Claim # 12-5-6

City Clerk's Office -

CITY OF MILWAUKEE
2012 FEB 14 AM 7:42
RONALD D. LEONHARDT
CITY CLERK

2-10-12

CITY OF MILWAUKEE
RECEIVED
2012 FEB 14 PM 4:40
OFFICE OF THE CITY ATTORNEY

To whom it may concern:

My name is Cherisse Bonjue and I am writing again Concerning an injury I sustained back in October of 2011.

I had a slight problem getting the medical (written) records because for some reason the woman in Medical Records said that she had n't gotten my messages asking for the records. Dr. Neubauer is the Orthopedic specialist I was referred to after the Emergency room. I do believe that I sent bills from the Doctor that took care of me at Wheaton/St. Francis Hospital.

I have more bills and receipts for medical equipment that we paid for because of not having insurance. We paid for office visits, Crutches and a Walking boot. I was given advice to send all of this information in along with An overall demand for pain and suffering which if I have to put

a price tag on what it's been through it would be around $10,000.00 along with my medical bills. Well, to get this out to you, I'll stop here so thank you for working with me and hope to hear from you soon.

Cherise Bogue

WFH-St. Francis Hospital
3237 S. 16th St.
Milwaukee, WI 53215
414-647-5165

DISCHARGE INSTRUCTIONS

Patient Name: BOZOVIC, CHERISSE M.	Visit Date: 10/16/2011
Med Rec No: 209964	Acct No: 11653444

The examination and treatment you received in the Emergency Department has been given on a emergency basis only. Should your condition worsen or any new symptoms develop, or should you not recover as expected, contact your doctor or the doctor you were given for follow-up care. If you cannot contact your doctor, return to the Emergency Department.

You were treated today by :

Joel Smukowski MD

ADDITIONAL FOLLOWUP INSTRUCTIONS

Arrange for a follow up appointment with JOSHUA NEUBAUER, MD in 3 - 5 days or immediately if your symptoms get worse.

Neubauer, Joshua , MD
3111 W. RAWSON
SUITE 200
FRANKLIN, WI 53132
414- 325- 4320

DISCHARGE INSTRUCTIONS

Ankle Fracture- Brief

Fractured Ankle

A fractured or broken ankle may involve one or both bones (tibia and or fibula). Most of the time, broken ankles do not require surgery. They usually heal in 6-12 weeks with proper care. A cast, splint, or walking boot or brace is usually applied to immobilize the joint. Do not scratch the skin under your splint or cast.

Keep your injured ankle elevated to the level of your heart on pillows and chairs for the next 3-4 days. You can apply ice packs to the injured area for 20-30 minutes every 3-4 hours during this time to help control swelling and pain. Use crutches to as instructed. Do not bear weight on your injury until your caregiver approves. Walking on a broken ankle before advised by your provider may compromise the long term result. Take your pain medicine as prescribed. Be sure to arrange for follow-up care, such as physical therapy) as recommended. This allows your ankle to be fully rehabilitated as quickly and completely as possible.

CALL YOUR CAREGIVER OR SEEK IMMEDIATE MEDICAL CARE IF YOU HAVE:
Increasing pain uncontrolled by pain medicine.
Numb, cold, pale, or painful toes.
Are not improving or are getting worse.
Have any other questions or concerns.

MAKE SURE YOU:
Understand these instructions.
Will watch your condition.

WFH-St. Francis Hospital
3237 S. 16th St.
Milwaukee, WI 53215
414-647-5165

DISCHARGE INSTRUCTIONS

Patient Name: BOZOVIC, CHERISSE M.	Visit Date: 10/16/2011
Med Rec No: 209964	Acct No: 11653444

DISCHARGE INSTRUCTIONS

Metatarsal Fracture(s), Undisplaced
Metatarsal Fracture(s), Undisplaced

A metatarsal fracture is a break in the bone(s) of the foot. These are the bones of the foot that connect your toes to the bones of the ankle.

DIAGNOSIS
The diagnoses of these fractures are usually made with X-rays. If there are problems in the forefoot and x-rays are normal a later bone scan will usually make the diagnosis.

TREATMENT & HOME CARE INSTRUCTIONS
Treatment may or may not include a cast or walking shoe. When casts are needed the use is usually for short periods of time so as not to slow down healing with muscle wasting (atrophy).
Activities should be stopped until further advised by your caregiver.
Wear shoes with adequate shock absorbing capabilities and stiff soles.
Alternative exercise may be undertaken while waiting for healing. These may include bicycling and swimming, or as your caregiver suggests.
It is important to keep all follow-up visits or specialty referrals. The failure to keep these appointments could result in improper bone healing and chronic pain or disability.
Warning: Do not drive a car or operate a motor vehicle until your caregiver specifically tells you it is safe to do so.

IF YOU DO NOT HAVE A CAST OR SPLINT:
You may walk on your injured foot as tolerated or advised.
Do not put any weight on your injured foot for the first 1-2 weeks or as directed by your caregiver. Slowly increase the amount of time you walk on the foot as the pain allows or as advised.
Use crutches until you can bear weight without pain. A gradual increase in weight bearing may help.
Apply ice to the injury for 15 to 20 minutes each hour while awake for the first 2 days. Put the ice in a plastic bag and place a towel between the bag of ice and your skin.
Only take over-the-counter or prescription medicines for pain, discomfort, or fever as directed by your caregiver.

SEEK IMMEDIATE MEDICAL CARE IF:
Your cast gets damaged or breaks.
You have continued severe pain or more swelling than you did before the cast was put on, or the pain is not controlled with medications.
Your skin or nails below the injury turn blue or grey, or feel cold or numb.
There is a bad smell, or new stains and/or pus-like (purulent) drainage coming from under the cast.

MAKE SURE YOU:

WFH-St. Francis Hospital
3237 S. 16th St.
Milwaukee, WI 53215
414-647-5165

DISCHARGE INSTRUCTIONS

Patient Name: BOZOVIC, CHERISSE M.	Visit Date: 10/16/2011
Med Rec No: 209964	Acct No: 11653444

DISCHARGE INSTRUCTIONS

Metatarsal Fracture(s), Undisplaced
Understand these instructions.
Will watch your condition.
Will get help right away if you are not doing well or get worse.

Document Released: 04/07/2004 Document Re-Released: 03/16/2010

If you had an X-ray: X-rays do not always show any injury or disease. Fractures (breaks in bones) are not always revealed on the initial X-rays, but may be revealed on subsequent X-rays. Your X-ray has been read on preliminary basis. Final reading will be made by a radiologist in 24 hours. You will be notified of any additional findings. If you had a culture, the final results will be reviewed. You will be notified if additional treatment is required. If you need a release to return to work or school, or an extension of the time period indicated, it should be obtained from your physician, company physician or the physician given to you for follow-up care.

