# Notice of Injury CITY OF MILWAUKEE 99 NOV -8 PM 1: 19

City of Milwaukee, City Clerk, Room 205, City Hall, 200 East Wells Switch Milwaukee, WI 53202 (Attention: Claims).

PLEASE TAKE NOTICE that on April 15, 1999, Ms. Bernice Winston was leaving Walgreens located at 51st and Capitol Drive in the City of Milwaukee and the State of Wisconsin, when tripped and fell to the ground. Ms. Winston asserts that her fall was cuased by in a crack in the sidewalk.

Ms. Winston suffered lacerations over her right eyebrow, a bruised right knee and an acute muscular strain in her right shoulder.

PLEASE TAKE FURTHER NOTICE that The City of Milwaukee is responsible for repairs and the care of all sidewalks. Due to the negligence of care to the sidewalks located on or about 51st and Capitol Drive in the city of Milwaukee, Ms. Winston suffered serious personal injuries.

We hereby make a demand upon the City of Milwaukee for Five hundred thousand Dollars for the injuries suffered by Ms. Bernice Winston.

Law Office of Elvis C. Banks

4011 W. Capitol Drive Suite 100 Milwaukee, WI 53216 (414) 442-2963 (414) 442-3276 (fax)



#### **Insurance Companies**

300 Tri-State International Office Center Suite 240 Lincolnshire, IL 60069

847/374-8920 FAX 847/940-3650 800/239-8692

P.O. Box 1480 Lincolnshire, IL 60069-1480 99 OCT -4 PM 12: 33
CITY CLERK ARDT

October 1, 1999

City Clerk of Milwaukee Attn: Claims 200 E. Wells St., Suite 205 Milwaukee, WI 53202

RE:

Claim Number:

Claimant:

Insured:

Date of Loss:

565 LN 074125

Bernice Winston

Walgreen Co. 04/15/99

#### Dear Sir or Madam:

Please accept this letter as notice of a claim being presented and be advised that we are the liability insurance carrier for Walgreens. Attorney Elvis Banks on behalf of Bernice Winston has presented a claim to our insured for tripping and falling on the sidewalk along Capitol Drive and suffered a laceration to the right eye, acute lumbar strain and a bruised right knee. This occurred near the store located at 5115 W. Capitol Drive, Milwaukee, WI.

My investigation into this matter has revealed that this is a city sidewalk and not the property or responsibility of Walgreens. I have enclosed copies of the information we received from Attorney Banks as well as copies of photos of the sidewalk. Therefore, I am tendering this claim to you for further handling and denying liability on behalf of Walgreens. I ask that you acknowledge our tender as soon as possible and confirm that you or your liability insurance carrier will investigate this matter and thereafter advise Attorney Elvis Banks and our office of your position.

Please be advised that Attorney Elvis Banks can be reached at 4011 W. Capitol Dr., Suite 100, Milwaukee, WI 53216. His telephone number is 1-414-442-2963.

I thank you in advance for your attention to this matter.

Sincerely,

KEMPER RISK MANAGEMENT SERVICES

Julie LeVine

Claim Representative

CC:

Law Offices of Elvis Banks 4011 W. Capitol Dr., Suite 100

Milwaukee, WI 53216

1999 OCT -4 PM 3: 1

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# LAW OFFICES OF ELVIS C. BANKS

4011 W. Capitol Drive Suite 100 Milwaukee, Wisconsin 53216 Phone (414) 442-2963 Fax (414) 442-3276 Pager (414) 591-7266

September 23, 1999

Kemper Insurance Companies Ms. Julie Levine Post Office Box 1480 Lincolnshire, IL 60069

Re:

My Client:

Ms. Bernice Winston

Your Insured:

Walgreens

Claim No.:

565 LN 074125 N 565

Date of Loss:

4/15/99

Dear Ms. Levine:

This letter will suffice as a complete settlement package for the personal injuries suffered by Ms. Bernice Winston.

#### I. Liability:

To briefly recapitulate, on or about April 15, 1999, at about 4:30 p.m. or soon thereafter, Ms. Bernice Winston exit Walgreens and was walking down the sidewalk on Capitol Drive when she suddenly tripped and fell forward face-down.

#### II. Damages:

#### A. Description of Damages suffered by Ms. Bernice Winston.

Ms. Bernice Winston experienced excruciating pain to her right eye. She also injured her right arm, leg and lower back. Since the accident, Ms. Winston has experienced difficulty sleeping and has been in pain daily. The Doctors that have treated her diagnosed Ms. Winston as having the following injuries:

\* Acute traumatic lumbosacral strain/spasms to her back, Bruised right knee and Bruised/Lacerated right eye. Minor abrasions to other parts of his body.

Ms. Winston states that she still experiences discomfort in her right eye, when the sun is shinning. During some of her daily activities at her employer she experiences spasms in her back.



#### B. Medical Expenses

Ms. Bernice Winston received treatment at Saint Joseph's Hospital with a total bill of \$-0- and Pyramid Chiropractic Clinic, S.C. total bill is \$2240.00

#### C. Wage Loss

Ms. Bernice Winston did not suffer any wage loss.

#### III. Settlement Request of Ms. Bernice Winston.

Based upon her medical expenses, loss wages and pain and suffering, my client is willing to settle this claim in the amount of \$20,000.00

When you have had a chance to review this matter, kindly provide a prompt response.

Thank you.

Very truly yours,

Elvis Cardell Banks

Attorney at Law

Dr. Adebayo Yusuf

5542 West Fond du Lac Avenue Milwaukee, Wisconsin 53216 (414) 461-2222

#### INITIAL REPORT

PATIENT NAME:

Bernice Winston

DATE OF INJURY:

04-15-99

DATE OF REPORT:

04-20-99

The above-named patient is a 60 year old female who is being seen for evaluation and treatment of injuries reportedly incurred in a fall accident on 4/15/99.

#### PRESENT HISTORY

Patient stated that on 4/15/99 at about 4:30 p.m. she was walking down the sidewalk on Capitol Drive when she suddenly tripped and fell forward face-down. Sated that she sustained a cut to her right upper eyelid, bruises to her right eye, right arm and right knee. Stated that she was conveyed in an ambulance to St Joseph's Hospital emergency room. Stated that her lacerated right eyelid was stitched and she was given a prescription for pain. Stated that she woke up with pain and stiffness in her lower back the following day and has continued to experience same.

#### **EXAMINATION**

On examination, a well developed, well nourished female who appeared to be in acute distress and discomfort. She was ambulatory without support. No pathological gait was indentified. She was alert and showed orientation towards places and things. Head was normocephalic without scalp lacerations. Stitched laceration to the lateral aspect of right eyebrow was identified. Moderate swelling of the right lateral infra-orbital area and the cheek was identified. Romberg's sign was negative. Postural analysis was unremarkable for spinal asymmetry. She complained of pain and stiffness in her lower back, pain in her right knee and right arm.

Thoracolumbar flexion 30 degrees, extension 10 degrees, right lateral bending was 25 degrees, left lateral bending 15 degrees, right rotation was 10 degrees, left rotation 10 degrees. Patient expressed pain during the performance of the motions. Cervical range of motions were within normal limits without pain.

Bernice Winston Initial Report Page two

Orthopedic examination revealed a positive Lesegue test right at 40 degrees and left at 65 degrees with pain in the lumbar spine. Leg lowering test was positive bilaterally at 30 degrees with pain in the lumbar spine. Hypertonicity of lumbar paravertebral muscles bilaterally. Hypertonicity of right quadratus lumborum and right gluteal muscles. Tenderness upon digital palpation of lumbar spine and sacral region. Heel and Toe walk caused increased pain in the lower back. Weakness of the Psoas muscles. Valsalva test was negative. SLR (sitting) test produced local pain in the lower back. Bruises were indentified in the right knee. No swelling was observed. Active range of motions of the right were within normal limits. Upper extremities were negative for bruises or swelling. Patient was advised to see an Ophthalmologist for further evaluation of her right eye.

Neurologic examination revealed deep tendon reflexes 2+ and symmetric. Sensory was intact.

#### DIAGNOSIS

- 1. Acute traumatic lumbosacral musculoligamentous strain with multiple lumbar vertebral subluxation complex secondary to the fall of 4/15/99 associated with lumbar paravertebral muscles spasm and lumbalgia.
- 2. Bruised right knee

E SHARES.

3. Lacerated right eyebrow.

#### PLAN

Patient is to begin corrective care with chiropractic vertebral adjustments, soft tissue therapy, and thermotherapy. The goal of care is to restore function to the injured regions of the spine, to increase range of motions to within normal limits without pain, to promote soft tissue healing, to restore normal strength and stability to joint structure and to return patient to activities of daily living without pain.

Respectfully Submitted,

Adebayo Yusuf, D.C.

5542 West Fond du Lac Avenue Milwaukee, Wisconsin 53216 (414) 461-2222

#### FINAL REPORT

PATIENT NAME:

Bernice Winston

DATE OF INJURY:

04-15-99

DATE OF REPORT:

08-10-99

The above-named patient is a 60 year old female who was being seen for evaluation and treatment of injuries reportedly incurred in a fall accident on 4/15/99.

#### FINAL DIAGNOSIS

Traumatic lumbosacral musculoligamentous strain secondary to

#### FINAL EVALUATION

A final assessment was performed on the patient on 8/4/99. Patient presented on this day and stated that her lower back has been feeling pretty good. Stated that she has not been getting stiffness in her lower back. Stated that her lower back gets sore every now and then, otherwise she feels much better. Examination revealed range of motions of thoraco-lumbar spine to be within normal limits. Normal tonicity of lumbar paravertebral muscles with mild tenderness upon digital palpation of lower lumbar spine. Patient has reached a healing plateau. She was discharged from my care on

Respectfully Submitted,

Adebayo Yusuf, D.C.

#### PYRAMID CHIROPRACTIC CLINIC 5542 WEST FOND DU LAC AVE. MILWAUKEE, WI 53216 (414) 461-2222

## STATEMENT OF ACCOUNT

| Bernice Winston                   |
|-----------------------------------|
| 3157 N.33rd Street                |
| Milwaukee, WI 53216               |
| (414) 447-1322                    |
| Billing(4/20/99-8/4/99)2115.00    |
|                                   |
| Report Fee Due Upon Receipt125.00 |

