

## KELIN R. OLSON, S.C. LAW OFFICES

Dedicated - Determined - Dependable

September 12, 2006

Milwaukee City Clerk 200 East Wells Street Room 205 Milwaukee, Wisconsin 53202

Re:

RE: My Clients: Nimiko Miner

Claim #: 06-V-83

Dear Mr. Langley:

Pursuant to your denial received on September 12, 2006 I am hereby requesting a hearing regarding my client Nimiko Miner. However, I would ask that the hearing be postponed as I also represent Erica Lieg, who was also injured as a result of the accident that occurred on April 9, 2006 but whose claim is still being compiled, and I would like to have them heard at the same time.

If you have any questions or concerns, please feel free to call me.

Thank you in advance for your anticipated cooperation.

Very truly yours,

KELIN R. OLSON

KRO/el

OFFICE OF

WECEN STORY



# KELIN R. OLSON, S.C. LAW OFFICES

Dedicated - Determined - Dependable

April 27, 2006

ROMALD & LEGINARD

City Clerk City of Milwaukee 200 East Wells St., Room 205 Milwaukee, Wisconsin 53202-3567

RE: Notice of Injury Form

My Client: Nimiko Miner Incident of: April 9, 2006

To Whom It May Concern:

Enclosed please find the original and four (4) copies for the Notice of Injury forms relative to the above matter.

Please indicate the date of receipt and filing on one of the enclosed copies, and then return same to my office.

Thank you for your assistance.

Sincerely,

Kelin R. Olson, Sr.

KRO/el Enclosure

#### NOTICE OF INJURY FORM

TO: CITY CLERK
200 EAST WELLS STREET
MILWAUKEE, WISCONSIN 53202

PLEASE TAKE NOTICE, that the undersigned will be making a claim for injuries and damages against you by virtue of the reasons set forth hereafter:

NAME OF CLAIMANT:

NIMIKO MINER

DATE AND TIME OF INJURIES AND OR DAMAGES SUSTAINED:

April 9, 2006 at approximately 6:00 p.m.

PLACE OR LOCATION WHERE INJURY OR DAMAGES OCCURRED:

West Locust Street & North 22<sup>nd</sup> Street Milwaukee, Wisconsin

MANNER IN WHICH DAMAGES OR INJURIES WERE RECEIVED OR OCCURRED:

Claimant was injured when a City of Milwaukee Fire Department truck, driven by Michael Scwade, made a right hand turn and struck the vehicle the claimant was in, which had stopped for the fire truck.

GROUNDS ON WHICH CLAIM IS MADE:

Negligence on the part of the City of Milwaukee Fire Department by its agents, servants and employees, including but not limited to failure to properly manage and control the vehicle.

#### GENERAL DESCRIPTION OF INJURIES AND DAMAGES:

PERSONAL INJURIES:

LEG PAIN BACK PAIN

MEDICAL EXPENSES PAIN AND SUFFERING

PLEASE TAKE NOTICE that satisfaction for such injuries or damages will be claimed, but that the amount of said demand is UNKNOWN at the present time.

## THIS IS <u>NOT</u> A NOTICE OF CLAIM PURSUANT TO SECTION 893.80, WISCONSIN STATUTES

Dated at Milwaukee, Wisconsin, this 27th day of April, 2006.

Claimant:

NIMIKO MINER

2444 NORTH 40<sup>TH</sup> STREET

MILWAUKEE, WISCONSIN 53210

KELIN R. OLSON, S.C. LAW OFFICES

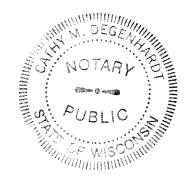
BY:

KÉLIN R. OLSON, SR., Attorney for the Claimant 407 West Silver Spring Drive Milwaukee, Wisconsin 53217

Telephone: (414) 961-8700

Subscribed and sworn to before me this 27th day of April, 2006.

Notary Public, State of Wisconsin My Commission Expires: 8/30/09



#### CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true copy of the attached:

#### NOTICE OF INJURY FORM

was served upon the hereinafter named:

#### CITY CLERK 200 EAST WELLS STREET MILWAUKEE, WISCONSIN 53172

By enclosing same in an adequately postpaid envelope, bearing the sender's name and address which was duly deposited in a U.S. Mailbox on the 27th day of April, 2006, pursuant to Section 801.14(2), Wisconsin Statutes.

FRICA LIEGI

POST OFFICE ADDRESS: 407 West Silver Spring Drive Milwaukee, Wisconsin 53217

Telephone: (414) 961-8700



### KELIN R. OLSON, S.C. LAW OFFICES

Dedicated - Determined - Dependable

August 28, 2006

City of Milwaukee C/O City Attorney's Office 200 East Wells Street Room 205 Milwaukee, Wisconsin 53202

RE: My Client: Nimiko Miner

Accident of: April 9, 2006 Insured

: City of Milwaukee

Claim #

: unknown

To Whom It May Concern:

Enclosed herewith are copies of the following items of medical information and special damages regarding the above client:

#### St. Joseph's Hospital Records of 4/9/06

Statement of 4/9/06	1,494.20
St. Joseph's EP, LLP	1,424.20
Statement of 4/9/06	194.00
Capitol Rehabilitation Clinic	
Records of 4/27/06 - 8/10/06	In
Statement of 4/27/06 - 8/10/06	1,775.00

TOTAL \$3,463.20

Please contact me at your earliest convenience to discuss settlement.

Very truly yours,

Kelin R. Olson, Sr.

KRO/el

#### ST. JOSEPH REGIONAL MEDICAL CENTER A MEMBER OF COVENANT HEALTHCARE

Account No: 71486994

Sched Date: 07/01/06 04:26 AM

MR#: 1053171

1.512 Co PATIENT INFORMATION

MINER NIMIKO D

2444 N 40 ST

MILWAUKEE WI 53210

Phone: 414 449-1392

DOB: 10/06/1987 Age: 18

Gender: F

MS: SINGLE

Religion: NONE

Employer: NONE

Phone #: Occupation:

ADDITIONAL CONTACT

NEAREST RELATIVE

Name: ZIGGLER CELIA D

Phone: 414 449-1392

Bus Phone: 414 476-0025 Relat: PARENT

> Name: MINER BETTY Phone: 414 263-2947

Bus Phone:

Relat: OTHER RELATIONSHIP

Notify: Y

Notify: Y

VISIT INFORMATION

INTERPRETER NEEDED: NO

Language: ENGLISH

Admit Reason: \PREGNANCY

Comment: QW-PASSPORT DOWN

Visit Type: P Location: Last Inp Date: Last Outpt Date:

PHYSICIAN INFO

Adm: PALABRICA CYNTHIA L. Att: PALABRICA CYNTHIA L. PCP: PALABRICA CYNTHIA L.

#### INSURANCE INFORMATION

PRIMARY: SELF PAY

GUARANTOR INFORMATION

Name: MINER NIMIKO D

2444 N 40 ST

MILWAUKEE WI 53210-0000

Phone #: 414 449-1392

Employer: NONE

Phone #:

PRINTED COPY

Date: 02/22/06

Time: 04:27 AM

115-31-71

#### PREGNANCY DISCHARGE INSTRUCTIONS

1.	Diet - At home you should eat:
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Push fluids - drink at least eight 8-ounce glasses of fluid per day.
3	No alcohol, beer or wine, or smoking.
4,	You have the following activity restrictions:  None.  Pace activities as instructed.  Frequent rest periods.  Strict bedrest with bathroom only privileges.  Stay home from work/school for day(s).  Sexual activity not allowed.
5.	Continue taking your previously prescribed medication.
6.	You have received and reviewed the following <b>prescribed medication</b> instruction sheets:  Take as directed.
(	Review the following information:    Fetal Movement Counting
,	Keep next doctor appointment on Hori day(s) / week(s):  Call to make next doctor appointment for day(s) / week(s):  as soon as you get home OR on Monday when office reopens.
	Call your doctor if you have any of the following or if any of the following persists:  Headache  Fever  Vaginal drainage or bleeding  Visual changes  Abdominal cramping/tightening  Return of symptoms  Contractions  minutes apart  Any questions  Decreased Fetal (Baby) Movement  Vaginal drainage or bleeding  Abdominal cramping/tightening  Return of symptoms  Ruptured bag of waters or fluid leaking from vagina
10.	Other:
Pati	iderstand and have received a copy of these instructions. They have been explained to me.  ient Signature:  Date: 1900  Date: 4900
300	Pregnancy Discharge Instructions  Of West Chambers Street Ilwaokee, WI 53210-1688  FOR THE PROPERTY OF THE PRO

S	ubstitution with therapeutic drug
	ternatives as approved by the Medical
E:	xecutive Committee is acceptable
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	aiternatives	as approved by the Medical PATIENT ORDERS Committee is acceptable	
***************************************	uniess initia	led.	Page 1 of 1
	Another bra	nd of drug identical in form may be dispensed unless checked.	
PLEAS		ALL ORDERS WHICH ARE TO BE FOLLOWED.	
DATE		ORDERS	
1-1-6	12115	Reason for visit	Known Latex Allergy: ☐ Yes ☐ No
		1. Assessments:  Doppler for < 25 weeks 20 minute initial continuous external fetal monitor strip. If reassuring Other:  Other:	ng, may ambulate.
v		2. Diet: As tolerated Clear liquids I ce Chips NPO	
		3. Activity: Ambulatory BR with BRP Bed rest	
		4. Treatments  Ultrasound for:  Biophysical Profile Amniotic Fluid Index Presentation Other:	
		5. Labs:  CBC, stat T&S, stat Kleihauer-Betke, stat PIH panel (AST, ALT, LDH, uric acid, creatinine, CBC), stat Urinalysis: Midstream Catheter Voided Foutine and micro, hold for C & S, send if results indicate UTI Toxicology screen (drugs) - requires signed informed consent- Cervical culture for Chlamydia, routine and GC. Vaginal/rectal swab to culture for Group B Strep. Other:	stat stat
		6. Medications:  Terbutaline ☐ 0.25 mg subq q20 min x 3 ☐ 2.5 mg po ☐ 5 mg p  ☐ Other: The tage of Colony A 7	o ☐ q hr. Hold if pulse > 120.
		7. IV Fluids: LR 1000 ml at ml/hr.	mi over min. mi over min.
	Oriente de la constante de la	8. Other:  Call provider for orders. Other:	
TO COMMAND TO THE PARTY AND TH	WANTE A Address of the Williams Adv. of purple and account	Meterine (=== 4-	22.6
		Provider:RN taking phone orde	er:



**Obstetric Observation Orders** 

92847 07/2005

MINER NIMIKO D

DOB 10/06/87 18 Y SEC F MR: 1053171

PALABRICA CYNTHIA L.