Location	Pat. Name	Sex	Age	MRN	Admission Date	Facility	Acct. Number
⊕ DIS 10/16/11 10:34	BOZOVIC, CHERISSE MELAINE	F	46 Y	209964	10/16/11 08:33	WFH-SF	11653444

Report for BOZOVIC, CHERISSE MELAINE (MRN: 209964)

TEST: RADIOLOGY
Collected Date & Time: 10/16/11 09:37

RADIOLOGY& Lat

cc:
JOEL SMUKOWSKI, MD, Ordering Physician

EXAM LOCATION: ST. FRANCIS

ORDERING PROVIDER: Joel Smukowski, MD
OCCURRENCE NUMBER: 202079089 EXAM DATE: 10/16/201

EXAM: LEFT ANKLE THREE VIEWS

INDICATION: Fall and ankle pain.

FINDINGS: Three views of the ankle were performed and compared to the examination of February 8, 2011. There is a nondisplaced spiral fracture involving the distal shaft of the fibula at the level of the tibiotalar joint. There is no dislocation. Ankle joint appears normal. There is fracture of the proximal shafts of the second and third metatarsals.

IMPRESSION:
1. Nondisplaced spiral fracture of the distal fibular shaft at the level of the tibiotalar joint.
2. Nondisplaced fractures at the bases of the second and third metatarsals.

This document was electronically signed by PHILLIP BAINBRIDGE, MD on 10/16/2011 13:34:45.

Radiologist:
PHILLIP BAINBRIDGE, MD

PB/lb D. 10/16/2011 09:37:16 T. 10/16/2011 12:08:02
Doc ID #: 8286291 Voice ID #: 8456940

WHEATON FRANCISCAN HEALTHCARE - ST. FRANCIS
NAME: BOZOVIC, CHERISSE M MRN: 209964
DOB: 11/21/1964 ACCT #: 11653444
VISIT TYPE: E ROOM: ED
DOCTOR: PHILLIP BAINBRIDGE, MD DATE: 10/16/2011

RADIOLOGY
Page 1 of 1

REPORT IS NOT FINAL UNLESS AUTHENTICATED

View GE Images

PATIENT INFORMATION SHEET

AGE 46

NAME Cherisse M. Borrero — DATE OF BIRTH ____ SEX ____

ADDRESS 3246 S. Clement Ave. — TELEPHONE (414) 763-9428

CITY/STATE/ZIP Milw, WI 53207 — CELL PHONE —

SOCIAL SECURITY # 396-66-0048 — E-MAIL ADDRESS —

EMPLOYER NAME Suds your Duds — MARITIAL STATUS Seperated

EMPLOYERS ADDRESS 3604 S. Clement Ave. — IS PAITENT EMPLOYED (YES) OR NO

CITY/STATE/ZIP Milw, WI 53207 — WORK RELATED INJURY - YES OR (NO)

OCCUPATION Laundromat attendant — DATE OF INJURY 10-16-11

IS THE PATIENT A FULL-TIME OR PART-TIME STUDENT (circle one) — EMPLOYER PHONE (414) 455-4644

NAME OF SCHOOL ____ — SCHOOL LOCATION ____

RACE: American or Alaskan Native ☐ Asian ☐ Black or African Amencan ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Declined ☐

ETHNICITY: Hispanic or Latino ☒ Non-Hispanic or Latino ☐ Declined ☐ Language: English Open choice ☐ Declined ☐

PHARMACY: Walgreens - 13th - Oklahoma LOCATION/PHONE# (414) 744-1193

Smoker: (Yes) / No

INSURED INFORMATION

INSURED RELATIONSHIP TO THE PATIENT: (SELF) SPOUSE PARENT OTHER (Circle one)

NAME ____ DATE OF BIRTH ____ SEX ____

ADDRESS ____ TELEPHONE#: ____

CITY/STATE/ZIP ____ SOCIAL SECURITY # ____

EMPLOYER NAME ____ EMPLOYER PHONE ____

EMPLOYER ADDRESS ____

INSURANCE INFORMATION

PRIMARY CARRIER Self Pay — GROUP# ____

ADDRESS ____ ID# ____

SECONDARY CARRIER ____ GROUP# ____

ADDRESS ____ ID# ____

NAME OF REFFERING PHYSICIAN (if any) Wheaton-Franciscan St. Francis Emergency

NAME OF PRIMARY PHYSICIAN DC. Amber Ellis-Omni Family medical

Assignment of Benefits: *I hereby assign all Medical and/or Surgical Benefits, including Major Medical Benefits to which I am entitled, private insurance and any other Health Plan to ORTHOPEDIC INSTITUTE OF WISCONSIN. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid for by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.*

X Cherisse M. Borrero — Signed

X 10-21-11 — Date

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE 10/21/11 DATE OF LAST PHYSICAL EXAM 10/13/11

LAST NAME Bozalis FIRST NAME: Cherisse

NAME OF PHYSICIAN REQUESTING THIS EVALUATION _____ DATE OF BIRTH: 11/21/64

CHIEF COMPLAINT

What is the main reason for your visit today? (Describe your problem in detail)

Fractured Ankle

History of Present Illness

Please answer the following questions

Location of the problem

On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 (7) (8) 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other 5 days ago

Does anything help or make the problem worse?

(Moving around) (Standing up) (Lying on my side)

Other _____

How long does the problem last?

30 minutes 1 hour (It is always there)

Other _____

Is anything else occurring at the same time?

(YES) No If yes, please explain.

Nausea Rash Headaches

Other Sprained Right Ankle

Is the problem constant or variable?

Dull then Sharp Very sharp then leaves (Always there)

Other _____

Does the problem interfere with your normal functions?

Yes ☒ No ☐ If yes, please explain

walking, bathing, leaving my home

Past Medical, Family & Social History

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.,)

Diabetes - father

Breast Cancer Sister's

COPD

List any personal past illness and/or surgeries and when they occurred.

Illness or Surgery	Date
Hysterectomy	8-2000

Are you on a special diet? Yes (No) (If Yes, please explain)

Do you have allergies? (Yes) No (If Yes, please explain)

Penicillin - Amoxil - Codeine

Do you smoke? ☒ Yes ☐ No
If yes, how much? 1 Pk. day

Do you drink? ☐ Yes ☒ No
If yes, how much? _____

Do you exercise regularly? ☐ Yes ☒ No
If yes, how much? _____

Are you currently taking any medication? If Yes, please list all.

Fluoxetine	40 mg
Methadone	80 mg

Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Y**es or **N**o.