BALANCE DUE ON ACCOUNT

\$\_\_2240.00

| D OMB-0938-0008 |   | <b>†</b> |
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| 2. PATIENT'S OR AUTHORIZED<br>to process this claim. I also rec  | D PERSON'S SIGNATU  | RE I authorize the re  | lease of any megic   | cal or other inf                             | ormation necessary     | 13. INSURED'S OR A   | al benefit   | ZED PE<br>s to the i                         | HSON S   | s SIGNA<br>gnea ph                            | TURE I au<br>ysician or s                              | thorize<br>Supplier for |
| Delow.   | pear payment or governi   | nem beneins einer ic   | mysell of to the p   | arty wno acce                                | ots assignment         | services describe  | below.   |  |  | <i>a</i>                                      |  |                         |
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|  |   | RELATE ITEMS 1.2   | 3 OR 4 TO ITEM   | 124E BY LINE                                 | <del>.</del> ()        | 20. OUTSIDE LAB?  YES  22. MEDICAID RESU   |  | N  | \$ CHA   | _0  | ф  |                         |
|  |   |  | 3 OR 4 TO ITEM   | I 24E BY LINE                                | =)                     | 20. OUTSIDE LAB?   |  | N<br>ORIG                                    | \$ CHA   |   | ф  |                         |
|  |   | RELATE ITEMS 1.2   | 3 OR 4 TO ITEM   | I 24E BY LINE                                | :)                     | 20. OUTSIDE LAB?  YES  22. MEDICAID RESU   | BMISSIO  | ORIG   | S CHA  | _0  | ф  |                         |
| 1. DIAGNOSIS OR NATURE OF  |   |  | 3 OR 4 TO ITEM   | 24E BY LINE                                  | <u>(1)</u>             | 20. OUTSIDE LAB?  YES  YES  22. MEDICAID RESU  | BMISSIO  | ORIG   | S CHA  | _0  | ф  |                         |
| 1. DIAGNOSIS OR NATURE OF  | ILLNESS OR INJURY.  | 3.<br>4.   | <br>D  |  | ±) <b>→</b>            | 20. OUTSIDE LAB?  YES  YES  22. MEDICAID RESU  | BMISSIO<br>ZATION I  | ORIG<br>NUMBER                               | S CHA  | _0  |  | •                       |
| 2. L A DATE(S) OF SERVICE  | ILLNESS OR INJURY.  | 3.  C    Vype   PROCEDURE: of   Exolain  | D<br>S. SERVICES. Of<br>Unusual Circumst   | R SUPPLIES                                   | E<br>SIRONOBIC         | 20. OUTSIDE LAB?  YES  YES  22. MEDICAID RESUICODE  23. PRIOR AUTHORIS   | ZATION N   | ORIG<br>NUMBER<br>H<br>EPSDT<br>Family       | S CHA  | _ O   | RESER  | VED FOR                 |
| DATE(S) OF SERVICE   | ILLNESS OR INJURY.  | 3.  4.  C    Vype   PROCEDURE:   | D<br>S. SERVICES, OF   | R SUPPLIES                                   | ₩                      | 20. OUTSIDE LAB?  YES  22. MEDICAID RESU CODE  23. PRIOR AUTHORI   | ZATION N   | ORIG<br>NUMBER<br>H<br>EPSDT<br>Family       | S CHA  | _ O   | RESER  |                         |
| DATE(S) OF SERVICE   | ILLNESS OR INJURY.  | 3.  C    Vype   PROCEDURE: of   Exolain  | D<br>S. SERVICES. OF<br>Unusual Circumst   | R SUPPLIES                                   | E<br>SIRONOBIC         | 20. OUTSIDE LAB?  YES  YES  22. MEDICAID RESUICODE  23. PRIOR AUTHORIS   | ZATION N  G  DAYS  OR  UNITS   | ORIG<br>NUMBER<br>H<br>EPSDT<br>Family       | S CHA  | _ O   | RESER  | VED FOR                 |
| DATE(S) OF SERVICE  DATE OF SERVICE  MM DD YY MM  O4 23 99  O4 23 99   | ILLNESS OR INJURY.  | 3.  C   L.  Type   PROCEDURE: of   Explain   E | D<br>S. SERVICES, OF<br>Unusual Circumst<br>I WODIFIEF   | R SUPPLIES                                   | E<br>SIRONOBIC         | 20. OUTSIDE LAB?  YES  YES  22. MEDICAID RESUICODE  23. PRIOR AUTHORIS  F  S CHARGES   | ZATION N  G DAYS OR UNITS  | ORIG<br>NUMBER<br>H<br>EPSDT<br>Family       | S CHA  | _ O   | RESER  | VED FOR                 |
| DIAGNOSIS OR NATURE OF  A  POATE(S) OF SERVICE  MM DD YY MM  O4 23 99  O4 23 99  O4 26 99  | ILLNESS OR INJURY.  | C   PROCEDURE   Explain   Invice   CPT-HCPCS   | S. SERVICES, OF Unusual Circumst MODIFIEF  | R SUPPLIES                                   | E<br>SIRONOBIC         | 20. OUTSIDE LAB?  YES  22. MEDICAID RESUICODE  23. PRIOR AUTHORIS  F  \$ CHARGES   | ZATION N  G DAYS OR UNITS  | ORIG<br>NUMBER<br>H<br>EPSDT<br>Family       | S CHA  | _ O   | RESER  | VED FOR                 |
| DIAGNOSIS OR NATURE OF  L A DATE(S) OF SERVICE MM DD YY MM  O4 23 99  O4 23 99   | ILLNESS OR INJURY.  | 3.  C   Exolain envice CPT/HCPCS 9701 9712   | S. SERVICES. OF Unusual Circumst MODIFIEF  | R SUPPLIES                                   | E<br>SIRONOBIC         | 20. OUTSIDE LAB?  YES X  22. MEDICAID RESUICODE  23. PRIOR AUTHORI  F  S CHARGES  20 00  20 00   | ZATION N  G DAYS OR UNITS  1 1 1 1   | ORIG<br>NUMBER<br>H<br>EPSDT<br>Family       | S CHA  | _ O   | RESER  | VED FOR                 |
| DIAGNOSIS OR NATURE OF  A  Prom DD YY MM  O4 23 99  O4 23 99  O4 26 99   | ILLNESS OR INJURY.  | 3.  C   PROCEDURE: of Explain   ervice CPT:HCPCS  9701  9712 9894  | S. SERVICES. OF Unusual Circumst MODIFIEF O 4  | R SUPPLIES                                   | E<br>SIRONOBIC         | 20. OUTSIDE LAB?  YES  YES  22. MEDICAID RESUICODE  23. PRIOR AUTHORI  5 CHARGES  20 OC  20 OC  35 OC  | G DAYS OR UNITS  | ORIG<br>NUMBER<br>H<br>EPSDT<br>Family       | S CHA  | _ O   | RESER  | VED FOR                 |
| DIAGNOSIS OR NATURE OF  DATE(S) OF SERVICE  M DD YY MM  O4 23 99  O4 23 99  O4 26 99  O4 26 99   | ILLNESS OF INJURY.  | 3.  C   PROCEDURE:   | S. SERVICES. OF UTUSUAL CITCUMSTEE VOODIFIEF O 4 0 4 2   | R SUPPLIES                                   | E<br>SIRONOBIC         | 20. OUTSIDE LAB?  YES  22. MEDICAID RESU  CODE  23. PRIOR AUTHORI  5 CHARGES  20 00  20 00  35 00  20 00   | EMISSION IN CAPACITY OF CAPACI | ORIG<br>NUMBER<br>H<br>EPSDT<br>Family       | S CHA  | _ O   | RESER  | VED FOR                 |
| DIAGNOSIS OR NATURE OF  DATE(S) OF SERVICE  M DD YY MM  04 23 99  04 23 99  04 26 99  04 26 99   | ILLNESS OR INJURY.  | 3.  C  | S. SERVICES, OF Unusual Circumst VODIFIEF O 4 0 4 2 4 4  | R SUPPLIES                                   | E<br>SIRONOBIC         | 20. OUTSIDE LAB?  YES  22. MEDICAID RESUICODE  23. PRIOR AUTHORIS  5 CHARGES  20 00  20 00  20 00  20 00  20 00  | ZATION I   | ORIG<br>NUMBER<br>H<br>EPSDT<br>Family       | S CHA  | _ O   | RESER  | VED FOR                 |
| DATE(S) OF SERVICE  A  DATE(S) OF SERVICE  MM DD YY MM  04 23 99  04 23 99  04 26 99  04 26 99  04 26 99  04 26 99   | ILLNESS OR INJURY.  | 3.  Crype PROCEDURE: Exolain invice CPT:HCPCS  9701  9712  9894  9701  9701  9712  | S. SERVICES. OF Unusual Circumst MODIFIEF  O  4  O  4  O  4  | R SUPPLIES                                   | E<br>SIRONOBIC         | 20. OUTSIDE LAB?  YES X 22. MEDICAID RESUICODE  23. PRIOR AUTHORIS  5 CHARGES  20 00 20 00 20 00 20 00 20 00 20 00   | EMISSIO  ZATION I  G DAYS OR UNITS  1 1 1 1 1 1 1 1 1 1 1 1  | ORIG<br>NUMBER<br>H<br>EPSDT<br>Family       | S CHA  | _ O   | RESER  | VED FOR                 |
| DIAGNOSIS OR NATURE OF  DATE(S) OF SERVICE  M DD YY MM  O4 23 99  O4 23 99  O4 26 99   | ILLNESS OR INJURY.  | 9701<br>9701<br>9701<br>9701<br>9712<br>9894<br>9712<br>9894   | S. SERVICES. OF Unusual Circumst   MODIFIEF   O   4   O   4   2   4   O   4   4   O   4   4   O   4   O   4   O   4   O   O  | R SUPPLIES                                   | E<br>SIRONOBIC         | 20. OUTSIDE LAB?  YES  22. MEDICAID RESUI  23. PRIOR AUTHORI  5 CHARGES  20 00  20 00  20 00  20 00  20 00  20 00  35 00  20 00  35 00  35 00  35 00   | ZATION I  G DAYS OR UNITS  1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1   | ORIG<br>NUMBER<br>H<br>EPSDT<br>Family       | S CHA  | _ O   | RESER  | VED FOR                 |
| DIAGNOSIS OR NATURE OF DATE(S) OF SERVICE MM DD YY MM DD YY MM DD 23 99 04 23 99 04 26 99 04 26 99 04 26 99 04 26 99 04 28 99 04 28 99 04 28 99  | S   | 3.  C   PROCEDURE:   | S. SERVICES. OF UTUSUAL CITCUMSTEF O O O O O O O O O O O O O O O O O O O   | R SUPPLIES                                   | E<br>SIRONOBIC         | 20. OUTSIDE LAB?  YES  22. MEDICAID RESUICODE  23. PRIOR AUTHORIS  5 CHARGES  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  | ZATION I   | ORIG<br>NUMBER<br>H<br>EPSDT<br>Family       | S CHA  | _ O   | RESER  | VED FOR                 |
| DATE(S) OF SERVICE  M DD YY MM  O4 23 99  O4 23 99  O4 26 99  O4 28 99   | 3   Place   T   of   DD   YY   Service   Se   11   11   11   11   11   11   1   | 3.  Crype PROCEDURE: of Exolain of CPT:HCPCS  9701 9712 9894 9701 9712 9894 9701 9712 9894 9701 9712 9894  | S. SERVICES, OF Unusual Circumst VODIFIEF OF 4 OF  | R SUPPLIES (ances)                           | E<br>DIAGNOSIS<br>CODE | 20. OUTSIDE LAB?  YES  22. MEDICAID RESU  23. PRIOR AUTHORI  5 CHARGES  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00   | ZATION I   | ORIG<br>NUMBER<br>H<br>EPSDT<br>Family       | S CHA  | _ O   | RESER  | VED FOR                 |
| DATE(S) OF SERVICE  A  FROM DD YY MM  04 23 99  04 23 99  04 26 99  04 26 99  04 26 99  04 26 99  04 26 99  04 28 99  04 28 99  04 28 99  04 28 99  04 28 99  04 28 99  04 28 99  04 28 99   | 3   Place   T   of   DD   YY   Service   Se   11   11   11   11   11   11   1   | 3.  Crype PROCEDURE:   | S. SERVICES, OF Unusual Circumst VODIFIEF OF 4 OF  | R SUPPLIES (ances)                           | E<br>DIAGNOSIS<br>CODE | 20. OUTSIDE LAB?  YES  22. MEDICAID RESU  CODE  23. PRIOR AUTHORI  5 CHARGES  20 00   | ZATION I   | ORIG<br>NUMBER<br>H<br>EPSDT<br>Family       | S CHA  | COB   | RESER  | VED FOR<br>NL USE       |
| DIAGNOSIS OR NATURE OF DATE (S) OF SERVICE MM DD YY MM  O4 23 99  O4 23 99  O4 26 99  O4 28 99  O4 30 99  FEDERAL TAX I.D. NUMBER  39—1723576  | ILLNESS OR INJURY.  | 3.  type PROCEDURE:  | S. SERVICES. OF CHARLES OF A COLOR OF A COLO | R SUPPLIES lances)  27. ACCEP (For gow       | T ASSIGNMENT?          | 20. OUTSIDE LAB?  YES  22. MEDICAID RESUICODE  23. PRIOR AUTHORI  5 CHARGES  20 00 | ZATION I   | ORIG   | S CHA  | COB   | RESERV<br>LOCA   | VED FOR<br>IL USE       |
| DATE(S) OF SERVICE MM DD YY MM  04 23 99  04 23 99  04 26 99  04 26 99  04 26 99  04 26 99  04 28 99   | JELNESS OF INJURY.  Place Tot of DD YY Service Se  11  11  11  11  11  11  11  11  SSN EIN  DR SUPPLIER                                     | 3.  C  | S. SERVICES. OF SERVICES.  | R SUPPLIES tances) 27. ACCEP (For gov) X YES | T ASSIGNMENT?          | 20. OUTSIDE LAB?  YES 22. MEDICAID RESUICODE  23. PRIOR AUTHORIS  5 CHARGES  20 00 21 00 25 00 28. TOTAL CHARGE  \$ 265  | ZATION I   | ORIG   | S CHA  | COB   | RESERV<br>LOCA   | VED FOR<br>NL USE       |
| DATE(S) OF SERVICE  DATE(S) OF SERVICE  MM DD YY MM  O4 23 99  O4 26 99  O4 26 99  O4 26 99  O4 26 99  O4 28 99  O4 29 99  O4 28 99  O4 30 99  O4 30 99  FEDERAL TAX I.D. NUMBER  39—1723576  INCLUDING DEGREES OR OF (I certify that the statements on III)   | Place T of DD YY ServiceSe  11 11 11 11 11 11 11 11 SSN EIN  DR SUPPLIER REDENTIALS the reverse   | 3.  C  | S. SERVICES. OF CHARLES OF A COLOR OF A COLO | R SUPPLIES tances) 27. ACCEP (For gov) X YES | T ASSIGNMENT?          | 20. OUTSIDE LAB?  YES  22. MEDICAID RESUICODE  23. PRIOR AUTHORI  5 CHARGES  20 00 | ZATION I   | NUMBER HEPSDIF Family Plan  9. AMOU          | S CHA  | COB  ID  OC  E, ADDE                          | 30. BALAN<br>\$ 2<br>RESS, ZIP (                       | NCE DUE                 |
| DATE(S) OF SERVICE A  DATE(S) OF SERVICE AM  DD  YY  MM  O4 23 99  O4 26 99  O4 26 99  O4 26 99  O4 26 99  O4 28 99  O4 30 99  FEDERAL TAX I.D. NUMBER  39-1723576  SIGNATURE OF PHYSICIAN OF INCLUDING DEGREES OR OF INCLUDING DE | Place T of DD YY ServiceSe  11 11 11 11 11 11 11 11 SSN EIN  DR SUPPLIER REDENTIALS the reverse   | 3.  C  | S. SERVICES. OF SERVICES.  | R SUPPLIES tances) 27. ACCEP (For gov) X YES | T ASSIGNMENT?          | 20. OUTSIDE LAB?  YES  22. MEDICAID RESU  CODE  23. PRIOR AUTHORI  5  \$ CHARGES  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  20 00  35 00  20 00  35 00  20 00  35 00  20 00  35 00  35 00  35 00  35 00  37 00  38 PHYSICIAN'S, SUI  | G DAYS ON I 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  | ORIGINUMBER HEPSDT Family Plan Plan 9. AMOL  | S CHA  | COB  COB  COB  COB  COB  COB  COB  COB        | RESERV<br>LOCA<br>30. BALAY<br>\$ 2<br>RESS, ZIP CC C1 | NCE DUE 65 OI CODE      |
| DIAGNOSIS OR NATURE OF DATE(S) OF SERVICE MM DD YY MM  O4 23 99  O4 26 99  O4 28 99  O4 29 99  O4 20 99  O | JELNESS OR INJURY.  Place Tot of DD YY Service Se  11  11  11  11  11  11  11  SSN EIN  DR SUPPLIER REDENTIALS the reverse a part thereof.) | 3.  C  | S. SERVICES. OF SERVICES.  | R SUPPLIES tances) 27. ACCEP (For gov) X YES | T ASSIGNMENT?          | 20. OUTSIDE LAB?  YES  22. MEDICAID RESU  CODE  23. PRIOR AUTHORI  5 CHARGES  20 00  21 00  22 00  23 5 00  20 00  20 00  21 00  22 00  23 5 00  24 00  25 00  26 70 00  27 00  28 TOTAL CHARGE  5 26 5  | G DAYS OR UNITS 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  | NUMBER HEPSDT Family Plan 9. AMOL            | S CHA  SINAL R  EMG  EMG  ON O | COB  ID  OC  E, ADDF  Ctilac                  | RESERV<br>LOCA<br>30. BALAY<br>\$ 2<br>RESS, ZIP CC C1 | NCE DUE 65 OI CODE      |

| PLEASE<br>DO NOT  |  |  |
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| 1. MEDICARE MEDICARD  |  |  |                     |  |                                  |                  |  |
|---|--|--|---------------------|--|----------------------------------|------------------|--|
|   | CHAMPUS CHAMP  | VA .   | HEA                 | LTH INSURAN  | OF 01                            |                  |  |
| (Medicare #) (Medicaid #)   |  | HEALTH PL  | FECA                | OTHER! to Black  | CE CLAI                          | <b>M FORM</b>    |  |
| 2. PATIENT'S NAME (Last Name, Fir   | st Name, Middle Initial)   | " (SSN or ID)  | L DEK FONG          | - NOONE  | D'S I.D. NUMBER                  | 1                |  |
| L Winetan n   |  | 3. PATIENT'S BIRTH   | DATE                | []X(D) 3   | 90-38-1                          | <b>301</b>       | (FOR PROGRAM                                 |
| 5. PATIENT'S ADDRESS (No., Street   | TITCE  | 07 27  | γ ·                 | EX 4. INSURED  | S NAME (Last Na                  | me Firet Name    | -  |
| 3157 N 33rd   |  | 6. PATIENT RELATION  | DNSHIP TO INC.      |  |                                  |                  | . Middle Initial)                            |
| CITY SSEA   |  | Self X Spouse  | C C C               | 7. INSURED   | <u>nston</u> ,<br>S ADDRESS (No. | <u> </u>         | Ce   |
| Marin.  | STATE  | 8. PATIENT STATUS  | Child               | Other  | - 1.0011E35 (NO.                 | , Street)        |  |
| ZIP CODE  | 1  | .1   |                     | CITY   | 57 N 3                           | 3rd              |  |
| TEL   | EPHONE (Include Area Code)   | Single M   | larried O           | ther 🗍   |                                  |                  | Tes  |
|   |  | Smale.   | · .                 | L MI   | <u>lwauke</u>                    | 3                | Sī   |
| 9. OTHER INSURED'S NAME (Last Nai   | ne, First Name Middle 1  |  | -Time Part-1        | ime  |                                  |                  | (INC)  |
| · L ·   |  | 10. IS PATIENT'S CON   | NOITION RELATE      | 532  | 16                               | 1                | (INCLUDE AREA                                |
| a. OTHER INSURED'S POLICY OR GRO  | OLIP AND CO  |  | - NCCATE            | 11. INSURED'S  | POLICY GROUP                     | OREFOLD          | <u>)                                    </u> |
|   | SOF NUMBER   | a. EMPLOYMENT? (CU   | IDDELIT             |  |                                  | ON PECA NUI      | MBER   |
| b. OTHER INSURED'S DATE OF BIRTH  |  |  |                     |  | DATE OF BIRTH                    |                  |  |
| MM DD YY  | SEX  | D. AUTO ACCIDENT?  | [ <b>∑</b> ]NO      | MM   | POL BIETH                        |                  | SEX  |
| C. EMPLOYER'S MANS  | M F  |  | PLAC                | E (State) b. EMPLOYED  | ·                                | M                | ] Fr   |
| C. EMPLOYER'S NAME OR SCHOOL NA   | ME   | YES  | □ NO ,              | E (State) b. EMPLOYER'S  | NAME OR SCH                      | OOL NAME         |  |
| d INCLIDATION   |  | OTHER ACCIDENT?  |                     | —— tan <u>ka</u> an palaingan  |                                  |                  |  |
| d. INSURANCE PLAN NAME OR PROGR   | AM NAME  | YES  | NO                  | c. INSURANCE F   | LAN NAME OR F                    | ROGRAM NAL       | E  |
|   |  | Od. RESERVED FOR LC  | CAL USE             |  |                                  |                  |  |
| 12. PATIENT'S OR ALL READ BACK OF   | FORM   |  |                     | d IS THERE AND   | THER HEALTH                      | ENEET D          |  |
| 12. PATIENT'S OR AUTHORIZED PERSO to process this claim. I also request paymeter.  SIGNED | FORM BEFORE COMPLETING &   | SIGNING THIS FORM  |                     | YES  | 25/2004                          |                  |  |
| below.  | ent of government benefits either to n   | ase of any medical or other  | er information nece | ssary: 13. INSURED'S O   | 77 - 27                          | es, return to an | d complete item 9 a                          |
| SIGNED  | en international designation of the contract o | to the party who   | accepts assignmen   | payment of me  | dical benefits to the            | PEHSON'S SIG     | NATURE I authoriz<br>Physician or supplie    |
| 14. DATE OF CURRENT: A ILLNESS (FI  | <del>_on_fi</del> l∞   | 8  |                     | The Property of the Party of th | Ded below.                       | - nacisigned p   | onysician or supplie                         |
| MM DD YY  |  | DATEO7   | /23/99              |  |                                  |                  |  |
|   | uennica : Ten FA   | TIENT HAS HAD SAME<br>FIRST DATE MM  | OR SIMILAR ILL      | SIGNED SIGNED  | Signatu                          | ire on           | 451-   |
| 17. NAME OF REFERRING PHYSICIAN OR  | OT: :co  |  |                     | FROM FROM  | T UNABLE TO W                    | ORK IN CURRE     | ALT CO                                       |
|   | 1, a. 10.1   | NUMBER OF REFERRIN   | NG PHYSICIAN        | FROM   |                                  | TO MM            | DD YY  |
| 19. RESERVED FOR LOCAL USE  |  |  |                     | 18. HOSPITALIZATI<br>MM E<br>FROM  | ON DATES RELA                    | TED TO CURR      |  |
|   |  |  |                     |  | ·υ γγ .                          | TO               | DD YY  |
| 21. DIAGNOSIS OR NATURE OF ILL NESS OF  |  |  |                     | 20. OUTSIDE LAB?   |                                  |                  | -  |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OF   | INJUHY. : RELATE ITEMS 1.2.3 O   | R 4 TO ITEM 24E BY I   | 100                 | YES  | NO I                             | S CHARGES        |  |
|   |  |  | AEI                 | 22. MEDICAID RESU  | MISSION                          | 0                | ф  |
| 2.1   | 3  |  | <b>*</b>            | CODE   | ORIG                             | INAL REF. NO.    |  |
| 24 A  |  |  |                     | 23. PRIOR AUTHORIZ   |                                  |                  |  |
| DATE(S) OF SERVICE <sub>TO</sub>  | 3   C   4.   | ==:-==   |                     | THO HORIZ  | ATION NUMBER                     |                  |  |
|   | Place Type PROCEDURES. SEI   | D SVICES OF S  | ]E                  |  |                                  |                  |  |
| MM DD YY  |  |  | DIAGNOSIS           | F  | GH                               | 1 1 1            |  |
| 04 30 99  |  | MODIFIER   | CODE                | \$ CHARGES   | DAYS EPSDT<br>OR Family          |                  | K  |
| 04 30 99  | 97014  | The state of the s |                     | 3  | UNITS Plan                       | EMG COB          | RESERVED FOF<br>LOCAL USE                    |
| 04 30 99  | 97010  |  |                     | 20 00  |                                  | 1                |  |
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| 05 03 99  | 78940  |  |                     | 50 00  | 1                                |                  |  |
| 05 03 00  | 97014  |  |                     | 35 00  |                                  |                  |  |
| 05 03 99  | 97010  | 1  |                     | 20 00  |                                  |                  |  |
| 05 07 90  | 97124  |  |                     | _ , , , , ,  | 1                                |                  |  |
|   | 1 98940  | / 1  | 4                   |  |                                  |                  |  |
| 05 07 99  |  |  | 33<br>34            | 20 00  | 1                                |                  |  |
|   | # // UI4   |  |                     | 35 00  | 1                                |                  |  |
| FEDERAL TAX I.D. NUMBER SSN EIN   | <u>→</u> . ■ 9/01∧!  |  |                     | 20 00  | 1                                | +                |  |
| 30-1707   | 26. PATIENT'S ACCOUNT NO   | D. 27. ACCEPT A  | SSIGNMENTS          | 20.00  | 1                                |                  |  |
|   | 02973  | 27. ACCEPT A<br>For govt. cla  | aims, see back)     | 28. TOTAL CHARGE   | 29. AMOUNT F                     | 1                |  |
| Cartify that the  | 32. NAME AND ADDRESS -   |  | NO                  | \$ 280 00  |                                  | , , ,            | ALANCE DUE                                   |
| apply to this bill and are made a part thereof.)  | RENDERED (If other than i  | nome or office)  | VICES WERE          | 3. PHYSICIAN'S SUBBUTE   | 0000                             | a od a           | 280 0  |
|   |  |  | . 1                 | 3. PHYSICIAN'S, SUPPLIE<br>& PHONE #   | n S BILLING NAI                  | ME, ADDRESS.     | ZIP CODE                                     |
| Adebayo Yusuf, D.C  |  |  | 1                   |  | n x                              |                  |  |
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| •   |  |  |                     |  | FORM HAT                         |                  |  |