ACCT: 71486994

#### Medication Aministration Reculu

	MINE	ER NIMIKO D				
	PALE	SEC F MD LOCAL	Account #1	MR4		
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# COLLABORATIVE CARE PLAN TRIAGE SUPPLEMENT LABOR & BIRTH -

Testa	Assess- mrits	Other Patient Priorities	Patient Care Priorities	Teaching (Cont.)	Day & Date
EtM baseline strip     Urine dipatick     Nunazine/terning of indicated	* Friage criteria: - cervical change regular uterine contractions ROM • V5 - Frenatal course & labs - Asserts anxiety/coping - Follow-up/referral needs		* Anxiety r/t questionable labor & admissava	PSO Velb knowledge of procedures performed (circle): SSE: Cultures Straight cath IV Vaginal exam	Date/Time: 44/06 300

United to 17 weeks
(10) 18950 \*Plan of care shared with

within 10 min of arrival to unit

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17353 \*Admitted in computer ME HIT HE OF PALLE DESIGN

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Other

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Patient Expected

Day & Date

Date Time:

AMERIC Page

328

| #310 Triage criteria met:

regular uterine contractions with cervical change and/or

Expected Outcomes

MOTHER ADDRESSOGRAPH

## PALABRICA CYNTHIA 008: 10/06/87 MINER NIMIKO D 16\ scx - **元** 1053171

71486994

#CCT#

• Alert social services for any evidence of special needs/follow up
• Possible SW • Possible CNS
• Possible home prescriptions
• I-incourage ambulation
<ul> <li>Clear liquids or as</li> </ul>
Date/Time: // //

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*Including but not limited to allergies/sensitivities to medications	s food		~		
tape, LATEX, iodine					
** Prescription, OTC, nutritional sup	plements.				
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☐ Visual deficit ☐ Evidence of phys	sical, emotional or	verbal abuse C	omment:		
Discharge: Do you have concerns a	about going home?	'Da No ☐ Yes [	Social work re	eferral	
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PLAN OF CARE: A Initiate attending automitical mant and an	RN Signature Kilapua KN Date 1/9/06
PLAN OF CARE: ☐ Initiate standing orders/treatment protocol ☐ Other:	Date 1 1100
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JOSEPH
JECTONAL MESICAL CENTER
A FORMAL PRINCIPLE
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3 10400 W North Maydan Road - Wallington W 51246

Obstetric Outpatient Assessment Record Triage

87622 1/05

MINER NIMIKO D

1008 107/06/87 164 SEX F MR: 1053171

PALABRICA CYNTHIA L

ACCIT

71486994

#### COVENANT SIGNATURE PROFILE

Date	Initials *as you would use in charting (Write Legibly)	Print Full Name	Written Signature	Title
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FACILITY \_\_\_\_

Covenant Signature Profile

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DOB: 10/06/87 18 y sex F MR: 1053171 PALABRICA CYNTHIA L. ACCT. 71486994

- D. Assignment and Agreement to Pay: I understand that I am responsible for a ... services that I receive and guarantee payment for these services. Thereby assign to the and the physicians and professionals associated with the Facility for application to my bill for services are of my rights and claims for reimbursement under any federal or state healthcare plan (including but not limited to Medicare or Medicaid), insurance policy, any managed care arrangement or any other similar third party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to me. I understand that I am responsible for any applicable co-payment, deductibles, co-insurance and/or non-covered costs and charges. understand that not all insurance companies pay the usual and customary fees of the hothly, the physicians and/or the professionals associated with the Facility. Therefore, when permised by law, any outstanding balance will be my responsibility. I understand and agree that I am responsible for the cost of collection and/or reasonable attorney fees related to my account. I understand that my health information will be released to my insurers, payers, or others for billing purposes. I also understand that I may receive separate bills from independent physicians involved in my care including radiologists, anesthesiologists, pathologists, emergency room physicians and other independent physicians. These physicians may or may not participate in all insurance networks.
- E. <u>Valuables</u>: Keeping valuables (such as cash, jewelry, documents) in the Facility is strongly discouraged. I understand that the Facility has a place where my valuables may be stored. If I choose to keep valuables in the Facility, I do so at my own risk and I understand and agree that Facility is not liable for loss or damage to any valuables that I do not turn over for storage.
- **F.** Photographing: I understand and agree that the Facility may take photographic, electronic and/or video images of me in cases when it is required to assist with my treatment or for my safety. If my care involves the delivery of a baby, I give consent for my baby to be photographed for security and/or personal use.
- G. <u>Privacy Notice</u>: I acknowledge that I was provided with a copy of Covenant Healthcare's Notice of Privacy Practices. Please refer to the Notice of Privacy Practices for more information regarding release of your health information and your right to access your health information.

Signature of Patient/Authorized Representative

 $\frac{4-9-66}{\text{Date}}$ 

Relationship of Authorized Representative

If unable to sign document, state reason:

Covenant HEALTHCARE

recrease of Comments replaces are written a war solved to the American Education and Page of 1999

St. Francis Hospital St. Michael Hospital Elmbrook Memorial Hospital St. Joseph Regional Medical Center Inpatient and Outpatient Consent for Treatment & Financial Agreement

MINER NIMIKO D

DOB 10/06/87 165 3EC F MR- 1053171
PALABRICA CYNTHIA L

ACCT\*
71486994

#### Covenant Healthcare

#### Inpatient and Outpatient Consent for Treatment & Financial Agreement

St. Joseph Regional Medical Center	St. Michael Hospital
Embrook Memorial Hospital	St. Francis Hospital
Covernant i leather and the mitals to account	

Covenant Healthcare Hospitals have a number of ambulatory/outpatient sites that are covered by this Agreement.

- A. Consent for Treatment: I am entering the above named facility (the "Facility") for the purpose of medical and or surgical treatment or diagnosis. I consent to my physician, other attending, consulting and/or referring physicians and their assistants and designees, and other Facility personnel, to provide me with such medical, surgical, diagnostic or other treatment services judged necessary and/or appropriate by my physician. This consent includes my consent for hospital services, diagnostic procedures and all medical treatment rendered under the instructions of my physician(s) including x-ray and laboratory procedures and other tests, treatments or medication, monitoring, and all other procedures or treatments that do not require my specific informed consent. I understand that in the course of diagnosis and treatment, cells, tissues and/or parts may be removed from my body. I authorize Facility personnel to preserve or use such cells, tissues or parts for teaching purposes and/or to dispose of any cells, tissues or parts that are removed.
- B. General Acknowledgments: I understand that the practice of medicine and surgery is not an exact science. I understand that medical and surgical treatment and diagnosis may involve risks of injury, and even death. No guarantees have been made to me with respect to the results of my examinations or treatments in the Facility. I understand that many of the physicians on the Facility's staff are not employees or agents of the Facility but, rather, are independent contractors who have been granted the privilege of using this Facility for the care and treatment of their patients. I understand that the Facility is not liable for any actions or omission of, or the instructions given by, such independent contractors who treat me while I am in the Facility. I understand and agree that I may be observed and/or receive care from medical, nursing, and other health care students in training at the Facility. I understand that it is my responsibility to follow instructions about and make arrangements for follow-up care. I understand that I may review and obtain a copy my medical record, at my own expense, and that this review shall take place in the Facility, during regular business hours.
- C. <u>Medicare Payments</u>: I acknowledge receipt of the "Important Message from Medicare," as applicable.

