September 12, 2012

Kimberly Virojana
3149 South 22nd st.
Milwaukee, WI 53215
Phone- 414-736-4259

To whom this may concern:

My name is Kimberly Virojana, please except this notice as the initial stage for me seeking reimbursements for my medical costs, pain and suffering costs and loss of Productivity costs, associated with a bicycle accident, that I would not have otherwise been in, had this particular sidewalk on the streets of the City of Milwaukee, been maintained and free of uneven sidewalks, creating a dangerous safety hazard for pedestrians.

It is my understanding that the Nation is in a Recession and we as a Country need to create and maintain Jobs. One of the focal points of creating jobs is having better roadways. There are Governmental Grants available for this very purpose, for each City in Wisconsin. It is my belief that this particular sidewalk located on the East side of the 2600 block of South Chase Ave., had been neglected for quite some time as evidenced by condition in which it was at the time of the accident. It has since been fixed.

On June 27, 2012, I was riding my bicycle downhill on the East side of the 2600 block of Chase Ave, Milwaukee, Wisconsin, when all of a sudden, the sidewalk became uneven and had (2) five inch dip and rises. I did not have enough time to stop because it was not until I was inches away from it, that I actually seen it, I didn't see because a shadow was casted over the uneven part, creating a camouflage effect. I couldn't go around it because it was too late, and, there was a wired fence on one side and the tree on the other side. Therefore, it left me no alternative, but to, do a wheelie over the first rise, but when the wheel came down, I hit the second rise and because of the speed in which I was going, I flew over the handle bars. The next thing I remember, the Emergency Medical Team was standing over me. I don't know how long I was laying there, I was unconscious, but clearly someone seen me, and dialed 911. I was taken to the St. Francis Hospital. I walked away with no broken bones. However, my Liver was bleeding, my face swollen and bruised (on the right side), my arm road rash (right side), wrist sprung, right elbow region was in severe discomfort and severe pain in my entire back and neck. I was initially taken by ambulance to St. Francis hospital, where X-rays and MRIs' were taken, it was at that time, and the Doctor discovered my Liver was bleeding. I was then transported to Froedtert Trauma Center for further medical attention. I was admitted overnight for observation, due to Liver Trauma.

My liver is still healing on its own, however, my back, neck and right are still being treated by a Physical Therapist and the Pain is somewhat tolerable because of Prescribed Pain Medication. My Internist has referred me to a Pain Management Doctor for further medical treatment.

I am seeking monetary compensation for Medical costs and Pain and Suffering and lost of Productivity, due to my injuries associated with my Bicycle accident on June

27' 2012 which was caused by The City of Milwaukee negligence. The amount that I am requesting is a total of $ 385,000 (Three hundred eighty-five thousand dollars) this amount includes current and pending medical expenses and medication, pain and suffering, loss of productivity and special furniture to accommodate back injury.

Thank You,
Kimberly Virojana

3149 South 22nd st.
Milwaukee, WI 53215
Phone- 414-736-4259

Froedtert HEALTH
Froedtert Hospital
Froedtert.com

INVOICE

For customer service or to make a payment please call 800-803-8155 or visit our website.

GUARANTOR NAME
KIMBERLY M VIROJANA

INVOICE DATE
09/04/12

PRIMARY INSURANCE
UHC - GA/UT/TX
POLICY #: 844613555
INSURED: KIMBERLY VIROJANA

SECONDARY INSURANCE
NO INSURANCE ON FILE

SERVICE DATE	PATIENT	DESCRIPTION	CHARGES	INS PMTS & ADJS	PATIENT PMTS	BALANCE DUE
06/27/12 - 06/28/12	KIMBERLY M VIROJANA	ACCOUNT # . 376527008 TRAUMA SURGERY OUTPATIENT	$8,690.54	-$8,490.54	$0.00	$200.00

Important Message:
Only accounts that currently have a patient due balance are shown on this invoice. Please call us at the phone number listed above if you would like an itemized statement. This invoice reflects charges for hospital services only. Physician charges will be billed separately by the Medical College of Wisconsin.

Please Pay This Amount by
09/25/12
$200.00

PLEASE DETACH AND RETURN BOTTOM PORTION WITH YOUR PAYMENT

Froedtert HEALTH
Froedtert Hospital
P.O. BOX 6545
Madison, WI 53716-0545

00308

7923533 3302

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

IF PAYING BY CREDIT CARD, PLEASE FILL OUT BELOW

☐ VISA ☐ MasterCard ☐ DISCOVER

CARD NUMBER | AMOUNT

SIGNATURE | EXP. DATE

INVOICE DATE	INVOICE AMT DUE
09/04/12	$200.00

38111-04A*3*
KIMBERLY M VIROJANA
3149 S 22ND ST
MILWAUKEE WI 53215-4404

Froedtert Hospital
P.O. Box 3202
Milwaukee WI 53201-3202

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MEDICAL COLLEGE PHYSICIANS

**1058140101

STATEMENT OF PHYSICIAN SERVICE

The back of the statement contains information on terms, conditions a
hours of operation. To make a payment or speak with customer servic
see the phone numbers listed below under **IMPORTANT MESSAGE**

SE HABLA ESPAÑOL

☐ Please check box and indicate change of address or insurance information on the reverse side.

