Notice of Injury

CITY OF MILWAUKEE
99 NOV -8 PM 1:19
RONALD D. LEONHARDT
CITY CLERK

City of Milwaukee, City Clerk, Room 205, City Hall, 200 East Wells Street, 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)

KEMPER

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

October 1, 1999

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

RE:

Claim Number:	565 LN 074125
Claimant:	Bernice Winston
Insured:	Walgreen Co.
Date of Loss:	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

Julie LeVine
Claim Representative

cc: Law Offices of Elvis Banks
4011 W. Capitol Dr., Suite 100
Milwaukee, WI 53216

074125
JKL

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

Pyramid Chiropractic Clinic, S. C.

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.

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

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.

Pyramid Chiropractic Clinic, S. C.

Dr. Adebayo Yusuf

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

1. Traumatic lumbosacral musculoligamentous strain secondary to the fall of 4/15/99.

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 8/4/99.

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 Receipt....125.00

BALANCE DUE ON ACCOUNT

$ 2240.00

6666

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
☐ (Medicare #)	☐ (Medicaid #)	☐ (Sponsor's SSN)	☐ (VA File #)	☐ (SSN or ID)	☐ (SSN)	☒ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
390-38-1391

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Winston, Bernice	07 27 1937 M ☐ F ☒	Winston, Bernice
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
CITY: Milwaukee / STATE: WI	8. PATIENT STATUS: Single ☐ Married ☐ Other ☐	CITY: Milwaukee / STATE: WI
ZIP CODE: 53216 / TELEPHONE (Include Area Code): (414) 447-1522	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE: 53216 / TELEPHONE (INCLUDE AREA CODE): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐	b. AUTO ACCIDENT? PLACE (State) ☐ YES ☒ NO	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on file DATE 07/23/99

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Signature on file

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☒ NO / $ CHARGES .00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. ___ 3. ___ 2. ___ 4. ___		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 04 20 99	11		90020			100 00	1				
2 04 20 99	11		72100			85 00	1				
04 21 99	11		98940			35 00	1				
3 04 21 99	11		97014			20 00	1				
04 21 99	11		97010			20 00	1				
4 04 21 99	11		97124			20 00	1				
04 23 99	11		98940			35 00	1				
5 04 23 99	11		97014			20 00	1				
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
39-1723576 ☐ ☒	02973	☒ YES ☐ NO	$ 335 00	$ 0 00	$ 335 00

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.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Adebayo Yusuf, D.C. SIGNED DATE 072399		Pyramid Chiropractic Clinic, 5542 W. Fond du lac Avenue MILWAUKEE, WI 53216 (414) 461-2222 PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 390-38-1391

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Winston, Bernice

3. PATIENT'S BIRTH DATE MM DD YY: 07 27 193[illegible] SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Winston, Bernice

5. PATIENT'S ADDRESS (No., Street): 3157 N 33rd

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 3157 N 33rd

CITY: Milwaukee | STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: Milwaukee | STATE: WI

ZIP CODE: 53216 | TELEPHONE (Include Area Code): (414) 447-1322

ZIP CODE: 53216 | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [X] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on file DATE: 07/23/99

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18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES: .00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____.__ 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 04 23 99		11		97010			20 00	1				
04 23 99		11		97124			20 00	1				
2 04 26 99		11		98940			35 00	1				
04 26 99		11		97014			20 00	1				
3 04 26 99		11		97012			20 00	1				
04 26 99		11		97124			20 00	1				
4 04 28 99		11		98940			35 00	1				
04 28 99		11		97014			20 00	1				
5 04 28 99		11		97010			20 00	1				
04 28 99		11		97124			20 00	1				
6 04 30 99		11		98940			35 00	1				

25. FEDERAL TAX I.D. NUMBER: 39-1723576 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 02973

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 265 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 265 00

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.

SIGNED [signature] DATE 07/23/99

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Pyramid Chiropractic Clinic,
5542 W. Fond du lac Avenue
MILWAUKEE, WI 53216
(414) 461-2222

PIN# GRP#

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

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STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: Milwaukee

STATE:

ZIP CODE: 53216

TELEPHONE (Include Area Code): (414) 447-1322

ZIP CODE: 53216

TELEPHONE (INCLUDE AREA COD): ( )

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b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [X] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-c

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1. [ ] 3. [ ]

2. [ ] 4. [ ]

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1	04	30	99			11		97014				1				
	04	30	99			11		97010			20 00	1				
2	04	30	99			11		97124			20 00	1				
	05	03	99			11		99213-			20 00	1				
3	05	03	99			11		98940			50 00	1				
	05	03	99			11		97014			35 00	1				
4	05	03	99			11		97010			20 00	1				
	05	07	99			11		97124			20 00	1				
5	05	07	99			11		98940			20 00	1				
	05	07	99			11		97014			35 00	1				
6																

25. FEDERAL TAX I.D. NUMBER: 39-1723576 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 02973

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $: 280 00

29. AMOUNT PAID $: 0 00

30. BALANCE DUE $: 280 0

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

SIGNED [signature] DATE 7/23/99

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Pyramid Chiropractic Clinic
5542 W. Fond du lac Avenue
MILWAUKEE, WI 53216
PIN# (414) 461-2222 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) — X OTHER

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 390-38-1391

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Winston, Bernice

3. PATIENT'S BIRTH DATE MM DD YY: 07 27 1937 | SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Winston, Bernice

5. PATIENT'S ADDRESS (No., Street): 3157 N 33rd

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 3157 N 33rd

CITY: Milwaukee | STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] | Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: Milwaukee | STATE: WI

ZIP CODE: 53216 | TELEPHONE (Include Area Code): (414) 447-1322

ZIP CODE: 53216 | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: | SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: | SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [X] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on file

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: Signature on file

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): DATE 07/23/99

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE:

17a. I.D. NUMBER OF REFERRING PHYSICIAN:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE:

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES: .00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE
1. [ ] 2. [ ] 3. [ ] 4. [ ]

22. MEDICAID RESUBMISSION CODE: | ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 05 07 99		11		97124			20 00	1				
2 05 10 99		11		98940			35 00	1				
		11		97014			20 00	1				
3 05 10 99		11		97010			20 00	1				
		11		97124			20 00	1				
4 05 12 99		11		98940			35 00	1				
		11		97014			20 00	1				
5 05 12 99		11		97010			20 00	1				
		11		97124			20 00	1				
6 05 14 99		11		98940			35 00	1				
		11		97014			20 00	1				

25. FEDERAL TAX I.D. NUMBER: 39-1723576 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 02973

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 265 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 265 00

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.)