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|  | CHAMPUS            | S CHARLES                              |                                       | HEAL                                  | TH INSLIDANCE                                    | ·                       |               |   |                 |
|--|--------------------|--|---------------------------------------|---------------------------------------|--|-------------------------|---------------|---|-----------------|
| (Medicare #) (Medicaid #)  | [] /C              | OI MINIF V                             | Unoup                                 | FECA                                  | OTHER 1a. INSURED                                | E CLAI                  | M FOR         | M   | PIC             |
| 2. PATIENT'S NAME (Last Name, Fir  | st Name, Middle    | SSN) (VA File                          | (SSN or ID)                           | (SSN)                                 |  |                         |               | (FOR PROGRAM  | M IAL           |
| Wineton no.  |                    | ······································ | 3. PATIENT'S BIRTH                    | DATE                                  |  | 0-38-2                  | L391          |   |                 |
| 5. PATIENT'S ADDRESS (No., Street  | птсе               |  | 上 07: 27: 1                           | OZM                                   | 4. INSURED'S                                     | NAME (Last N            | ame, First N  | ame, Middle Initial)  |                 |
| 1  |                    |  | 6. PATIENT RELATIO                    | NSHIP TO INSLIDE                      | W11  | າຮຽດກ                   | Dane          | nione milian  |                 |
| 3157 N 33rd  |                    | _                                      | Self X Spouse                         |                                       | - MOUNEUS  | ADDRESS (No             | Street        | 1108  |                 |
| 1  |                    | STATE                                  |                                       | Child Oth                             |  | 57 N 3                  |               |   |                 |
| ZIP CODE   |                    |  | ]                                     | · · · · · · · · · · · · · · · · · · · | CITY   | 1, 1, 0                 | ora_          |   |                 |
| TEL  | EPHONE (Include    | de Area Code)                          | Single Ma                             | arried Othe                           | " Mil  | istma atau              |               | s   | STATE           |
| 53214  | 1                  | 1                                      | Employed Full-                        | -Time Part-Tim                        | I ZIP CODE                                       | wauke                   |               | <u> </u>  |                 |
| 9. OTHER INSURED'S NAME (Last Na   | me, First Name.    | Middle Initial)                        | Stur                                  | io                                    | 16 L—1   | _                       | TELEPH        | ONE (INCLUDE AREA   | A COI           |
|  |                    |  | 10. IS PATIENT'S CON                  | IDITION RELATED T                     |  | 6                       |               |   |                 |
| a. OTHER INSURED'S POLICY OR GR  | OUP NUMBER         |  |                                       |                                       | TO: 11. INSURED'S F                              | OLICY GROU              | IP OR FECA    | NUMBER  |                 |
|  |                    | 1                                      | a. EMPLOYMENT? (CUI                   | RRENT OR PREVIO                       | <u> </u>   |                         |               |   |                 |
| b. OTHER INSURED'S DATE OF BIRTH   | 1                  |  | YES                                   | MNO                                   | a. INSURED'S DA                                  | TE OF BIRTH             |               | CEV   |                 |
| MM DD YY   | 3EX                |  | b. AUTO ACCIDENT?                     | PLACE (                               | /O   | 1.5                     | i             | SEX   |                 |
| C. EMPLOYER'S NAME OR SCHOOL NA  | M                  |  | YES                                   |                                       | State) b. EMPLOYER'S I                           | NAME OR SCI             | IOOL NAME     | F   | $\sqcup$        |
|  | AME                | c                                      | OTHER ACCIDENT?                       | MO                                    | <del>***</del> ********************************* |                         |               |   |                 |
| d. INSURANCE PLAN MAME OF THE  |                    |  | YES                                   |                                       | C INSURANCE PL                                   | AN NAME OR              | PROGRAM       | Manage  |                 |
| d. INSURANCE PLAN NAME OR PROGE  | IAM NAME           | 110                                    | Od. RESERVED FOR LO                   | NO                                    | 24 Mars 1  |                         | HOGHAM        | NAME 2  |                 |
|  |                    |  |                                       | Conseque Co.                          | d. IS THERE ANOT                                 | HER HEALT               | DEN           | <del></del>   | 5               |
| PEAD BACK O  12. PATIENT'S OR AUTHORIZED PERSO  13. PATIENT'S OR AUTHORIZED PERSO  15. PATIENT'S OR AUTHORIZED PERSO  15. PATIENT'S OR AUTHORIZED PERSO  15. PATIENT'S OR AUTHORIZED PERSON  16. PATIENT'S OR AUTH | F FORM BEFOR       | E COMPLETING .                         | SIGNING THIS FORM.                    |                                       | YES [  |                         |               |   | in the          |
| to process this claim. I also reduest pay below.   | ment of government | E. Lauthorize the rele                 | ase of any medical or oth             | er informa-                           | 13 INSURENCE OF                                  | 44.4                    | yes, return t | to and complete item of   | 1 3 4           |
|  |                    | Contents enther to m                   | nyself or to the party who            | accepts assignment                    | ary payment of medi                              | ical benetits to        | PERSON'S      | to and complete item 9<br>SIGNATURE I authori<br>ned physician or suppl | ize :           |
| SIGNED Signatura   |                    |  |                                       | 7.13 (4.74)                           | services describe                                | ed below.               | the undersig  | ned physician or suppl  | lier fo         |
|  |                    |  | DATE O7                               | 7/23/99                               |  |                         |               |   | - 13.6<br>- 7.5 |
| PRECNAMA   | cideuti OH         | l cive                                 | ATIENT HAD !                          |                                       | SIGNED C   | Signat                  | ure d         | on file   |                 |
| NAME OF REFERRING PHYSICIAN OF   | OTHER COUR         | <del></del> !                          |                                       |                                       | :SS. 1:6. DATES PATIENT                          | UNABLE TO               | WORK IN CI    | URRENT OCCUPATION   | _               |
|  | O THE ROUGH        | 17a. i.D. i                            | NUMBER OF REFERRI                     | NG PHYSICIAN                          | =ROM   |                         | TO            | MM DD YY  | ON .            |
| RESERVED FOR LOCAL USE   |                    |  |                                       | o.o.a.                                | 18. HOSPITALIZATIO                               | N DATES RE              | ATED TO C     | URRENT SERVICE-   |                 |
|  |                    |  |                                       |                                       |  | J 11                    | ТО            | MM DD YY  |                 |
| DIAGNOSIS OR NATURE OF THE   |                    | •                                      |                                       |                                       | 20. OUTSIDE LAB?                                 |                         | S CHAR        | CEO   |                 |
| DIAGNOSIS OR NATURE OF ILLNESS (   | OR INJURY. RE      | LATE ITEMS 1.2.3 O                     | R 4 TO ITEM 24E BY I                  | NC)                                   | YES X  | NO I                    |               | r   |                 |
| ·  |                    |  | - 20, 5                               |                                       | 22. MEDICAID RESUB                               | MISSION                 |               | -00   |                 |
|  |                    | 3                                      | · · · · · · · · · · · · · · · · · · · | *                                     | 1 2002   | J. OR                   | IIGINAL REF   | NO.   |                 |
|  |                    |  |                                       |                                       | 23. PRIOR AUTHORIZ                               | ATION NI IMP            | -n-           |   |                 |
| DATE(S) OF SERVICE   | ВС                 | 1 4. [                                 |                                       |                                       |  | TOTAL LACIMIDA          | =H            |   |                 |
| DATE(S) OF SERVICE   | Place Type         | PROCEDURES, SE                         | RVICES. OR SUPPLIES                   | Ē                                     | _ <del></del>                                    |                         |               |   |                 |
|  | Service Service    | Explain Unusu                          | ual Circumstances)  VODIFIER          | UIAGNOSIS                             |  | DAYS EPSD               |               | K   |                 |
| 05 07 99   | 11                 | g ·                                    | MODIFIER                              | CODE                                  | \$ CHARGES                                       | OR Family<br>UNITS Plan |               | RESERVED FO   | DR              |
| 5 10 99  | <del> </del>       | 97124                                  |                                       |                                       | <b>4</b>   | Olari Si Plan           |               | DB LOCAL USE  |                 |
| 5 10 99  | 11                 | 98940                                  |                                       |                                       | 20 00  | 1                       |               |   |                 |
| 5 10 99  | 11                 | 97014                                  |                                       |                                       | 35 00  | 1                       | -             | +   |                 |
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| ATURE OF PHYSICIAL   | X 02               | 2973                                   | [ No. 25 11 1                         | stamps, see back)                     | 28. TOTAL CHARGE                                 | 29. AMOUN               | T PAID        | 30 PAL  | - 1             |
| UDING DEGREES OR CREDENTIALS ify that the statements on the reverse to this bill and one   | 32. NAM            | E AND ADDRESS O                        |                                       | ∐ NO                                  | \$ 265 00  | 1 6                     | ا ـ الم       | 30. BALANCE DUE   |                 |
| "y wat the statements on the severes   | HEN                | DERED (If other than                   | home or office)                       | HVICES WERE 3                         | 3. PHYSICIAN'S, SUPPLIE                          | R'S BILLING             | 0 00          | \$ 265 0  |                 |
| to this bill and are made a see the  |                    |  |                                       | 1                                     | & PHONE #  | L &                     | NAME, ADDE    | RESS, ZIP CODE  | 71              |
| and are made a part thereof.)  |                    |  |                                       |                                       | TO DIMENSE                                       | ואמיות                  | ~~~~          |   | 11              |
| and are made a part thereof.)  | 0                  | •                                      |                                       |                                       | 5540 11 -  | ··- · •                 | ac L I        | c clinic  | _ 17            |
| to this bill and are made a part thereof.)   | AN                 |  |                                       |                                       | Pyramid C<br>5542 W. F                           | CHICA (1)               | , , , , ,     |   | "               |
| apart thereof.)  | A.K.               | <b></b>                                |                                       |                                       | MILWAUKEE  | OHO QI                  | 1 Tac         |   | <b>"</b>        |
| and are made a part thereof.)  | SERVICE RIRE       | _                                      | LEASE PRINT OR                        | Pi                                    | 5542 W. F<br>MILWAUKEE<br>(414) 461-             | OHO QI                  | 1 Tac         |   | >               |

