

Nov 2, 2003

Dear Grant Langley,

I wish to appeal your decision on my fall July 31, 2003. I don't know where the Sewer Maintenance crew got West Blue mound and North 76th Street. I told Steve Sitzberger just where I had fallen. I was in bed for a week before I could even get out of bed. I feel your decision is very on just. I start have bruising.

Thank You.
Green Puhl

CITY OF MILWAUKEE

2003 NOV -7 PM 2:35

RONALD D. LEONHARDT
CITY CLERK

OFFICE OF
CITY ATTORNEY

03 NOV 10 PM 4:04

CITY OF MILWAUKEE
RECEIVED

To Whom This May Concern,

On August 31, 2003 at 6:30 PM I was walking East on 7th Blumond. As I approached the decline of the corner to cross the street, I tripped on the raised portion of the cement. Causing me to fall over the curb and hitting my head on the road. Resulting in being rushed to Froedert Memorial Hospital. I have enclosed a copy of the hospital report along with a picture three days after the fall. As of August 17, 2003. I am still having migraine headaches and back spasms.

For more medical information please contact Dr LuAnn Moraski at 414-456-5990.

I am seeking all my medical bills associated with this claim to be payed. I still have bruising on my face and neck. And a permanent scar over my eye.

I am also seeking \$2500.00 for pain and suffering.

If you have any questions please feel free to contact me by phone 414-258-2921

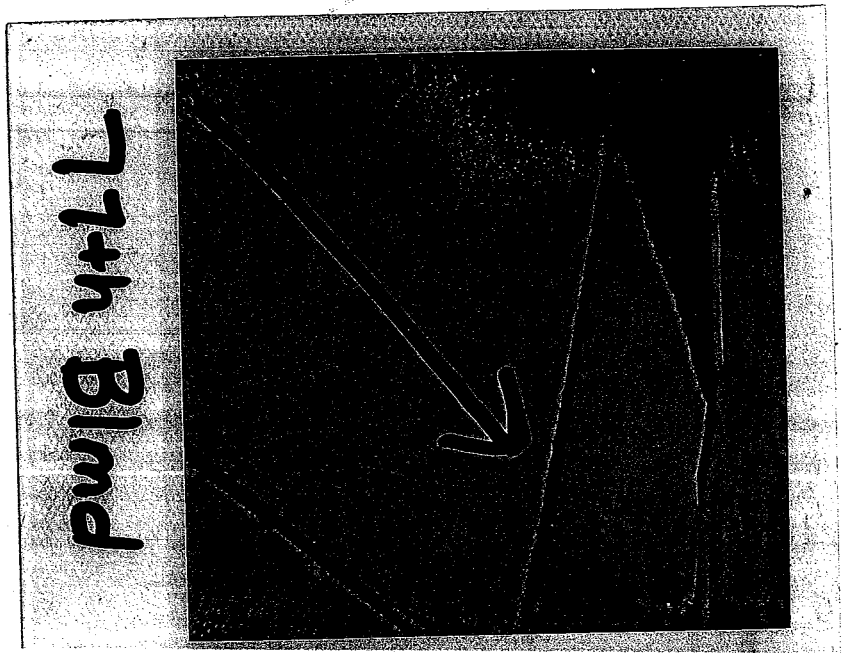
Thank you,
Karen Puze

2003 AUG 28 PM 3:50
CITY OF MILWAUKEE
RONALD D. LEONARD
CITY CLERK

03 AUG 28 PM 3:21
CITY OF MILWAUKEE
RECEIVED
OFFICE OF
CITY ATTORNEY



8-3-03



77th Blind



KAREN BOHL
212 N 70
MILWAUKEE WI 53210-3834

Page 1 of 3
Account Number 414 258-2921 727 6
Billing Date Jul 13, 2003

Web Site www.ameritech.com

Monthly Statement

Jun 14 - Jul 13, 2003

Bill-At-A-Glance

| | |
|--------------------------------|--------------------|
| Previous Bill | .00 |
| Payment | .00 |
| Adjustments | .00 |
| Balance | .00 |
| Current Charges | 102.87 |
| Total Amount Due | \$102.87 |
| Current Charges Due in Full By | Aug 4, 2003 |

Billing Summary

Questions? Call:

| | |
|---|---------------|
| SBC Local Services 1-800-924-1000 | 102.87 |
| Repair Service: 1-888-611-2344 | |
| Automated Billing/Payment Arrangements: 1-800-538-0503 | |
| Total of Current Charges | 102.87 |

News You Can Use - Summary

- AVOID DISCONNECTION
 - LONG DISTANCE CHANGE
 - BEST TIMES TO CALL
 - LOCAL TOLL INFO
 - WELCOME MESSAGE
 - VOICE MAIL INFO
- See "News You Can Use" for additional information.

