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February 16, 2001

City of Milwaukee
City Attorney's Office
800 City Hall
200 East Wells Street
Milwaukee, WI 53202-3551

Attn: Mr. Bob Overholt

Re: Our Client : Beverly R. Berry
D/Accident : July 27, 2000
Claim No. : 00-L-151

Dear Mr. Overholt:

Enclosed herewith please find the following items of medical information and special damages in regard to the above matter:

1. St. Mary's Hospital records of 7-27-00, along with their billing statement in the amount of \$ 174.92
 2. Infinity Healthcare Physicians, S.C. billing statement of 7-27-00 in the amount of \$ 217.00
 3. Dr. E.B. Zussman's records of 7-31-00 through 10-30-00
 4. Capitol Rehabilitation Clinic physical therapy records of 7-31-00 through 9-20-00, along with their billing statement of 7-31-00 through 10-30-00 in the amount of \$2,475.00
- TOTAL SPECIALS TO-DATE: \$2,866.92**

February 16, 2001

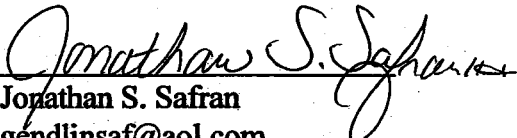
- Page 2 -

Based upon the enclosed specials submitted, we are hereby making a demand in the amount of \$9,500.00, as and for a full and final settlement of this matter. After you have a chance to review the enclosed, please contact me to discuss settlement.

Very truly yours,

GENDLIN & SAFRAN, S.C.

By:


Jonathan S. Safran
gendlinsaf@aol.com

JSS/ch
Enclosures

St. Mary's Hospital

2323 North Lake Drive * Milwaukee, WI 53211-0503

EMERGENCY

PATIENT NAME BERRY, BEVERLY R		TITLE	DATE OF BIRTH 05/24/1964	AGE 36	SEX F	RACE B	MS S	PT TYPE E	HOSP SERV EMR	MEDICAL RECORD NO. 109341
ADDRESS 5867 N 37TH ST MILWAUKEE WI 53209-		PREVIOUS NAME	RELIGION BAP	SOCIAL SECURITY NO 387-86-3946	OCCUPATION		PRIN FIN CL G	REG BY ADMPGA	REGISTRATION DATE & TIME 07/27/00 23:07	
HOME PHONE 414/461-1546		WORK PHONE/EXT. 999/999-9999 x	ACCOUNT NO. 105854021							
PRIMARY CONTACT/ADDRESS WILEY			RELATION RENEE	B	SECONDARY CONTACT/ADDRESS			RELATION		
HOME PHONE 414/875-8668			HOME PHONE			WORK PHONE/EXT.			WORK PHONE/EXT.	
GUARANTOR/PHONE BERRY			RELATION BEVERLY R	P	ADDRESS 5867 N 37TH ST		CITY/STATE/ZIP MILWAUKEE WI 53209-			
Home 414/461-1546			Work 999/999-9999 x							
PRTY	INSURANCE	ADDRESS/CITY/STATE		PHONE/ZIP		AUTH/WIPRO NO				
1.	PRIMECARE MEDICAID	P O BOX 3153 MILWAUKEE		WI 414/443-4830 53201-3153		x x x				
ACCIDENT DATE TYPE DESCRIPTION								ATTENDING DR.		
07/27/00 A MOTOR VEHICLE ACCIDENT								SCHNEIDER, KATHLEEN		007935
DIAGNOSIS/SYMPTOMS								PRIMARY DR.		
								MANNAN, MD		000019
ADVANCE DIRECTIVES										
DK										

ORDERS	ORDERS CONTINUED
<input type="checkbox"/> FINGER STICK GLUCOSE	<input type="checkbox"/> PREVIOUS MEDICAL RECORD
<i>Ice pack to neck & low back</i>	<input type="checkbox"/> O ₂ _____ LITERS
<i>Vicodin $\overline{\overline{\text{TT}}}$ P.O.</i>	<input type="checkbox"/> PULSE OXIMETRY
	<input type="checkbox"/> SPOT <input type="checkbox"/> CONTINUOUS
	<input type="checkbox"/> MONITOR _____
	<input type="checkbox"/> RESTRAINTS \geq _____ HRS.
	<input type="checkbox"/> EKG _____