Constitutional Symptoms
Fever Y N
Chills Y N
Headache Y N
Other _____

Eyes
Blurred vision (Y) N
Double vision Y N
Pain Y N
Other _____

Allergic/Immunologic
Hay Fever Y N
Drug allergies (Y) N
Other _____

Neurological
Tremors Y N
Dizzy spells Y N
Numbness/tingling Y N
Other _____

Endocrine
Excessive thirst Y N
Too hot/cold Y N
Tired/sluggish Y N
Other _____

Gastrointestinal
Abdominal pain Y N
Nausea/vomiting Y N
Indigestion/heartburn Y N
Other _____

Cardiovascular
Chest pain Y N
Varicose veins Y N
High blood pressure Y N
Other _____

Integumentary
Skin rash Y N
Boils (Y) N
Persistent itch Y N
Other _____

Musculoskeletal
Joint pain (Y) N
Neck pain Y N
Back pain (Y) N
Other _____

Ear/Nose/Throat/Mouth
Ear infection Y N
Sore throat Y N
Sinus problem Y N
Other _____

Genitourinary
Urine retention Y N
Painful urination Y N
Urinary frequency Y N
Other _____

Respiratory
Wheezing (Y) N
Frequent cough Y N
Shortness of breath Y N
Other _____

Hematologic/Lymphatic
Swollen glands Y N
Blood clotting problem Y N

Other _____

Psychologic
Are you generally satisfied with your life? (Y) N
Do you feel severely depressed? Y (N)
Have you considered suicide? (Y) N
Other _____

Physician use only: (Comments/Notes)

Physician _____ Date _____
Physician _____ Date _____
Physician _____ Date _____
Physician _____ Date _____
Physician _____ Date _____
Physician _____ Date _____

Date: 11/18/11 : 12:35pm
Title: Followup patient visit
Providers: JN
D.O.S. 11/18/11

Bozovic, Cherisse
D.O.B.11/21/64
ID #:109191

The patient returns for her left ankle. She has a distal fibula fracture.
X-rays taken today show stable position of the fracture. Her foot and ankle are neurovascularly intact. She has present dorsiflexion and plantar flexion though with limited range of motion as expected. She will continue range of motion exercises on her own. She will return to see me in 4 weeks for an x-ray which an insertion shift questions, problems, concerns.

Procedure: Established Patient Level 2: 99212

Diagnosis: FIBULA FRACTURE, UNSPECIFIED: 823.81

Dictated by Joshua M Neubauer, M.D.

SIGNED BY Joshua M Neubauer (JN) 11/18/2011 12:36PM

Date: 10/21/11 : 01:56pm
Title: New patient visit
Providers: JN
D.O.S. 10/21/11

Bozovic, Cherisse
D.O.B.11/21/64
ID #:109191

History of Present Illness: Cherisse Bozovic
The patient comes in today for her left ankle. She is a pleasant 46-year-old patient who fell proximally 5 days ago injuring her left ankle. She was seen at St. Francis Hospital emergency department and subsequently given follow up with me.

Past medical history
Asthma
Substance abuse

Past surgical history
Hysterectomy

Medications
Fluoxetine
Methadone

Allergies to medications
Penicillin
Codeine
Cataracts

Family history
Noncontributory

Social history
The patient smokes cigarettes. She denies alcohol and illicit drug use.

Examination
This is a pleasant 46 roll patient was moderately over nourished however she is in no acute distress. Her left ankle demonstrates intact dorsiflexion plantar flexion inversion and eversion. She has brisk capillary refill to her toes and a palpable dorsalis pedis pulse. She has intact sensation first web space, lateral foot, plantar foot. She has soft tissue swelling laterally as well as ecchymosis to the lateral aspect of her ankle and extending posteriorly.

Assessment and plan

46 roll patient with left ankle fracture.
X-rays were taken in the office today which demonstrate stable position of the fracture as well as stable syndesmosis. She has a fracture of the distal aspect of the fibula at the level of the syndesmosis. She will continue with crutches for assistance. In addition I have given her a prescription for a cam walker boot. She was placed back in a splint prior to leaving the office today. She will return to see me in 4 weeks with new x-rays of her left ankle.

Her patient history form and review of symptoms was reviewed and signed by me today.

Procedure: New Patient Level 3: 99203

Procedure: Ankle: 73610

Diagnosis: FIBULA FRACTURE, UNSPECIFIED: 823.81

Dictated by Joshua M Neubauer, M.D.

 # SIGNED BY Joshua M Neubauer (JN) 10/21/2011 01:59PM

EMPLOYEE NAME	SOC. SEC. NO.	Employee #	Department	PAYROLL PERIOD	CK. NUMBER	CK. DATE
Cherisse M Bozovic	*** ** ****	436	51500	1/15-- 1/28/2012	12144	2/01/2012

EARNINGS	HOURS	RATE	CURRENT	YEAR TO DATE
WAGES	18.00	7.50	135.00	427.50
Overtime				33.75
* Total *			135.00	461.25

DEDUCTIONS	CURRENT	YEAR TO DATE
FICA Ins	5.67	19.37
FICA Med	1.96	6.69
Net Pay	127.37	435.19

Froebel Realty Co., Inc.

Gross Pay	Fed W/H	FICA Ins	FICA Med	State W/H	Fed Ex Cd	St Ex Cd	Addon FWH	Addon SWH	
461.25		19.37	6.69		M 0	M 0			

DETACH AND RETAIN FOR YDUR RECORDS

EMPLOYEE NAME	SOC. SEC. NO.	Employee #	Department	PAYROLL PERIOD	CK. NUMBER	CK. DATE
Cherisse M Bozovic	*** ** ****	436	51500	1/01-- 1/14/2012	12118	1/18/2012

EARNINGS	HOURS	RATE	CURRENT	YEAR TO DATE
WAGES	18.00	7.50	135.00	292.50
Overtime	1.00	11.25	11.25	33.75
* Total *			146.25	326.25

DEDUCTIONS	CURRENT	YEAR TO DATE
FICA Ins	6.14	13.70
FICA Med	2.12	4.73
Net Pay	137.99	307.82

Froebel Realty Co., Inc.

Gross Pay	Fed W/H	FICA Ins	FICA Med	State W/H	Fed Ex Cd	St Ex Cd	Addon FWH	Addon SWH	
326.25		13.70	4.73		M 0	M 0			

DETACH AND RETAIN FOR YOUR RECORDS

EMPLOYEE NAME	SOC. SEC. NO.	Employee #	Department	PAYROLL PERIOD	CK. NUMBER	CK. DATE
Cherisse M Bozovic	*** ** ****	436	51500	12/18--12/31/2011	12092	1/04/2012

EARNINGS	HOURS	RATE	CURRENT	YEAR TO DATE
WAGES	21.00	7.50	157.50	157.50
Overtime	2.00	11.25	22.50	22.50
* Total *			180.00	180.00

DEDUCTIONS	CURRENT	YEAR TO DATE
FICA Ins	7.56	7.56
FICA Med	2.61	2.61
Net Pay	169.83	169.83

Froebel Realty Co., Inc.