Local Services Provided by SBC Illinois, SBC Indiana, SBC Michigan, SBC Ohio or SBC Wisconsin based upon the service address location.
Return bottom portion with your check in the enclosed envelope.

SBC Benefits

• Total SBC Savings **23.85**
Savings details are reflected within your bill.

Plans, Promotions and Discounts

Debits and credits in this section have been applied to the SBC Local Service total in the Billing Summary section of the bill.

| No. | Description | |
|-----|---|---------------|
| 1 | Reward for Voice Mail Discount 50% for bill period Jul 13, 2003 | 3.86CR |

SBC Local Services

| Monthly Service - Jul 13 thru Aug 12 | |
|--------------------------------------|-------|
| Ameritech Voice Mail Feat Pkg | 1.50 |
| Busy Line Transfer | |
| Alternate Answering | |
| Msg Wtg Audible & Visual Ind | |
| Star Code Access | |
| Economy Local Solution SM | 27.95 |
| Local Line | |
| Caller Identification | |
| Calling Name Display | |
| Call Waiting | |
| Local/ECC Saver Pack Unlimited | |
| Anytime Rate | |
| LINE-BACKER@ | |

By choosing Economy Local Solution SM, you are saving \$23.85 over the cost of the same services purchased separately.

| | |
|-------------------------------|--------------|
| Abbreviated Toll Free Service | .00 |
| Touch-Tone Service | .00 |
| Voice Mail 98 | 4.45 |
| Caller ID With Call Waiting | .00 |
| Primary No PIC State Chrg | .00 |
| Federal Access Charge | 5.06 |
| Total Monthly Service | 38.96 |

Local Calls
Ameritech Local Saver Pack Unlimited
(436 Call(s) were placed this month)

Discharge Instructions

Your diagnosis is head contusion, forehead laceration, hand contusion
Your medicines are Vicodin - 1-2 tabs every 6 hours as needed
[starter pack]

Do not drive, operate heavy equipment, or swim on the following medicines: Vicodin

FOLLOW UP:

- Clinic to follow up with your primary doctor or urgent care in
- Your Doctor is 5 days - 7 days for suture removal
- You must call this number to make appointment _____
- Your appointment is at _____
- We will notify you by mail if cultures taken are positive.
- Your x-rays will be evaluated by a radiologist. If there is new information we will contact you.

Other Instructions (check boxes for instruction sheet)

- | | | | | |
|-------------------------------------|--------------------------------------|--|--|--|
| <input type="checkbox"/> Analgesic | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Asthma / Bronchitis | <input type="checkbox"/> Fractures / Sprains | <input type="checkbox"/> S.T.D.s/Vaginosis |
| <input type="checkbox"/> Antibiotic | <input type="checkbox"/> Inhaler | <input type="checkbox"/> Back Pain | <input checked="" type="checkbox"/> Gastritis / GE | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Bactrim | <input type="checkbox"/> Prednisone | <input type="checkbox"/> Cast Care/Neurovascular | <input checked="" type="checkbox"/> Head Injury | <input type="checkbox"/> Wound / Suture Care |
| <input type="checkbox"/> Compazine | <input type="checkbox"/> Tetanus | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Motor Vehicle Crash | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Flexeril | <input type="checkbox"/> Tylenol # 3 | <input type="checkbox"/> Crutches | <input type="checkbox"/> Musculoskeletal | |
| | <input type="checkbox"/> Vicodin | <input type="checkbox"/> Dental Pain | <input type="checkbox"/> Pharyngitis | |

RXs

- Filled # 1
- Scripts Given # 1

Other Instructions your face and eye will get progressively more
black and blue over the next few days

watch for signs of infection - increased redness, swelling and
pain around cut

Return to the emergency department if you are worse in any way or if: trouble moving your eye
or decreased vision, worsening headache, persistent vomiting

VISIT VERIFICATION

- Seen On _____ Time In _____ Time Out _____
- Medical staff concludes that the condition of the patient DOES NOT warrant absence from work / school.
 - Medical staff concludes that the condition of the patient DOES warrant absence from work / school.
 - The patient is able to return to work / school on _____
 - Restrictions, if any avoid driving until you can use both eyes

I understand that the treatment received was given on an emergency basis only, and therefore, discharge may have occurred before all medical problems were apparent, diagnosed, and/or treated. I have read and understand the above. I received a copy of this form and applicable instruction sheets and will arrange for follow-up care as indicated above.

