00	13 75	20 00			66 75	8-22-67	66 75	
	20 00 (4) 15 00 (4) 75	19 00 2 00	20 00			123 25	8-23-67	190 00	66 75
	68 50	15 00	20 00			57 00	8-24-67	247 00	123 25
	20 00	18 00	20 00			46 75	8-25-67	293 75	190 00
	8 00	16 75	20 00			36 75	8-26-67	330 50	247 00
	75	5 25	20 00			29 25	8-27-67	359 75	293 75
	4 00	3 75	20 00			28 25	8-28-67	388 50	330 50
		3 00	17 00			28 00	8-29-67	411 50	359 75
	8 00	4 00	17 00			21 00	8-30-67	432 50	388 50
		2 00	17 00			19 00	8-31-67	451 50	411 50
		10 00	17 00			27 00	9-1-67	478 50	432 50
	1 00 5 00 (4)	2 00 16 40	17 00			41 40	9-2-67	519 90	451 50
		16 40	17 00			33 40	9-3-67	553 30	478 50
	9 00	2 00 13 80	17 00			40 80	9-4-67	594 10	519 90

TOTAL CHARGES

BLUE CROSS-INS. COVERAGE

DUE FROM PATIENT

LESS PATIENT PAYMENTS

BAL. DUE FROM PATIENT

LEDGER COPY

NEW BORN: LIVING ( ) YES ( ) NO; CASE NO.

BIRTH DATE _____ SEX _____ NAME _____

PAYMENT SHOULD BE MADE TO ( ) HOSP. ( ) SUBSCRIBER

SIGNED _____ DATE _____

HOSPITAL OFFICER

BURROUGHS CORPORATION TODD DIVISION — R

MISCELLANEOUS CODE	EXPLANATION
2. OXYGEN	
3. EKG-EEG-BMR	
4. EMERGENCY ROOM	
5. TRANSFUSIONS	
6. TELEPHONE	
7. PHYSICAL THERAPY	

1. MISCELLANEOUS	
DIAPER SERVICE	.11
BIRTH CERTIFICATE	.12
BABY FORMULA	.13
BABY PICTURE	.14
CIRCUMCISION	.15
SHOCK THERAPY	.16
ORTHOPEDIC EQUIP.	.17

1. MISCELLANEOUS	
W & G SUCTION	.18
CROUPAIRE	.19
BENNET. POS. PRESSURE	.20
VISITOR MEALS	.21
REFUNDS	.22
	.23
	.24

◇ OR - REPRESENTS A CREDIT CANCELLING A PREVIOUS CHARGE

8355-2-B