Gross Pay	Fed W/H	FICA Ins	FICA Med	State W/H	Fed Ex Cd	St Ex Cd	Addon FWH	Addon SWH	
180.00		7.56	2.61		M 0	M 0			

DETACH AND RETAIN FOR YOUR RECORDS

			Employee #	Department			
Cherisse M Bozovic		*** ** ****	436	51500	12/04--12/17/2011	12065	12/21/2011

WAGES	16.00	7.50	120.00	5183.77	Fed W/H		13.11
Overtime				149.07	FICA Ins	7.14	226.08
BONUS			50.00	50.00	FICA Med	2.46	78.05
* Total *			170.00	5382.84	WI W/H		41.07
					Net Pay	160.40	5024.53

Froebel Realty Co., Inc.

Gross Pay	Fed W/H	FICA Ins	FICA Med	State W/H	Fed Ex Cd	St Ex Cd	Addon FWH	Addon SWH
5382.84	13.11	226.08	78.05	41.07	M 0	M 0		

			Employee #	Department			
Cherisse M Bozovic	*** ** ****	436	51500	11/06--11/19/2011	12013	11/23/2011	

WAGES	4.00	7.50	30.00	4891.27	Fed W/H		13.11
Overtime				149.07	FICA Ins	1.26	211.69
* Total *			30.00	5040.34	FICA Med	.43	73.08
					WI W/H		41.07
					Net Pay	28.31	4701.39

Froebel Realty Co., Inc.

Gross Pay	Fed W/H	FICA Ins	FICA Med	State W/H	Fed Ex Cd	St Ex Cd	Addon FWH	Addon SWH
5040.34	13.11	211.69	73.08	41.07	M 0	M 0		

EMPLOYEE NAME	SOC. SEC. NO.	Employee #	Department	PAYROLL PERIOD	CK. NUMBER	CK. DATE
Cherisse M Bozovic	*** ** ****	436	51500	10/09--10/22/2011	11960	10/26/2011

EARNINGS	HOURS	RATE	CURRENT	YEAR TO DATE
WAGES	11.25	7.50	84.38	4831.27
Overtime				149.07
* Total *			84.38	4980.34

DEDUCTIONS	CURRENT	YEAR TO DATE
Fed W/H		13.11
FICA Ins	3.54	209.17
FICA Med	1.22	72.21
WI W/H		41.07
Net Pay	79.62	4644.78

Froebel Realty Co., Inc.

Gross Pay	Fed W/H	FICA Ins	FICA Med	State W/H	Fed Ex Cd	St Ex Cd	Addon FWH	Addon SWH	
4980.34	13.11	209.17	72.21	41.07	M 0	M 0			

DETACH AND RETAIN FOR YOUR RECORDS

Froebel Realty Co Inc Id: D138 CURRENT CHECK LISTING 9/28/11 Page 1

Cherisse M Bozovic	Check#	Regular	Overtime	Vac Pay	Sick Pay	Other	Gross
3746 S Clement Avenue	11908 Hrs:	29.25	.00	.00	.00		29.25
Milwaukee WI 53207	9/28 Amt:	219.38	.00	.00	.00		219.38
[redacted] 436 396 66 0048	M T D Hrs:	55.25	2.00	.00	.00		57.25
Born: 11/21/64 Dept: 51500	Amt:	414.38	22.50	.00	.00		436.88
Hire: 1/16/11 Rate: 7.5000	Q T D Hrs:	220.25	5.50	.00	.00		225.75
Chgd: 2/15/11 Prev: 7.2500	Amt:	1651.88	61.88	.00	.00		1713.76
Pension: N Defr Comp: N	Y T D Hrs:	608.00	13.25	.00	.00		621.25
Gender: F Non Emp: N	Amt:	4551.89	149.07	.00	.00		4700.96

Deduct:	Fed WH	FICA	State WH	S.D.I.	ERROR	DRAW	Misc	Net Pay
11908	.00	12.39	.36	.00				206.63
M T D	.00	24.68	.63	.00				411.57
Q T D	.00	96.83	10.71	.00				1606.22
Y T D	13.11	265.60	41.07	.00				4381.18

Froebel Realty Co Inc Id: D138 CURRENT CHECK LISTING 10/12/11 Page 1

Cherisse M Bozovic	Check#	Regular	Overtime	Vac Pay	Sick Pay	Other	Gross
3746 S Clement Avenue	11934 Hrs:	26.00	.00	.00	.00		26.00
Milwaukee WI 53207	10/12 Amt:	195.00	.00	.00	.00		195.00
[redacted] 436 396 66 0048	M T D Hrs:	26.00	.00	.00	.00		26.00
Born: 11/21/64 Dept: 51500	Amt:	195.00	.00	.00	.00		195.00
Hire: 1/16/11 Rate: 7.5000	Q T D Hrs:	26.00	.00	.00	.00		26.00
Chgd: 2/15/11 Prev: 7.2500	Amt:	195.00	.00	.00	.00		195.00
Pension: N Defr Comp: N	Y T D Hrs:	634.00	13.25	.00	.00		647.25
Gender: F Non Emp: N	Amt:	4746.89	149.07	.00	.00		4895.96

Deduct:	Fed WH	FICA	State WH	S.D.I.	ERROR	DRAW	Misc	Net Pay
11934	.00	11.02	.00	.00				183.98
M T D	.00	11.02	.00	.00				183.98
Q T D	.00	11.02	.00	.00				183.98
Y T D	13.11	276.62	41.07	.00				4565.16

Froebel Realty Co Inc Id: D138 CURRENT CHECK LISTING 10/26/11 Page 1

Cherisse M Bozovic	Check#	Regular	Overtime	Vac Pay	Sick Pay	Other	Gross
3746 S Clement Avenue	11960 Hrs:	11.25	.00	.00	.00		11.25
Milwaukee WI 53207	10/26 Amt:	84.38	.00	.00	.00		84.38
[redacted] 436 396 66 0048	M T D Hrs:	37.25	.00	.00	.00		37.25
Born: 11/21/64 Dept: 51500	Amt:	279.38	.00	.00	.00		279.38
Hire: 1/16/11 Rate: 7.5000	Q T D Hrs:	37.25	.00	.00	.00		37.25
Chgd: 2/15/11 Prev: 7.2500	Amt:	279.38	.00	.00	.00		279.38
Pension: N Defr Comp: N	Y T D Hrs:	645.25	13.25	.00	.00		658.50
Gender: F Non Emp: N	Amt:	4831.27	149.07	.00	.00		4980.34

Deduct:	Fed WH	FICA	State WH	S.D.I.	ERROR	DRAW	Misc	Net Pay
11960	.00	4.76	.00	.00				79.62
M T D	.00	15.78	.00	.00				263.60
Q T D	.00	15.78	.00	.00				263.60
Y T D	13.11	281.38	41.07	.00				

Check Stubs are a Continuation of Wage Statement From October

RECEIPT

DATE 11·18·11 No. 584340

RECEIVED FROM Cherisse Bozovic 109191 $50.00

Fifty and 00/100 DOLLARS

○ FOR RENT
○ FOR self pay Dr. Newbauer

ACCOUNT		
PAYMENT	50	00
BAL. DUE		

(C) CASH
(C) CHECK
(C) MONEY ORDER
(C) CREDIT CARD

FROM _____ TO _____

BY CRS

Y110447780

Wheaton Medical Equipment Team
PO Box 860012
Minneapolis MN 55486-6000
ADDRESS SERVICE REQUESTED

Wheaton Franciscan Medical Equipment Team

Date:	1/10/2012
Patient Name:	CHERISSE M BOZOVIC
Account:	919987
Balance:	$51.00

00260200240052084470532074067 46---Y110447780 557

Cherisse M Bozovic
3746 S Clement Ave
Milwaukee WI 53207-4067

Wheaton Medical Equipment Team
PO Box 860012
Minneapolis MN 55486-6000

*** Please detach the upper portion and return with your payment ***

Statement

Serv.Date	Description	Amount	Payment	Balance
10/16/2011	CRUTCH UNDERARM (Purchase)	$51.00		
		Total Balance Due		$51.00

PAYMENT DUE BY: 15 days from statement date.