SIGNED: Adebayo Yusuf, D.C. DATE: 072399

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Pyramid Chiropractic Clinic,
5542 W. Fond du lac Avenue
MILWAUKEE, WI 53216
(414) 461-2226

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)

PHYSICIAN OR SUPPLIER INFORMATION

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) — X OTHER

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 390-38-1391

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Winston, Bernice

3. PATIENT'S BIRTH DATE MM DD YY: 07 27 1937 SEX: F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Winston, Bernice

5. PATIENT'S ADDRESS (No., Street): 3157 N 33rd

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street): 3157 N 33rd

CITY: Milwaukee STATE: WI

8. PATIENT STATUS: Single Married Other

CITY: Milwaukee STATE: WI

ZIP CODE: 53216 TELEPHONE (Include Area Code): (414) 447-1322

Employed Full-Time Student Part-Time Student

ZIP CODE: 53216 TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO X

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO X PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on file DATE 07/23/99

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Signature on file

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO X $ CHARGES .00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
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05 14 99		11		97010			20 00	1				
2 05 17 99		11		98940			35 00	1				
05 17 99		11		97014			20 00	1				
3 05 17 99		11		97012			20 00	1				
05 17 99		11		97124			20 00	1				
4 05 21 99		11		98940			35 00	1				
05 21 99		11		97014			20 00	1				
5 05 21 99		11		97012			20 00	1				
05 21 99		11		97124			20 00	1				
6 05 24 99		11		98940			35 00	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN: 39-1723576 X

26. PATIENT'S ACCOUNT NO.: 02973

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO

28. TOTAL CHARGE $ 265 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 265 00

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.

SIGNED [redacted] DATE 072599

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Pyramid Chiropractic Clinic,
5542 W. Fond du lac Avenue
MILWAUKEE, WI 53216
PIN# (414) 461-2222 GRP#

PHYSICIAN OR SUPPLIER INFORMATION

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500
FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938

PICA

HEALTH INSURANCE CLAIM FORM

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN): 390-38-1391

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Winston, Bernice

3. PATIENT'S BIRTH DATE MM DD YY: 07 27 193[illegible] SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Winston, Bernice

5. PATIENT'S ADDRESS (No., Street): 3157 N 33rd

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 3157 N 33rd

CITY: Milwaukee

STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: Milwaukee

STA

ZIP CODE: 53216

TELEPHONE (Include Area Code): (414) 447-1322

ZIP CODE: 53216

TELEPHONE (INCLUDE AREA C): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [X] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on file DATE: 07/23/99

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authori payment of medical benefits to the undersigned physician or suppl services described below.

SIGNED: Signature on file

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATIC MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES: .00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE

1. [ ] 3. [ ]

2. [ ] 4. [ ]

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23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED F LOCAL US
1 05 24 99		11		97014			20 00	1				
2 05 24 99		11		97012			20 00	1				
05 24 99		11		97124			20 00	1				
3 05 28 99		11		98940			35 00	1				
05 28 99		11		97014			20 00	1				
4 05 28 99		11		97012			20 00	1				
05 28 99		11		97124			20 00	1				
5 06 04 99		11		99213-			50 00	1				
06 04 99		11		97014			20 00	1				
6 06 04 99		11		97012			20 00	1				
06 04 99		11		97124			20 00	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN: 39-1723576 [ ] [X]

26. PATIENT'S ACCOUNT NO.: 02973

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 265 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DI: $ 265

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.

SIGNED [signature] DATE 07/23/99

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Pyramid Chiropractic Clini
5542 W. Fond du lac Avenue
MILWAUKEE, WI 53216
(414) 461-222[illegible]

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500

FORM RRB-

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA [X]

HEALTH INSURANCE CLAIM FORM

PICA [ ]

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

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7. INSURED'S ADDRESS (No., Street): 3157 N 33rd

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8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

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ZIP CODE: 53216 TELEPHONE (Include Area Code): (414) 447-1322

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10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [X] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE:

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

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16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

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20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES: .00

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3 06 25 99	11		97124			20 00	1				
07 02 99	11		98940			35 00	1				
4 07 02 99	11		97014			20 00	1				
07 02 99	11		97012			20 00	1				
5 07 02 99	11		97124			20 00	1				
07 09 99	11		98941			45 00	1				
6 07 09 99	11		97014			20 00	1				

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 39-1723576

26. PATIENT'S ACCOUNT NO.: 02973

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 290 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 290 00

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.

SIGNED: [signature] DATE: 07/23/99

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5542 W. Fond du lac Avenue
MILWAUKEE, WI 53216
PIN# (414) 461-2222 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

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Winston, Bernice	07 27 1937 M [ ] F [X]	Winston, Bernice
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3157 N 33rd	Self [X] Spouse [ ] Child [ ] Other [ ]	3157 N 33rd
CITY: Milwaukee / STATE: WI	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]	CITY: Milwaukee / STATE: WI
ZIP CODE: 53216 / TELEPHONE (Include Area Code): (414) 447-1322	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE: 53216 / TELEPHONE (INCLUDE AREA CODE): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [X] NO [ ]	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

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17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES .00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07 09 99	11		97012			20 00	1				
07 16 99	11		98940			35 00	1				
2 07 16 99	11		97012			20 00	1				
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
39-1723576 [ ] [X]	02973	[X] YES [ ] NO	$ 75 00	$ 0 00	$ 75 00

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.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Adebayo Yusuf, D.C. SIGNED: [signature] DATE: 07/23/99		Pyramid Chiropractic Clinic, 5542 W. Fond du lac Avenue MILWAUKEE, WI 53216 (414) 461-2222 PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

6666

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA [X]

HEALTH INSURANCE CLAIM FORM

PICA [ ]

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #)	MEDICAID [ ] (Medicaid #)	CHAMPUS [ ] (Sponsor's SSN)	CHAMPVA [ ] (VA File #)	GROUP HEALTH PLAN [ ] (SSN or ID)	FECA BLK LUNG [ ] (SSN)	OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 390-38-1391

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Winston, Bernice	07 27 193[illegible] M [ ] F [X]	Winston, Bernice
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
CITY: Milwaukee / STATE: WI	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]	CITY: Milwaukee / STATE: WI
ZIP CODE: 53216 / TELEPHONE (Include Area Code): (414) 447-1322	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE: 53216 / TELEPHONE (INCLUDE AREA CODE): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [X] NO [ ]	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on file DATE 09/21/99

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Signature on file

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES .00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. ____ 3. ____ 2. ____ 4. ____		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 08 04 99	11		99214		75 00	1				
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
39-1723576 [ ] [X]	02973	YES [X] NO [ ]	$ 75 00	$ 0 00	$ 75 00