| PLEASE  |  |  |
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| DO NOT  |  |  |
| STAPLE. |  |  |
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|   | AMPUS  | CHAMPVA   | GROUP                                   | CE O   | INSURANCE  |   | Z11A1 1           |                            | M  | Dio.  |
|---|--|---|---|--|--|---|-------------------|----------------------------|--|---|
|   | onsor's SSN)                                       | (VA File  | HEALTH PLAN                             | BLK LUNG   | THER 1a. INSURED'S I.  | D. NUM  | BER               |                            |  | PICA<br>OR PROGRAM IN IT                      |
| 2. PATIENT'S NAME (Last Name, First Name,   | Middle Initial)                                    | <u> </u>  | 3. PATIENT'S BIRTH DA                   | (SSN)  |  | ~38-  | -139              | 91                         |  |   |
| Winston, Bernice  |  |   | MM DD YY                                | SEX  | 4. INSURED'S NA  | ME (Las   | t Name,           | First Na                   | ame, M                                       | liddle Initial)                               |
| 5. PATIENT'S ADDRESS (No., Street)  | <del></del>  |   |   | 937 F  | Wins   |   |                   |                            |  |   |
| 3157 N 33rd   |  |   | 6. PATIENT RELATIONS                    |  | 7. INSURED'S AD  | DRESS   | (No., Str         | reet)                      | 120  |   |
| CITY 17 331 G   | <del></del>  | STATE   | Self X Spouse                           | Child Other  | 3157   |   |                   |                            |  |   |
| Milwaukee   |  | 1 1   | 8. PATIENT STATUS                       |  | CITY   |   |                   | <del>_</del>               |  |   |
|   | E (Include Area                                    | WI WI   | Single Marr                             | ried Other   | ] Milu   | ian k   | (00               |                            |  | STATE   |
|   | - (michana Ates                                    | a Code)   | Employed Full-Ti                        | _  | ZIP CODE   | ruai  |                   | TELEPL                     | ONE (  | INCLUDE AREA COL                              |
| OTHER INSURED'S NAME (Last Name, First  | 447-   | 1322  | Stude                                   | nt Student   | 53216  |   |                   | (                          | ) 30101<br>                                  | INCLUDE AREA COL                              |
| o wine (cast name, First  | . Name, Middle                                     | Initial)  | 10. IS PATIENT'S COND                   | DITION RELATED TO:   | 11. INSURED'S PO   |   | POUR              | (                          | <i>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</i> |   |
| OTHER INSURED'S POLICY OR GROUP NU  |  |   |   |  | · 1  | .c.o.i Gi   | NOUP (            | IN FECA                    | NUME   | BER   |
| OWNER MODIFIED S FOLICY OR GROUP NU   | IMBER  | j,  | a. EMPLOYMENT? (CUR                     | RENT OR PREVIOUS)  | a. INSURED'S DAT   | E OF DI   | DT.               |                            |  |   |
| OTHER INSURED'S DATE OF BIRTH   |  |   | YES                                     | NO   | MM   | סס א  | YY                |                            |  | SEX   |
| MM DD YY  | SEX  | t   | . AUTO ACCIDENT?                        | PLACE (Sta   | te) h EMPLOYEDE N  | 1   |                   |                            | М  | ] F. [ ]                                      |
| MPI OVERIO  | F_   | ] ]   | YES                                     | NO   | b. EMPLOYER'S NA   | AME OH  | SCHOO             | DL NAM                     | E  |   |
| MPLOYER'S NAME OR SCHOOL NAME   |  | c   | OTHER ACCIDENT?                         |  | C INCHES TO A STORY  |   |                   |                            |  |   |
|   |  | ,   | YES                                     | ∏NO  | c. INSURANCE PLA   | N NAME  | OR PR             | ROGRAN                     | MAN N  | E   |
| ISURANCE PLAN NAME OR PROGRAM NAI   | ME   | 1   | Od. RESERVED FOR LO                     | 我想 医巴里克氏纤维性 经净点的 医二  |  |   |                   |                            |  |   |
|   | ar Section   |   | . 116 1 2 2 2 2                         |  | d. IS THERE ANOTH  | IER HEA   | ALTH BE           | NEFIT                      | PLAN?  |   |
| PATIENT'S OF AUTHORIZED SECTION   | M BEFORE CO  | OMPLETING &   | SIGNING THIS FORM.                      | The transfer of the second   | YES  | NO X  | If ye             | s. retur                   | n to and                                     | d complete item 9 a-d                         |
| PATIENT'S OF AUTHORIZED PERSON'S SK<br>to process this claim: I also request payment of<br>below.   | GNATURE La<br>government be                        | uthorize the rele   | ease of any medical or othe             | er information riecessary  | 13. INSURED'S OR A   | AUTHOR  | コラニロロ             | CDOOL                      |  | 1985  |
| -coπ.   |  | (0 )  |   | accepts assignment   | services describe  |   |                   | unders                     | igned p                                      | NATURE I authorize<br>physician or supplier i |
| IGNED STORAGE OF  | <u>~ **1</u> * * * * * * * * * * * * * * * * *     |   | DATE                                    |  |  |   |                   |                            |  |   |
| ATE OF CURRENT A ILLINESS (First sum  | nptom) OR  | 15 IF F   |   | 1/23/99  | SIGNED S   | iar   | 13+1              | 150                        | _on  | # \$ Y 25 ***                                 |
| PREGNANCY/LMP   | OR<br>P)   | GIV   | PATIENT HAS HAD SAME<br>E FIRST DATE MM | OR SIMILAR ILLNES:<br>DD YY  | 16. DATES PATIENT  | UNABL   | E TO W            | ORK IN                     | CURRI  | ENT OCCUPATION                                |
| AME OF REFERRING PHYSICIAN OR OTHE  | ER SCURCE  | 17a LD  | . NUMBER OF REFERRI                     | - 机铁铁铁头数弧,引领。  | ном  |   |                   | · T                        | יייייי כ                                     | UU YY   |
| <u></u>   |  |   | omben of Referri                        | ING PHYSICIAN  | 18. HOSPITALIZATIO   | N DATE  | SRELA             | TED TO                     | CURF   | RENT SERVICES                                 |
| ESERVED FOR LOCAL USE   |  |   |   |  | FROM   | , א   |                   | TO                         | IVIIVI                                       | DD YY   |
|   |  |   |   |  | 20. OUTSIDE LAB?   |   |                   | <u> </u>                   | ARGES  | )   |
| AGNOSIS OR NATURE OF ILLNESS OR INJ   | JURY, :RELAT                                       | E ITEMS 1 2 2   | ORATO ITEMASE                           | (8.07)   |  | NO  |                   |                            | ,  | ah.   |
|   | ••   |   | THE TO DEM 24E BY L                     | TIME)  | 22. MEDICAID RESULT CODE   | MISSIO  | N OF              |                            |  | 00  |
| ·   |  | 3. 느  | <del></del>                             | <b>*</b>   |  |   |                   | GINAL F                    | EF. NO                                       | <b>)</b> .                                    |
|   |  |   |   |  | 23. PRIOR AUTHORIZ   | ATION I   | NUMBE             | R                          |  | <del></del>                                   |
| A : 8   | Ci   | 1   |   |  | 1  |   |                   |                            |  | . *   |
|   | ce i Type   PF                                     | ROCEDURES.  | D<br>SERVICES. OR SUPPLIE               | <u> </u>   | F  | G   | Н                 | · ·                        | J  | 1   |
|   | f i of i   |   | usual Circumstances)                    | DIAGNOSIS  |  |   | EPSDT<br>Family   |                            |  | RESERVED FOR                                  |
| of of   | ice Servicei C                                     | PT/HCPCS  | MODIFIED                                |  |  |   |                   |                            |  | ,   |
| DD YY MM DD YY Servi  | /ICe Service C                                     | JE I/HUPUS  | MODIFIER                                | . GODE   | \$ CHARGES   | UNITS   | Plan              | EMG                        | COB  | LOCAL USE                                     |
| DD YY MM DD YY Servi  | /ice Service  0                                    | 97124   | MODIFIER                                | . GODE   |  | UNITS   | Plan              | EMG                        | COB  | LOCAL USE                                     |
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|---|---------------------------------|---------------------|--------------------|----------------|----------------------------------|---------------------|----------------------------------|----------------------|----------------------|--------------------|------------|-----------------------|--------------|--|
|   | IEDICAID                        | CHAN                |                    | CHAMPVA        |                                  |                     | FECA /                           | OTHER 1a. INSU       | REDIGI               | CL                 | AIM        | FOR                   |              | Р                                      |
| 2. PATIENT'S NAME (La   | fedicaid #)                     | (Spons              | or's SSN)          | (VA File       | 1 (00,10)                        | ( <i>aı</i>         | (SSN)                            | <b>45.</b>           |                      |                    |            |                       | (F           | OR PROGRAM II                          |
|   |                                 |                     |                    |                | 3. PATIENT'S BI                  | RTH DAT             | E SEX                            |                      | 390-                 | ME/(a              | -13        | 91                    |              | fiddle Initial)                        |
| Winston 5. PATIENT'S ADDRESS                                      | No Street                       | <u>ice</u>          |                    |                | 07 27                            | 193                 | 3 🏋 🗍 🕝 F                        | X                    | dine                 | - <del>-</del>     | or institu | e, First N            | lame, N      | liddle Initial)                        |
| 1 .   |                                 |                     |                    |                | 6. PATIENT REL                   | ATIONSH             | IIP TO INSURED                   | 7. INSUR             | Wins                 | DRESS              | (No. S     | ReL                   | nic          | e                                      |
| 3157 N 3  | <u>ssra</u>                     |                     |                    | 72             | Self X Spo                       |                     | Child Other                      |                      | 3157                 |                    |            |                       |              |  |
| Millianila  |                                 |                     |                    | STATE          | 8. PATIENT STA                   | TUS                 |                                  | CITY                 | <u> </u>             | 18                 | 33         | ra                    |              |  |
| Milwauke<br>ZIP CODE  |                                 | PHONE /             | Include Area (     | WI             | Single                           | Marrie              | d Other                          | $\neg$ $\mid$ ,      | 1i l w               | .a.d               | ·~~        |                       |              | ST                                     |
| 53216   | 1                               | )                   | moude Area (       | Code)          | Employed                         | r <del>-</del>      |                                  | ZIP CODE             |                      | ·uu i              | 100        | TEI EDI               | HOME         |  |
| 9. OTHER INSURED'S NA   | ME (Last Name                   | 14)                 | 447-1              | 1322           | . L1                             | Full-Tim<br>Student | Student                          | 7   57               | 3216                 |                    |            | 1                     | HONE (       | INCLUDE AREA                           |
|   | (                               | -, 1 H GL 14        | arrie, wilddie ii  | nitiai)        | 10. IS PATIENTS                  | CONDIT              | ION RELATED TO                   | 11. INSUR            |                      |                    | ROUP       | OR FEC                | A NILIA      | OFD.                                   |
| a. OTHER INSURED'S PO   | LICY OR GRO                     | UP NUM              | BEB .              |                |                                  |                     |                                  | - 1                  |                      |                    |            |                       | A NUM        | DEM                                    |
|   |                                 |                     | oe                 | 1              | a. EMPLOYMENT                    | ? (CURRE            | ENT OR PREVIOUS                  |                      | D'S DAT              | E OF B             | IATH       |                       |              |  |
| b. OTHER INSURED'S DA   | TE OF BIRTH                     |                     | SEX                |                | نا                               | YES                 | Mo                               | <u> </u>             | MM                   |                    | YY         |                       | -м [         | SEX                                    |
| MM DD YY  |                                 | и <u>Г</u>          | 5EX<br>F [──]      | - 1            | b. AUTO ACCIDEN                  |                     | PLACE (St                        | ate) b. EMPLOY       | ER'S NA              | AME OF             | SCHO       | OL NAM                |              | F_                                     |
| c. EMPLOYER'S NAME OF   |                                 |                     |                    |                | لسا                              | /ES                 | MNO                              | _                    |                      |                    |            |                       |              |  |
|   |                                 | -                   |                    | 1              | COTHER ACCIDE                    |                     | ·                                | C. INSURAN           | ICE PLA              | N NAM              | E OR P     | ROGRA                 | M NAM        |  |
| d. INSURANCE PLAN NAM   | E OR PROGRA                     | M NAME              | <u> </u>           |                | <u> </u>                         |                     | NO                               | 1                    |                      | #1.4<br>249        |            |                       |              |  |
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| 12 PATIENTS OR AUTHOR TO process this claim. I all Delow          | RIZED PERSOI<br>so request paym | N'S SIGN            | NATURE : aut       | horize the rel | ease of any medica               | ORM.<br>If or other | information necessa              | 13. INSURE           | DOUR                 |                    | DIZER      | DEDOO                 |              | 11 12 12 1                             |
| j   |                                 | o. go               | Activities of DeVi | ents either to | myself or to the par             | rty wno ac          | cepts assignment                 | services             | of medic<br>describe | al bene<br>d below | fits to ti | ie under              | signed       | NATURE I authori<br>physician or suppi |
| SIGNED Sign   | anturo                          | on                  | # : 1 <u>-</u>     |                |                                  |                     |                                  |                      |                      | 4.0                | aliani.    | in the second         | égi.         | 300<br>800                             |
| 14 DATE OF GUDGELE  | ▲ ILLNESS (Fit                  | 'SI Symot           | (mn) OP            | 15 15 1        | DATE                             | _07,                | /23/99                           | SIGNE                | <u> </u>             | igr                | nat        | ure                   | 'nη          | file                                   |
| MM DD YY  | PREGNANC                        | ident) Ol<br>Y(LMP) | R                  | GIV            | 'A LENICHAS HAD<br>'E FIRST DATE | SAME C              | OR SIMILAR ILLNES                | SS. 16. DATES P      | ATIENT               | UNABL              | E TO V     | ORK IN                | CURR         | ENT OCCUPATION                         |
| 17. NAME OF REFERRING   | PHYSICIAN OR                    | OTHER               | SOURCE             |                | NUMBER OF RE                     |                     |                                  |                      |                      |                    |            | '3                    | O ''''       | עיך טט אין                             |
|   | dina.                           | •                   |                    |                |                                  | . CHIUNG            | a PHYSICIAN                      | 18. HOSPITA          | LIZATIO              | N DATE             | SREL       | ATED TO               | O CURI       | RENT SERVICES                          |
| 19. RESERVED FOR LOCAL  | USE                             |                     |                    | <del></del>    |                                  |                     |                                  | FROM                 |                      |                    |            |                       | O MM         | DD YY                                  |
| -   |                                 |                     |                    |                | 11.                              |                     |                                  | 20. OUTSIDE          | LAB?                 | ٠.                 |            | \$ CH                 | ARGES        | 3                                      |
| 21. DIAGNOSIS OR NATURE   | OF ILLNESS (                    | DR INJUI            | RY. RELATE         | iTEMS 1.2.3    | OR 4 TO ITEM 24                  | E BY LIN            | IE)                              | YES                  |                      | NO                 |            |                       | . (          | ρφ                                     |
| 1. 1  |                                 |                     |                    |                |                                  |                     | <u> </u>                         | 22. MEDICAID<br>CODE | HESUE                | BMISSIC            | ON OR      | IGINAL I              | REF NO       |  |
|   |                                 |                     |                    | 3. L           | <del></del>                      | 3                   |                                  | 22 PRIOR 41          |                      |                    | !          |                       | _            | <b>J.</b>                              |
| 2   |                                 |                     |                    | · 4 !          |                                  |                     |                                  | 23. PRIOR AU         | HORIZ                | ATION              | NUMBE      | R                     |              |  |
| 24. A  DATE(S) OF SERV  | //CE                            | : 8                 | C                  |                | <u> </u>                         |                     |                                  | <u> </u>             |                      | ,                  |            |                       |              |  |
| From YY MM  | /10                             | of                  | ype PHC            | - explain ur   | SERVICES, OR S                   | UPPLIES             | DIAGNOSIS                        | †                    |                      | DAYS               | EPSD       | 1                     | J            | К                                      |
|   | <u> </u>                        | Service             | Service CP         | T/HCPCS        | MODIFIER                         | .65/                | CODE                             | \$ CHARG             | ES                   | OR                 | Family     | EMG                   | СОВ          | RESERVED F<br>LOCAL US                 |
| 05 24 99  | ·                               | 11                  |                    | 97014          |                                  |                     |                                  |                      |                      |                    | IGII       | <del></del> -         | <del> </del> | LOOKE 03                               |
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|   |                                 |                     | 26. PATIEN         | IT'S ACCOU     | NT NO. 27.                       | ACCEPT              | ASSIGNMENT?<br>claims, see back) | 20<br>28. TOTAL CHAP |                      | 1                  |            |                       |              |  |
| 39-1723576  |                                 | K                   | 029                |                | . :1 2                           | X YES               | I NO                             |                      | 5 0                  |                    |            | NT PAIL               |              | 30. BALANCE DI                         |
| . SIGNATURE OF PHYSICIAN INCLUDING DEGREES OR C                   | PENEMITIALO                     | 3                   | 32. NAME A         | ND ADDRE       | SS OF FACILITY                   |                     | <u>:</u>                         |                      |                      |                    |            | O,                    | oq           | s 265                                  |
| (I certify that the statements of apply to this bill and are made | on the coveres                  |                     | HENDE              | nen (il other  | than home or offic               | (e)                 |                                  | 33. PHYSICIAN'S      | ه, ۲۰۰۲<br>د ک       | LIER'S E           | BILLING    | NAME,                 | ADDR         | ESS, ZIP CODE                          |
|   |                                 |                     |                    |                |                                  |                     |                                  | EEAO                 | T.CI                 | uni<br>-           | rop        | rac                   | tic          | ESS, ZIP CODE<br>Clini                 |
| Adebayo Yu  | şuf, D                          | . C                 | . 1                |                |                                  |                     |                                  | MTI IIA              | W.,                  | ron<br>-           | d c        | iu 1                  | ac           | Avenue                                 |
| ENED  | C DATE                          | <b>V</b>            | <b>1</b> 40        |                |                                  |                     |                                  | MILWA                | UKE                  | E,                 | WΙ         | 532                   | 16           |  |
| (APPROVED BY AMA COUN   | CIL ON MEDIO                    | AL CED              | MOE CO             |                |                                  |                     |                                  | PINA14)              | 461                  | -22                | $2P_{GF}$  | RP#                   | _            |  |