Covenant -

St. Francis Hoppital St. Michael Huspital Elmbrock Memorial hespital St. Joseph Regional Medical Center Inpatient and Outpatient Consent for Treatment & Financial Agreement

i manciai Agreeine

MINER NIMIKO D

DOB 14/406/87 18/3/2/2 MR: 105317L

PALABRICA CYNTHIA L

ACCI\*
7:486994

RE

1820 2'03 R8

#### ST. JOSEPH REGIONAL MEDICAL CENTER A MEMBER OF COVENANT HEALTHCARE

Account No: 71517538

MR#: 1053171

Sched Date: 04/09/06 07:31 PM

PATIENT INFORMATION

NEAREST RELATIVE Name: ZIGGLER CELIA D

MINER NIMIKO D 2444 N 40 ST

Phone: 414 449-1392 Bus Phone: 414 476-0025

MILWAUKEE WI 53210

Relat: PARENT

Name: MINER BETTY

Phone: 414 449-1392 Notify: Y

DOB: 10/06/1987 Age: 18

Gender: F MS: SINGLE

Religion: NONE

Phone: 414 263-2947 Bus Phone:

Employer: NONE

Phone #: Relat: OTHER RELATIONSHIP

Occupation: Notify: Y

VISIT INFORMATION

INTERPRETER NEEDED: NO

Language: ENGLISH

Admit Reason: BACK PAIN

Comment: WYS T1079874

Visit Type: E

PHYSICIAN INFO

Adm:

Location: EMERGENCY DEPT#TRAUMA/MAJ

Last Inp Date:

Att: ROSIER THOMAS A

Last Outpt Date:

PCP: PALABRICA CYNTHIA L.

ADDITIONAL CONTACT

#### INSURANCE INFORMATION

PRIMARY: UNITEDHEALTHCARE T19

Plan: STANDARD

PO BOX 659770

SAN ANTONIOTX 78265

Phone #: 866 592-2364 Subr: MINER NIMIKO D

Relat: PATIENT IS INSURED -

Policy#: 3920299460

Group#: Group Name:

GUARANTOR INFORMATION

Name: MINER NIMIKO D

2444 N 40 ST

MILWAUKEE WI 53210-0000

Phone #: 414 449-1392

Employer: NONE

Phone #:

PRINTED COPY

Date: 04/12/06

Time: 11:03 AM

St. Joseph Regional Medica	r				Em	ergenc	eparl	ment	QualChart <sup>®</sup>		
ORDER SHEET / TRAUMA/MAJOR	}		Heiq	ght:		Weight:	I	s/kgs	Allergies:		
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	St. Joseph F					ency Depar					ge 1 of 2
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MEDICAL DECISION MAKING: Consideration of the following conditions may be warranted for the presenting problem. These conditions are not final diagnoses.  DIFFERENTIAL DIAGNOSES: Abdominal Injury Normal Exam Upper Extremity Injury Head / Facial Injury Lower Extremity Injury Other:  DISPOSITION:	S	t. Joseph Re	egional Medic <u>enter</u>		Emergency Departs		Page 2 of 2
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This form is to assist the physician's documentation of clinical care and treatment. It is not intended to supplant that judgement or create a standard of care.

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EMERGENCY DEPARTMENT RECORD PAGE 2

MINER NIMIKO D

108 10/06/87 18/1 SEX | MR: 1053171

1.MERGENCY CONSULTANTS INC

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Emergency Dept. 414-447-2171

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Date

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Patient Name





	<b>副新聞國及元獻國際經濟學</b>				
Provisional Diagnosis	Physician who cared for you				
We have examined and treated you today on an emergency/urgent care/outpatient see your doctor, or return here.	basis only. If symptoms or medical problem(s) fail to improve, call us at 447-2171,				
You must arrange for an exam with your physician in days. You should arrange for an exam with your physician if your condition does not improve in days. Physician Community Clinic Telephone To find a doctor, call our Covenant Physician Referral Service, 877-226-8362 Additional Instructions	Please follow the instructions below as indicated for:  I Abdominal Complaint I Animal Bite I Nosebleed I Back Pain I Burn Care I Cast Care I Chest Pain I Cold - Adult/Child I Crutch Waiking/Crutches I Cylture I Eye Injury I Fever - Child I Fever - Child I Fever - Child I Fever - Child I Headache I Head Injury - Adult/Child Other I High Blood Pressure I High Blood Pressure I High Blood Pressure I Nosebleed I Nosebleed I Nosebleed I Selizure I Selizure I Sore Throat I Strain, Sprain, Fracture I Strain, Sprain, Fracture I Strain Strain Fracture I Head Injury I Urinary Tract Infection I Venereal Disease I Veniting/Diarrhea - Adult/Child I Wound Care/Suture After Care I IV Conscious Sedation Other				
You had sutures/staples. They must be removed in days.  You were prescribed sedatives or pain medications that may make you drowsy. Do not drink alcohol, drive, or operate machinery while you are taking those medications.	If you received x-rays, they do not always show injury or disease. Fractures (breaks in the 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 a preliminary basis. Final reading will be made by the Radiologist. You or your referral physician will be notified of any additional findings through the Emergence Department.				
If cultures were done today. Results will not be available for 72 hours. We will call you if the culture is positive and additional treatment is required.	If you received an EKG it has been read on a preliminary basis by the physician on duty. A final reading will be made and you or your referral physician will be contacted if additional treatment is required.				
I have received discharge instructions and understand that I have received emerger I also understand my primary care physician may receive a copy of my ED record	ncy care only. I am to call or see my family physician for further care.				
Patient signature:					
Work/School Release.  May return to work/school immediately with no limitations Off work/school today may return next scheduled shift/day. Off work/school for days. Re-check by family/company doctor May return to work/school with the following limitations:	Today's date: or preferred doctor prior to return recommended.				



**GENERAL DISCHARGE INSTRUCTIONS ED-SJRMC** 

MINER NIMIKO D (108 | 1070|6787 18 y sex in MR 1053171

EMERGENCY CONSULTANTS INC 71517538

#### Covenant Healthcare

#### Inpatient and Outpatient Consent for Treatment & Financial Agreement

St. Joseph Regional Medical Center	St. Michael Hospital
Elmbrook Memorial Hospital	St. Francis Hospital

Covenant Healthcare Hospitals have a number of ambulatory/outpatient sites that are covered by this Agreement.

- A. <u>Consent for Treatment</u>: I am entering the above named facility (the "Facility") for the purpose of medical and/or surgical treatment or diagnosis. I consent to my physician, other attending, consulting and/or referring physicians and their assistants and designees, and other Facility personnel, to provide me with such medical, surgical, diagnostic or other treatment services judged necessary and/or appropriate by my physician. This consent includes my consent for hospital services, diagnostic procedures and all medical treatment rendered under the instructions of my physician(s) including x-ray and laboratory procedures and other tests, treatments or medication, monitoring, and all other procedures or treatments that do not require my specific informed consent. I understand that in the course of diagnosis and treatment, cells, tissues and/or parts may be removed from my body. I authorize Facility personnel to preserve or use such cells, tissues or parts for teaching purposes and/or to dispose of any cells, tissues or parts that are removed.
- **B.** General Acknowledgments: I understand that the practice of medicine and surgery is not an exact science. I understand that medical and surgical treatment and diagnosis may involve risks of injury, and even death. No guarantees have been made to me with respect to the results of my examinations or treatments in the Facility. I understand that many of the physicians on the Facility's staff are not employees or agents of the Facility but, rather, are independent contractors who have been granted the privilege of using this Facility for the care and treatment of their patients. I understand that the Facility is not liable for any actions or omission of, or the instructions given by, such independent contractors who treat me while I am in the Facility. I understand and agree that I may be observed and/or receive care from medical nursing and other health care students in training at the Facility. I understand that it is my responsibility to follow instructions about and make arrangements for follow-up care. I understand and agree that my health information may be redisclosed in accordance with applicable state and federal laws. I understand that I may review and obtain a copy my medical record, at my own expense, and that this review shall take place in the Facility during regular business hours.
- C. <u>Medicare Payments</u>: i acknowledge receipt of the 'Important Message from Medicare,' as applicable

Covenant

St. En incus Hespital St. Michael Hospital Einbruck Memocial Hospital St. Joseph Pegional Medical Curren Inpatient and Outpatient Consent for Treatment & Financial Agreement MINER NIMIKO D

TOB 10/06/87 18: SEX 1 MR 1053171
FMERGENCY CONSULTANTS INC

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- D. Assignment and Agreement to Pay: I understand that I am responsible for payment for the services that i receive and guarantee payment for these services. I hereby assign to Facility and the physicisms and professionals associated with the Facility, for application to my bill for services, all of my rights and plams for reimbursement under any federal or state healthcare plan (including but not limited to Medicare or Medicaid: insurance policy, any managed care arrangement or any other similar third party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to me. I understand that I am responsible for any applicable co-payment, deductibles, co-insurance and/or non-covered costs and charges, understand that not all insurance companies pay the usual and customary fees of the Facility, the physicians and/or the professionals associated with the Facility. Therefore, when permitted by law, any outstanding balance will be my responsibility. I understand and agree that I am responsible for the cost of collection and/or reasonable attorney fees related to my account. I understand that my health information will be released to my insurers, payers, or others for billing and related purposes. This may include re-disclosure of information obtained from other health care providers and required for payment purposes. I also understand that I may receive separate bills from independent physicians involved in my care including radiologists, anesthesiologists, pathologists, emergency room physicians and other independent physicians. These physicians may or may not participate in all insurance networks.
- E. Valuables: Keeping valuables (such as cash, jewelry, documents) in the Facility is strongly discouraged. I understand that the Facility has a place where my valuables may be stored. If I choose to keep valuables in the Facility, I do so at my own risk and I understand and agree that Facility is not liable for loss or damage to any valuables that I do not turn over for storage.
- F. Photographing: I understand and agree that the Facility may take photographic, electronic and/or video images of me in cases when it is required to assist with my treatment or for my safety. If my care involves the delivery of a baby. I give consent for my baby to be photographed for security and/or personal use.
- G. Privacy Notice: | acknowledge that | was provided with a copy of Covenant Healthcare's Notice of Privacy Practices. Please refer to the Notice of Privacy Practices for more information regarding release of your health information and your right to access your health information.