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.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Adebayo Yusuf, D.C.		Pyramid Chiropractic Clinic. 5542 W. Fond du lac Avenue MILWAUKEE, WI 53216 (414) 461-2222
SIGNED [signature] DATE 09/21/99		PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

NEW PATIENT INFORMATION SHEET

TODAY'S DATE: 7-20 99

NAME: Winston / Bernice / _____ BIRTH DATE: 7 / 27 / 1937
Last First Middle Initial

AGE: 60 MARRIED: ____ SINGLE: X WIDOW(ER): ____ DIVORCED: ____ SEPARATED: ____ CHILDREN: 7

ADDRESS: 3157 N 33 St / _____ / ____ / Milwaukee / Wis / 53216
House # St.#/Name Apt. City State Zip Code

TELEPHONE: (414) 447 1322 Ext. ____ WORK TELEPHONE: ( ) _____ Ext. ____

OCCUPATION: Food Service WHERE EMPLOYED: Mount Sinai Hospital

SPOUSE'S NAME: _____ OCCUPATION: _____

WHERE EMPLOYED: _____ CITY: _____ STATE: _____

PREVIOUS CHIROPRACTOR: _____ TELEPHONE: ( ) ___ ____ Ext. ____

DO YOU PREFER TO PAY BY: CASH ____ CHECK ____

IS THIS AN INSURENCE CASE: YES ____ NO ____

NAME OF INSURANCE COMPANY: _____ (Primary Ins.) _____

ADDRESS: _____ / _____ / _____ / _____ Phone: ( ) _____
Number # St.#/Name City State

POLICY #: _____ GROUP #: _____ I.D.#: _____

PATIENT S.S.#: 390 38 1391 INSURED S.S.#: ___ - __ - ____

NAME OF INSURED: _____ ADDRESS: _____ PHONE: ( ) _____
(IF NOT SAME AS PATIENT)

NAME OF SECONDARY INS. CO.: _____ PHONE: ( ) ___ ____ Ext. _____

ADDRESS: _____ / _____ / _____ / _____ / _____
Number # ST. #/Name City State Zip Code

POLICY #: _____ GROUP #: _____ I.D.#: _____

NAME OF INSURED: _____ / _____ / _____ / _____ / _____
(IF NOT SAME AS PATIENT) Address City State Zip Code

PERSONAL INJURY CASE: ATTORNEY: Banks PHONE: ( ) ___ ____ Ext. ____

ADDRESS: _____ Suite #: _____ / _____
City

NEW PATIENT INFORMATION CONTINUED.....

********All Information MUST Be Completed Below*********

TO THE PATIENT: Please list below the FIVE or so main complaints you have, in order of importance to you. Include the lenght of time/ date of which you had the complaint.

1. Lower Back How Long? 4-15-99
2. Right Abscess nea How Long? 4 15 99
3. Right arm How Long? 4 15 99
4. _____ How Long? _____
5. _____ How Long? _____

COMMENTS: _____

LIST ANY SURGERY YOU HAVE HAD: HISTR Date/Year 8-1972

_____ Date/Year _____

_____ Date/Year _____

ANY Injuries, Accidents, Falls, Work Injuries: _____

FAMILY HISTORY: Please list any Family Illiness such as Tuberculosis, Diabetes, Cancer, or High or Low Blood Pressure; BELOW

Father Sister mathe Brother

FEMALE HISTORY: DATE OF LAST MENSTRUAL CYCLE: 8-19-72
(Circle One) Regular or Irregular?

BIRTH CONTROL PILLS: YES___ NO___

ARE YOU PREGNANT AT THIS TIME?: YES_____ NO____

ON THE NEXT PAGE IS A LIST OF POSSIBLE SYMPTOMS. PLEASE CIRCLE ANY THAT MAY APPLY TO YOU OR YOUR CHILD. (PLEASE READ CAREFULLY).....

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

Headache
Fever
Chills
Sweats
Fainting
Dizziness
Convulsions
Loss of Sleep
Fatigue
Nervousness
Loss of Weight
Numbness/Pain in (Arms,Hands,Legs)
Allergy
Neuralgia

EYES, EARS, NOSE & THROAT

Failing Vision
Near Sightedness
Far Sightedness
Crossed Eyes
Eye Pain
Deafness
Earache
Ear Noises
Ear Discharge
Nose Bleeds
Nasal Obstruction
Sore Throat
Hay Fever
Asthma
Gum Trouble
Frequent Colds
Enlarge Thyroid
Tonsillitis
Sinus
Enlarge Glands

SKIN

Skin Eruptions
Itching
Bruises Easily
Dryness
Boils
Sensitive Skin
Hives or Allergy

RESPIRATORY

Chronic Cough
Spitting up Phlegm
Chest Pain
Difficult Breathing

CARDIO-VASCULAR

Rapid Beating Heart
Slow Beating Heart
High Blood Pressure
Low Blood Pressure
Pain Over Heart
Previous Heart Stroke
Hardening of Arteries
Swelling of Ankles
Poor Circulation
Paralytic Stroke

MUSCLE & JOINT

Stiff Neck
Back Ache
Swollen Joints
Tremors
Painful Tail Bone
Foot Trouble
Hernia
Pain Between Shoulders
Spinal Curvature
Faulty Posture

GENITOURINARY

Frequent Urination
Painful Urination
Blood in Urine
Pus in Urine
Kidney Infection or Stones
Bed Wetting
Inability to Control Urine
Prostate Trouble

GASTROINTESTINAL

Poor Appetite
Difficult Digestion
Excessive Hunger
Belching or Gas
Nausea
Vomiting
Pain over Stomach
Distention of Abdomen
Constipation
Diarrhea
Hemorrhoids (Piles)
Intestinal Worms
Gall Bladder Trouble
Liver Trouble
Jaundice
Colitis

WOMEN ONLY

Painful Menstrual Periods
Excessive Flow
Hot Flashes
Irregular Cycle
Cramps or Backache
Previous Miscarriage
Vaginal Discharge
Lumps in Breast
Menopausal Symptoms
Congested Breasts

Are you on Drugs? If so, please list and give reason WHY?