Call 414-258-2800, select Option 4 to be connected to the Billing Department option #4 or ask to speak to the Billing Department.

Please retain this statement for tax purposes. This will be your only copy.

MAKE CHECKS PAYABLE TO:

Orthopedic Institute of Wisconsin

2901 Kinnickinnic River Parkway
Suite 102
Milwaukee, WI 53215
(414) 384-6700
www.theortholnstitute.com
Business Address

Return Service Requested

IF PAYING BY CREDIT CARD, FILL OUT BELOW		
CHECK CARD USING FOR PAYMENT ☐ DISCOVER ☐ MASTERCARD ☐ VISA		
CARD NUMBER		SECURITY CODE
SIGNATURE		EXP. DATE
STATEMENT DATE	**PAY THIS AMOUNT**	**ACCOUNT #**
01/09/12	724.00	279126
Payment Due:	01/29/12	**SHOW AMOUNT PAID HERE** $

ADDRESSEE:

Cherisse Bozovic 1 5
3746 S CLEMENT AVE
MILWAUKEE, WI 53207-4067

REMIT TO:

ORTHOPEDIC INSTITUTE OF WISCONSIN
2901 KINNICKINNIC RIVER PKWY STE 102
MILWAUKEE WI 53215-3660

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

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

CHARGES APPEARING ON THIS STATEMENT ARE NOT INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

Date	Patient	Description	Charge	Payment/ Adjustment	Patient Balance
10/21/11	Cherisse	FX DISTAL FIBULAR/LATERAL MA	1197.00		548.00
10/21/11	Cherisse	X - Ray: Ankle Ap / Lat / O	175.00		38.00
10/27/11	Cherisse	CREDIT SELP PAY PATIENT		-686.00	
11/18/11	Cherisse	GLOBAL VISIT	50.00		50.00
11/18/11	Cherisse	X - Ray: Ankle Ap / Lat / O	88.00		88.00

ACCOUNT # 279126	STATEMENT DATE 01/09/12	PAY THIS AMOUNT 724.00

BILLING QUESTIONS: (414) 384-6700

PAYMENT DUE BY: 01/29/12

Orthopedic Institute of Wisconsin
2901 Kinnickinnic River Parkway
Suite 102
Milwaukee, WI 53215
(414) 384-6700
www.theortholnstitute.com
Business Address

If you have questions regarding how your insurance company handled reimbursement for the services, please call your insurance company directly. For other billing inquiries, please call (414) 384-6700

Corporate Office
1444 S. 113th St.
West Allis, WI 53214
414.258.2800 or 800.942.6422
www.knueppels.com

KNUEPPEL HEALTHCARE SERVICES, INC.

Retail Locations
West Allis: 414.258.2800
Racine: 262.321.0110
Mequon: 262.240.1700

INVOICE

DATE	NUMBER
10/22/2011	284968

TO
BOZOVIC, CHERISSE
3746 S CLEMENT AVE
MILWAUKEE WI 53207

Private

SERVICE DATE	SERVICE TIME
10/22/2011	

ITEM	QTY		PRICE	DISCOUNT
BLEAL032005BB	1	WALKING BOOT NON-PNUEMATIC	$175.00	$0.00

Cash Amount Tendered: $200.00

Total Price:	$175.00
Total Disc.:	$0.00
Total Tax:	$0.00
Amount Paid:	$175.00
Balance:	$0.00

PLEASE READ BEFDRE SIGNING

- I certify that the equipment provided was done so with my consent and approval, is in satisfactory condition, is appropriate for my current needs and can be used safely and effectively in the settings of anticipated use. I have received warranty information and instructions regarding its proper operation, use and care.
- I understand that benefit quotes are based on information provided by my insurance and are not a guarantee of payment, that I will be personally responsible for all charges not covered by my insurance, that I am required to promptly pay any balance owed on my account and if I default on payment, I will be responsible for paying all collection costs including, but not limited to, third-party collection agency fees, attorney's fees and court costs.
- Returns are accepted only within 14 days of purchase with the original receipt, in the original, unopened and undamaged packaging. Products are NOT RETURNABLE If they are used, custom-made, for personal care or worn against the body. All returns are subject to a 20% re-stocking fee.

Person Ordering/Receiving Product — Relationship to Client — Date: 10-22-2011

☐ Minor ☒ Adult Prepared by: Arlove Delivered by: _____

Wheaton Franciscan Healthcare

Correspondence
Wheaton Franciscan Healthcare
PO.Box 5995
Peoria, IL 61601-5995

FINAL NOTICE

SUMMARY STATEMENT

Account Summary

Guarantor name:	CHERISSE M BOZOVIC
Statement date:	02/03/2012
Total charges*:	$1,054.00
Insurance payments and adjustments:	$0.00
Patient payments and adjustments:	$-474.30

Due Date: **02/24/2012**
Amount you owe: **$579.70**

*This reflects all charges to date.

Account Activity

Balance by Location

St. Francis Hospital:	$579.70
Amount you owe for all services:	$579.70

0-30 Days	31-60 Days	61-90 Days	91+ Days
$0.00	$0.00	$0.00	$579.70

The balance due should be paid within 21 days. This chart shows you the time that has passed since the initial billing for each amount due.

Payment Information

Pay your bill online!
Visit: www.mywheaton.org/billpayment
Document Code: P-TVDHT-48169-LDKFQM
Reference Account #: 11653444

Amount Due: **$579.70**

Important Message

Please note your account has balances older than 90 days that are considered past due. **To avoid future collection activity, the balance needs to be paid immediately.** If you are unable to make full payment, you need to contact our office to discuss payment options.

Questions

Please contact:

Customer Service (877) 304-6332

Hours: Monday through Thursday 8 am - 8 pm
Friday 8 am - 5 pm

Online: www.mywheaton.org/contact_us
E-mail: wheatonbusinessoffice@wfhc.org

Please detach bottom portion and return with your payment.

Wheaton Franciscan Healthcare

Correspondence
Wheaton Franciscan Healthcare
PO Box 5995
Peoria IL 61601-5995

☐ Check here if address or insurance information is incorrect, and indicate change(s) on reverse side.