Signature of Patient/Authorized Representative

Relationship of Authorized Representative

If unable to sign document, state reason;

Impatient and Outpatient Consent for Treatment &

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MINER NIMIKO D DOI: 10/06/87 18+ 3EX + MR 1053171 EMERGENCY CONSULTANTS INC

#### ST JOSEPH REGIONAL MEDICAL CTR PAGE: 1

BOX 68-9510

#### MILWAUKEE, WI 53268-9510

Statement on: 05/03/06 at 12:13 PM

Guarantor: MINER NIMIKO D

2444 N 40 ST

MILWAUKEE, WI 53210-0000

Patient: MINER NIMIKO D Visit #: 71517538

AR Seg: 04/09/06 to 04/09/06

Date	Svc Code	Description	Units	Debits	Credits
04/09/06 04/09/06 04/14/06	12808186 61549282 9848064	ACETAMIN TAB 325MG UD ED CARE LEVEL 2 ALLOW T19 UHC	3 1 -1	11.07 279.25	148.27-
* - Not po	sted			Balance:	142.05

#### ST JOSEPH REGIONAL MEDICAL CTR

BOX 68-9510

MILWAUKEE, WI 53268-9510

Statement on: 05/03/06 at 12:12 PM

Guarantor: MINER NIMIKO D

2444 N 40 ST

MILWAUKEE, WI 53210-0000

Patient: MINER NIMIKO D

Visit #: 71486994

AR Seg: 04/09/06 to 04/09/06

PAGE: 1

Date	Svc Code	Description	Units	Debits	Credits
04/09/06 04/09/06 04/09/06 04/09/06 04/09/06 04/14/06	12808186 56382755 56382850 56382860 61549282 9848064	ACETAMIN TAB 325MG UD OUTPATIENT IN BED/HOU OBSTETRICAL ADMISSION REGULAR CARE/HOUR ED CARE LEVEL 2 ALLOW T19 UHC	2 1 1 1 1 -1	7.38 35.00 663.25 219.00 279.25	1061.83-
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DATE

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05/23/06

NIMIKO D MINER 2444 N 40 ST MILWAUKEE WI 53210

432591

432591

ACCOUNT NUMBER

04/09/06

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT OF \$\_\_\_\_

DATE PHYSICIAN MO DY YR	TRANSACTION DESCRIPTION			5-8-12-20 Sec. 16:55	PROC	AMOUNT
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Payment may be made by check, money					,	
bill is for the Physician services-not for th						
Notice: If you have already paid this bill, p				-		
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You can email your insurance information	or billing questions to				*	
apollobilling@eci-med.com or call 1-800-					*	
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05/23/06	MAKE CHECK PAYABLE	TO: ST JOSEPH'S EME	R PHYS LLP	

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CURRENT	30 DAYS	60 DAYS	90 DAYS	120 DAYS AND OVER
194.00	0.00	0.00	0.00	0.00

#### MAKE CHECKS PAYABLE TO:

CAPITOL REHABILITATION CLINIC 7220 West Capitol Drive MILWAUKEE, WISCONSIN 53216 (414) 464-4888 FAX (414) 464-1850

Account # 010082-00

RETURN UPPER PORTION OF STATEMENT WITH PAYMENT

> Selffer interges and payments not appearing on this statement will topes: on next month's statement.

SHOW AMOUNT

NIMIKO MINER 2444 N. 40TH ST.

MILWAUKEE, WI 53210

COS NIMIKO

MINER NEW BALANCE

08/23/06 01 \$ 1775.00

CHARGES APPEARING ON THIS STATEMENT ARE NOT INCLUDED ON ANY HOSPITAL BILL OR STATEMENT EXPLANATION OF ACTIVITY PROC. DIAG CHARGES & 04/27/06 BG1 COMPREHENSIVE OFFICE VISIT 230.00 05/12/06 BG1 EST. PT. INTERMEDIATE OFFIC 98.00 06/02/06 BG1 EST. PT. INTERMEDIATE OFFIC 98.00 06/15/06 BG1 ELECTRICAL STIMULATION 46.00 06/15/06 BG1 THERAPEUTIC EXERCISE 15 MIN 100.00 06/19/06 BG1 ELECTRICAL STIMULATION 46.00 06/19/06 BG1 THERAPEUTIC EXERCISE 15 MIN 100.00 06/19/06 BG1 P T MINI EVAL-FIRST PT CONT 50.00 06/26/06 BG1 ELECTRICAL STIMULATION 46.00 06/26/06 BG1 THERAPEUTIC EXERCISE 15 MIN 100.00 06/29/06 BG1 ELECTRICAL STIMULATION 46.00 06/29/06 BG1 THERAPEUTIC EXERCISE 15 MIN 100.00 07/06/06 BG1 EST. PT. INTERMEDIATE OFFIC 98.00 07/10/06 BG1 ELECTRICAL STIMULATION 46.00 07/10/06 BG1 THERAPEUTIC EXERCISE 15 MIN 100.00 07/10/06 BG1 P T MINI RE-EVAL 35.00 07/11/06 BG1 ELECTRICAL STIMULATION 46.00 07/11/06 BG1 THERAPEUTIC EXERCISE 15 MIN 100.00 07/19/06 BG1 ELECTRICAL STIMULATION 46.00 07/19/06 BG1 THERAPEUTIC EXERCISE 15 MIN 100.00

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08/23/06	**/**/**	0.00	0.00	0.00	0.00	0.00	1775.00	0.00



#### MAKE CHECKS PAYABLE TO:

CAPITOL REHABILITATION CLINIC 7220 WEST CAPITOL DRIVE Milwauker, Wisconsin 53216 (414) 464-4888 FAX (414) 464-1850

Account # 010082-00

RETURN UPPER PORTION OF STATEMENT WITH PAYMENT

> HOPPING parges and payments not appearing on this statement will 160920 - 6 next month's statement.

SHOW WALL ME

NIMIKO MINER 2444 N. 40TH ST.

MILWAUKEE, WI 53210

NIMIKO MINER

NEW BALANCE

08/23/06 02 \$ 1775.00

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

PROC DIAG CHARGES A

CODE CODE CODE

DESITES

08/10/06 BG1 EST. PT. EXTENDED OFFICE VI

144.00

STATE. NEW DAYS OF LAST AMT. OF LAST CHICKS & PAYMENTS OVER 30 DAYS **OVER 60 DAYS** OVER 90 DAYS **OVER 120 DAYS** CLOSING DATE PAYMENT PAYMENT & CREDITS 08/23/06 \*\*/\*\*/\*\* 0.00 0.00 0.00 0.00 0.00 1775.00 0.00

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CAN'T AFFORD	O TO BE IMPAIRED	fexo	fenadine HCl

Please see accompanying prescribing information.

fexofenadine HCl POWERUNIMPAIRED

IMMER IVIMIKO DATE - TIME 8P CPT CODE WT **ALLERGIES Formedic** JUL 0 6 2006 JUL 20 2006 JUL 21 2006 JUL 2 4 2006 AUG 10 2006



The most commonly reported adverse events with Allegra 180 mg and placebo in seasonal allergic rhinitis patients 12 and older are headache (10.6% vs 7.5%), upper respiratory tract infection (3.2% vs 3.1%), and back pain (2.8% vs 1.4%)

ALG-AM-19296-1 (025) \$22005 Aventis Pharmaceuticals Inc. Aventis Pharmaceuticals, a member of the sanoff-aventis Group







CAPITOL REHABILITATION CLINIC 7220 WEST CAPITOL DRIVE MILWAUKEE, WISCONSIN 53216 (414) 464-4888 Fax (414) 464-1850

AUGUST 10, 2006

FINAL EVALUATION RE: NIMIKO MINER

DOI: 4-9-06

Nimiko Miner comes to the clinic today for re-evaluation of injuries sustained relating to an MVA on 4-9-06.

She is an 18 year old African American right-handed female who was involved in an MVA on 4-9-06. She was initially seen in our clinic on 4-27-06 and assessed to have sustained a lumbar sprain/strain injury and a left hip contusion. At that point the patient was 7-1/2 months pregnant. Physical therapy was deferred and patient was urged to follow-up regularly. Patient gave birth on 5-22-06 and was recommended to start physical therapy for persistent low back and left hip complaints on her visit with me on 6-2-06. Patient gained improvements with therapies. She received a total of 7 therapy sessions. The last session was received on 7-19-06. Patient reports to have continued to make further improvements thereafter.

On follow-up today patient reports complete resolution of low back and left hip symptoms. She has not needed to take medications for pain and has been going about her activities of normal daily living and has been caring for her newborn baby.

PHYSICAL EXAMINATION shows full and functional range of motion over the neck and upper extremities as well as the mid and low back and lower extremities with no pain, tenderness or discomfort in any of these areas at this time.

The rest of the systemic and neurological examination findings are unremarkable.

#### IMPRESSION:

- 1). Lumbar sprain/strain, resolved.
- 2). Left contusion, resolved.

#### PLAN:

- 1). Discharge the patient from my care and supervision at this time.
- 2). Patient was advised to continue her home exercise program for her own benefit and well-being.
- 3). May discontinue medications.
- 4). Patient was advised to call on the clinic for any future questions or concerns.