_____
_____
_____
_____

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

____Alcoholism
____Anemia
____Appendicitis
____Arthritis
____Cancer
____Diabetes
____Diphtheria
____Emphysema
____Epilepsy
____Goiter
____Heart Disease
____Malaria
____Miscarriage
____Multiple Sclerosis
____Pleurisy
____Pneumonia
____Polio
____Rheumatic Fever
____Stroke
____Tuberculosis
____Typhoid Fever
____Ulcers
____Venereal Disease
____Gout

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

Signed Bernice Winston

Dated 4 - 20 - 1999

INSURANCE

ON ALL INSURANCE 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 — SYMPTOMATIC REPORT

4/20/99 Pt stated that on 4-15-9, at about 4.30 pm she was walking down the sidewalk on Capitol Drive when she suddenly tripped and fell ~~down~~ forward face-down stated that she sustained a cut to her right upper eyelid bruises to her right eye, right arm & rt knee. Stated that she was conveyed in an ambulance to St. Josephs Hospital ER - stated that her ~~rt~~ lacerated rt eye lid was stitched & she was given a Rx for pain. Stated that she woke up 5 pain, stiffness in her LB. The following day and has continues to experience same

Past History
Pt stated that she was well & was doing fine prior to this fall. She denied any recent injury or fall prior to this fall of 4/15/99.
Had Hysterectomy - 1972

Review of systems
Pt has a hx of high blood pressure & she is currently on medication.

Objective/Neurological
O/E, a well dev. well nourished B/F appeared to be in acute distress & discomfort was ambulatory & support.
No pathological gait was identified
was alert & oriented to time, places & things.
Head was normocephalic & scalp laceration stitched laceration to the lateral aspect of rt eyebrow identified.
mod. swelling to the right lateral infraorbital area on the cheek identified.
PERRLA
Romberg's sign - ve

ME

Bernice Winston

SYMPTOMATIC REPORT

4/23/99 States that she is still having difficulty getting around because her LB still hurts a lot. Lumbar paravertebral muscles & Rt quadratus lumborum still hypertonic. Rt gluteal muscles still hypertonic. Lumbar spine & sacral region still tender to digital palpation.

4/26/99 Still c/o pain & stiffness in her LB. Lumbar paravertebral muscles & Rt quadratus lumborum still hypertonic Rt gluteal muscles still hypertonic Lumbar spine & sacral region still tender to digital palpation.

4/28/99 States that it still hurts & feels stiff in her LB. Lumbar paravertebral muscles & Rt quadratus lumborum still hypertonic. Rt gluteal muscles still hypertonic. Lumbar spine & sacral region still tender to digital palpation.

4/30/99 Reports some relief in her LB. States that her LB still gets stiff. Lumbar spine & sacral region still tender to digital palpation. Lumbar paravertebral muscles & Rt quadratus lumborum still hypertonic. ↓ hypertonicity of Rt gluteal muscles.

5/3/99 States that her LB bothered her a lot while at work today. Gets shooting pain in her LB. Lumbar paravertebral muscles & Rt quadratus lumborum still hypertonic. Mild. hypertonicity of Rt gluteal muscles. Tenderness still present upon digital palpation of lumbar spine & sacral region.

5/7/99 States that she still gets shooting pain in her LB but she is moving around better. Thoracolumbar spine still hypomobile. Lumbar paravertebral muscles still hypertonic including the Rt quadratus lumborum & hypertonicity of Rt gluteal muscles.

NAME: Berice Wingfan SYMPTOMATIC REPORT

5/28/99 Stated that her UB feels sore & tight today. Hypertonicity of lumbar para-vertebral muscles. & hypertonicity of Rt quadratus lumborum. Lumbar spine still tender to digital palpation.

6/4/99 States that she is getting around better & ↓ discomfort. Reported ↓ intensity of pain & frequency of stiffness in her UB. ↑ mobility of thoracolumbar spine. Lumbar paravertebral muscles still moderately hypertonic. Lumbar spine & sacral region still tender to digital palpation.

6/25/99 Presented today c today c stiffness - pain in her UB. Stated that she was feeling better until a few days ago when her UB got pretty stiff & achy. Hypomobility of lumbar spine. Hypertonicity of paravertebral muscles. Tenderness upon digital palpation of lumbar spine.

7/2/99 States that her UB bothered her at work today. C/o stiffness & pain in her UB. Hypertonicity of lumbar paravertebral muscles. Lumbar spine still tender to digital palpation.

7/9/99 States that her UB feels better today. Reported ↓ stiffness in her UB & hypertonicity of lumbar paravertebral muscles. Lower lumbar spine still tender to digital palpation.

7/16/99 States that it feels sore & tight in the lower ~~part~~ part of her UB. Mod. hypertonicity of Rt lumbar paravertebral muscles. Mod. tenderness upon digital palpation of lumbar spine. ↑ mobility of thoracolumbar spine

Bernice, Winston

ADJUSTIC REPORT

	Date 4/21/99	Date 4/23/99	Date 4/26/99	Date 4/28/99	Date 4/30/99	Date 5/3/99
	0	0	0	0	0	0
	1	1	1	1	1	1
	2	2	2	2	2	2
	3	3	3	3	3	3
	4	4	4	4	4	4
	5	5	5	5	5	5
	6	6	6	6	6	6
	7	7	7	7	7	7
	1	1	1	1	1	1
	2	2	2	2	2	2
	3	3	3	3	3	3
	4	4	4	4	4	4
	5	5	5	5	5	5
	5	6	6	6	6	6
	7	7	7	7	7	7
	8	8	8	8	8	8
	9	9	9	9	9	9
	10	10	10	10	10	10
	11	11	11	11	11	11

	Date 5/7/99	Date 5/10/99	Date 5/12/99	Date 5/14/99	Date 5/17/99	Date 5/21/99
	0	0	0	0	0	0
	1	1	1	1	1	1
	2	2	2	2	2	2
	3	3	3	3	3	3
	4	4	4	4	4	4
	5	5	5	5	5	5
	6	6	6	6	6	6
	7	7	7	7	7	7
	1	1	1	1	1	1
	2	2	2	2	2	2
	3	3	3	3	3	3
	4	4	4	4	4	4
	5	5	5	5	5	5
	6	6	6	6	6	6
	7	7	7	7	7	7
	8	8	8	8	8	8
	9	9	9	9	9	9
	10	10	10	10	10	10
	11	11	11	11	11	11
	12	12	12	12	12	12
	1	1	1	1	1	1

Bernice Winston

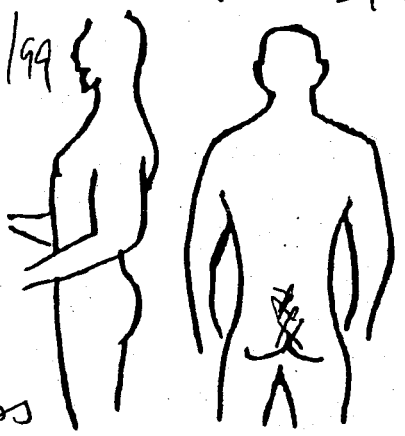
4/20/99

TIENT STANDING

NERAL APPEARANCE

Nourishment	G___	F ✓	P___
Color	G___	F ✓	P___
Stature	G___	F ✓	P___
Attitude	G ✓	F___	P___
ıbulation	G___	F ✓	P___