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| MODICARE   MEDICAD   CHAMPA   CHAMPA   CHAMPA   SSS of   MEDICAN   CHAMPA   CHAMPA   SSS of   MEDICAN   CHAMPA   CHAMPA   SSS of   MEDICAN   | STAPLE IN THIS AREA  | OR PROGRAM IN ITEM 1)   |
|--|--|---|
| NATION   PROPERTY  | HEALTH INSURANCE CLAIM FORM  1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN BLK LUNG (SSN) (SS | OR PROGRAM IN ITEM 1)   |
| 1. MEDICARE   MEDICARE   CHAMPILA   CHAMPI   | HEALTH INSURANCE CLAIM FORM  1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN BLK LUNG (Medicare #) (Medicare #) (Sponsors SSN) (VA File #) (SSN or ID) (SSN) (SSN | OR PROGRAM IN ITEM 1)   |
| Marcher   Michael   County   | 1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP FECA OTHER 1a. INSURED'S I.D. NUMBER (FOUND MEDICAID (Medicare #) (Medicare #) (Medicare #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) XD) 390-38-1391  2. PATIENT'S NAME (Last Name, First Name, Middle initial) 3. PATIENT'S BIRTH DATE SEX MM   DD   YY   | OR PROGRAM IN ITEM 1)   |
| Marcher   Michael   County   | 1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN BLK LUNG (Medicare #) (Medicare #) (Medicare #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) XD) 390-38-1391  2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX MINSURED'S NAME (Last Name, First Name, M DD: YY WINSTON, Bernic 5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No., Street) 3157 N 33rd Self X Spouse Child Other 3157 N 33rd  | OR PROGRAM IN ITEM 1)   |
| WASCASE AND  | Medicare #)   (Medicaid #)   (Sponsor's SSN)   (VA File #)   HEALTH PLAN   BLK LUNG   (SSN)   XD)   390-38-1391  |   |
| 2.77    | 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)  3. PATIENT'S BIRTH DATE SEX  Winston Bernice  5. PATIENT'S ADDRESS (No., Street)  3. PATIENT'S BIRTH DATE SEX  Winston, Bernice  6. PATIENT'S ADDRESS (No., Street)  7. INSURED'S ADDRESS (No., Street)  Self Spouse Child Other 3157 N 33rd  |   |
| Winston   Bernice   On   On   On   On   On   On   On   O   | Winston, Bernice  O7 27 1937 FX Winston, Bernic  5. PATIENT'S ADDRESS (No., Street)  6. PATIENT RELATIONSHIP TO INSURED  7. INSURED'S ADDRESS (No., Street)  Self X Spouse Child Other 3157 N 33rd   |   |
| SATISTICATION   STATE   STAT   | 5. PATIENT'S ADDRESS (No., Street)  6. PATIENT RELATIONSHIP TO INSURED  7. INSURED'S ADDRESS (No., Street)  3157 N 33rd  Self Spouse Child Other  3157 N 33rd  |   |
| 3157 N 33rd  | 3157 N 33rd Self X Spouse Child Other 3157 N 33rd  | e   |
| STATE   LAPTICE  | 3137 K 337 G   |   |
| STATE   RATHER STATUS  |  |   |
| 20   COC   |  | STATE   |
| 20   COC   | Milwaukee  | . MI  |
| STATES   S   |  |   |
| 10. IS PATIENT'S CONDITION RELATED TO:  11. INSURED'S POLICY GROUP OR PECA MAMBER  2. EMPLOYMENT' (CURRIENT OR PREVIOUS)  2. THERR INSURED'S POLICY OR GROUP NUMBER  3. EMPLOYMENT' (CURRIENT OR PREVIOUS)  3. INSURANCE OF BRITH  5. COTHER RISURED'S DATE OF BRITH  5. COTHER RISURED'S OATE OATE OATE OATE OATE OATE OATE OATE  | 1  | )   |
| a. OTHER INSUREDS POLICY OR OROUP NUMBER  1. SEMPLOYMENT (CURRENT OR PREVIOUS)  2. THE RESERVED SHATE OF BIRTH  SEX  1. AUTHOR RECIPETY  1. PLACE (State)  1. SEMPLOYMENT SHAME OR SCHOOL NAME  2. DEPLOYMENT SHAM   | JULIU 117 117 1022   | /<br>MBER   |
| VES  | 3, OTHER MOORES OF THE CONTROL OF TH | , DET   |
| VES  | A SAMPLOVACADO DO LOVIOR COOLINA MINARED.  |   |
| D. OTHER MSUREDS DATE OF BRITH MARK  D. OTHER ACCIDENT?  PLACE (State)  C. DITHER ACCIDENT?  C. DITHER ACCIDENT PLACE (CO. DITHER SOLD)  C. DITHER ACCIDENT PLACE (CO. DITHER SOLD)  C. DATES PATENT MAMBE OF SCHOOL PLACE ACCIDENT  | MM DD YY   | _ :   |
| YES   NO   NSURANCE PLAN NAME OR SCHOOL NAME   10th RESERVED FOR LOCAL USE   10th RESERVED FOR   |  | F []  |
| C. EMPLOYER'S NAME OR SCHOOL NAME  | THE OP WY  | :   |
| A NOBIRANCE PLAN NAME OF PROGRAM NAME  | M F YES NO NO CONTROL OF THE PROPERTY OF THE P |   |
| 102. RESERVED FOR LOCAL USE  | C. EMPLOYER'S NAME OR SCHOOL NAME C. OTHER ACCIDENT? C. INSURANCE PLAN NAME OR PROGRAM NA  | ME  |
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| Specific Content of the properties of the prop   | d. INSURANCE PLAN NAME OR PROGRAM NAME 10d: RESERVED FOR LOCAL USE d. IS THERE ANOTHER HEALTH BENEFIT PLA  | N?  |
| READ BACK OF FORB BEFORE COMPLETING & SIGNING THIS FORM.  312 PATIENTS OF ANTHORIZED FERSONS SIGNATURE Laumonta in resease the anymetic of or other information necessary to process this claim. I also request payment of government benefits within 1 also payment of government bene   | YES V-NO If yes return to  | and complete item 9 a-d   |
| 32   PATE(PTS) DR AUTH-ORZED PERSON'S SIGNATURE. 1 authors the release of any reflection of other information necessary to proceed the claim. Host proqued playment of operations the release of any reflection of the process of the   | September 2015 Annual Control of the | Sverigation in the second second  |
| SIGNED   | 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE   authorize the release of any medical or other information necessary payment of medical benefits to the undersigned  | ed physician or supplier for  |
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| CITY   |   | •  | l              | 8. PATIENT STA   | ATUS                                  | _                  | CITY                                      |                       |  |              | S               | STATE             |
| Milwaukee                                      | TELEBURYE                               |  | WI             | Single   | Married                               | Other              | Milwa                                     |                       |  |              |                 | WI.               |
| ZIP CODE                                       |   | Include Area Co                              | 1              | Employed   | ¬ Full-Time ┌─                        | Part-Time          | ZIP CODE                                  |                       | TELEPHON   | IE (INCL     | UDE ARE         | A CODE)           |
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| 9. OTHER INSURED 5 NAME (                      | Last Name, First N                      | ame, Middle inii                             | iiai)          | IU. IS PATIENT   | 5 CONDITION                           | RELATED TO:        | 11. INSURED S POLIC                       | Y GHOUP C             | H FECA N   | UMBEH        |                 |                   |
| a, OTHER INSURED'S POLICY                      | OR GROUP NUM                            | IBER   | —— <u> </u>    | a. EMPLOYMEN   | T? (CURRENT                           | OR PREVIOUS)       | a. INSURED'S DATE C                       | E BIRTH               | <del></del>                                      |              | 054             |                   |
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| REA<br>12. PATIENT'S OR AUTHORIZ               | D BACK OF FORM<br>ED PERSON'S SIG       |  |                |  |                                       | ormation necessary | 13. INSURED'S OR AU<br>payment of medical |                       |  |              |                 |                   |
| to process this claim. I also rebelow.         |   |  |                |  |                                       |                    | services described l                      |                       |  | j p,         | 5.0.0.0.        | Spare 101         |
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|  | ature or                                |  |                | DATE   | ~ 1.6.6                               | 23/99              | SIGNED S                                  |                       |  |              |                 |                   |
| MM DD YY                                       | ILLNESS (First sym<br>INJURY (Accident) | OR   | G              | IVE FIRST DATI   |                                       | SIMILAR ILLNESS.   | 16. DATES PATIENT U<br>MM DD<br>FROM      | NABLE TO              | WORK IN (  | MM           | DD :            |                   |
| 17. NAME OF REFERRING PH                       | PREGNANCY(LMP<br>YSICIAN OR OTHE        |  |                | I.D. NUMBER OF   | F REFERRING F                         | PHYSICIAN          | 18. HOSPITALIZATION                       | DATES RE              |  | 1 1 2 2 1 2  | NT SERV         | ICES              |
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| 19. RESERVED FOR LOCAL U                       | SE                                      |  | <del>}</del> - |  | · · · · · · · · · · · · · · · · · · · |                    | 20. OUTSIDE LAB?                          |                       | <del></del>                                      | RGES         |                 |                   |
| •  |   |  |                |  |                                       |                    | YES X                                     | NO                    |  | .0           | p               |                   |
| 21. DIAGNOSIS OR NATURE O                      | OF ILLNESS OR IN                        | JURY. (RELATI                                | E ITEMS 1.     | 2.3 OR 4 TO ITE  | M 24E BY LINE                         | ) ———              | 22. MEDICAID RESUB                        | MISSION               | RIGINAL F  |              | <del>-</del>    |                   |
|  |   |  | 3.             | :  |                                       | <b>Y</b>           |   |                       | THOMAS !   |              |                 |                   |
| ·  |   |  |                |  |                                       |                    | 23. PRIOR AUTHORIZ                        | ATION NUM             | BER  |              |                 |                   |
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| 24. A  | CE 81                                   |  | OCEDUR         | D<br>ES, SERVICES.   | OR SUPPLIES                           | E                  | F   | G P                   |  | J            |                 | K                 |
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| apply to this bill and are made                | e a part inereof.)                      |  |                |  |                                       |                    | 5542 W.                                   |                       |  |              |                 | nue               |
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| FEDERAL TAX I.D. NUMBER SSN EIN  39-1723576  SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (Lordly hat the statements or the reverse apply to this bill and are made a part thereof.)  Adebayo Yusuf, D.C.  DATE  28. PATIENT'S ACCOUNT NO.  27. ACCEPT ASSIGNMENT? [For govi. claims, see back]  5 75 00 \$ 0 00 \$ 75 01  32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE APHONE. PLYTAMIC Chiropractic Clinic 5542 W Fond du lac Avenue MILWAUKEE, WI 53216  PHYSICIAN'S SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE APHONE. PLYTAMI' Chiropractic Clinic 5542 W Fond du lac Avenue MILWAUKEE, WI 53216  PHYSICIAN'S PRINT OR TYPE  FORM HCFA-1500 (12-90)  |  |                         |                               |   | ces)            |                       | \$ CHARG   | ES                    |             |               | G COB      |                                       |              |
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| FEDERAL TAX I.D. NUMBER SSN EIN  39-1723576  30. BALANCE DUE  39-1723576  31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  Adebayo Yusuf, D.C.  DATE  22. ACCEPT ASSIGNMENT? [For govt. claims, see back)  3 PHYSICIAN OR SUPPLIER RENDERED (If other than home or office)  32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)  33. PHYSICIANS. SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE RENDERED (If other than home or office)  34. PHONE #  DY TAME  ADDRESS OF ACILITY WHERE SERVICES WERE PLY TAME  ADDRESS OF ACILITY WHERE SERVICES WERE PLY TAME  ADDRESS, ZIP CODE  MILWAUKEE, WI 53216  PINA 414) 461-222 C GRP#  FORM HCFA-1500 (12-90)   |  |                         |                               | · <del>····································</del> |                 |                       |  | <del></del> ,         |             | <del>i</del>  | $\top$     |                                       |              |
| FEDERAL TAX I.D. NUMBER SSN EIN  39-1723576  30973  SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (Icerify that the statements on the reverse apply to this bill and are made a part thereof.)  Adebayo Yusuf, D.C.  DATE 092199  DATE 092199  PLEASE PRINT OR TYPE  128. TOTAL CHARGE  29. AMOUNT PAID  30. BALANCE DUE  27. ACCEPT ASSIGNMENT? [For govt. claims, see back)  3 PHYSICIANS SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE  RENDERED (If other than home or office)  3 PHYSICIANS, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE  A PHONE #  DY TAMIO Chiropractic Clinic  5542 W Fond du lac Avenue  MILWAUKEE, WI 53216  PINA 414) 461-222 CGRP#  FORM HCFA-1500 (12-90)   |  | 1                       |                               | i   |                 |                       |  | :                     |             |               |            |                                       |              |
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| apply to this bill and are made a part thereof.)  Adebayo Yusuf, D.C.  MILWAUKEE, WI 53216  PIN: 414) 461-222 GRP#  FORM HCFA-1500 (12-90)  | SIGNATURE OF PHYSICIAN OR SUPPL  |                         | 2. NAME AND A                 | DDRESS OF FACILIT                                 | Y WHERE SE      | ERVICES WERE          |  | N'S. SUP              | PLIER'S     | BILLING NA    | ME, ADD    | RESS, ZIP CO                          | DE           |
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| FORM HCFA-1500 (12-90)  | Adebayo Yusuf,   | D.C.                    | · ·                           |   |                 |                       |  | . *                   | ••          |               |            | 5                                     |              |
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#### NEW PATIENT INFORMATION SHEET

|                              |                    |  | TODAY'S DATE                 | E: 4-30 99   |
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| AGE: 60 MARRIED:             | single:wid         | OW(ER):DIVORCED:_                      | SEPARATED:                   | _CILLIAREN:  |
| ADDRESS: 3/57/1/33           | 3 5/1<br>St.#/Name | MILWAUK                                | <u> </u>                     | 3216<br>Code |
| TELEPHONE: (414) <u>HH-7</u> | 1322 Ext           | WORK TELEPHONE: (                      | )                            | Ext.         |
| OCCUPATION: 706DS            | selluce            | WHERE EMPLOYED:                        | Mount Since                  | n Horit      |
| SPOUSE'S NAME:               |                    | OOOUPAMION:                            |                              |              |
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| PREVIOUS CHIROPRACTOR:       |                    | _ Telepione: ( )                       | Ext                          | <b>:</b>     |
| DO YOU PREFER TO PAY B       | r: Casi Che        | CK                                     |                              |              |
| IS THIS AN INSURENCE C       | ASE: YESNO         | _                                      |                              |              |
| NAME OF INSURANCE COMPA      | MY:                |  | (Primar                      | 7 Ins.)      |
| ADDRESS: Number #            | //<br>St,#/Name    |  |                              |              |
| POLICY #:                    | GROUP #:_          | I.D.                                   | ):                           |              |
| PATIENT S.S.#: 3_60          | 38 <u>139</u> L n  | ASURED S.S.#:                          |                              |              |
| NAME OF INSURED:             | <del></del>        | ADDRESS:                               | PHONE:<br>TOT SAME AS PATIEN | :( )<br>TT)  |
| NAME OF SECONDARY INS.       | <b>.:</b>          | PHONE: (                               | ) E                          | ext.         |
| ADDRESS:                     | //                 | ////                                   | /<br>State 2                 | ip Code      |
|                              |                    | <b></b>                                |                              | np coe       |
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| PERSONAL INJURY CASE:        | ATTORNEY:          |  | NE: ( )                      | Ext          |
|                              | ADDRESS:           |  | Suite #:                     |              |

### \*\*\*\*\*\*\*\* Below\*\*\*\*\*\*\*

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| *FAMILY HISTORY*  | Cancer, or                              | iligh or Lov             | Blood Press                               | me: BETTA   | •                          | ٠,            |
| -ather            | 3                                       | rester                   | mat                                       | he R        | rether                     | <u> </u>      |
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|                   | BIR                                     | ni control               | PILLS: YES                                | NO          |                            |               |
|                   | <b>NRE</b>                              | YOU PREGNA               | nt at this t                              | ME?: YES    | NO                         |               |
| ON THE NEXT PAGE  | E IS A LIST OF                          | POSSIBLE S               | ympioms. PLE                              | ISE CIRCLE  | TAIT YM                    | MY APPLY      |