Benjamin S. Gozon, M.D. Physiatrist

NIMIKO MINER DOI: 4-9-06 TODAY: 7-6-06

Nimiko Miner comes to the clinic today for re-evaluation of injuries sustained relating to an MVA on 4-9-06.

Patient had tolerated therapies over the past few weeks. Patient reports continued improvement along the low back symptoms. Low back pain however still comes and goes and seems to be exacerbated with periods of increased activity.

PHYSICAL EXAMINATION today shows some mild tightness along the bilateral lumbar paraspinal region with functional range of motion.

#### IMPRESSION:

- 1). Lumbar sprain/strain.
- 2). Left hip contusion, resolved.

#### PLAN:

- 1). Continue physical therapy to the affected areas of the low back with emphasis on therapeutic exercise and strengthening and stabilization.
- 2). Continue current medications and restrictions.
- 3). Return to clinic in a few weeks for re-evaluation and follow-up.

NIMIKO MINER DOI: 4-9-06 TODAY: 6-2-06

Nimiko Miner comes to the clinic today for re-evaluation of injuries sustained relating to an MVA on 4-9-06.

Patient gave birth to her baby girl on 5-22-06. Low back pain symptoms seem to have improved somewhat. Patient however still has some bothersome discomfort and occasional tightness with periods of increased activity in the area. Left hip pain has resolved.

PHYSICAL EXAMINATION shows some mild tenderness along the bilateral lumbar paraspinal region. Range of motion is quite functional over the lumbar spine with moderate stiffness, mild guarding and some weakness on end range.

#### IMPRESSION:

- 1). Lumbar sprain/strain.
- 2). Left hip contusion, resolved.

#### PLAN:

- 1). Start physical therapy to the affected areas of the low back twice weekly with emphasis on therapeutic exercise and lumbar stabilization. I believe that the patient will benefit from a short course of therapy given her situation.
- 2). Recommended intake of regular Tylenol as needed for pain.
- Return to clinic in a few weeks for re-evaluation and follow-up.

NIMIKO MINER DOI: 4-9-06 TODAY: 5-12-06

Miss Miner comes to the clinic today for re-evaluation of injuries sustained relating to an MVA on 4-9-06.

Currently patient reports that his low back pain symptoms are unchanged. They are still quite bothersome at this time with significant left hip discomfort. Patient sees her OB/GYN very regularly at this point and was advised that she may be giving birth any day now.

PHYSICAL EXAMINATION today shows some tender spasms noted along the bilateral lumbar paraspinal region. Range of motion is functional over the lumbar spine with significant stiffness and guarding at end range.

There is some tenderness noted along the left hip as well.

#### IMPRESSION:

- 1). Lumbar sprain/strain.
- 2). Left hip contusion.

#### PLAN:

- 1). Patient was advised to return to clinic after child birth.
- 2). I will make a determination whether physical therapy will be beneficial for the patient at that point.

Benjamin & Gozon, M.D. Physiatrist



APRIL 27, 2006

INITIAL EVALUATION RE: NIMIKO MINER

DOI: 4-9-06

Nimiko Miner comes to the clinic today for the chief complaint of low back and left leg pain.

HISTORY OF PRESENT ILLNESS: She is an 18 year old African American right-handed female victim of an MVA on 4-9-06. Patient was a restrained front seat passenger of a parked vehicle that was suddenly hit on the rear driver's side by another vehicle. Patient was jerked forward and thrown back into her seat. No head injury was sustained. Onset of symptoms was hours later which prompted a visit to St. Joseph's Hospital Emergency Room. Patient was released the same day after having monitored fetal movement. Persistent symptoms prompted consult to our clinic.

Currently patient reports mid low back pain which is characterized as dull and achy with sharp and stabbing exacerbations rated at 4/10. This is worsened by range of motion activities and certain positions of sitting. She denies any radiation into the lower extremities or paresthesias in these areas.

Tenderness is noted on palpation along the left hip and with laying on this area as well as with walking activities. Patient reports that she has some difficulty with laying on her left side during sleep at night.

PAST MEDICAL HISTORY: Unremarkable.

MEDICATIONS: Prenatal vitamins.

ALLERGIES are to Risperdal which produces edema and hives.

PERSONAL SOCIAL HISTORY: Patient is single and is a senior in high school. She is 7-1/2 months pregnant.

FAMILY HISTORY: Positive for hypertension and diabetes on both sides of her family.

REVIEW OF SYSTEMS: Denies any history of loss of consciousness or seizures. Denies any chest pain, shortness of breath, nausea, vomiting, fevers, chills, weight loss or any bowel or bladder problems.

PHYSICAL EXAMINATION shows a well developed, well nourished age appropriate African American female who is currently not in distress.

NIMIKO MINER PAGE 2 4-27-06

SYSTEMIC EXAMINATION shows pink conjunctivae and anicteric sclerae.

CHEST is clear to auscultation.

HEART has regular rate and rhythm.

ABDOMEN shows fundic height appropriate for gestational age.

MUSCULOSKELETAL EXAMINATION shows tender spasms noted along the bilateral lumbar paraspinal region. Flexion is limited to 80 degrees, extension 5 degrees and lateral flexion 20 degrees with moderate pain, stiffness and guarding at end range.

Tenderness is noted along the left hip region. Sitting root sign, straight leg raise test and Fabere's testing are all negative.

NEUROLOGICAL EXAMINATION: Within normal limits.

#### IMPRESSION:

- 1). Lumbar sprain/strain.
- 2). Left hip contusion.

#### PLAN:

- 1). Patient may benefit from physical therapy to the affected areas of the low back and left hip at this time. Patient however reports that as per her OB/GYN her cervix has started to efface. The station of the baby's head seems to be descending. Due to this, I would defer from physical therapy in the clinic at this point. Patient was advised to carry out delivery of the baby and I will re-assess her after childbirth.
- 2). Patient was advised continued use of Tylenol as needed.
- 3). Return to clinic after childbirth if symptoms continue to persist.

Benjamin S. Gozon, M.D.

BG/cmz

	Patient History Questionaire Suc June 1, 66
	Patient History Questionaire Duc June 1, 06 7
N	ame: Manako D. 41. Maner Occupation: School Age: 18
1	When did your present pain start? April 9,2006
2.	What was the cause of your pain? (check all applicable)
	☐ Suddenly ☐ Pulling ☐ Gradually ☐ Injured at Work
	☐ Lifting
	☐ Fall ☐ Bending ☐ Sports Injury ☐ No Cause
. W	hat activities make the pain worse? (check all applicable)
	☐ Exercise (during) ☐ Bending Forward ★Sitting
	☐ Exercise (after)
	■ Bending Backward Sneezing Walking
4.	What reduces your pain? (check all applicable)
	☐ Injections for Pain ☐ Lying Down ☐ Standing
	☐ Muscle Relaxants ☐ Sitting ☐ Exercise. Therapy
	☐ Anti-Inflammatory Drugs   ☑ Pain Pills ☐ Nothing
	☐ Manipulation
5.	How long have you had this pain? April 9, 2004
	Years Months ' Weeks X Days
6.	Have you had any of these diagnostic studies? (check all applicable)
	☐ CT (computerized tomography) Scan ☐ Diagnostic X-Rays
	☐ Myelogram (x-ray with dye injection) ☐ Electromyogram (EMG)
	Arthrogram or Sonogram
_	☐ MRI (magnetic resonance imaging) ☐ Injections
7.	Have you been hospitalized for your problem?
	How many times?
0	Have you had surgery for this problem? NO
٥.	List any other problems you have been hospitalized for? \( \mathcal{N} / \Omega
Q	What medications are you currently taking? Prenadal VIHaumINS
<i>,</i>	what medications are you currently taking? TENALAL VILANMINS
10.	Do you take Antacids? _ No _ 11. Do you have Allergies? UES
11.	Do you Smoke? No 13. Do you drink alcoholic beverages?
14.	Do you have any of the following: (check all applicable)
	THIV/AIDC
	Thomasis Cancer
	Deptepsy
	☐ Sexual Difficulties ☐ Diabetes ☐ Arthritis
15.	What other types of doctors have you seen for this pain? () 45 H
٠	The of goester have you seen for this paint. 1995.
16.	Describe areas of pain or injury:

17. If you were in a motor vehicle accident, was your seatbelt \(\sigma\) On \(\sigma\) Off

18. If you were in a motor vehicle accident, were you the ☐ Driver 1 Passenger ☐ Pedestrian

19. Where is your pain now? Mark the areas on your body where you feel the sensations as described below using the appropriate symbols. Include all affected areas.