Cane(s) _____
Crutch(s) _____
Wheelchair _____
Non-Ambulatory _____
Height 5'5" Weight 182 lbs



Thoracic - Lumbar Motion

	Norm	Exam	Pain
Flexion	75-90°	30	Pain
Extension	30°	10	↓
Lateral Right	35°	25	↓
Lateral Left	35°	15	↓
Rotation Right	30°	10	↓
Rotation Left	30°	10	↓

TIENT SEATED

Valsalva test -ve

vical Motion SLR(sitting) test prod. local pain in LB

	Norm	Exam	Pain
xion	45°	WNL	Neg
tension	55°	↓	↓
eral Left	40°	↓	↓
eral Right	40°	↓	↓
tation Left	70°	↓	↓
tation Right	70°	↓	↓

aminal Compression	R	N	L N
oulder Depressor	R	N	L N
Fanning	R	±	L ±
eps Reflex	R	+2	L +2
ceps Reflex	R	+2	L +2
dial Reflex	R	+2	L +2
ellar Reflex	R	+2	L +2

od Pressure
___/96 bent (rt) 160/85/___ (lt)
se _____
spiration 16 bpm

Pt on Blood Press medication

PATIENT PRONE

Achilles Reflex	R	+2	L +2
Nachlas-ely	R	___	L Pain
	BOTH	Pain	& pain @ L/S
Derifield Cerv.	R ___	L ___	
Sac.	R ___	L ___	
P-I	R ___	L ___	
S-I Motion	R ___	L ___	

SEGMENT	TENDER	SPASMS	LISTING
OCC			
C1			
C2			
C3			
C4			
C5			
C6			
C7			
T1			
T2			
T3			
T4			
T5			
T6			
T7			
T8			
T9			
T10			
T11			
T12			
L1	X		
L2	X		
L3	X		
L4	X		
L5	X		
SAC-BAS			
SAC-APE			
RT-IL			
LT-IL			
COCCYX			

TIENT SUPINE

@ 40° c pain @ L/spine

segue R Pain L Pain @ 65° c pain
aggard R Neg L Neg @ L/S spine
ldthwait
S-I R ↓ L ↓
Lumbar R Pain L Pain
over's sign R Neg L Neg
g Lowering R Pain L Pain @ 30° c pain
rnig's Sign R Neg L Neg @ L/Spine
bere-Patrick
Part 1 R ↓ L ↓
Part 2 R ↓ L ↓
Part 3 R ↓ L ↓
kle Clonus R ↓ L ↓
wheel
Ankle R ___ LEVEL _____
L ___ LEVEL _____
Wrist R ___ LEVEL _____
L ___ LEVEL _____
hinksi R ___ L ___
o Hall

X RAYS

AP / Lat

	14 x 17	10 x 12	8 x 10
CERV			
THOR			
LUMBAR	3	3	
SPEC VIEW			

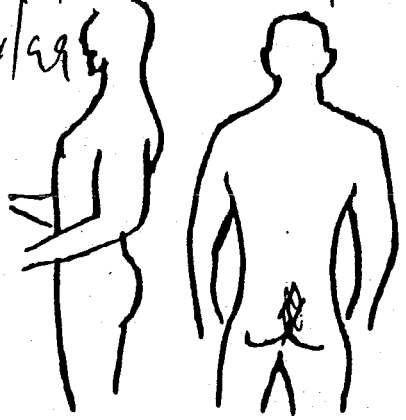
Bernice Winston
6/4/98

TIENT STANDING

NERAL APPEARANCE

Nourishment	G___	F___	P___
Color	G___	F___	P___
Stature	G___	F___	P___
Attitude	G___	F___	P___
ibulation	G___	F___	P___

Cane(s) _____
Crutch(s) _____
Wheelchair _____
Non-Ambulatory _____
Height Weight



Thoracic - Lumbar Motion

	Norm	Exam	Pain
Flexion	75-90°	60	Pos
Extension	30°	20	↓
Lateral Right	35°	WNL	Neg
Lateral Left	35°	30	Pos
Rotation Right	30°	WNL	Neg
Rotation Left	30°	25	Pos

TIENT SEATED

vical Motion

	Norm	Exam	Pain
xion	45°		
ension	55°	N	
eral Left	40°		
eral Right	40°		
tation Left	70°		
tation Right	70°		

aminal Compression R L
ulder Depressor R L
Fanning R L
eps Reflex R L
ceps Reflex R L
fial Reflex R L
ellar Reflex R L

od Pressure
___/___/___ (rt) ___/___/___ (lt)
e _____
piration _____

PATIENT PRONE

Achilles Reflex R ___ L ___
Nachlas-sly R ___ L ___
BOTH Pos c/o pain e L/S
Derifield Cerv. R ___ L ___
Sac. R ___ L ___
P-I R ___ L ___
S-I Motion R ___ L ___

SEGMENT	TENDER	SPASMS	LISTING
OCC			
C1			
C2			
C3			
C4			
C5			
C6			
C7			
T1			
T2			
T3			
T4			
T5			
T6			
T7			
T8			
T9			
T10			
T11			
T12			
L1			
L2			
L3	X		
L4	X		
L5	X		
SAC-BAS			
SAC-APE			
RT-IL			
LT-IL			
COCCYX			

IENT SUPINE

gue R Neg Neg
gard R ___ L ___
lthwait
t
umbar
ver's sign
Lowering
lg's Sign
re-Patrick
rt 1
rt 2
rt 3
e Clonus
oel
kle

R ___ LEVEL _____
L ___ LEVEL _____
ist R ___ LEVEL _____
L ___ LEVEL _____
R ___ L ___

X RAYS

	14 x 17	10 x 12	8 x 10
CERV			
THOR			
LUMBAR			

Pyramid Chiropractic Clinic

Dr. Adebayo Yusuf

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

X-RAY ANALYSIS

NAME: Bernice Winston
DATE: 4-20-99
AREAS: L/S spine (In House)
VIEWS: AP, Lat

Normal lumbar lordotic curvature
Narrowing of disc spaces L3-4, L4-5, L5-S1
Anterior osteophytosis L2-S1
Lumbar rotational malpositions & resultant levo-scoliosis
Rt unilateral sacralization of L5

X Rays Neg for fx

Pyramid Chiropractic Clinic, S. C.