Please underline all of the following symptoms which you have now or have had previously. We want ALL the facts about your health before we accept your case. Your health report is CONFIDENTIAL and is treated as such by this CLINIC.

|    | GENERAL SYMPTOMS      | SKIN                   | GENITOURINARY              | Are you on Drugs?                     |
|----|-----------------------|------------------------|----------------------------|---------------------------------------|
|    | Jane Comment          | -                      |                            | if so, please list and                |
|    | Headache              | Skin Eruptions         | Frequent Urination         | give reason WHY?                      |
|    | Fever                 | Itching                | Painful Urination          | give reason will                      |
|    | Chills                | Bruises Easily         | Blood in Urine             |                                       |
|    | Sweats                | Dryness                | Pus in Urine               |                                       |
|    |                       | Boils                  |                            |                                       |
|    | Fainting              | Sensilive Skin         | Kidney Infection or Stones | · · · · · · · · · · · · · · · · · · · |
|    | Dizziness             |                        | Bed Wetting                |                                       |
|    | Convulsions           | Hives or Allergy       | Inability to Control Urine | CHECK THE FOLLOWING                   |
|    | Loss of Sleep         |                        | Prostate Trouble           | CONDITIONS YOU HAVE HAD               |
|    | Faligue               | RESPIRATORY            |                            |                                       |
|    | Nervousness           |                        | GASTROINTESTINAL           | Alcoholism                            |
|    | Loss of Weight        | Chronic Cough          | Poor Appellle              | Anemia                                |
|    | Numbness/Paln In      | Spitting up Philegm    | Difficult Digestion        | Appendicilis                          |
|    | (Arms,Hands,Legs)     | Cliest Paln            | Excessive Hunger           | Arthullis                             |
|    | Allergy               | Difficult Breathing    | Belching or Gas            | Cancer                                |
| 41 | Neuralgia             |                        | Nausea                     | Diabetes                              |
|    |                       | CARDIO-VASCULAR        | Voinling                   | Diplitheria                           |
|    | EYES, EARS, NOSE      |                        | Pain over Stomach          | Emphysema                             |
|    | & THROAT              | Rapid Beating Heart    | Distention of Abdomen      | Epilepsy                              |
|    | and the second second | Slow Beating Heart     | Consilpation               | Gøller                                |
|    | Failing Vision        | High Blood Pressure    | Diarrhea                   | Heart Disease                         |
|    | Near Siglitedness     | Low Blood Pressure     | Hemorrholds (Plles)        | Malaria                               |
|    | Far Sightedness       | Pain Over Heart        | Intestinal Worms           | Miscarriage                           |
|    | Crossed Eyes          | Previous Heart Stroke  | Gall Bladder Trouble       | Multiple Sclerosis                    |
|    | Eye Paln              | Hardening of Arteries  | Liver Trouble              | Pleurisy                              |
|    | Dealness              | Swelling of Ankles     | Jaundice                   | Pneumonia                             |
|    | Earache               | Poor Circulation       | Colitis                    | Polio                                 |
|    | Ear Noises            | Paralytic Stroke       |                            | Rheumatic Fever                       |
|    | Ear Discharge         |                        |                            | Stroke                                |
|    | Nose Bleeds           | MUSCLE & JOINT         | WOMEN ONLY                 | Tuberculosis                          |
|    | Nasal Obstruction     |                        |                            | Typhoid Fever                         |
|    | Sore Throat           | Stiff Neck             | Painful Menstrual Periods  | Ulcers                                |
|    | Hay Fever             | Back Aclie             | Excessive Flow             | Venereal Disease                      |
|    | Asthma                | Swollen Joints         | Hot Flashes                | Gout                                  |
|    | Gun Trouble           | Tremors                | Irregular Cycle -          |                                       |
|    | Frequent Colds        | Painful Tail Bone      | Cramps or Backache         |                                       |
|    | Enlarge Thyrold       | Foot Trouble           | Previous Miscarringe       |                                       |
|    | Tonsillitis           | Hernia                 | Vaginal Discharge          |                                       |
|    | Sinus                 | Pain Between Shoulders | Lumps in Breast            |                                       |
|    | Enlarge Glands        | Spinal Curvature       | Menopausal Symptoms        |                                       |
|    | 290 0.000             | Faulty Posture         | Congested Breasts          |                                       |

I ACKNOWLEDGE THAT ALL THE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

Signed Beri Celleus Ton

INSURANCE

OH ALL HISURANCE ASSIGNMENTS \$100
DEDUCTIBLE MUST BE MET IN THE BEGINNING
UNLESS PRIOR ARRANGEMENTS ARE MADE.

NOTICE TO OUR NEW PATIENTS

FULL PAYMENT FOR CHIROPRACTIC SERVICES RENDERED IS DUE AT THE END OF EACH VISIT. IF FOR ANY REASON THIS REQUEST CANNOT BE MET, ARRANGEMENTS MUST BE MADE IN ADVANCE BEFORE SEEING THE DOCTOR.

Bernice Winston Pr staten that on 4-15-9, ar about 4.30 pm she was walking down the sidewalk on Capital Brive while the suddenly tripped and fell down to wast face-down stated what what sustained a cur to her right upper eyelire bourses to her right am & N Knee shates they she was conveyed in an am sulance to st. Josephio ! Hospital ETR Stated that her of accorded of eye hid was stitched a she was stitched a she was the hot that the hot her UB. The following day and has continued to experience same Par story War she was well providence fine prior to her fall. The denier any recent in fund or fall prior to this fall of 1915199 Pertur of suptement 1972

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| Bernice With   | s home             |                  |  | 3  |  |
|--|--------------------|------------------|--|--|--|
| TIENT STANDING   | 3 ( 0 ) (          |                  |  |  |  |
| NERAL APPEARANCE, 4/20/99  | Thoracic - L       | .umbar Moti      | on   |  |  |
| Nourishment G_FXP_ Color G_FXP_  |                    |                  | Norm   | Exam   | Pain                                     |
| Stature G_FAP_   | Flexion            |                  |  | 30   | 7,                                       |
| Attitude G_F_P_  | . 1                |                  | 75-900   |  | he                                       |
| abulation G_F P_   | Extension          |                  | 300  | 10   | _  |
| Cane(s) Crutch(s)  | Lateral Righ       | nt               | 350  | 25   |  |
| Wheelchair   | // Lateral Left    |                  | 350  | 15   |  |
| Hon-Ambulatory   | Rotation Ri        | laht             | 300  | 10   |  |
| Height S Weight (82 lbs)   | Rotation Le        | · }              |  |  |  |
|  | Tiotation Ce       | :'\ [            | 300  | 10   | <u> </u>                                 |
| VICE MOTION SUSSIFEST POR LOCAL  NORM EXEM Phin  NORM EXEM Phin  | PATIENT PRONE      | <u> </u>         |  |  | •  |
| vical Motion 8448145/ feet prod. Will  | Achilles Reflex    | H +2             | ite  |  |  |
| Norm Exam Phin   | Nachlas-ely        |                  |  | 0 (  | ~ /                                      |
| xion 450 WNL Nee   | n- 141   1   n     | BOTH _           | Ari &  | fun  | 6 42                                     |
|  | Deriffeld Cerv.    | - R              | L  | l de la companya de l | en e |
| tension 550  | P.                 | - R              | L  |  |  |
| eral Left 400  | S-I Matlon         | R                | L  | Paragonal property   |  |
| eral Right 400   | SEGMENT            | TENDER           | CDAC   |  |  |
| tation Left 700  | occ                | I                | SPAS   | WIS -  | LISTING                                  |
| tation Right 700 U   | CI                 |                  |  |  |  |
| aminal Compression B   | C2                 |                  |  |  | Tighter<br>Annual                        |
| oulder Depressor R L LE  | C3                 |                  | ,  |  |  |
| 1 Fanning  | C4<br>C5           | <u> </u>         |  |  | A  |
| eps Rellex  ceps Rellex  R 12 1  | C6                 | <u> </u>         | <del>-    </del>                                 |  | A COLUMN TO                              |
| dial Reflex R TV I TV  | C7                 |                  |  |  |  |
| ellar Hellex A TL  | T1                 |                  |  |  |  |
| and Pressure   | T2<br>T3           |                  | <u> </u>   |  |  |
| - ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) (  | TA                 |                  | <del>- </del>                                    |  |  |
| " - 10 mm Blood Press  | T5                 |                  |  |  | <del></del> _                            |
| prom Blood Press spiration Hobrid TIENT SUPINE  Prom Blood Press medication  1 6 400 Fland Cyspla  | <u> </u>           |                  |  |  |  |
| - 1/2 m (a)  | T7 T8              | <del></del>      |  |  |  |
| TIENT SUPINE @ 48 & part & 45ph  | 10 Tg              |                  |  |  |  |
| PILLE COS EDM  | T10                |                  |  |  |  |
| breeze the state of the state o | 111                |                  |  |  |  |
| S1 A   | T12                | ! <del>V</del> - | _  | ,  |  |
| Lumbar H L   | L2                 | N Y              | -  | -  |  |
| over's sign ANDLOUS  | L3                 | NI W             | -  <i> </i>                                      |  |  |
| Lowering APUT LASS @ 30 E /a-  | L4                 | XX               |  |  | <del></del>                              |
| orig's Sign  April Hole Was elfor  | L5                 | - XX.            | 7.   |  |  |
| Part 1 A L   | SAC-BAS<br>SAC-APE | 110              |  |  |  |
| Part 2 R   | RT-IL              | <del></del>      | -  <u>-</u>                                      |  |  |
| Part 3 R I L   | LTIL               | <del></del>      |  |  | · · · · · · · · · · · · · · · · · · ·    |
| kle Clonus R T L T   | COCCYX             |                  |  |  | · · · · · · · · · · · · · · · · · · ·    |
| wheel  | Y BAYS             | Plan             |  | L_   |  |
| Ankle RLEVEL   | X RAYS             | 14 × 17          | 10 × 12  | 2  | 8 × 10                                   |
| Wrist R LEVEL  | CERV               |                  | <del>                                     </del> |  |  |
| Wrist R LEVEL  | THOR               | <u> </u>         | 1  |  |  |
| sinkel # 1   | WARAS Y            | 21-27            |  | <del></del>  | <del></del>                              |

| HENTSIANDING BERNICO Winst                            | o~                |                    |          |                 |
|---|-------------------|--------------------|----------|-----------------|
| HERAL APPEARANCE GGGGGGGGGGGGGGGGGGGGGGGGGGGGGGGGGGGG | Thoracle - Lumber | Motlon             |          |                 |
| Stature G F P   |                   | Norm               | Exam     | <b>.</b>        |
| Attitude G_F_P  | Flexion           | 75-900             | (00)     | Palm            |
| bulation G_F_P_                                       | Extension         | 300                |          | Pos             |
| Cane(s) Crytch(s)                                     | Lateral Right     |                    | 20       |                 |
| Whoelchale  | Lateral Left      | 350                | MNT      | Nep             |
| Hon-Ambulatory  | •                 | 350                | 30       | 100             |
| Helglit Welglit                                       | Hotation Alght    | 300                | MAG      | New             |
|   | Rotation Lett     | 300                | 2        | <del>()</del> - |
| HENT SEATED   | 44.44.            |                    |          | [0]             |
| vical Motion  | PATIENT PHONE     | 10 (               |          |                 |
| Norm Exam Pale  | Achilles Hellex H | # L 1/2            |          |                 |
| - Talli   | Nachlas-ely H     | Le Le              | 01/      |                 |
| <del>- 450</del>                                      | Derifield Cerv. H | 1 180 5 100        | uel/s    |                 |
| ension 550  | Sec. 17           |                    |          |                 |
| eral Celt   | S.I Mollon n      |                    |          |                 |
| exat filight 400                                      | 5-1 Motion #      |                    |          |                 |
| Talfon Lett 700                                       | SEGMENT TEND      | ER SPASI           | WC       | D#111-          |
| Jatino Hight 700                                      | Occ               |                    | <u> </u> | STING           |
|   | <u>C1</u>         |                    | estina.  |                 |
| Hilder Defressor                                      | C2 C3             |                    | , B      |                 |
| 1 Familia   | C4                |                    |          |                 |
| nni Rellex<br>-egic Rellex                            | CS CS             |                    |          |                 |
| fial Rolley H With                                    | C6                |                    |          |                 |
| allar Hellex H E L                                    | 11 -              |                    |          |                 |
| nd Pressure   | T2                |                    |          |                 |
|   | T3   1            |                    |          |                 |
| piration  | 15                |                    |          |                 |
|   | 18                | <del>-</del> -     |          |                 |
| IENT SUPINE   | 17                |                    |          |                 |
| THE TRANSPORT   | T8 19             |                    |          |                 |
| To Men I I I I I I I I I I I I I I I I I I I          | 110               |                    |          |                 |
| Ilhwait   | TII               |                    |          |                 |
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| umbar H N 3 A N O D                                   |                   |                    |          |                 |
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| ig's Sign   | L4 XX             | — —— <del>  </del> |          |                 |
| re-Patrick  | L5 XX             |                    |          |                 |
| "II I Et must   | SAC-BAS IN        |                    |          |                 |
| "   | NT-IL I           | <u> </u> i         |          |                 |
| • Clanus  | LT-IL             | <del>  -</del>     |          |                 |
| line)   | COCCYX            |                    |          |                 |
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| ist it level  | RAYS 14 x 17      | 10 × 12            | 8 ×      | 10              |
| L LEVELC  | ERV               |                    |          |                 |
| H I   | Hor               |                    |          |                 |
| 3140  | UMBAR             |                    |          |                 |

## Pyramid Chiropractic Clinic

Dr. Adebayo Yusuf

5542 West Fond du lac Avenue Milwaukee, Wisconsin 53216 (414) 461-2222

#### X-RAY ANALYSIS

Bernice Winston

DATE:

4-20-99

AREAS:

Ls spine (In House)

VIEWS:

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Normal Indaha Corre una Naviour popular spacers Long Ly. 4. Ly. 15- 12 Anterior osteophy bois Lz-5

I mter robotional malpositions & resultant Le vo-scaluscris

Rt unilateral sacralization of Li

Y Rays Neg for to

# Py

Pyramid Chiropractic Clinic, S. C.