Instructions received and understood by patient Karen Puhl Date _____

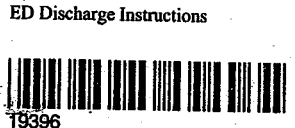
INSTRUCTIONS GIVEN TO PATIENT BY:

RN Signature [Signature] # _____
Date / Time _____

Rx's RESPONSE TO INSTRUCTIONS

- Follow-up Instructions Reviewed
- Verbalizes accurate understanding
- Other Instructions - See Narrative
- Returns demonstrations accurately
- Medication Instructions Reviewed
- Aware of S/S for return to ED

09 05 97 38
PUHL, KAREN
03/20/1947 F REG 07/31/2003
315502542 EAR-E



Froedtert Hospital

9200 West Wisconsin Avenue
Milwaukee, WI 53226-3596

Phone: 800-803-8155
http://billpay.froedtert.com

Remit To: P.O. Box 3202 • Milwaukee, WI 53201-3202



KAREN PUHL
212 N. 70TH ST
MILWAUKEE, WI 53213-3834



IF PAYING BY CREDIT CARD, PLEASE FILL OUT BELOW

CHECK CARD TO BE USED FOR PAYMENT

| | | |
|--------------|------------------------|----------------|
| CARD NUMBER | AMOUNT | |
| SIGNATURE | EXP. DATE | |
| INVOICE DATE | PLEASE PAY THIS AMOUNT | ACCOUNT NUMBER |
| 09/09/2003 | \$107.35 | 315502542 |
| PATIENT NAME | | |
| KAREN PUHL | | |

PAYMENT IS DUE UPON RECEIPT.

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

0000 0000000315502542 0010735 0000000 0000000000 7

INVOICE

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT.

Tuesday, September 9, 2003

Patient: Karen Puhl
Account: 315502542
Amount Due: \$107.35

Date of Service: 07/31/2003
Patient Service: Emergency
Primary Insurance Billed: MEDICARE PART A & B
Secondary Insurance Billed: SELF PAY

Dear Karen Puhl:

Thank you for selecting Froedtert Hospital for your health care services. For your records, below is a summary of the charges for this account. If you would like an itemized statement, please call Patient Financial Services at 800-803-8155.

| | | |
|-------------------------------|-----------|-----------------|
| Pharmacy | \$ | 70.40 |
| Sterile Supplies | \$ | 152.50 |
| Diagnostic X-Ray | \$ | 138.00 |
| Emergency Room | \$ | 947.00 |
| Self-Administerable Drugs | \$ | 0.00 |
| Total Charges | \$ | 1,322.68 |
| Total Payments | \$ | 1,174.03 |
| Final Balance | \$ | 1,041.20 |
| Please Pay This Amount | \$ | 107.35 |

Please pay

RONALD J. COLEMAN
CITY CLERK
2003 SEP 23 PM 2:22
CITY OF MILWAUKEE

Please mail payment in full today or contact Patient Financial Services at 800-803-8155 to arrange payment. Please visit us at <http://billpay.froedtert.com> if you would like to make a payment online using Mastercard, Visa or Discover or if you would like to view a list of Frequently Asked Questions. A \$25 service fee will be charged for any checks returned.

Physician charges will be billed separately by the Medical College of Wisconsin.

Our commitment is to your health. We appreciate your confidence in us.

Sincerely,
Patient Financial Services

OFFICE OF
CITY ATTORNEY
03 SEP 23 PM 3:40
RECEIVED
CITY OF MILWAUKEE

*Supplemental
Info. on
claim recently
submitted.*

Froedtert Hospital
9200 West Wisconsin Avenue
Milwaukee, WI 53226-3596