Dr. Adebayo Yusuf

5842 West Fond du Lac Avenue
Milwaukee, Wisconsin 53216
(414) 461-2222

RECORDS RELEASE

TO St. Joseph's Hospital

I Hereby Authorize You to Release to Dr. Bayo Yusuf, D.C.
Any Information including the Diagnosis and Records of Any Treatment or Examination Rendered to Me During the Period.

FROM 4-15-99 TO _____

WITNESS _____

DATE 4/20/99 SIGNATURE Bernice Winston

Plt's Name : Bernice Winston

D. O. B : 7-27-37

St JOSEPH'S HOSPITAL
200 W. Chambers St. • Milwaukee, WI 53210-1695

EMERGENCY DEPARTMENT RECORD

WINSTON BERNICE
DOB: 07/27/37 61Y SEX: F MR: 81707
SANABRIA CARLOS R
ACCT#: 70045175

CHIEF COMPLAINT: head laceration s/p fall | WT. | LMP/EDC | TIME | FHT

PAST MEDICAL HISTORY ☐ TB_____ ☐ FAMILY HX TB ☐ POSITIVE SKIN TEST ☐ REC'D MEDICATION
☐ RESP. ☐ CARDIAC ☐ NEURO ☐ RENAL ☐ DM ☐ PSYCH ☐ AODA
☐ CANCER ☐ OTHER HTN

PRIMARY RN: J Vanzin

ALLERGIES: LATEX ☐ YES ☐ NO
OTHER: ASA, codeine

TETANUS ☐ > 10 YRS. ☐ NEVER

4.15.99

MEDICATIONS - NAME AND DOSE
water pill
heart pill
2 nacardia
Premarin

TIME/INITIALS	BP	P	R	TEMP	O2 SAT. / FIO2
1720	177/99	85	20	97.3	
1750	185/101	84			
	199/96				

HISTORY AND PHYSICAL TIME: 1756

#240317 ~~DEDICATED~~

EVALUATION/TREATMENT

☐ OLD RECORDS
☐ CBC
☐ H/H
WBC
DIFF
B
S
E
L
M
☐ PT
INR
☐ PTT
☐ TYPE & SCREEN

☐ I-6 (2STAT)
☐ CHEM 7
Na
K
Cl
CO
Glucose
BUN
Creat
☐ ETOH
☐ DIGOXIN
☐ THEOPH.
☐ DILANTIN
☐ ED DRUG SCRN

☐ CK - MB SCREEN
☐ LDH
☐ SGOT (AST)
☐ SGPT (ALT)
☐ GGT
☐ BILIRUBIN
☐ ALK PHOS
☐ LIPASE
☐ AMYLASE
☐ AMMONIA
☐ KETONES
☐ CA
☐ PHOS
☐ MG
☐ BHCG

☐ ECG
☐ STREP SCREEN
☐ BLOOD CULTURE
☐ VDRL
☐ GC CULTURE
☐ CHLAMYDIA
☐ WET MOUNT
☐ ABG #1 ON ____L
pH
PCO_2
PO_2
HCO_3
☐ UA
☐ C&S
☐ OTHER
☐ URINE PREG.

☐ PORTABLE CXR ☐ PORTABLE C SPINE
☐ PA & LA CXR ☐ C SPINE
☐ ADMISSION CXR ☐ LS SPINE
☐ ABD SERIES ☐ ULTRASOUND _____
☐ CT_____ ☐ OTHER_____
INTERPRETATION
READ BY ☐ ED MD ☐ RADIOLOGY

LACERATION LOCATION | LENGTH 2 CM | NO. SUTURES 5 SKIN SUBQ.

TREATMENT
IV_____ RATE_____ O_2 AT_____ ☐ O_2 SAT
☐ MONITOR / RN TO ACCOMPANY PATIENT ☐ YES ☐ NO
☒ TETANUS 0.5 IM ☐ VISUAL ACUITY
☐ STRAIGHT CATH ☐ FINGERSTICK GLUCOSE _____
☐ FOLEY ☐ NG ☐ ORTHO BP & P ☐ DIPSTICK URINE _____

TIME	ORDER
	1% lido
	Wound prep
	6-0 ethilon
	Neosporin
	Dressing

DIAGNOSIS/DISCHARGE PLAN

FINAL DIAGNOSIS
(R) eyebrow laceration
Closed Cranial Trauma

ADMITTING PHYSICIAN
☒ REFERRED TO PMD
☐ TRANSFERRED TO

ROOM NO.
☐ ICU
☐ CARDIAC TELE
☐ MEDICAL TELE
☐ MEDICAL
☐ 24 HR OBS.

PATIENT MAY RETURN
☐ NO RESTRICTIONS
☒ KEEP CLEAN AND DRY
☐ NO HEAVY LIFTING
☐ OTHER
☐ WORK/SCHOOL/GYM ON _____
☐ RESTRICTIONS UNTIL _____
☐ DO NOT USE IMPAIRED PART
☐ SITTING JOB

CALL PHYSICIAN TO FOLLOW-UP: ☐ ONLY AS NEEDED OR IF NOT IMPROVING
☒ WITHIN 2 DAYS OR SOONER IF FEELING WORSE
☒ IN 7 DAYS FOR SUTURE REMOVAL
☐ OTHER
Head injury instr - awake q 2 hrs

FURTHER DISABILITY TO BE DETERMINED BY YOUR PERSONAL PHYSICIAN

I HAVE RECEIVED DISCHARGE INSTRUCTIONS AND UNDERSTAND THAT I HAVE RECEIVED EMERGENCY CARE ONLY. I AM TO CALL OR SEE MY FAMILY PHYSICIAN FOR FURTHER CARE.

PATIENT SIGNATURE

PHYSICIAN SIGNATURE S Peters PAC / Sanabria

FORM 3958 2/98 R1

EMERGENCY DEPARTMENT RECORD

St Joseph's Hospital
5000 W. Chambers St. · Milwaukee, WI 53210-1688

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.
3. Procardia.
4. 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. Nares 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.

St Joseph's Hospital
5000 W. Chambers St. · Milwaukee, WI 53210-1688

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 IM. 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:
1. Right eyebrow laceration.
2. Closed cranial trauma.