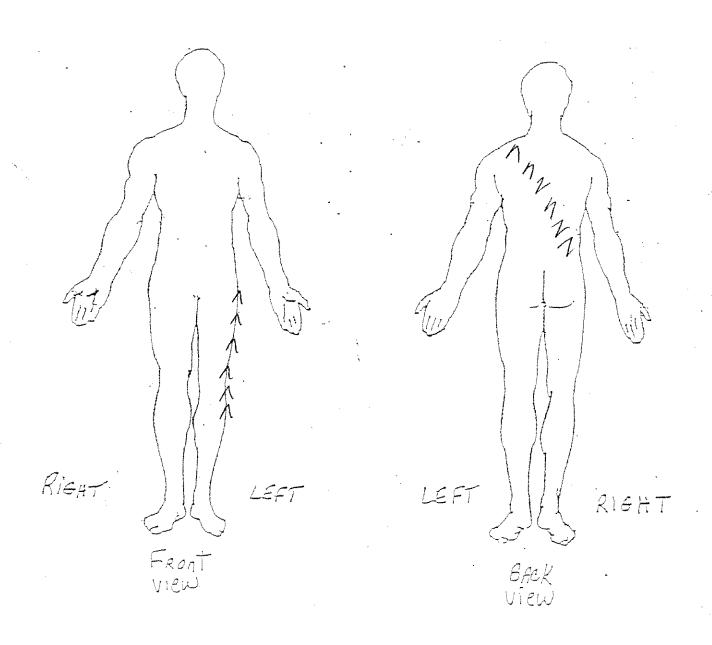
Aching AAAAAA

Numbness

Pins & Needles

Burning XXXX

Stabbing



ES & HP X IP/HP CONTRAST U/S PHONO DIATHERMY FLUIDO	Name: Nimiko  Frequency of treatment:  3x/wk 2x/wk Name: Nimiko
TYPE OF TREATMENT WHIRLPOOL TRACTION CER./LUM. PARAFFIN IONTO EVAL	Miner Doi: 4.0 Injury as a re Now MYC MYA + FALL OTHER
TENS OMT TPI 1 <sup>ST</sup>	DOI: 4-9-06 Injury as a result of: 6-3-06  W/C  MVA + 8-10-04  FALL  OTHER

DATE:	8/10/00			
NAME:	Nimiko	mines		
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-MAY LIFT	UNDER			
-MAY SQUAT	OR CRAWL.			
-MAY BEND	OR TWIST @ WATS	ST		
-MAY CLIME SHOULDER	OR REACH ABOVE HEIGHT			
-MAY USE T	HE RIGHT/LEFT H	IAND	***************************************	
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BENJAMIN S.	. Gozon, M.D.		F.B. ZUSSMAN.D.	<u> </u>

	DATE: 7-6-06	
	NAME: Dim iko Mener	
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Libri,	Ben Storm, MKW	
\$	BENJAMIN S. GOLON M.D.	E.B.Zussman,D.O.

DATE: 129-CG			
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BENJAMIN S. GOZON, M.D. (US)		E.B.ZUSSMAN, D	,0.

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PLEASE EXCUSE FROM WORK/SCHOOL ON #127/00 AS HE SHE HAD A DOCTOR'S/THERAPY APPOINTMENT
SCHEDULED AT 9:00. THE PATIENT LEFT THE CLINIC AT 10:10
1. THE PATIENT REPORTS TO BE A STUDENT AND MAY RETURN TO SCHOOL ON WITH NO RESTRICTIONS.
2. THE PATIENT MAY RETURN TO WORK ON WITH NO RESTRICTIONS.
THE PATIENT MAY RETURN TO WORK/SCHOOL ON WITH THE FOLLOWING RESTRICTIONS:
*RESTRICTIONS*
-NO/LIMITED PUSHING, PULLING OR CARRYING OVER LBS
-NO/LIMITED LIFTING OVER LBS
-NO/LIMITED BENDING OR TWISTING AT THE WAIST.
-NO/LIMITED CLIMBING OR REACHING ABOVE SHOULDER HEIGHT.
-NO/LIMITED USE OF THE RIGHT/LEFT HAND.
-ALTERNATE SITTING & STANDING ACTIVITIES.
-5 MINUTE REST BREAK FOR EVERY HOUR WORKED.
TO WORK HOURS A DAY.
-NO PARTICIPATION IN GYM CLASS.
-SEDENTARY WORK ONLY.
A DETERMINATION OF WORK/SCHOOL STATUS WILL BE MADE ON
IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CONTACT THIS DEFICE AT (414) 464-4888.
BENJAMIN S. GOZON M.D. E.B. ZUSSMAN, D.O.
BENJAMIN S. GOZON, M.D. E.B. ZUSSMAN, D.O.

Therapy Record Patient Name:	, <u>1. L</u>	17 <u>.</u>	hC	<i>;</i>	11	1176	1,7		1934)		DOI	: 4	- (	<u> </u>	**************************************		
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Thomas Malone, PT Julie Bauer, PTA Mary Spath, PTA Lea Minerley, aide Aaron Rivera, aide

Therapy Pt. Name	Record :: Nimika Mi	DOI: 4-9-06
Date	Area(s) being Rx	Rx received this date:
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		Modality tolerance:
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		Rx) - JB PTA
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Pt. Name:	ecora Nimiko	Miner DOI: 4.9.06
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Comments:

Therapy Intake Form	Physician 4.5	
Patient Name: 101-000	NEWST .	
	W/C MYA Fall Chronic	
Other:	Pain Scale (1<10) 1. Lacerations/Bruises Eder	The second state of the se
type of Palli: Dizzinese/Rh	arred Vision >- \ Lacerations/Bruises \ Eder	na Oliver
Sensation WNL	Altered	
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Prior Medical History:	TENS 15 - 32 TEN	
Assistive Device:		
Committee ! Dr. Male		
Work Status: (100 Nd 1	5 2TH 6 HOE'S VESTICTIONS	
And the second s		<u> </u>
	GOALS	
Goal Status Key:	GOALIS	
M= Met	PM= Partially Met/ Improved W= Worse	
= Met Inconsistently	NP= No Progress NC= Non-com	pliant
- Wet medisistently		
Short Term Goals: Estimated	Time to Achieve: 3-4 & &S	GOALS
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Therapist Signature Date
Capitol Rehab Clinic 7220 W. Capitol Dr. Milwaukee, WI 53216
(414)464-4888 Fax (414)464-1850

PT. NAME:	<u> </u>	DOI:_	4-9-62

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# Capitol Rehabilitation Clinic

Physical Therapy Initial Evaluation

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	Physical Therapist signature

## Capitol Rehabilitation Clinic 7220 W. Capitol Dr. Milwaukee WI. 53216

Physical Therapy Follow Up

Name: Municko Miner

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### Office Policies

Appointments: It is important for you to receive the treatments your doctor has ordered for you to recover from your injury. Please phone the office if you will be late or unable to attend your scheduled appointment.

<u>Therapy Services</u>: When making your appointment it's a must that you schedule on days you can complete your entire treatment regime. As part of your recovery it's essential to complete exercises in the clinic. If you are unable to stay for your full treatment you must reschedule your appointment. If you wear loose clothing that will move with you stretching will be easier and more beneficial.

Due to the nature of our equipment it is **extremely important small/young children are supervised by you at all times.** They could become seriously injured if they are exploring any of the therapy equipment.

Work Status: It is important for you to discuss your work status with your doctor at each doctor visit. Please inform the staff of any changes in your status between visits. Be sure to ask for your updated work status sheet when scheduling your appointments.

<u>Contagious Diseases</u>: If you are ill with a contagious disease (flu, chicken pox etc), both for yourself, other patients and our staff, please phone the office and reschedule your appointment. For lengthy illnesses treatments and doctor appointments will be at our discretion.

<u>Confirmation of Appointments</u>: If is the policy of this office to confirm scheduled appointments. If you are unavailable when we call, we would like to leave a message stating

"this is Capitol Rehab Clinic calling, I'd like to leave a message for patient name to confirm the appointment for patient name on date at time."

Please check below to indicate your preference:

OK to leave a message

Do not leave a message

Patient signature

O 1500

Date

You may change your preference at anytime by notifying our staff. We will require you to sign a new form indicating your change.

Thank you,

The Capitol Rehab Clinic Staff

Capitol Rehabilitation Clinic Irrevocable Lien Patient Name: YEMER Date of Injury: 49.00 I fully understand that I am directly and personally responsible to Capitol Rehabilitation Clinic for all fees of medical services rendered. This Lien authorizes the appropriate Insurance Company to pay directly to Capitol Rehabilitation Clinic such sums as may be due and owing for medical services rendered. I understand that this Lien is Irrevocable. I also understand that I will be held responsible for any attorney's fees, collection agency costs, court costs or any other expense incurred in order to collect the amount owed to Capitol Rehabilitation Clinic. This lien authorizes Capitol Rehabilitation Clinic to provide the said insurance company with any medical information necessary to process claims for payment. **Insurance Company** Insurance Co. Name: UNITED Walth Phone: Address: Adjuster: **Potential or Pending Litigation** This Lien authorizes the Attorney representing me to withhold such sums from settlement, judgment or verdict as may be necessary to adequately protect fees for medical services rendered by Capitol Rehabilitation Clinic. This Lien authorizes the Attorney representing me to pay directly to Capitol Rehabilitation Clinic such sums as may be due and owing for medical services rendered by reason of the above listed date of injury. This Lien is made regardless of the outcome of any pending or potential litigation. This agreement is made solely for Capitol Rehabilitation Clinic's additional protection and in consideration of awaiting payment. I agree that a photocopy of this original authorization shall be considered equally authentic as the

Patient Signature: 18 Million Weller Date: 4.27.06

Parent/Guardian Signature: 10 Lio Lagran Date: 4.27.06

Relationship to patient: 10 Pate: 10 Pa

original.

