TO: CITY CLERK
ATTN: CLAIMS
200 EAST WELLS ST.
ROOM 205
MILWAUKEE, WI. 53202-3567

'04 JUL 13 PM 3:20

FROM: FLORENCE SCOTT
2928 NORTH 23RD STREET
MILWAUKEE,WI.53206
414-442-7572

To whom it may concern;

ON Thursday april 29th2004,about 1:30p.m. while my grandson and I was across the street from my home-visiting a neighbor in her frontyard .

My grandson who is 2years old , had ran out the gate and into the street.

As I was running to catch him- I stepped off the curb, when I made my first step into the street, I tripped on a pothole and fell down{which there are numerous pot holes on both sides of the street}.

I was in great pain and had to be helped up by a neighbor from down the street.

Then I went home, within 5 or 10 minutes my daughter happened to stop by, after about 10 minutes we decided to go to the hospital {st. joseph}.While at the hospital I learned that my wrist was fractured.

At the hospital- they rapped my arm and wrist and put my arm in a slang.

They also gave me a name and phone # to a bone specialist, and told me to call and make an appointment to see him.

I did call and made the appointment.

This incident was witness by at least 4 neighbors in 4 different residents,on my side of the street.

P.S. I am seeking a settlement of $7,500 + hospital and doctors cost.{for which I am including some bills}.

X Florence Scott

7-12-04

ST. JOSEPH REGIONAL MEDICAL CENTER

COVENANT HEALTHCARE

P.O. Box 68-9510
Milwaukee, WI 53268-9510
Address Service Requested

PATIENT NAME	
SCOTT, FLORENCE A	
AMOUNT DUE	**PATIENT NUMBER**
994.50	71056228

STATEMENT DATE	SERVICE FROM	SERVICE THROUGH
06/07/04	04/29/04	04/29/04

PLEASE MAKE CHECK OR MONEY ORDER PAYABLE TO:
ST. JOSEPH REGIONAL MEDICAL CENTE

AMOUNT ENCLOSED $

FLORENCE SCOTT
2928 N 23 STREET
MILWAUKEE, WI 53206-1647

ST. JOSEPH REGIONAL MEDICAL CENTER
BOX 68-9510
MILWAUKEE, WI 53268-9510

☐ IF ADDRESS OR INSURANCE COMPANY HAS CHANGED, PLEASE CHECK HERE AND COMPLETE INFORMATION REQUESTED ON REVERSE SIDE.

IMPORTANT: PLEASE DETACH & ENCLOSE THIS PORTION WITH YOUR PAYMENT

Questions Concerning this Statement can be e-mailed to:
covenantbusinessoffice@covhealth.org

CUSTOMER SERVICE: (414) 456-3000
(888) 553-5009

This is a reminder of the AMOUNT DUE from you for hospital services referenced in this statement. AMOUNT WAS DUE UPON RECEIPT. This is our second billing.

If you have already mailed your payment, please disregard this statement and accept our thanks.

If there is a reason why you have not paid the bill, please call to discuss the situation. We want to resolve any problem as soon as possible.

If there is no problem, please mail your payment today. We look forward to your response. Thank you.

DESCRIPTION	DEBITS	CREDITS
EMERGENCY DEPT	723.75	0.00
PHARMACY	33.00	0.00
RADIOLOGY	237.75	0.00

THESE CREDIT CARDS ARE ACCEPTED. COMPLETE INFORMATION ON THE REVERSE SIDE.

VISA

BALANCE DUE FROM PATIENT 994.50

AS A COURTESY TO YOU, WE HAVE BILLED BOTH YOUR PRIMARY AND SECONDARY INSURANC

PATIENT NAME	PATIENT NUMBER	PRIMARY INSURANCE	SECONDARY INSURANCE
SCOTT, FLORENCE A	71056228	SELF PAY	

VISIT TYPE	SERVICE FROM	SERVICE THROUGH	TOTAL CHARGE	TOTAL PAYMENT / CREDIT	AMOUNT DUE
EMERGENCY MEDICINE	04/29/04	04/29/04	994.50	0.00	994.50