Dr. Adebayo Yunuf

6642 West Found thi Lac Avenue Milwauker, Wisconsin 53210 (414) 461-2222

#### RECURDS RELEASE

| Tradicipated the type property in a comment    | osis and Records of Any Treatment or Examination |
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| Rendered to Me During the Period. FROM 4-15-97 | 10   |
|  | NATURE Ben he Wister                             |
|  |  |
| s Name,  | Bernice Winston                                  |

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| P  | AST MEDICAL HISTORY   | <del></del>   | FAMILY HX TB   |   | E SKIN TEST  | REC'D MEDIC                             |  | ACCT*:                                   | •                       |   |   |  |  |
|  | RESP.   CARDIAC   | , ( )   | DM PSYCH   | AODA P  | RIMARY RN  |   |  | 70045                                    | 175                     |   | <b>              </b>                             | iri ini ini ini  | l Mili lani  |
| _  | CANCER OTHER  | <u> </u>  |  | c   | <u>) (W</u>  | <u> </u>                                | $\geq$ $\perp$   |  | ÷                       |   |   |  |  |
|  | 100   | YES NO  |  |   | TETANUS  | >10 YF                                  | ı  | ٠.                                       |                         | 4.  | .15.0   | 19 -   |  |
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| 7  | OSK US.   | 1354  |  |   |  | 1750                                    | 1851   | 101                                      | 84                      |   |   |  |  |
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|  |   |   | 1998)<br>170   |   |  |   |  | *:<br>#4                                 | L 1                     |   |   |  |  |
| _  |   |   |  |   |  |   |  | 77                                       |                         | 03  | 17  | DEDICA   | TED  |
|  | OLD RECORDS   | ☐1-6 (2STAT)  | CK - MB SCREEN   | ECG   |  |   | LACERA   | TION LO                                  | CATION                  | Æ   | NGTH CM   | NO. SUTURES  | SUBQ.  |
|  | Г СВС   | ☐ CHEM 7  | [*□ LOH  | 1   |  |   |  |  |                         |   | <u> </u>  | _> 0   | JUDU.  |
|  |   | - La   | T SCOT (AST)   | 1   |  | - 1. A                                  | TREATA   | MENT                                     |                         |   | -   |  |  |
|  | Пн∕н  | Na<br>K   | SGOT (AST)   |   |  |   | TREATM   | MENT                                     | RATE                    |   | O <sub>2</sub> AT                                 | □0-  | SAT  |
|  | НИН   | Na<br>K<br>Cl   | ☐ SGPT (ALT)<br>☐ GGT  | STREP SCRE  |  | 3G #1 ONL                               | IV   |  |                         |   | O <sub>2</sub> AT                                 |  | SAT  |
|  | □ нин<br>wвc  | ĸ   | SGPT (ALT) GGT BILIRUBIN   | BLOOD CUL   |  |   | IV   |  |                         |   |   |  |  |
| Į.   | WBC<br>DIFF<br>B  | K<br>CI<br>CO<br>Glucose  | ☐ SGPT (ALT)<br>☐ GGT  | ☐ BLOOD CUL   | TURE pl  |   | IV<br>MON<br>DUETA   | IITOR / RI<br>ANUS<br>AIGHT CA           | TH   F                  | MPANX PA  | TIENT Y   | ES NO  |  |
| IMENI                                      | ₩BC<br>DIFF   | K<br>CI<br>CO<br>Glucose<br>BUN   | ☐ SGPT (ALT) ☐ GGT ☐ BILIRUBIN ☐ ALK PHOS ☐ LIPASE ☐ AMYLASE   | BLOOD CUL   | TURE pl  | 4                                       | IV<br>MON<br>DUETA   | IITOR / RI<br>ANUS<br>AIGHT CA           | TH   F                  | MPANX PA  | TIENT Y   | ES NO  |  |
| _  | WBC<br>DIFF<br>B<br>S<br>E<br>L   | K<br>CI<br>CO<br>Glucose<br>BUN<br>Creat  | ☐ SGPT (ALT) ☐ GGT ☐ BILIRUBIN ☐ ALK PHOS ☐ UPASE ☐ AMYLASE ☐ AMMONIA  | ☐ BLOOD CULTURI   | TURE ph  | 1<br>co <sub>2</sub>                    | IV<br>MON<br>DUETA   | IITOR / RI<br>ANUS O<br>AIGHT CA         | TH   FI                 | INGERSTIC   | K GLUCOSE   | ES NO VISUAL ACUI  |  |
| TREAL                                      | WBC<br>DIFF<br>B<br>S<br>E<br>L   | K CI CO Glucose BUN Creat   | GGPT (ALT) GGT BILIRUBIN ALK PHOS LIPASE AMYLASE AMMONIA KETONES   | BLOOD CULTURI GC CULTURI CHLAMYDIA WET MOUNT  | TURE ph  | 1<br>CO <sub>2</sub><br>CO <sub>3</sub> | IVMON  DIETA  STRA   | IITOR / RI<br>ANUS O<br>AIGHT CA         | TH   FI                 | INGERSTIC   | K GLUCOSE   | ES NO VISUAL ACUI  |  |
| TREAL                                      | WBC<br>DIFF<br>B<br>S<br>E<br>L<br>M  | K<br>CI<br>CO<br>Glucose<br>BUN<br>Creat  | ☐ SGPT (ALT) ☐ GGT ☐ BILIRUBIN ☐ ALK PHOS ☐ UPASE ☐ AMYLASE ☐ AMMONIA  | BLOOD CULTURI GC CULTURI CHLAMYDIA WET MOUNT  | TURE PO  | 1<br>CO <sub>2</sub><br>CO <sub>3</sub> | IVMON  DIETA  STRA   | IITOR / RI<br>ANUS O<br>AIGHT CA         | TH   FI                 | INGERSTIC   | K GLUCOSE   | ES NO VISUAL ACUI  |  |
| TREAL                                      | WBC DIFF B S E L M INR  | K CI CO Glucose BUN Creat  ETOH DIGOXIN THEOPH. DILANTIN  | GGPT (ALT) GGT BILIRUBIN ALK PHOS LIPASE AMYLASE AMMONIA KETONES CA PHOS   | BLOOD CULTURI OF CHLAMYDIA OF MET MOUNT OF UA C&S   | TURE PI  | 1<br>CO <sub>2</sub><br>CO <sub>3</sub> | IVMON  DIETA  STRA   | IITOR / RI<br>ANUS O<br>AIGHT CA         | TH   FI                 | INGERSTIC   | K GLUCOSE   | ES NO VISUAL ACUI  |  |
| TREAL                                      | WBC DIFF B S E L M PT INR PTT TYPE & SCREEN   | K CI CO Glucose BUN Creat  ETOH DIGOXIN THEOPH. DILANTIN ED DRUG SCRN   | GGPT (ALT) GGT BILIRUBIN ALK PHOS LIPASE AMYLASE AMMONIA KETONES CA  | BLOOD CULTURI GC CULTURI CHLAMYDIA WET MOUNT  | TURE PI  | 1<br>CO <sub>2</sub><br>CO <sub>3</sub> | IVMON  DIETA  STRA   | HITOR / RH<br>ANUS O<br>AIGHT CA<br>EY N | TH DFI                  | INGERSTIC<br>THO BP & F   | K GLUCOSE P DIPST                                 | ES NO VISUAL ACUI  |  |
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| TREAL                                      | WBC DIFF B S E L M PT INR PTT TYPE & SCREEN   | K CI CO Glucose BUN Creat  ETOH DIGOXIN THEOPH. DILANTIN ED DRUG SCRN   | GGPT (ALT) GGT BILIRUBIN ALK PHOS LIPASE AMYLASE AMMONIA KETONES CA PHOS   | BLOOD CULTURI CONTROL CHLAMYDIA WET MOUNT UA C&S URINE PREG   | TURE PO  | 1<br>CO <sub>2</sub><br>CO <sub>3</sub> | IVMON  DIETA  STRA   | HITOR / RH<br>ANUS O<br>AIGHT CA<br>EY N | TH DFI                  | INGERSTIC<br>THO BP & F   | K GLUCOSE P DIPST                                 | ES NO VISUAL ACUI  |  |
| TREAL                                      | WBC DIFF B S E L M PT INR PTT TYPE & SCREEN PORTABLE CXR  | K CI CO Glucose BUN Creat  THEOPH. DILANTIN DED DRUG SCRN   | GGPT (ALT) GGT BILIRUBIN ALK PHOS LIPASE AMYLASE AMMONIA KETONES CA PHOS   | BLOOD CULTURI CONTROL CHLAMYDIA WET MOUNT UA C&S URINE PREG   | TURE PO  | 1<br>CO <sub>2</sub><br>CO <sub>3</sub> | IVMON  DIETA  STRA   | HITOR / RH<br>ANUS O<br>AIGHT CA<br>EY N | TH DFI                  | INGERSTIC<br>THO BP & F   | K GLUCOSE P DIPST                                 | ES NO VISUAL ACUI  |  |
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| EVALUATION TREAT                           | WBC DIFF B S E L M PT INR PTT TYPE & SCREEN PORTABLE CXR ADMISSION CXR ABO SERIES   | K CI CO Glucose BUN Creat  ETOH DIGOXIN THEOPH. DILANTIN ED DRUG SCRN PORTABLE C SPINE LS SPINE ULTRASOUND  | GGPT (ALT) GGT BILIRUBIN ALK PHOS LIPASE AMYLASE AMMONIA KETONES CA PHOS MG BHCG   | BLOOD CULTURI VDRL GC CULTURI CHLAMYDIA WET MOUNT UA C&S URINE PREG   | TURE PHONE P | 1<br>CO <sub>2</sub><br>CO <sub>3</sub> | IV MON   | IITOR / RI<br>ANUS                       | Vous                    | INGERSTIC<br>THO BP & F   | K GLUCOSE P DIPST                                 | TES NO VISUAL ACUI   |  |
| EVALUATION TREAT                           | WBC DIFF B S E L M PT INR PTT TYPE & SCREEN PORTABLE CXR ADMISSION CXR ABD SERIES   | K CI CO Glucose BUN Creat  ETOH DIGOXIN THEOPH. DILANTIN ED DRUG SCRN PORTABLE C SPINE LS SPINE ULTRASOUND  | GGPT (ALT) GGT BILIRUBIN ALK PHOS LIPASE AMYLASE AMMONIA KETONES CA PHOS MG BHCG   | BLOOD CULTURI VDRL GC CULTURI CHLAMYDIA WET MOUNT UA C&S URINE PREG   | TURE PHONE P | 1<br>CO <sub>2</sub><br>CO <sub>3</sub> | IV MON  DIETA  STRA  FOLE  TIME  | IITOR / RI<br>ANUS                       | Vous                    | INGERSTIC<br>THO BP & F   | K GLUCOSE P DIPST                                 | TES NO VISUAL ACUITION NO.   |  |
| PLAN EVALUATION THEAT                      | WBC DIFF B S E L M PT INR PTT TYPE & SCREEN PORTABLE CXR ADMISSION CXR ABD SERIES   | K CI CO Glucose BUN Creat  ETOH DIGOXIN THEOPH. DILANTIN ED DRUG SCRN PORTABLE C SPINE LS SPINE ULTRASOUND  | GGPT (ALT) GGT BILIRUBIN ALK PHOS LIPASE AMYLASE AMMONIA KETONES CA PHOS MG BHCG   | BLOOD CULTURI VDRL GC CULTURI CHLAMYDIA WET MOUNT UA C&S URINE PREG   | TURE PHONE P | 1<br>CO <sub>2</sub><br>CO <sub>3</sub> | IV MON  DIETA  STRA  FOLE  TIME  | IITOR / RI<br>ANUS                       | Vous                    | INGERSTIC<br>THO BP & F   | K GLUCOSE P DIPST DER                             | OM NO. CU CARDIAC TELE   |  |
| PLAN EVALUATION THEAT                      | WBC DIFF B S E L M PT INR PTT TYPE & SCREEN PORTABLE CXR ADMISSION CXR ABD SERIES   | K CI CO Glucose BUN Creat  ETOH DIGOXIN THEOPH. DILANTIN ED DRUG SCRN PORTABLE C SPINE LS SPINE ULTRASOUND  | GGPT (ALT) GGT BILIRUBIN ALK PHOS LIPASE AMYLASE AMMONIA KETONES CA PHOS   | BLOOD CULTURI VDRL GC CULTURI CHLAMYDIA WET MOUNT UA C&S URINE PREG   | TURE PHONE P | 1<br>CO <sub>2</sub><br>CO <sub>3</sub> | IV MON  I STRU  FOLL  TIME  ADMITTI  | IITOR / RI<br>ANUS                       | TEGLECO TH FR G OR VOUL | INGERSTIC<br>THO BP & F   | K GLUCOSE P DIPST                                 | OM NO. CU CARDIAC TELE MEDICAL  VISUAL ACUI  VISUAL ACUI  OM NO. CU CU CARDIAC TELE MEDICAL TELE |  |
| PLAN EVALUATION THEAT                      | WBC DIFF B S E L M PT INR PTT TYPE & SCREEN PORTABLE CXR ADMISSION CXR ABD SERIES CT FINAL DIAGNOSIS  | K CI CO Glucose BUN Creat  ETOH DIGOXIN THEOPH. DILANTIN DED DRUG SCRN PORTABLE C SPINE C SPINE LS SPINE ULTRASOUND OTHER   | GGPT (ALT) GGT BILIRUBIN ALK PHOS LIPASE AMYLASE AMMONIA KETONES CA PHOS BHCG BHCG   | BLOOD CULTURI VDRL GC CULTURI CHLAMYDIA WET MOUNT UA C&S URINE PREG   | TURE PHONE PROPERTY P | H CO2 CO3 R                             | ADMITTI  | ING PHYS                                 | TEMPORE OF TO           | MPANYON<br>INGERSTIC<br>ITHO BP & F<br>ORD<br>WILL<br>POUR<br>INGERSTIC<br>ORD<br>ORD<br>WILL<br>POUR<br>INGERSTIC<br>INGERSTIC<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD | K GLUCOSE P DIPST                                 | OM NO.  CU CARDIAC TELE  MEDICAL TELE  |  |
| UISCHAHGE PLAN EVALUATION TREAT            | WBC DIFF B S E L M PT INR PTT INR PTT TYPE & SCREEN PA & LA CXR ADMISSION CXR ADMISSION CXR ABD SERIES CT FINAL DIAGNOSIS PATIENT MAY RETURN NO RESTRICTIONS  | K CI CO Glucose BUN Creat  DIGOXIN THEOPH. DILANTIN DED DRUG SCRN  PORTABLE C SPINE LS SPINE ULTRASOUND OTHER WORK/SCHOOL/G RESTRICTIONS I  | GGPT (ALT)  GGT  BILIRUBIN  ALK PHOS  LIPASE  AMMONIA  KETONES  CA  PHOS  MG  BHCG   | BLOOD CULTURI OF CHLAMYDIA OF CASS  CALL PH CASS  BLOOD CULTURI OF CHLAMYDIA OF CHLAMYDIA OF CASS  CALL PH OF CASS  CALL PH OF CASS  CALL PH OF CASS  | TURE PHOESE POOR PROPERTY PHOESE PHOE | FOLLOW-UP-DAYS OR SOONE                 | IV MON  DIETA  STR.  FOLE  TIME  ADMITTE  TRAN  ON  R IF FEEL  | ING PHYS                                 | TEMECO                  | INGERSTIC<br>THO BP & F   | K GLUCOSE P DIPST                                 | OM NO. CU CARDIAC TELE MEDICAL  VISUAL ACUI  VISUAL ACUI  OM NO. CU CU CARDIAC TELE MEDICAL TELE |  |
| IS/DISCHAHGE PLAN   EVALUATION TREAT       | WBC DIFF B S E L M PT INR PTT INR PTT TYPE & SCREEN PA & LA CXR ADMISSION CXR ADMISSION CXR ABD SERIES CT FINAL DIAGNOSIS PATIENT MAY RETURN NO RESTRICTIONS  | K CI CO Glucose BUN Creat  ETOH DIGOXIN THEOPH. DILANTIN DED DRUG SCRN C SPINE ULTRASOUND OTHER WORK/SCHOOL/G   | GGPT (ALT)  GGT  BILIRUBIN  ALK PHOS  LIPASE  AMMONIA  KETONES  CA  PHOS  MG  BHCG   | BLOOD CULTURI VDRL GC CULTURI CHLAMYDIA WET MOUNT UA C&S URINE PREG   | TURE PHOESE PROPERTY PHOESE PH | H CO2 CO3 R                             | IV MON  DIETA  STR.  FOLE  TIME  ADMITTE  TRAN  ON  R IF FEEL  | ING PHYS                                 | TEMECO                  | MPANYON<br>INGERSTIC<br>ITHO BP & F<br>ORD<br>WILL<br>POUR<br>INGERSTIC<br>ORD<br>ORD<br>WILL<br>POUR<br>INGERSTIC<br>INGERSTIC<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD | K GLUCOSE P DIPST                                 | OM NO. CU CARDIAC TELE MEDICAL  VISUAL ACUI  VISUAL ACUI  OM NO. CU CU CARDIAC TELE MEDICAL TELE |  |
| IS/DISCHAHGE PLAN   EVALUATION TREAT       | WBC DIFF B S E L M PT INR PTT TYPE & SCREEN PORTABLE CXR ADMISSION CXR ADMISSION CXR ABD SERIES CT FINAL DIAGNOSIS PATIENT MAY RETURN NO RESTRICTIONS KEEP CLEAN AND C  | K CI CO Glucose BUN Creat  ETOH DIGOXIN THEOPH. DILANTIN DED DRUG SCRN  PORTABLE C SPINE C SPINE ULTRASOUND OTHER WORK/SCHOOL/G RESTRICTIONS I  | GGPT (ALT)  GGT  BILIRUBIN  ALK PHOS  LIPASE  AMMONIA  KETONES  CA  PHOS  MG  BHCG   | BLOOD CULTURI VDRL GC CULTURI CHLAMYDIA WET MOUNT UA Cas URINE PREG INTERPRETATIO   | TURE PHOESE PROPERTY PHOESE PH | FOLLOW-UP-DAYS OR SOONE                 | IV MON  DIETA  STR.  FOLE  TIME  ADMITTE  TRAN  ON  R IF FEEL  | ING PHYS                                 | TEMECO                  | MPANYON<br>INGERSTIC<br>ITHO BP & F<br>ORD<br>WILL<br>POUR<br>INGERSTIC<br>ORD<br>ORD<br>WILL<br>POUR<br>INGERSTIC<br>INGERSTIC<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD | K GLUCOSE P DIPST                                 | OM NO. CU CARDIAC TELE MEDICAL  VISUAL ACUI  VISUAL ACUI  OM NO. CU CU CARDIAC TELE MEDICAL TELE |  |
| IS/DISCHAHGE PLAN   EVALUATION TREAT       | WBC DIFF B S E L M PT INR PTT TYPE & SCREEN PORTABLE CXR ADMISSION CXR ABD SERIES CT FINAL DIAGNOSIS PATIENT MAY RETURN NO RESTRICTIONS KEEP CLEAN AND C  | K CI CO Glucose BUN Creat  ETOH DIGOXIN THEOPH. DILANTIN DED DRUG SCRN  PORTABLE C SPINE C SPINE ULTRASOUND OTHER WORK/SCHOOL/G RESTRICTIONS I  | GGPT (ALT)  GGT  BILIRUBIN  ALK PHOS  LIPASE  AMMONIA  KETONES  CA  PHOS  MG  BHCG   | BLOOD CULTURI VDRL GC CULTURI CHLAMYDIA WET MOUNT UA CAS URINE PREG INTERPRETATIO   | TURE PHOESE PROPERTY PHOESE PH | FOLLOW-UP-DAYS OR SOONE                 | IV MON  DIETA  STR.  FOLE  TIME  ADMITTE  TRAN  ON  R IF FEEL  | ING PHYS                                 | TEMECO                  | MPANYON<br>INGERSTIC<br>ITHO BP & F<br>ORD<br>WILL<br>POUR<br>INGERSTIC<br>ORD<br>ORD<br>WILL<br>POUR<br>INGERSTIC<br>INGERSTIC<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD | K GLUCOSE P DIPST                                 | OM NO. CU CARDIAC TELE MEDICAL  VISUAL ACUI  VISUAL ACUI  OM NO. CU CU CARDIAC TELE MEDICAL TELE |  |
| UISCHAHGE PLAN   EVALUATION TREAT          | WBC DIFF B S E L M PT INR PTT TYPE & SCREEN PORTABLE CXR ADMISSION CXR ADMISSION CXR ADD SERIES CT FINAL DIAGNOSIS PATIENT MAY RETURN NO RESTRICTIONS KEEP CLEAN AND C NO HEAVY LIFTING OTHER   | K CI CO Glucose BUN Creat  DIGOXIN THEOPH. DILANTIN DED DRUG SCRN  PORTABLE C SPINE C SPINE ULTRASOUND OTHER WORK/SCHOOL/G RESTRICTIONS I RY DO NOT USE IMI   | GGPT (ALT)  GGT  BILIRUBIN  ALK PHOS  LIPASE  AMMONIA  KETONES  CA  PHOS  BHCG  BHCG  SYM ON  UNTIL  PAIRED PART   | BLOOD CULTURI OF CHLAMYDIA OF CASS  CALL PH | TURE PHOESE PROPERTY PHOESE PH | FOLLOW-UP-DAYS OR SOONE                 | IV MON  DIETA  STR.  FOLE  TIME  ADMITTE  TRAN  ON  R IF FEEL  | ING PHYS                                 | TEMECO                  | MPANYON<br>INGERSTIC<br>ITHO BP & F<br>ORD<br>WILL<br>POUR<br>INGERSTIC<br>ORD<br>ORD<br>WILL<br>POUR<br>INGERSTIC<br>INGERSTIC<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD | K GLUCOSE P DIPST                                 | OM NO. CU CARDIAC TELE MEDICAL  VISUAL ACUI  VISUAL ACUI  OM NO. CU CU CARDIAC TELE MEDICAL TELE |  |
| DIAGINUSIS/DISCHANGE PLAN EVALUATION THEAT | WBC DIFF B S E L M PT INR PIT TYPE & SCREEN PORTABLE CXR ADMISSION CXR ADMISSION CXR ABD SERIES CT FINAL DIAGNOSIS PATIENT MAY RETURN NO RESTRICTIONS KEEP CLEAN AND C NO HEAVY LIFTING OTHER   | K CI CO Glucose BUN Creat    ETOH   DIGOXIN   THEOPH.   DILANTIN   ED DRUG SCRN    PORTABLE C SPINE   ULTRASOUND   OTHER   ULTRASOUND   OTHER   WORK/SCHOOL/G   RESTRICTIONS INY   DO NOT USE IMINE   SITTING JOB | GGPT (ALT)  GGT  BILIRUBIN  ALK PHOS  LIPASE  AMMONIA  KETONES  CA  PHOS  BHCG  BHCG   SYM ON  LIVITIL  PAIRED PART  | BLOOD CULTURE VORL GC CULTURE CHLAMYDIA WET MOUNT C&S  URINE PREG INTERPRETATIO   | TURE ph  | FOLLOW-UP-DAYS OR SOONE                 | ADMITTI  ADMITTI  REFE  TRAN   ING PHYSERRED TO                         | TEMECO                  | MPANYON<br>INGERSTIC<br>ITHO BP & F<br>ORD<br>WILL<br>POUR<br>INGERSTIC<br>ORD<br>ORD<br>WILL<br>POUR<br>INGERSTIC<br>INGERSTIC<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD | K GLUCOSE P DIPST                                 | OM NO. CU CARDIAC TELE MEDICAL  VISUAL ACUI  VISUAL ACUI  OM NO. CU CU CARDIAC TELE MEDICAL TELE |  |
| BVALUATION THEAT                           | WBC DIFF B S E L M PT INR PTT TYPE & SCREEN PORTABLE CXR ADMISSION CXR ABD SERIES CT FINAL DIAGNOSIS PATIENT MAY RETURN NO RESTRICTION NO RESTRICTION NO HEAVY LIFTING OTHER FURTHER DISABILITY VE RECEIVED DISCHARET I HAVE RECEIVED EMB | K CI CO Glucose BUN Creat  DIGOXIN THEOPH. DILANTIN DED DRUG SCRN  PORTABLE C SPINE C SPINE ULTRASOUND OTHER WORK/SCHOOL/G RESTRICTIONS I RY DO NOT USE IMI   | GGPT (ALT)  GGT  BILIRUBIN  ALK PHOS  LIPASE  AMMONIA  KETONES  CA  PHOS  BHCG  BHCG  GYM ON  JUNTIL  PAIRED PART  YOUR PERSONAL PHYS  UNDERSTAND  AM TO CALL  | BLOOD CULTURI OF CHLAMYDIA OF CASS  CALL PH | TURE ph  | FOLLOW-UP-DAYS OR SOONE                 | ADMITTI  ADMITTI  REFE  TRAN   ING PHYS                                 | TEMECO                  | MPANYON<br>INGERSTIC<br>ITHO BP & F<br>ORD<br>WILL<br>POUR<br>INGERSTIC<br>ORD<br>ORD<br>WILL<br>POUR<br>INGERSTIC<br>INGERSTIC<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD<br>ORD | K GLUCOSE P DIPST                                 | OM NO. CU CARDIAC TELE MEDICAL  VISUAL ACUI  VISUAL ACUI  OM NO. CU CU CARDIAC TELE MEDICAL TELE |  |