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

S. Peters PA-C
SHANNON PETERS, P.A.-C

C. Sanabria, MD
CARLOS R. SANABRIA, M.D.

CRS/TL585/SP /Job:240317 dd: 04/15/99 dt: 04/15/99
Batch: 1122

OUTPATIENT/EMERGENCY NURSING CARE RECORD

St Joseph's Hospital Milwaukee
5000 West Chambers Street
Milwaukee, WI 53210

WINSTON BERNICE
DOB: 07/27/37 61 Y SEX: F MR: 81707
SANABRIA CARLOS R
ACCT#: 70045175

REGISTRATION

TIME IN TRIAGE	1 2 3	PATIENT NAME
1720	☐ ☒ ☐	Winston Bernice
BIRTHDATE	AGE	CHIEF COMPLAINT
7-27-37		Laceration S/P fall

MODE OF ARRIVAL: ☐ CARRIED ☒ AMBULANCE ☐ AMBULATORY ☐ W/C — Upstate
PRIVATE PHYSICIAN: ☒ REC ☐ PMD
FAMILY WITH PATIENT: ☐ YES ☐ NO
HMO CODE: ☐ 0=N/A ☐ 1=YES/PHYS ☐ 2=HMO HOTLINE ☐ 3=AUTO AUTH ☐ 4=LIFE/LIMB THF ☐ 5=NO AUTH
TODAY'S DATE: 4-15-99
AUTHORIZED/DENIED BY:

DIRECT EMERGENCY ADMISSIONS ONLY

STREET ADDRESS | CITY | STATE | ZIP | TELEPHONE

SEX: ☐ M ☒ F
MARITAL STATUS: ☐ S ☐ M ☐ W ☐ D ☐ P
RESPONSIBLE PARTY
☐ ACCIDENT LOCATION: DATE/TIME
INSURANCE

PLAN

☐ DIVERT REGISTRATION ☐ REASSURANCE ☐ W/C ☐ V.S. ☐ ELEVATION ☐ SPLINT
☐ PATIENT TO REGISTER AND WAIT TO BE CALLED ☐ ICE ☐ DRESSING ☐ OTHER

TRIAGE RN: Bellcock RN

FUNCTIONAL/REALITY ASSESSMENT

☐ HEALTH PERCEPTION/MANAGEMENT ☐ ACTIVITY/EXERCISE ☐ SELF-PERCEPTION/CONCEPT ☐ COPING/STRESS TOLERANCE
☐ NUTRITIONAL/METABOLIC ☐ COGNITIVE/PERCEPTUAL ☐ ROLE/RELATIONSHIP ☐ VALUE/BELIEF
☐ ELIMINATION ☐ SLEEP/REST ☐ SEXUALITY/REPRODUCTIVE

SUBJECTIVE: 1730
"I fell outside on the street I wasn't dizzy & I fell - ϕ LOC"
Denies N/V
Denies headache

OBJECTIVE:
Alert oriented x 4 w/ VSS
laceration - approx 1 inch (R) eyebrow
(R) upper cheek swollen
Pupils equal round & reactive

☐ SEE ADDITIONAL NURSING RECORD

NURSING DIAGNOSIS: Impaired Skin Integrity

PLAN / INTERVENTION / EVALUATION

TIME	NURSING INTERVENTIONS	RESPONSE/EVALUATIONS
1849	Sutures placed x 7 per PAC Peters MV	
1849	Pt d/c'd to home. Verbalizes understanding. MV	

☐ SR

☒ PT. VERBALIZES UNDERSTANDING OF AND/OR CAN REPEAT INSTRUCTIONS.
☐ ADEQUATE RETURN DEMONSTRATION OF _____ OBSERVED

TIME	MEDICATION:	RESPONSE/EVALUATIONS
		INTAKE PO / IV / IV / CREDIT
1800	PROCEDURES: Sterile Prep c Shur Clens. Rinsed c Sterile Water. Applied antibiotic ointment to sutured site. Applied bnd-aid — Stan Wagner EMT	OUTPUT URINE / EMESIS / OTHER

DISCHARGE PLAN

☒ REVIEW MD DISCHARGE PLAN
☐ DISCHARGE PER MD
☐ ADMISSION PROCEDURE EXPLAINED
☐ REFERRAL

NOTIFIED:
☐ NURSING HOME
☐ POLICE ☐ CORONER
☐ FAMILY ☐ CLERGY

MODE OF ADMISSION/DISCHARGE
☐ AMBULANCE
☐ WHEELCHAIR ☐ CARRIED
☒ AMBULATORY ☐ CART

NOTIFICATION OF ADMISSION TO: ☐ X-RAY ☐ VALUABLES CHECKLIST
ADMISSION REPORT | SHIFT REPORT | TIME PATIENT ADMITTED
SIGNATURE — PRIMARY RN: J. Kanapka

WHITE - Medical Records; YELLOW - Emergency Department; PINK - Emergency Physician's Copy; GOLD - Patient Registration

5115 W. CAPITOL DRIVE
MILWAUKEE, WI 53216

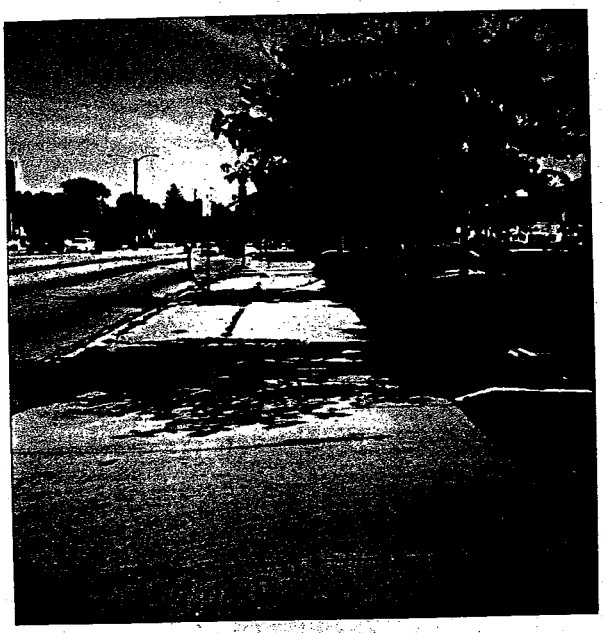
9-22-99

CLAIM # 74125

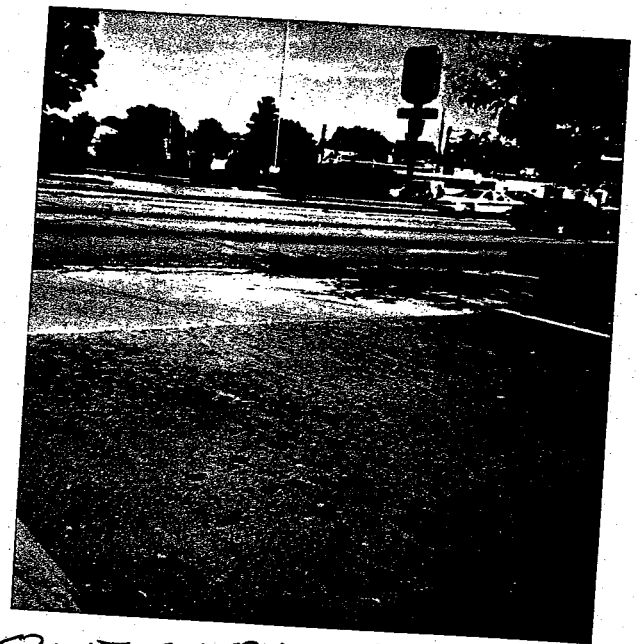
I TALKED TO JOE LUSTEK HE SAID THAT THE CITY WAS NOT WORKING ON THE STREET THAT DAY.