Capitol	Reha	bilita	tion	Clinic	

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

\*You may refuse to sign this Acknowledgement\*

I, <u> </u>		Notice of Privacy Practices.  , have received a copy of this
	1	April 27, 2006
	·	For Office Use Only
We atte Be obta	mpt ined	ed to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not because:
		Individual refused to sign
		Communications barriers prohibited obtaining the acknowledgement
	□	An emergency situation prevented us from obtaining acknowledgement
	0	Other (please specify)

# Consent for Disclosure of Medical Record Information

Print Patient's Name: MINIRO D'M. MINER
Address: 2444 No. 4004 Sct. City State/Zip: Aster Milwauker, WI 535
Birth date: 10 06:87 Social Security =: 392.02.9946 Phone #: (444) 449.1392
I,, do hereby authorize St. Josephs
to release to: CAPITOL REHABILITATION CLINIC 7220 W. CAPITOL DR. MILWAUKEE, WI 53216
The following information: Concerning the following dates: $4900$ / I understand that the information disclosed includes: Physical Illness $3$ Emotional Illness $3$ Alcohol, Drug Abuse $5$ HIV results or related diagnosis
Check one: Complete Chart  Limited inpatient (includes: Face Sheet, Discharge Summary, History & Physical, Consultation Reports, Lab Reports, X-ray Reports, Operative Reports, Pathology Reports)  Outpatient services (includes: Emergency room reports, Physician Progress Notes, Lab Work, X-ray Reports, Other)  Other
Claim resolution   Coordinating care for dependent/spouse   Insurance Eligibility/Benefits  YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:  Right to Receive Copy of this authorization-I understand that if I sign this authorization, I may be provided with a copy of this authorization. Right to refuse to sign this authorization-I understand that I am under no obligation to sign this form and that Capitol Rehabilitation Clinic may not condition treatment, payment, enrollment in a health plan or eligibility of health care benefits on my decision to sign this authorization except regarding; a) research-related treatment b) health plan enrollment or eligibility c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party. WI law requires the patient's authorization to disclose 252.15 or 51.30 records for payment purposes.  Right to Withdraw This Authorization-I understand I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Capitol Rehabilitation Clinic. I am aware that my withdrawal will not be effective until received by Capitol Rehabilitation Clinic and will not be effective regarding the uses and/or disclosures of my health information that Capitol Rehabilitation Clinic has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the folicy itself. Right to inspect or copy Health Information to be Used or Disclosed-1 understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. may arrange to inspect my health information or obtain copies of my health information used or disclosed based on this authorization may estable to re-disclosure and no longer protected by Federal privacy standards. Expiration date-If no prior n
PARENT/GUARDIAN SIGNATURE: (elia) L. Kiales Date: 4.27.06
Relationship to patient: Wolfer 1)0
Witness:

# Consent for Disclosure of Medical Record Information

Print Patient's Name: YIMIKO D.M. YIMER
Address: 2444 No. 410th Sci. City/State/Zip: Hester Y/Jelizauker 101 532.
Birth date: 10 12 87 Social Security #: 392.42. 9944 Phone #: (444) 449.1392
, do hereby authorize
RECEIVED MAY 1 6 2000 St. Josephs
to release to: CAPITOL REHABILITATION CLINIC 7220 W. CAPITOL DR. MILWAUKEE. WI 53216
The following information: Concerning the following dates: 19,00 I understand that the information disclosed includes: Physical Illness © Emotional Illness © Alcohol, Drug Abuse © HIV results or related diagnosis
Check one: Complete Chart  Limited inpatient (includes: Face Sheet, Discharge Summary, History & Physical, Consultation Reports, Lab Reports, X-ray Reports, Operative Reports, Pathology Reports)  Outpatient services (includes: Emergency room reports, Physician Progress Notes, Lab Work, X-ray Reports, Other)  Other  Other
PURPOSE FOR NEED OF DISCLOSURE: (check applicable categories) **Dontinuing Medical Care** Claim resolution **Goordinating care for dependent/spouse **Insurance Eligibility/Benefits*  YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: Right to Receive Copy of this authorization-I understand that if I sign this authorization, I may be provided with a copy of this authorization. Right to refuse to sign this authorization-I understand that I am under no obligation to sign this form and that Capitol Rehabilitation Clinic may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding: a) research-related treatment b) health plan enrollment or eligibility c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third parry. WI law requires the patient's authorization to disclose 252.15 or 51.30 records for payment purposes. Right to Withdraw This Authorization-I understand I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Capitol Rehabilitation Clinic. I am aware that my withdrawal will not be effective until received by Capitol Rehabilitation Clinic and will not be effective regarding the uses and/or disclosures of my health information that Capitol Rehabilitation Clinic has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. Right to inspect or copy Health Information to be Used or Disclosed- I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Capitol Rehabilitation Clinic-Medical Records Dept.
PARENTE/CHARDY IN COMPANY OF THE PARENTE OF THE PAR
PARENT/GUARDIAN SIGNATURE: (elia) A. Yegler Date: 4.27.06 Relationship to patient: 4/27.06
Witness: Date: 4.27.06
11 4-9-COEK Date. 17 87 COC

			· `
GRAV	PRET		LIVE
EDD DATES	GEST (WKS)	EDD U/S	GEST (WKS)
PRIMARY COMPLAINT ☐ abdominal pain/cramps ☐ contractions ☐ PROM/SROM ☐ vaginal bleeding ☐ ¼ fetal activity	ALLERGIES/ ON SENSITIVITIES · RED		REACTION
MVA/fall/altercation A SU ☐ fever/nausea/vomiting ☐ pain, other ☐ other	MEDICATIONS,**		Last dose
*Including but not limited to altergies/sensitivities to medications tape, LATEX, lodine ** Prescription, OTC, nutritional sup herbal remedies, other	plements,		
☐ See Significant Findings  Mobility: Ambulatory ☐ Bedres: Learning needs: ☐ Auditory de  Safety: No needs ☐ Auditory de  Usual deficit ☐ Evidence of phys  Discharge: Do you have concerns a  Nutrition: ☐ No needs ☐ Therape	t	Livesempl	
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RN Signature KUKANG Date 45 A	\(\alpha\) \(\frac{1}{2}\) \(\frac{1}{2}\) \(\frac{1}{2}\)	neck-go two nos	oftalized for sixcut zyrsag
RECIONAL MEDICAL CENTER  Cobount & HOSPITAL  3 8000 W Chambers St. Milwackee, W 20210  3 101 North Mayfair Road - Wallwatha, W 33226  3 10400 W North Ave. Wallwatha, W 33226  3 10400 W North Ave. Wallwatha, W 33226  and have recommend the state of the	Obstetric Outpatient Nursing History 87623 2/05	MINER NIMIKO DOB 10/06/87 16 GEK PALABRICH CYN ACCI# 71486994	D F MR: 1053171 THIR L:

FOCUS NOTES/SIGNIFICANT FINDINGS Time in: Date Date VITAL Respiratives 2.7 Blood Pressure Effacement : % Citatation (67) et hit her a stomen. Is noting mild about an Station (++ cm) UTERING ACTIVITY BROGER HERCHEN he intesity Baseline FHR Long Term M Var-ability Reactivity Decelerations Bload giucose/ Meter ID POINT OF CARE Time \* = See Notes = 4 = no change Key: √ = Assessment WNL Neurological/Mental State 1 Cardiovascular Respiratory Integumentary ☐ See Significant Findings Sheet for further charting Invasive Line FINAL ASSESSMENT: CRNST CReassuring for GA 18yof Gife C3) here to Spirit in as restained passenger of the behal while styled. Faiting deploying in this test a stag deploying in this head a believe the property of the security. The head a believe to the property of the security. The man serve years the security. Gastrointestinal Nutrition/Hydration Genitourinary × Musculoskeletal Peripheral-Vascular Ċ Comfort TOCO . M. T Sve by thek on PET FATS DOOD TV GR Coping L CTAPIL
Abd. 635 sigt, great NT PLAN Geraware, alect (14) Spiritual / Valuing H-222 Continuity of Care 1844 4 MIA Safety Patient Education · Ye to now Tyleid for part Initials DISPOSITION: DODIScharge D Admit - L&D D Admit - Antepartum PHYSICAL-ASSESSMENT URINE DISCUSSED WITH Provider Signature Co-signature ☐ Intact ☐ Bulging Protein\ MEMBRANES ☐ Ruptured Date Glucose). ☐ Nitrazine Test ☐ neg ☐ equivocal ☐ pos Ketones Nitrites ☐ Fern Test ☐ neg ☐ pos Leukocytes Time disposition decision made <u>9210</u> Time out. <u>2230</u> ☐ Sterile Speculum Exam (findings) To O'Home D

By SWalk D Wheelchair D Alone D With HCM C FLUID 🗆 Clear 🗆 Bloody 🗆 Foul Odor 🗀 Meconium Stained REFERRALS Discharge instructions reviewed. Patient verbalizes understanding ☐ Social Services ☐ Interpreter ☐ \_ PLAN OF CARE: D Initiate standing orders/treatment protocol