00814867 - 00538

CHERISSE M BOZOVIC
3746 S CLEMENT AVE
BAY VIEW WI 53207-4067

P-TVDHT-48169-LDKFQM

IF PAYING BY CREDIT CARD, FILL OUT BELOW

CHECK CARD USING FOR PAYMENT ☐ MasterCard ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS

CARD NUMBER | SIGNATURE CODE

SIGNATURE | EXP. DATE

PRINT CARDHOLDER NAME

DOCUMENT CODE	DUE DATE	AMOUNT DUE
P-TVDHT-48169-LDKFQM	02/24/2012	$579.70

SHOW AMOUNT PAID HERE
$

WFH-177

MAKE CHECKS PAYABLE AND SEND TO:

WHEATON FRANCISCAN HEALTHCARE
SDS 12-3088
PO BOX 86
MINNEAPOLIS MN 55486

Wheaton Franciscan Healthcare

For questions, please contact:
Customer Service (877) 304-6332
Hours: Monday through Thursday 8 am - 8 pm
Friday 8 am - 5 pm
E-mail: wheatonbuslnessoffice@wfhc.org

Guarantor Name: **CHERISSE M BOZOVIC**
Statement Date: 02/03/2012
Page: Page 3

Note: Charges appear as patient responslbility is determined; therefore, some charges may not appear on the statement.

St. Francis Hospital

Service Description		Payment Activity			
		Date	*Activity Description*	*Amount*	*Due from Patient*
Date of Service:	**10/16/2011**		**Initial Charge**	**$1,054.00**	
Patient Name:	CHERISSE M BOZ	10/20/2011	ALLOW SELF PAY DISCOUNT	$-474.30	
Visit Type:	OUTPATIENT				
Service Area:	EMERGENCY MEDI		**Due from Patient**		**$579.70**
Account Number:	11653444				
Primary Insurance:	SELF PAY				
Secondary Insurance:					

St. Francis Hospital services **Total due from patient:** **$579.70**

Total due from patient for all services: $579.70

For questions or itemized bill requests, call toll free at (877) 304-6332 or e-mail wheatonbusinessoffice@wfhc.org. Financial assistance is available to those who qualify. For more information please call (877) 304-6332. You may pay your bill online at www.mywheaton.org/billpayment. For information on scheduling an in-person billing consultation, go to www.mywheaton.org/billconsult.

12-22-11

On October 10 between 7:30 and 8:30 a.m. I had left my home at 3746 S. Clement ave. to go to my car for work. I tripped over something that made me fall and injur myself. After the injury I realized that what made me fall and sprain my left ankle was an uneven curb and a pot hole all in one spot. Further more my left ankle was fractured in the fall and I broke 3 toes.

I feel that as a direct result of this portion of the curb being uneven and the pot hole that these injuries resulted. My husband called 911 but the EmT's believed that my foot was just sprained so transportation to the Hospital would be too expensive so my husband drove me to Wheaton Franciscan Hospital/St. Francis where X-rays revealed a fracture in the left ankle and a break across my toes. I was then referred to an Orthopedic Specialist whom I saw

shortly afterward. He determined that I did not need surgery But I needed to follow up with him every 4 weeks. Also as a result of this injury I was off of work for 5 weeks. I work in a laundromat located at 3604 S. Clement ave. and I do have to walk around to clean machines, rest room etc.

If you would kindly review my evidence id greatly appreciate it and can be reached either at Home at (414) 763-9428 or my Cell phone which is (414) 721-6631.

I work approximately 38 hrs. every 2 weeks.

I look forward to hearing from you.

Thank You

Cherisse Bonjour

Loss Location:
Client said at/near 2012 E. Lovelond Ave. where her car was parked (around corner from her home)

(INCLUDE)

F0209964

STATEMENT

We accept Master Card, Visa Discover, American Express. Please see back of statement.

EMERGENCY MEDICINE SPECIALISTS
9875 S FRANKLIN DR
PO BOX 320930
FRANKLIN WI 53132

5901d
5392A
SU06

RETURN SERVICE REQUESTED

Please Include Security Code From Back Of Card	
CHECK CARD USING FOR PAYMENT ☐ MASTERCARD ☐ VISA ☐ DISCOVER ☐ AMERICAN EXPRESS	
CARD NUMBER	EXP. DATE
CARDHOLDER NAME	SECURITY CODE
SIGNATURE	AMOUNT

>02136 8077640 001 092096
CHERISSE M BOZOVIC
3746 S CLEMENT AVE
MILWAUKEE WI 53207-4067

REMIT TO:
EMERGENCY MEDICINE SPECIALISTS
9875 S FRANKLIN DR
PO BOX 320930
FRANKLIN WI 53132-6151

PLEASE RETURN THIS PORTION WITH PAYMENT

Office Phone Number	Statement Date	Your Account Number	Page No.	Patient Balance	SHOW AMOUNT PAID HERE
(414) 858-2200	11/06/11	F0209964	01	433.00	$

CHARGES APPEARING ON THIS STATEMENT ARE NOT INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

DATE	PROVIDER NAME	EXPLANATION OF ACTIVITY	PATIENT NAME	CHARGES AND DEBITS	PAYMENTS AND CREDITS	BALANCE
01611	SMUKOWSKI M	CPT: 99284 LEVEL 4 VISIT	C BOZOVIC	433.00		433.00

For services at St. Joseph's, Franklin Hospital,
St. Francis Hospital or Elmbrook Memorial Hospital

tement
e: 11/06/11

PLEASE INDICATE YOUR ACCOUNT NUMBER WHEN CALLING OUR OFFICE: F0209964

CURRENT	30-60 DAYS	60-90 DAYS	> 90 DAYS	TOTAL	INS PENDING	PATIENT BALANCE PAY THIS AMOUNT
433.00				433.00	0.00	433.00

ND INQUIRIES/PAYMENTS TO
EMERGENCY MEDICINE SPECIALISTS (414) 858-2200
9875 S FRANKLIN DR
PO BOX 320930
FRANKLIN WI 53132-8895

136 8077640 002137 002137 00001/00001 920966912

PLEASE RETURN THIS STUB WITH YOUR PAYMENT

BELL AMBULANCE
264-BELL
(414-264-2355)

"IF IT DOESN'T SAY BELL ON THE SIDE, YOU'VE JUST BEEN TAKEN FOR A RIDE!!!"®

549 E WILSON ST
MILWAUKEE, WI,
53207-1635

#BUNDSFD
#26 11 0289 0025 0 10#

CHERISSE M BOZOVIC
3746 S CLEMENT AVE
MILWAUKEE, WI 53207-4067

Client Name: **BOZOVIC, CHERISSE M**

Trip Number:

[redacted]

Service Date: **10/16/2011**

Amount Due: $ 131.28

Billing Date: **11/03/2011**

Billing Department: (414) 486-2000
Toll-Free Number: (800) 896-6200
Se Habla Español: (414) 486-4016