KEEP THIS PORTION FOR YOUR RECORDS.
See reverse side for credit card and patient financial information.
Please visit our website for answers to frequently asked questions at www.covhealth.org

637 01/01 R255-167 SP2

A MEMBER OF COVENANT HEALTHCARE

ST. JOSEPH REGIONAL MEDICAL CENTER

COVENANT HEALTHCARE

P.O. Box 68-9510
Milwaukee, WI 53268-9510
Address Service Requested

PATIENT NAME	
SCOTT, FLORENCE A	
AMOUNT DUE	**PATIENT NUMBER**
389.75	71060326

STATEMENT DATE	SERVICE FROM	SERVICE THROUGH
05/17/04	05/06/04	05/06/04

PLEASE MAKE CHECK OR MONEY ORDER PAYABLE TO:
ST. JOSEPH REGIONAL MEDICAL CENTE

AMOUNT ENCLOSED $

FLORENCE SCOTT
2928 N 23 STREET
MILWAUKEE, WI 53206-1647

ST. JOSEPH REGIONAL MEDICAL CENTER
BOX 68-9510
MILWAUKEE, WI 53268-9510

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covenantbusinessoffice@covhealth.org

CUSTOMER SERVICE: (414) 456-3000
(888) 553-5009

Thank you for choosing our facility for your health care needs.

The remaining AMOUNT DUE for hospital services referenced in this statement is your responsibility. AMOUNT DUE UPON RECEIPT. Please mail your payment today.

If you have already mailed your payment, please disregard this statement and accept our thanks for your prompt response.

DESCRIPTION	DEBITS	CREDITS
ORTHOPEDIC CLINIC	389.75	0.00

THESE CREDIT CARDS ARE ACCEPTED. COMPLETE INFORMATION ON THE REVERSE SIDE.

VISA

BALANCE DUE FROM PATIENT 389.75

AS A COURTESY TO YOU, WE HAVE BILLED BOTH YOUR PRIMARY AND SECONDARY INSURANCE

PATIENT NAME	PATIENT NUMBER	PRIMARY INSURANCE	SECONDARY INSURANCE
SCOTT, FLORENCE A	71060326	SELF PAY	

VISIT TYPE	SERVICE FROM	SERVICE THROUGH	TOTAL CHARGE	TOTAL PAYMENT / CREDIT	AMOUNT DUE
ORTHOPAEDIC MEDICAL	05/06/04	05/06/04	389.75	0.00	389.75

KEEP THIS PORTION FOR YOUR RECORDS.
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Please visit our website for answers to frequently asked questions at www.covhealth.org

659 01/01 R255-151 SP1

A MEMBER OF COVENANT HEALTHCARE

ST. JOSEPH REGIONAL MEDICAL CENTER

Covenant HEALTHCARE

P.O. Box 68-9510
Milwaukee, WI 53268-9510
Address Service Requested

PATIENT NAME	
SCOTT, FLORENCE A	
AMOUNT DUE	**PATIENT NUMBER**
734.50	71077680

STATEMENT DATE	SERVICE FROM	SERVICE THROUGH
06/14/04	06/03/04	06/03/04

PLEASE MAKE CHECK OR MONEY ORDER PAYABLE TO:
ST. JOSEPH REGIONAL MEDICAL CENTE

AMOUNT ENCLOSED $

FLORENCE SCOTT
2928 N 23 STREET
MILWAUKEE, WI 53206-1647

ST. JOSEPH REGIONAL MEDICAL CENTER
BOX 68-9510
MILWAUKEE, WI 53268-9510

☐ IF ADDRESS OR INSURANCE COMPANY HAS CHANGED, PLEASE CHECK HERE AND COMPLETE INFORMATION REQUESTED ON REVERSE SIDE.

IMPORTANT: PLEASE DETACH & ENCLOSE THIS PORTION WITH YOUR PAYMENT

Questions Concerning this Statement can be e-mailed to:
covenantbusinessoffice@covhealth.org

CUSTOMER SERVICE: (414) 456-3000
(888) 553-5009

Thank you for choosing our facility for your health care needs.