G 10400 W North Ave. Wallwatesa WI 91126

Obstetric Outpatient Triage

ATOMA KIND

Assessment Record

MINER NIMIKO D 008 10/06/87 18 y sex r MR: 1053171 PALABRICA CYNTHIA L 71486994

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	St. Joseph Regi	onal Medic	Center		Emergei	ncy Depart	ent Q	ualChar	t <sup>®</sup>	Pag	ge 1 of 2
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	*		ns Stable : exce	nt pp				Rate:	NL	Brady	Tachy
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320	* DENOTES		: NL Hypoxic			Interp.	, , , , , , , , , , , , , , , , , , ,	Ectopy:	None	PVCs	PACs
a.m. kp.m.	QUALITY INDICATO										
HISTORY:		HX from Patient	Unobtainable due ent Family / Ca			MS Extremis	01	her:	***************************************		***************************************
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Eyes	• •		Blurred Vision	- \$					Roa	p.e.	2.22
ENT			Ear Ache	4.5				v	icoa.	re , tak	26
CV			Chèst Pain Cough	<b>N</b> ===			<b>M</b>				
Respiratory GI	Negative SOB  Negative Vom		Diarrhea								
GU	Negative Dyst	=	-lematuria	Force:	LOW !	<u>Mode</u> rate Hig	h Dir	ect Gla	incing		
MS			Myalgia	Restraints:	None			d From Vel			
Skin	Negative Rash		3ruising		Lap / <u>Sh</u>			ged Extrica			
Neuro	Negative Head	fache \	Weakness		Car Seat	No Helmet	All Da	g Deployed	,		
Psych	Negative Anxi	ous (	Depressed								
YES All	other systems eithe	reviewed ar	nd negative	w							
NO	or non-contributory	for chief con	nplaint								
PAST MEDICA	AL HISTORY:	reviously Hea		VR / Comfort	-	Immunization	s: Ur	nknown T	etanus U	TD Not	UTD
Endocrine	DM I DM II	*	old Hyperthyroid		emia	* Pneumoco	***************************************				
CV	CAD/MI HTN	CHF na Bronchiti	Afib s Pneumonia	DVT PE			***************************************				
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Other:					MIK	JED ALTA	Tizes	rs			
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Lives Alone / W	ith Family Nursing	Home Assis	sted Living		7151	531 IIII					
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C+	Joseph Re	egional Medic - Penter		Emergency Departr	<u>ાt QualChart</u> જ	
31	MOTOR V	EHICLE ACCIDENT		(Circle)pertinent positive	uings. Backəlaşh pertir	nent negative findings.
HYSICAL EXA		EXAM LIMITED DUE TO:	Dementia	Altered MS Extremis	Other:	
HYSICAL EXA	WINA HOW.		Abnormal I	Findinas:	Complaint-Spe	cific Findings
		Normal Findings:	Bi-Annearin	a: Mild Mod Severe	C-Collar / Backboard	(PTA / ED)
Appearance	Normal	Well-Appearing No Pain Distress	Pain Distre.	ss: Mild Mod Severe	Removed w/consent p	USI EXAM
		Well-Nourished	Obese / Th	in / Cachectic	GCS / N	
Eyes	Normal	PERL / EOMI	R Pupil Conjunctive	L Pupil I Inflammed	Tenderness / Spasm: Paraspinal	
	Normal	Conjunctiva Clear Ears Normal	TMs Occlud	ded	Cervical	
ENT	Monnai	Nose Normal	Rhiborrhea	/ Epistaxis	Thoracic	
		Oropharynx Normal	Erythema / Nonsupple	Exudate / Dry Muccsa	Lumbar	Jo Dight / Loft
Neck	Normal	Supple Stant	Ainway Ohe	structed	Diminished Breath Sour Pelvis / Hip Stable / L	Instable
Respiratory	Normal	Airway Patent CTA	Rales @ .		Extremity Injury / Deform	nity
		Breath Sounds Equal	Rhonchi @	73	Exposition and the	
			Wheezes @ Retractions		(m, m)	( . )
		Respiration Nonlabored RRR	IRR Tac	hycardia Bradycardia		<u> </u>
Cardiovascular	(Normal	Pulses Normal	Abn. Pulse	s @		
		No Rub / Murmur	Murmur		1.	/,///,
GI / GU	Normal	Soft / Nontender	Macc @		10 11	-
•		No Masses Bowel Sounds Normal	Bowel Sou	nds Hypo Hyper		
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MS	Normat	Strength / ROM Intact				
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Skin	Normal	Warm & Dry Color Normal	Cvanosis	@	A = Ab	ntusion /~ ()~(
*1	Normal	Sensory / Motor Intact	Focal Defi	cit @		formity
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		CN Intact	AVPU	Disoriented		ndemess
		A & O x 3  Affect / Mood Appropriate		Depressed	S = Sw	relling (30)
Psychiatric	Normal	Mitot: Moda / FFF				Pain Scale (0-10
MEDICAL DEC	ISION MAKIN	VG: Consideration of the following of	L	VALUATION:	.) Improved Worse VS	S
may be warranted for the	he presenting proble	m. These conditions are not final diagn	oses. Time	:Unchanged	Improved Weise	
DIFFERENTIAL	DIAGNOSES:					
Abdominal Injury		Neck / Spinal Injury	Time	:Unchanged	Improved Worse VS	ss
Abrasions / Cont	usions	Normal Exam Upper Extremity Injury				
Chest Injury		Opper Extremity injury	PHY	s. NOTIFICATION/CONS	ULTS: Chart Copy Availa	ble to Addt'l Care Providers
Head / Facial Inj		. **		ussed case/management/disp	position of patient with:	
Lower Extremity	Injury		1.		at	a.m. / p.m
Other:				e:		/ n m
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Z		11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Disc	Camil	y Other:	
	1 - 76012	To Same of Camero		Standard After-Care Instru	ctions Given to Patient Upor	Discharge from ED.
			Sun	ervising / Management / Procedo	ure / Progress Notes Attache	ed: Yes No
Critical Ca	re Provided	For: min		714 ( A.d.	dendum Dictated: Yes	No
SIGNATURE			MD/DO	Chart / Ad	deligalii biolatoa.	
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ر : ₹ <u>-</u>	Supervising Ph	nysician attests performing perfiner	it History.	I HLRGEI	MILY CONSULT	ANIS INC
1	Observed Example	ination, and Medical Decisions				A CONTRACTOR OF THE CONTRACTOR
a.m. / p.m.	\$ 5. CIÀDICOS ŒVESTAS	3183001, G119 110 and	(Initials)	HC1*		

I have reviewed available Ancillary / Nursing Staff documentation.

This form is to assist the physician's documentation of clinical care and treatment. It is not intended to supplant that judgement or create a standard of care. 04/09/06 08:34 pm (c) 1997-2005 Emergency Consultants, Inc.

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١	Miner N	MIKE	FX		Brace OFC	I B.S. Device	Family with	pahent	Mode of Arrival; W/C
1	Chief Complaint		NUM PS	Wt (Kg)	UFC	B.305440	Yes T No		Ambuliatory 3
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1	See Nursing notes for ty		tion.	YO NO	Referral Give	n 🗆	_ Never □	- T	
ŀ	Medications			None 🗀	Additional Tri			Pre-Hos	oital Treatment: None 💢
1	Medicanoris	Sa	e Admission Med	d. Record 🗀	Assessment			Oxygen	rd ☐ Splinting ☐
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Į	Herbal or Alternative Me Past Medical History: (	ed:		0.1.10.75	NEUDO C	DENAL C. SEL	ZURE   NI	COTINE	NFECTIOUS DZ
Ì	Past Medical History: (	CARDIAC	□ RESP. ⊔	CANCEH L	NEURO	HER LEP	4023		
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EMERGENCY DEPARTMENT RECORD PAGE 1



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EMERGENCY DEPARTMENT RECORD PAGE 2

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TODAY'S DATE: 4.27.06

CAPITOL REHABILITATION CLINIC Patient Name: \( \sum\_{\text{IMZKO}} \) \( \ Social Security# 392.02.9946

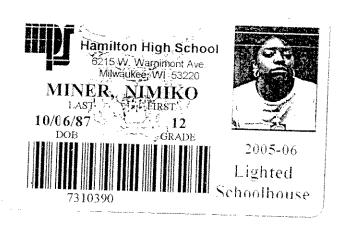
Spouse's Name:

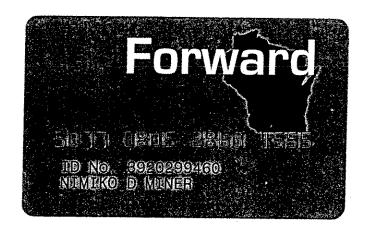
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Birth Date:  $\frac{\lambda}{N}$  SS#  $\frac{392.02.994}{392.02.994}$ Spouse's Address: N/N Spouse's Employer: N/N
Parent/Guardian Name, (if patient is a minor) N/N Parent Employer Name & Phone# (if patient is a minor) N/A Referring Physician Name: N/A Insurance Information Policy# List any other Insurance Coverage: Accident Information ( if applicable ) Consent to Treat a Minor ( if applicable) This authorization provides consent for Capitol Rehabilitation Clinic (including physicians and staff) to examine and treat the minor patient listed above.

Date: 4.27.04 Célia A. Kirles Parent or Legal Guardian Signature Date: Witness Payment Agreement and Assignment of Insurance Benefits I understand that I am fully responsible for payment of the medical services rendered by Capitol Rehabilitation Clinic. I hereby assign insurance benefits payable for medical services rendered to me (or minor patient) by Capitol Rehabilitation Clinic to be paid directly to Capitol Rehabilitation Clinic. I understand that I am responsible for any applicable co-payment, deductible, co-insurance and/or non-covered costs deemed by the insurance company. I agree that I am responsible for the cost of collection and/or reasonable attorney fees related to my Jeples, Minusonino Date: 4.27.06 account.

Signature of Patient, Parent or Legal Guardian





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