2708

VERLY R
 351 109341
 KATHLEEN H
 MD
 1/24/1964

EHR

TESTS	CHEMISTRY	CULTURE & SENS
<input type="checkbox"/> CBC	<input type="checkbox"/> MSSP	<input type="checkbox"/> GC
<input type="checkbox"/> H & H	<input type="checkbox"/> LFT	<input type="checkbox"/> CHLAMYDIA
<input type="checkbox"/> WBC	<input type="checkbox"/> AMYLASE	<input type="checkbox"/> WET MOUNT
<input type="checkbox"/> DIFF	<input type="checkbox"/> LIPASE	<input type="checkbox"/> BLOOD
SEGS _____	<input type="checkbox"/> SGOT	<input type="checkbox"/> URINE
BANDS _____	<input type="checkbox"/> LDH	<input type="checkbox"/> _____
EOS _____	<input type="checkbox"/> TROPONIN	
BASO _____	<input type="checkbox"/> CPK-MB	
MONO _____	<input type="checkbox"/> CPK	
LYMPHS _____	<input type="checkbox"/> BILI (TOTAL)	
<input type="checkbox"/> PLATELET	<input type="checkbox"/> ABG-1	
<input type="checkbox"/> GLUCOSE	TIME _____ BE _____	
<input type="checkbox"/> BUN / CREAT /	HCO ₃ _____ PO ₂ _____	
<input type="checkbox"/> LYTES	pCO ₂ _____ O ₂ Sat _____	
Na _____ CL _____	ph _____	
K _____ CO ₂ _____		
<input type="checkbox"/> PT/INR		
<input type="checkbox"/> PTT		
<input type="checkbox"/> ETOH		
<input type="checkbox"/> UA		
<input type="checkbox"/> PREG. TEST		
<input type="checkbox"/> _____		
<input type="checkbox"/> _____		

TIME IN _____ HISTORY / PHYSICAL

pt was belted driver

struck on passenger side

11:45 am, went to sleep

@ 1800 @ pain @ neck & shoulder

headache

nocturnal resp

exherting / chest abd.

AMN: @

DICTATED

DIAGNOSIS

1. Low back strain

2. @ neck & shoulder strain

X-RAYS / IMAGING

CHEST

C-SPINE

PRESCRIPTIONS

_____ # _____ TAKE

_____ # _____ TAKE

_____ # _____ TAKE

AFTER CARE INSTRUCTIONS

BURN FEVER

ASTHMA HTN

CRUTCHES WOUND / SUTURE

URI IMMUNIZATION

NOSE BLEED URINE INFECTION

SPRAIN, FX HEAD INJURY

BACK PAIN CLEAR LIQUIDS

OTHER _____

ADDITIONAL INSTRUCTIONS

Rest under observath

Continue for all,

Take Vicodin $\overline{\overline{\text{TT}}}$ P.O. q 4-6 hrs.

WORK EXCUSE

NO YES # WORK DAY(S) _____

RETURN TO EMERGENCY DEPARTMENT IF

any new symptoms other than muscle pain

REFERRAL GIVEN TO: _____ PHONE _____

PATIENT SIGNATURE *Beverly Berry* MD

CALL FOR APPOINTMENT TO BE SEEN IN _____ DAY(S)

S. J. ... MD

St. Mary's Hospital, Milwaukee
2323 North Lake Drive Milwaukee, Wisconsin 53211

DATE:	07/27/2000	MRN:	109341
RM #:		NAME:	BERRY, BEVERLY R
PHYS.	KATHLEEN SCHNEIDER, MD	DOB:	05/24/1964
HOSP.SER:	EMR	PT.NUM:	105854021

EMERGENCY DEPARTMENT REPORT

c: I. Mammen, MD

CHIEF COMPLAINT: Back pain.