STATEMENT DATE	PATIENT NAME	ACCOUNT NUMBER	AMOUNT ENCL
08/11/2012	VIROJANA,K	3M2340386	$

RESPONSIBLE PARTY

KIMBERLY M VIROJANA
3149 S 22ND ST **105814
MILWAUKEE,WI 53215

MAKE CHECK PAYABLE TO: MEDICAL COLLEGE OF WISCONSI
PAY ON-LINE AT: www.mcw.edu / paymybill
OR CALL TO PAY: (414) 955-4511 or 1-800-242-1649

☐ VISA ☐ MC ☐ DISCOVER ☐ AMR EXP

CARD NUMBER EXPIRATI

CARD HOLDER SIGNATURE
x

AMOUNT CHARGE
$

RETURN TOP PORTION WITH YOUR PAYMENT TO: P.O. BOX 13308 - MILWAUKEE, WI 53213-0308

RETAIN THIS PORTION FOR YOUR RECORDS

IRS TAX I.D. #39-0806

ACCOUNT NUMBER	INSURANCE INFORMATION	STATEMENT DATE
3M2340386	**PRIMARY:** UNITED HLTH CARE UT 30555 Insured: KIMBERLY M WHITAKER Effective Date: 01/01/2009 **SECONDARY:**	08/11/2012
PATIENT NAME		Payments received after statement date will not appear on this statement.
KIMBERLY M VIROJANA		

DATE	DESCRIPTION	CHARGES	INSURANCE PAYMENTS AND ADJUSTMENTS	PATIENT PAYMENTS AND ADJUSTMENTS	BALANCE DUE
	Invoice Number: 47054579				
	Department: TRAUMA SURGERY				
	Location: MCW FMLH - WEST				
07/06/12	99213 OFFICE/OUTPT VISIT ESTAB PT	148.00			
07/20/12	UHC HMO PMT/DISALLOW		0.00		
07/20/12	UHC HMO PMT/DISALLOW		118.00		$30.(

IMPORTANT MESSAGE:

To call Customer Service or make a payment, call (414) 955-4511 or 1-800-242-1649.

Only invoices with a balance due appear. If your total payment is not reflected, a portion was applied to one or more invoices previously reported as outstanding.

Please Pay This Amount by 08/28/2012

$30.00

Empi®

599 Cardigan Road
P.O. Box 64640
St. Paul, MN 55164-9856
Phone: 800-328-2536
651-415-9000

SALES AGREEMENT

FAX INFORMATION TO 800-400-5022

Included: *(check all that apply)*
- ☐ Prescription
- ☐ Letter of Medical Necessity
- ☐ Patient Face Sheet
- ☐ Copies of Insurance Card
- ☐ Patient Medicare/Medicaid Information Form

PATIENT INFORMATION - PLEASE COMPLETE IN FULL FOR ACCURATE CLAIM SUBMISSION

DATE OF ISSUE	PATIENT NAME (Last, First, Middle)			SOCIAL SECURITY #
ADDRESS	**CITY**	**STATE**	**ZIP**	**DATE OF INJURY**
PHONE #	**DATE OF BIRTH**	**WORK PHONE #**		**SEX**
( )		( )		☐ MALE ☐ FEMALE
PRESCRIPTION WRITTEN BY (Physician Name)	**DIAGNOSIS (ICD 9) CODE(S)**	**PHYSICIAN PHONE #**		**FAX #**
		( )		( )
PHYSICIAN ADDRESS	**CITY**	**STATE**	**ZIP**	

COMPLETE INSURANCE INFORMATION OR ATTACH COPY OF DEMOGRAPHIC INFORMATION

☒ PRIVATE INSURANCE ☐ MEDICARE ☐ MEDICAID ☐ AUTO ☐ WORK COMP

PRIMARY INSURANCE	POLICY HOLDER NAME	POLICY/CLAIM #	GROUP #
ADDRESS **CITY** **STATE** **ZIP**		**PHONE #**	**INSURED'S SOCIAL SECURITY #**
		( )	
SECONDARY INSURANCE	**POLICY HOLDER NAME**	**POLICY/CLAIM #**	**GROUP #**
ADDRESS **CITY** **STATE** **ZIP**		**PHONE #**	**INSURED'S SOCIAL SECURITY #**
		( )	
ADJUSTOR NAME	**ATTORNEY**		**ATTORNEY PHONE #**
			( )

IF WORK COMP PROVIDE: EMPLOYER NAME | ADDRESS | CITY | STATE | ZIP

CLINIC INFORMATION

CLINIC #	CLINIC NAME	PHONE #	FAX #
		( )	( )

QUANTITY	PRODUCT DESCRIPTION	SERIAL NUMBER	RENTAL	PURCHASE

Insurance and/or Contracted Pricing May Apply

Patient Signature Required for Proof of Delivery, Assignment of Benefits, Acknowledgement of Receipt of Privacy Notice and Terms and Conditions of Agreement
I have received the device and / or supplies listed above on the date indicated in the Date of Issue area and I hereby authorize payment of medical benefits to Empi for services furnished. I choose to use this particular equipment and the particular company. I have reviewed the terms and conditions of this Agreement inclusive of the retail pricing information. I further authorize the release of any medical information required for treatment, payment and healthcare operations. I understand that any balance remaining relative to the cost of the device and/or supplies after my insurer has remitted appropriate payment and Empi has taken applicable discounts will be my responsibility. In addition, I acknowledge that I have received Empi's Notice of Privacy Practices, which is required to be provided to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient Signature _____ Date _____

Guarantor or Legal Representative (if patient unable to sign) _____ Date _____

E-mail Address _____ ☐ Please do NOT send me additional information about Empi products.