Service Date:

Trip Number: **11-2890025**
Client Name: **BOZOVIC, CHERISSE M**
Caller:
From Location: **1207 E SAVELAND AVE**
To Location: **<NO TRANSPORT>**
Insurance Information

Bill Patient **Patient SSN**

BELL AMBULANCE
264-BELL
(414-264-2355)

"IF IT DOESN'T SAY BELL ON THE SIDE, YOU'VE JUST BEEN TAKEN FOR A RIDE!!!"®

Billing Department: (414) 486-2000
Toll-Free: (800) 896-6200
549 E WILSON ST
MILWAUKEE, WI, 53207-1635

DATE	DESCRIPTION OF TRANSACTION	HCPC	QUANTITY	UNIT PRICE	AMOUNT
10/16/11	**BLS Emerg First Response - F**	**A0429**	**1**	**$120.00**	**$120.00**
10/16/11	**BLS Disposables**	**A0382**	**1**	**$11.28**	**$11.28**

BELL AMBULANCE
264-BELL
(414-264-2355)

"IF IT DOESN'T SAY BELL ON THE SIDE, YOU'VE JUST BEEN TAKEN FOR A RIDE!!!"®

PLEASE PAY THIS AMOUNT => $131.28

You have not provided us with insurance information, therefore immediate payment in full is now due. Thank you.

Rev - 10/22/2001 IRS NUMBER 39-1207000

DO NOT SEND PAYMENTS OR CORRESPONDENCE TO THIS ADDRESS.
RADIOLOGY SPECIALISTS OF MILWAUKEE, S.C.
PO Box 1259 Dept #88681
Oaks, PA 19456

12-15-11

OFFICE PHONE: 414-455-4794
Office Hours: 9:00AM-4:00PM MON-FRI

Fax: 414-359-5701

1912 - 7

CHERISSE MELAINE BOZOVIC
3746 S CLEMENT AVE
MILWAUKEE WI 53207-4067

Patient Name: CHERISSE MELAINE BOZOVIC
Account #: RSM11653444
Amount Due: $103.00

FINAL NOTICE!

According to our records, your balance of $103.00 is delinquent and remains unpaid to our practice. Please pay the amount in full immediately using the bottom portion of this letter or call 414-455-4794 to make payment arrangements.

To pay online go to: https://pay.instamed.com/MILWAUKEERAD

If payment is not received within 10 days your account may be placed for collection without further involvement by RADIOLOGY SPECIALISTS OF MILWAUKEE, S.C..

Please understand that failure to pay could adversely affect your credit rating.

Respond to this collection notice today.

CC: Collection Coordinator

FINAL NOTICE!

1911

Please detach and return bottom portion with your payment in enclosed envelope

GUARANTOR NAME AND ADDRESS:

CHERISSE MELAINE BOZOVIC
3746 S CLEMENT AVE
MILWAUKEE WI 53207-4067

AMOUNT OF PAYMENT	$

Payment Due
12/25/11

SERVICES PROVIDED BY:

RADIOLOGY SPECIALISTS OF MILWAUKEE, S.C.
PO BOX 14307
MILWAUKEE WI 53214-0307

Patient Name: CHERISSE MELAINE BOZOVIC
Account #: RSM11653444
Amount Due: $103.00

06 2 116534444 121511 10300

PLEASE SEND ALL PAYMENTS AND CORRESPONDENCE TO THIS ADDRESS.

7 - 1912

Y1 0D2E20D5

Wheaton Medical Equipment Team
PO Box 860012
Minneapolis MN 55486-6000
ADDRESS SERVICE REQUESTED

Wheaton Franciscan Medical Equipment Team

Date:	12/9/2011
Patient Name:	CHERISSE M BOZOVIC
Account:	919987
Balance:	$51.00

00260200240050292405532074067 46---Y1 002E20D5 787
Cherisse M Bozovic
3746 S Clement Ave
Milwaukee WI 53207-4067

Wheaton Medical Equipment Team
PO Box 860012
Minneapolis MN 55486-6000

*** Please detach the upper portion and return with your payment ***

Statement

Serv.Date	Description	Amount	Payment	Balance
10/16/2011	CRUTCH UNDERARM (Purchase)	$51.00		
		Total Balance Due		$51.00

PAYMENT DUE BY: 15 days from statement date.

Call 414-258-2800, select Option 4 to be connected to the Billing Department option #4 or ask to speak to the Billing Department.

Please retain this statement for tax purposes. This will be your only copy.

DO NOT SEND PAYMENTS OR CORRESPONDENCE TO THIS ADDRESS

Radiology Specialists Of Milwaukee, S.C.
PO Box 1259 Dept #88681
Oaks, PA 19456

Billing Questions: 414-455-4794
Fax: 414-359-5701
Office Hours: 9:00AM-4:00PM MON-FRI

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NO.
11-15-11	$103.00	RSM11653444

To pay online go to: https://pay.instamed.com/MILWAUKEERAD
Credit cards are accepted for payment

CHARGES AND CREDITS MADE AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT.

SHOW AMOUNT PAID HERE $

MAKE CHECKS PAYABLE / REMIT TO:

1910-8

CHERISSE MELAINE BOZOVIC
3746 S CLEMENT AVE
MILWAUKEE WI 53207-4067

Radiology Specialists Of Milwaukee, S.C.
PO BOX 14307
MILWAUKEE WI 53214-0307

06 2 11653444 11151 10300

Patient: CHERISSE MELAINE BOZOVIC

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

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT IN ENCLOSED ENVELOPE

Patient: CHERISSE MELAINE BOZOVIC — **Referring Physician SMUKOWSKI JOEL**

Account No: RSM11653444 — **Services Were Provided at: WFH ST FRANCIS**

DATE	PROC CODE	DIAGNOSIS	UNITS	DESCRIPTION OF SERVICES	CHARGES	PAY/ ADJ	INSUR. PENDING	PATIENT BALANCE
10-16-11	73564	959.7	1	Knee, 4 Or More Views	58.00			58.00
10-16-11	73610	825.25	1	Ankle Complete Min 3 Views	45.00			45.00

Se habla espanol 866-729-7008

Current	31-60 Days	61-90 Days	Over 90 Days
$103.00	$0.00	$0.00	$0.00

PAYMENT DUE: 11/29/11

PATIENT BALANCE DUE : $103.00

If you have insurance please contact our office. You are responsible for the amount indicated in PATIENT BALANCE DUE.