074125
JKL

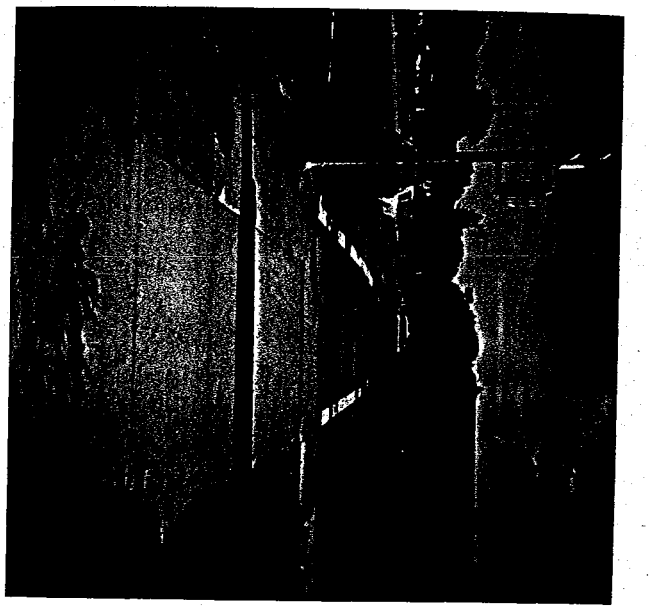
GREG BEAUDRY



FRONT OF STORE FACING EAST. 53 YARDS TO CORNER

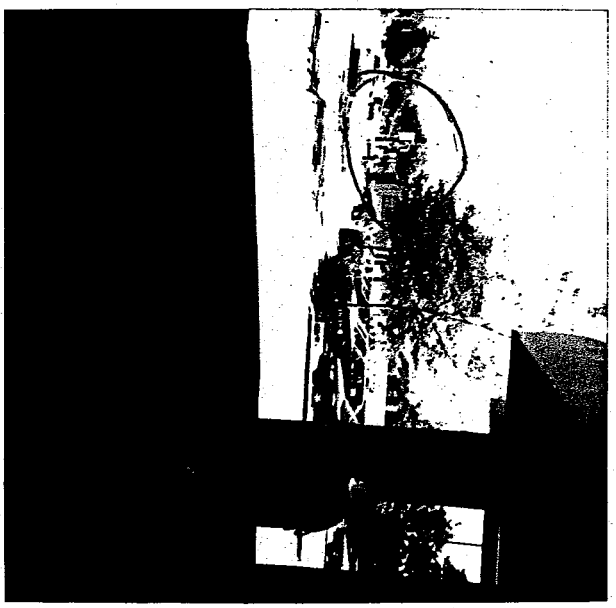


FRONT ENTERANCE OF STORE

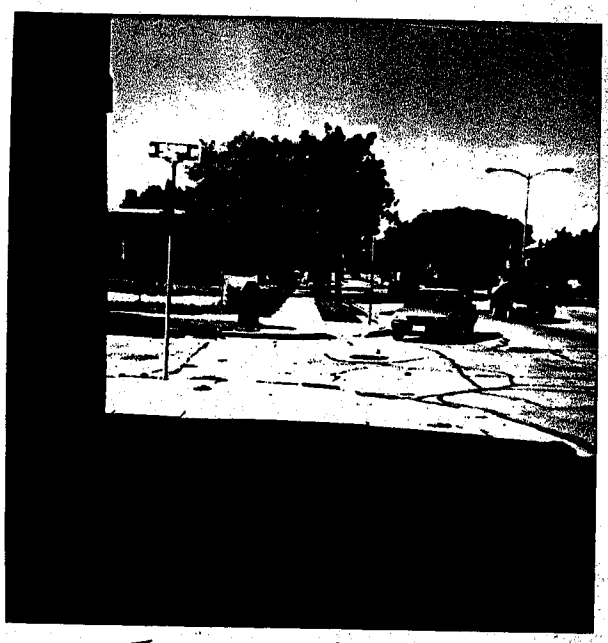


EAST CORNER. ABOUT 53 YDS TO CORNER

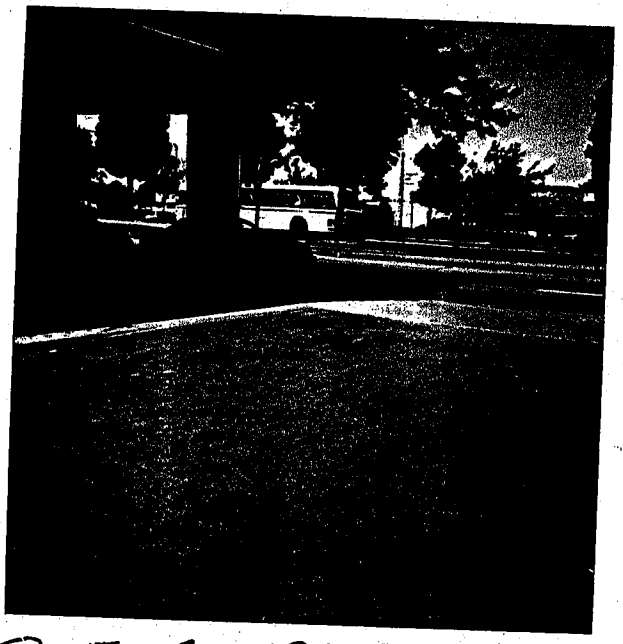
SIDE OF STORE FACING NORTH FROM WEST SIDE OF STORE 38 YDS TO CORNER.



FRONT OF STORE FACING EAST. ABOUT 53 YDS TO CORNER



FRONT OF STORE FACING WEST TO CORNER. 38yds TO CORNER



FRONT OF STORE FACING NORTH.