HISTORY OF PRESENT ILLNESS: The patient is a 36-year-old lady who was a belted driver struck on her passenger side in a motor vehicle accident approximately 11:45 a.m. this morning. The patient went to sleep at home this afternoon. When she woke at approximately 1800 hours she noticed she was having pain in the right side of her neck and shoulder area and also in the right low back. This did not resolve with ibuprofen. She has no paresthesias, weakness or numbness in her extremities. She has not had any chest or abdominal discomfort. She did not strike her head or any other portion of her body inside the vehicle. She has been ambulatory since the incident.

PAST MEDICAL HISTORY: Past medical history is negative.

MEDICATIONS: None. The patient had taken Motrin at 1830 hours.

ALLERGIES: None.

PHYSICAL EXAMINATION: VITAL SIGNS: Blood pressure 139/65, temperature 99.5°, pulse 95, respiratory rate 20. **HEENT:** The patient has no evidence by inspection or palpation of trauma to her head or face. She has symmetric pupils. There are no cranial nerve deficits. There is no blood in the nose or mouth. The tympanic membranes are clear. Dentition is stable. **NECK:** There is no tenderness over the cervical spine, but there is tenderness over the paraspinal muscles on the right extending onto the superior portion of the shoulder on the right side. Trachea is midline. There is no tenderness over the thoracic spine. **CHEST:** The breath sounds are clear and equal. There is no rib tenderness. Respirations are not labored. **BACK:** There is no flank tenderness on either side in the costovertebral angles, but there is tenderness in the right lower back just above the iliac crest. There is no tenderness directly over the spine in the lower back. **ABDOMEN:** The abdomen is soft and nontender, moderately obese. **EXTREMITIES:** Peripheral pulses are equal. There is no deformity or tenderness over the extremities. **NEUROLOGIC:** There are no motor deficits, no sensory deficits. Her gait is steady.

EMERGENCY DEPARTMENT COURSE: The patient had ice packs applied to her right neck and right low back. She was given two Vicodin orally. She was observed in the emergency

EMERGENCY DEPARTMENT REPORT

St. Mary's Hospital, Milwaukee

DATE: 07/27/2000

MRN: 109341

NAME: BERRY, BEVERLY R

EMERGENCY DEPARTMENT REPORT

department and began to feel improved. Repeat vital signs showed a pulse of 80, respiratory rate of 18, blood pressure 122/59.

DISPOSITION: The patient was discharged home accompanied by a family member.

DIAGNOSIS: Low back strain and right neck and shoulder strain from motor vehicle accident.

PLAN: The patient should rest under observation for 24 hours. Continue ibuprofen. Take Vicodin one or two every 4-6 hours for pain which is severe. If any new symptoms arise other than muscle pain, she will need to return to the emergency department for repeat examination.

KS/slr DD: 07/28/2000 DT: 07/31/2000

KATHLEEN SCHNEIDER, MD



2323 NORTH LAKE DRIVE
P.O. BOX 503
MILWAUKEE, WI 53201-0503

MEDICAL RECORD (M)

EMERGENCY SERVICES NURSING

NAME: Berry, Beverly R DOB: 5-24-64 PRIMARY MEDICAL DOCTOR: Manna ST Muck ROOM NO.: 8

TRIAGE TIME: 2305 CHIEF COMPLAINT: Back pain

SOCIAL SECURITY #: 58 1863946 TRIAGE NOTE: P MSA @ 1145. wakes up @ 1200 E back pain. @ loc. (+) STAT Solt.

DIRECT BACK TRIAGED TO X-RAY

V.S. ELEVATION SPLINT ICE DRESSING OTHER

LEGAL GUARDIAN: _____ HISTORY OBTAINED FROM: _____ TRIAGE NURSE: [Signature]

CONDITION OF PATIENT ON ARRIVAL: GOOD FAIR POOR CRITICAL EXPIRED

PATIENT TRANSPORT ON ARRIVAL: AMBULATORY WHEELCHAIR CARRIED STRETCHER AMBULANCE

C-COLLAR O₂ BOARD IV SPLINT

MEDS: 0 / motrin 1830.