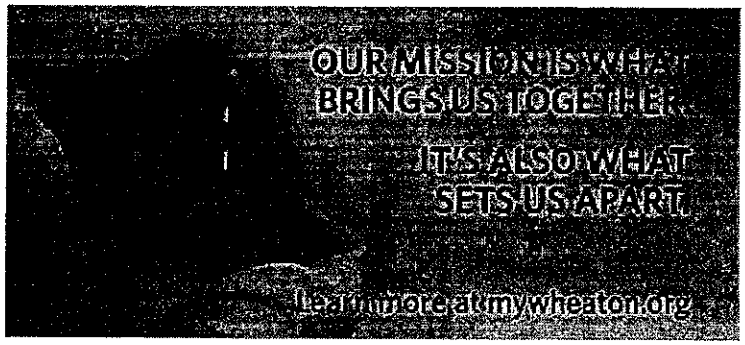
RADIOLOGY SPECIALISTS OF MILWAUKEE, S.C.
PO BOX 14307
MILWAUKEE WI 53214-0307
414-455-4794
Tax ID: 391984839

STATEMENT

SEE REVERSE SIDE FOR IMPORTANT BILLING INFORMATION

Wheaton Franciscan Healthcare
Correspondence
Wheaton Franciscan Healthcare
PO.Box 5995
Peoria, IL 61601-5995

SUMMARY STATEMENT



Account Summary

Guarantor name:	CHERISSE M BOZOVIC
Statement date:	11/07/2011
Total charges*:	$1,054.00
Insurance payments and adjustments:	$0.00
Patient payments and adjustments:	$-474.30
Due Date:	**12/01/2011**
Amount you owe:	**$579.70**

*This reflects all charges to date.

Account Activity

Balance by Location

St. Francis Hospital:	$579.70
Amount you owe for all services:	$579.70

0-30 Days	31-60 Days	61-90 Days	91+ Days
$579.70	$0.00	$0.00	$0.00

The balance due should be paid within 21 days. This chart shows you the time that has passed since the initial billing for each amount due.

Payment Information

Online bill pay is now available!
Visit: www.mywheaton.org/billpayment
Document Code: P-BNDMJ-74626-KCXRPL

Amount Due: $579.70

Important Message

All payments are posted to the oldest visit first unless specified on the back of the tear off portion of this statement. If you prefer, payments can be made online at www.mywheaton.org/billpayment or by calling Customer Service toll free at (877) 304-6332. **If you are paying less than the full amount due, you need to contact our office to discuss payment options.**
For information on scheduling an in-person billing consultation, go to www.mywheaton.org/billconsult.

Questions

Please contact:

Customer Service (877) 304-6332

Hours: Monday through Thursday 8 am - 8 pm
Friday 8 am - 5 pm

Online: www.mywheaton.org/contact_us
E-mail: wheatonbusinessoffice@wfhc.org

Please detach bottom portion and return with your payment.

Wheaton Franciscan Healthcare
Correspondence
Wheaton Franciscan Healthcare
PO Box 5995
Peoria IL 61601-5995

☐ Check here if address or insurance information is incorrect, and indicate change(s) on reverse side.

00703920 - 00888
CHERISSE M BOZOVIC
3746 S CLEMENT AVE
BAY VIEW WI 53207-4067

IF PAYING BY CREDIT CARD, FILL OUT BELOW.

CHECK CARD USING FOR PAYMENT ☐ MasterCard ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS

CARD NUMBER | SIGNATURE CODE

SIGNATURE | EXP. DATE

PRINT CARDHOLDER NAME

DOCUMENT CODE	DUE DATE	AMOUNT DUE
P-BNDMJ-74626-KCXRPL	12/01/2011	$579.70

SHOW AMOUNT PAID HERE
$

MAKE CHECKS PAYABLE AND SEND TO:

WHEATON FRANCISCAN HEALTHCARE
SDS 12-3088
PO BOX 86
MINNEAPOLIS MN 55486

WFH-177
BPD112 - 00703920-001785-01/02-0-0

Wheaton Franciscan Healthcare

For questions, please contact:
Customer Service (877) 304-6332
Hours: Monday through Thursday 8 am - 8 pm
Friday 8 am - 5 pm
E-mail: wheatonbusinessoffice@wfhc.org

Guarantor Name: **CHERISSE M BOZOVIC**
Statement Date: 11/07/2011

Note: Charges appear as patient responsibility is determined; therefore, some charges may not appear on the statement.

St. Francis Hospital

Service Description		Payment Activity			
		Date	*Activity Description*	*Amount*	*Due from Patient*
Date of Service:	**10/16/2011**		**Initial Charge**	**$1,054.00**	
Patient Name:	CHERISSE M BOZ	10/20/2011	ALLOW SELF PAY DISCOUNT	$-474.30	
Visit Type:	OUTPATIENT				
Service Area:	EMERGENCY MEDI		**Due from Patient**		**$579.70**
Account Number:	11653444				
Primary Insurance:	SELF PAY				
Secondary Insurance:					

St. Francis Hospital services	**Total due from patient:**	**$579.70**

Total due from patient for all services: $579.70

For questions or itemized bill requests, call toll free at (877) 304-6332 or e-mail wheatonbusinessoffice@wfhc.org. Financial assistance is available to those who qualify. For more information please call (877) 304-6332. You may pay your bill online at www.mywheaton.org/billpayment. For information on scheduling an in-person billing consultation, go to www.mywheaton.org/billconsult.

BPD112 - 00703920-001796-02/02-0-0

MAKE CHECKS PAYABLE TO:

Orthopedic Institute of Wisconsin

2901 Kinnickinnic River Parkway
Suite 102
Milwaukee, WI 53215
(414) 384-6700
www.theorthoInstitute.com
Business Address

Return Service Requested

ADDRESSEE:

Cherisse Bozovic 1 2
3746 S CLEMENT AVE
MILWAUKEE, WI 53207-4067

IF PAYING BY CREDIT CARD, FILL OUT BELOW
CHECK CARD USING FOR PAYMENT
☐ DISCOVER ☐ MASTERCARD ☐ VISA

CARD NUMBER	SECURITY CODE
SIGNATURE	EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT #
12/12/11	1272.00	279126

Payment Due:	01/01/12	SHOW AMOUNT PAID HERE $

REMIT TO:

ORTHOPEDIC INSTITUTE OF WISCONSIN
2901 KINNICKINNIC RIVER PKWY STE 102
MILWAUKEE WI 53215-3660

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

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

CHARGES APPEARING ON THIS STATEMENT ARE NOT INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

Date	Patient	Description	Charge	Payment/ Adjustment	Patient Balance
10/21/11	Cherisse	FX DISTAL FIBULAR/LATERAL MA	1197.00		1197.00
10/21/11	Cherisse	X - Ray: Ankle Ap / Lat / O	175.00		175.00
10/27/11	Cherisse	PAYMENT BY CREDIT CARD FROM		-50.00	
11/22/11	Cherisse	PAYMENT BY CREDIT CARD FROM		-50.00	

ACCOUNT # 279126	STATEMENT DATE 12/12/11	PAY THIS AMOUNT 1272.00

Orthopedic Institute of Wisconsin

2901 Kinnickinnic River Parkway
Suite 102
Milwaukee, WI 53215
(414) 384-6700
www.theorthoInstitute.com
Business Address

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