ORM 3958 2/98 R1

EMERGENCY DEPARTMENT RECORD



#### EMERGENCY ROOM NOTE

NAME: WINSTON, BERNICE

MRI: 08-17-07

DATE: 04/15/99 RM: ER

DOCTOR: CARLOS R. SANABRIA, M.D.

cc: JOSE OSCAR N. TOLEDO, M.D.

DATE OF BIRTH: 07/27/37

DICTATED BY: SHANNON PETERS, P.A.-C

CHIEF COMPLAINT: Eyebrow laceration.

HISTORY OF PRESENT ILLNESS: This is a 61-year-old black female who states that she tripped on some uneven pavement and hit her right eyebrow on the cement. She denies any loss of consciousness, denies any visual changes, denies any headache, denies any neck pain, denies any numbness, tingling or weakness in any of her extremities, denies any nausea or vomiting, denies any difficulty with ambulation or balance, and denies any other injuries.

ALLERGIES: ASPIRIN, CODEINE.

#### MEDICATIONS:

1. Water pill.

2. Cholesterol pill.

?. Procardia.

s. Premarin.

PAST MEDICAL HISTORY: Hypertension and hypercholesterolemia.

IMMUNIZATION/TETANUS STATUS: Unsure.

#### PHYSICAL EXAMINATION:

VITAL SIGNS: Blood pressure 197/99, pulse 85, respirations 20, temperature 97.3.

GENERAL: Patient is alert and oriented times three and in no acute distress.

HEENT: Normocephalic. There is approximately a 2 cm long laceration to the lateral aspect of the right eyebrow. There is partial thickness of the skin. No deep structures are involved. No foreign body is noted. There is no overt tenderness with palpation. There is a small amount of swelling noted to the infraorbital lateral area on the cheek which is minimally tender to palpation. The skin is intact there. Pupils equal, round and reactive to light. Sclerae and conjunctivae are clear. Extraocular muscles are intact, no entrapment. Tympanic membranes and canals are clear bilaterally. Mares are patent. Oropharynx is clear with moist mucosal membranes. NECK: Supple with full range of motion, nontender to palpation. HEART: Regular rate and rhythm.

LUNGS: Clear to auscultation bilaterally.

EXTREMITIES: No clubbing, cyanosis or edema. CMS is intact. NEUROLOGIC: Cranial nerves II-XII are intact. Coordination and balance are intact. Cerebellar function is intact. Patient is alert and oriented times three with steady gait.



#### EMERGENCY ROOM NOTE

NAME: WINSTON, BERNICE

MRI: 08-17-07 DATE: 04/15/99 RM: ER

DOCTOR: CARLOS R. SANABRIA, M.D.

EMERGENCY DEPARTMENT COURSE AND TREATMENT: Patient was given a dT THE laceration was anesthetized using 1% lidocaine and was prepped in a sterile fashion. Ethilon 6-0 was used to close the wound with a total of five simple interrupted sutures. The edges were approximated well. Neosporin and a dressing was then applied.

DISPOSITION: Patient was discharged home in good condition and told to follow up with her primary care physician in two days for recheck and in seven days for suture removal. She was given head injury instructions to awaken q.2 hours. She is to keep the sutured areas clean and dry as possible and she was told to take her water pill every day as directed as her blood pressure was slightly increased today. The patient states she has been taking it only every other day or when she felt like it.

#### DIAGNOSES:

- Right eyebrow laceration.
- Closed cranial trauma.

This patient's chart was reviewed by Dr. Sanabria who agrees with the stove evaluation and treatment plan.

CARLOS R. SANABRIA, M.D.

CRS/TL585/SP /Job:240317 dd: 04/15/99 dt: 04/15/99

Eatch: 1122



## **OUTPATIENT/EMERGENCY** NURSING CARE RECORD

**WINSTON BERNICE** 

DOB: 07/27/37 61 Y SEX: F MR: 81707 S

|         |     |     |      | 1 11 / |      |
|---------|-----|-----|------|--------|------|
| ANABR I | [8] | CAR | 31 D | 9      | 0    |
|         |     |     |      |        |      |
| CT#:    | 111 |     |      | #196£  | EIIS |

|                         | TIME IN TRIAGE  1720  DiffithDate  AGE  CHIEF COMPLAINT   | B        | MEE  | 70045175                                |  |  |
|-------------------------|---|----------|--|---|--|--|
| AT S                    | MODE OF ARRIVAL AMBULANCE AMBULANCE WICE PHYSI  TODAY'S DATE  AUTHORIZED/DENIED BY  4-15-97                                 | ICIAN    | el<br>Dem  | D   LYES LINO                           | HMO CODE  0 0=N/A  1=YES/PHYS  2=HMO HOTLINE | 3=AUTO AUTH 4=LIFE/LIMB THF 5=NO AUTH  |
| <u></u>                 | STREET ADDRESS CITY   | RGEN     | CY ADMISSIONS STAT                                 | E ZIP                                   | TELEPHONE                                    |  |
|                         | SEX MARITAL STATUS RESPONSIBLE PARTY  MARITAL STATUS  RESPONSIBLE PARTY   | LOCATION |  | DATE/TIME INSURANCE                     |  | **************************************   |
|                         | DIVERT REGISTRATION REASSURANCE WIC V.S. ELEVATI  |          | SPLINTOTHER  | _ Bel                                   | Cock RN                                      | SS TOLERANCE   |
|                         | ☐ HEALTH PERCEPTION/MANAGEMENT ☐ NUTRITIONAL/METABOLIC ☐ COGNITIVE/PERCEPTUA ☐ ELIMINATION ☐ SLEEP/REST  SUBJECTIVE: /730   |          | SELFPERCEP  ROLE/RELATIC  SEXUALITY/RE  OBJECTIVE: | PRODUCTIVE                              | ( VALUEBELIEF                                |  |
| VAL / FIEALI<br>SSMENT  | "I fell artside on the street<br>I wasn't dizzy a I lell b<br>La"   | -        | Alox to<br>lgcenation<br>Wingon                    | n-opprox                                | Jind R)                                      | y sh   |
| ASSE                    | Denies headache   |          |  | , | y  |  |
|                         | NURSING DIAGNOSIS Impaned Skin Integrity  | 2.3      | SEE ADDITIONAL NUR                                 | SING RECORD                             |  |  |
| UATION                  | NURSING INTERVENTIONS  1884 Suffered Per PAC  Teters N  1849 It do'd to home Verbalizes  inderstanding.                     | √<br>M/  |  | RESPONSE/EVA                            | LUATIONS                                     |  |
| TION / EVAL             | □ SR  |          |  | ERSTANDING OF AND/OR CAN                | REPEAT INSTRUCTIONS.                         | OBSERVED   |
| Š.                      | TIME MEDICATION:  |          |  | RESPONSE/EVA                            | LUATIONS                                     | INTAKE   |
| PLAN / INTERVENTION / E |   |          |  |   |  | POIV |
|                         | 1800 Sterile Prepa Shur Clem<br>artification bintment to  | 7        | insed = Si<br>tured Si<br>n Was                    | Sterle Was                              | er Applie                                    | URINE_<br>EMESIS_<br>OTHER_  |
| IAN I                   | REVIEW MD DISCHARGE PLAN  DISCHARGE PER MD  NOTIFIED:  NURSING HOME  DISCHARGE PER MD                                       |          | CORONER  | MODE OF ADM                             |  | CIARA  |
| <u>.</u> <u>.</u>       | ADMISSION PROCEDURE EXPLAINED  REFERRAL  NOTIFICATION OF ADMISSION TO:  ADMISSION REPORT  SHIFT  X-RAY  VALUABLES CHECKLIST | REPORT   | CLERGYTIME PATIENT                                 | ADMITTED SIGNATURE -                    |  | CART   |

9-22-99

CLAIM # 74125

I TALKED TO JOE LUSTEK HE SAID THAT
THE CITY LUAS NOT CHORKING ON THE

STREET THAT DAY

074125 UKL

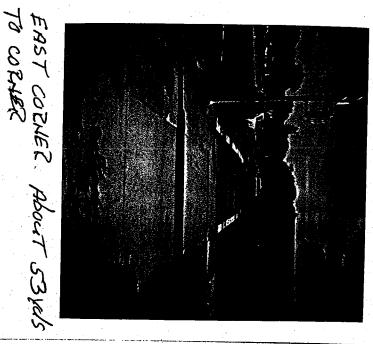
GREG BEAUdRY



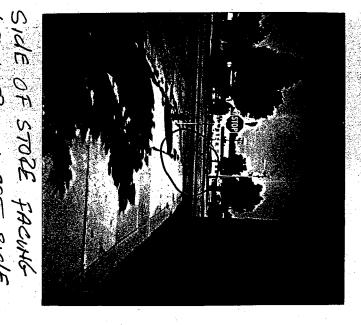
FRONT OF STORE FRONKS
EAST: 53 VARds TO CORNER



FRONT ENTERACYCE OF STORE



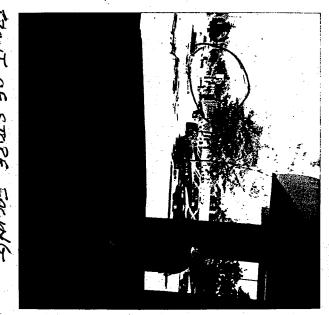
HORTH From WEST SICLE OF STORE 38 KdS TO CORNER.



FRONT OF STORE FACING

EAST- About 53 yels TO

CORNER



FRONT OF STORE FACUSO

FRONT OF STORE FACING-WEST TO CORNER - 38 Yds