The remaining AMOUNT DUE for hospital services referenced in this statement is your responsibility. AMOUNT DUE UPON RECEIPT. Please mail your payment today.

If you have already mailed your payment, please disregard this statement and accept our thanks for your prompt response.

DESCRIPTION	DEBITS	CREDITS
ORTHOPEDIC CLINIC	456.25	0.00
RADIOLOGY	278.25	0.00

THESE CREDIT CARDS ARE ACCEPTED. COMPLETE INFORMATION ON THE REVERSE SIDE.

VISA

BALANCE DUE FROM PATIENT 734.50

AS A COURTESY TO YOU, WE HAVE BILLED BOTH YOUR PRIMARY AND SECONDARY INSURANC

PATIENT NAME	PATIENT NUMBER	PRIMARY INSURANCE	SECONDARY INSURANCE
SCOTT, FLORENCE A	71077680	SELF PAY	

VISIT TYPE	SERVICE FROM	SERVICE THROUGH	TOTAL CHARGE	TOTAL PAYMENT / CREDIT	AMOUNT DUE
ORTHOPAEDIC MEDICAL	06/03/04	06/03/04	734.50	0.00	734.50

KEEP THIS PORTION FOR YOUR RECORDS.
See reverse side for credit card and patient financial information.
Please visit our website for answers to frequently asked questions at www.covhealth.org

464 01/01 8255-172 SP1

A MEMBER OF Covenant HEALTHCARE

ST JOSEPH'S EMER PHYS LLP
ST JOSEPH REGIONAL MEDICAL CTR
75 REMITT. DR #1574
CHICAGO IL 60675 1574

DOCTOR 21970 JOSEPH C LEE DO
TAX ID NUMBER: 38-3420925

S

IF PAYING BY CREDIT CARD, FILL OUT BELOW
CHECK CARD TYPE USING FOR PAYMENT

☐ MASTERCARD ☐ VISA ☐ AMERICAN EXPRESS ☐ DISCOVER

CARD NUMBER	EXP. DATE
SIGNATURE	AMOUNT

GROUP NUMBER	GUAR. / ACCOUNT NUMBER
218001	313014

STATEMENT DATE	PAY THIS AMOUNT	SHOW AMOUNT PAID
06/12/04	271.00	

2485 01
FLORENCE A SCOTT
2928 N 23RD ST
MILWAUKEE, WI 53206-1647

CXSTM

Make checks payable and send to:
ST JOSEPH'S EMER PHYS LLP
ST JOSEPH REGIONAL MEDICAL CTR
75 REMITT. DR #1574
CHICAGO IL 60675 1574

Please detach and return the top portion with your payment.

☐ Please check box if above address is incorrect or if insurance information has changed and indicate change(s) on reverse side

If you have any questions please contact us at (800) 219-9811

DATE	PROVIDER	TRANS CODE	DESCRIPTION	CHARGES/ DEBITS	PAYMENTS/ CREDITS	BALANCE INFORMATION
***PATIENT NAME - FLORENCE SCOTT 313014						
04/29/04	LEE,JOSEPH	99284 81342	EMERGENCY DEPT VISIT	271.00		
			ACCOUNT BALANCE			271.00

Please make check payable to St. Joseph's Emergency Physicians, LLP..
Payment may be made by check, money order, or major credit card. This bill is for the Physician services-not for the hospital charges.
Notice: If you have already paid this bill, please disregard this statement. Thank you.
You can email your insurance information or billing questions to apollobilling@eci-med.com or call 1-800-219-9811.

Payment may be made by check, money order, or credit card. If paying by check, please write the account number on your check.
We would appreciate your prompt attention to this statement.
Please contact our office if you do not agree with the balance due.

ST JOSEPH'S EMER PHYS LLP

STATEMENT DATE	ACCOUNT BALANCE	PENDING INSURANCE	PLEASE PAY THIS AMOUNT
06/12/04	271.00	0.00	271.00

21354535 36974-4 2485

Florence Scott
2928 N. 23rd St.
Milw. WI. 53206

City Clerk
Attn: claims
200 E. Wells St.
Room-205
Milwaukee, WI. 53202-3567