Please check all those that apply:

Chills Rash Growth and Development Normal Yes No

Anorexia Pulling @ Ears R L Damage Sweats

Vomiting 24 Hrs. Apnea During Feeding Fatigue

Mucous Membrane Wet Dry Wet Diapers 24 Hrs. Headache

Recent Immunization Weight Loss Dyspnea

Recent Exposure to Illness Cough Cyanosis

Recent Injury Excessive Salivation Seizure Activity

Sunken Anterior Fontanelle

ALLERGIES: N/A

Last Antipyretic: _____ Amount: _____

Wt:	Kg	Last Tetanus			
Immunizations:	DPT	MMR	Polio	HIB	Hepatitis
TIME	BP	TEMP	PULSE	RESP.	PEAK FLOW:
2307	139/65	99.5	95	20	
0100	115/50	-	80	16	
0200	129/59	-	80	18	

Current Health History: N/A Disability: _____

Chronic Illness: _____ Premature: _____ Problem Pregnancy/Delivery: _____

SKIN COOL WARM HOT DRY DIAPH. NORMAL COLOR PALE CYANOTIC FLUSHED

ORIENTED TO: PERSON PLACE TIME

PUPILS PERIL PINPOINT DILATED

CARDIOVASCULAR RHYTHM: REG. IRREG. CLEAR WHEEZES RALES MONITOR ALARM ON O₂ PER @ _____ L PEDAL EDEMA R L RHONCHI

RESPIRATORY SOUNDS CLEAR WHEEZES RALES DIMINISHED COARSE RHONCHI

ABDOMINAL SOFT FIRM DISTENDED TENDER BOWEL SOUNDS Y N LAST BM _____

TIME	IV SITE	AMOUNT	IV FLUIDS / BLOOD	NEEDLE	RATE	AMT. GIVEN	RN

INTAKE: _____ IV: _____ ORAL: _____ TOTAL: _____

OUTPUT: _____ URINE: _____ EMESIS: _____ NG: _____ TOTAL: _____

(7:30) presents with pain to neck and back back relieved by motrin ms
medicated with aspirin, Percocet and resting
on back to neck and back on bed
Repeats in pain to neck and back on bed
instructions re: rest and pt uses
bags under standing on

ADDRESS GRAPH: _____

EHR: _____

BEVERLY R 109341
KATHLEEN M
KATHLEEN M
KATHLEEN M
KATHLEEN M
KATHLEEN M
KATHLEEN M

DO YOU SUSPECT THIS PATIENT TO BE A VICTIM OF ABUSE / NEGLECT? YES NO

DISPOSITION OF CASE: DISCHARGED ADMITTED ROOM NO. EXPIRED TRANSFER (SEE FORM)

CONDITION OF PATIENT ON DISCHARGE: NO CHANGE IMPROVED GOOD POOR EXPIRED

TRANSPORTATION ON DISCHARGE: AMBULATORY WHEELCHAIR CART AMBULANCE CARRIED

DISPOSITION OF PERSONAL PROPERTY: FAMILY WITH PATIENT SECURITY

REPORT GIVEN TO: [Signature] TIME: _____ RN: _____

**ST MARY'S MILWAUKEE
DISCHARGE INSTRUCTIONS**

Patient Instructions

Thank you for coming to Columbia/St. Mary's Hospital for Emergency Services. The examination and treatment you have received has been on an emergency basis only, and is not a substitute for complete medical care. Follow up care by your usual or primary doctor complements the treatment recieved here. If you do not have a usual doctor, or the doctor referral listed below does not accept medicare, or your insurance plan, please call St. Mary's Hospital Ozaukee Medical Staff Services at 414-243-7375, or St. Mary's Hospital Milwaukee Physician Referral Service at 414-291-1288, or Columbia Hospital, at 414-963-9355.

Doctors who are specialists will review your EKG and Xrays. You or your doctor will be called if their views on your care are different from what you were first told. The emergency department will notify you and/or your doctor of any significant lab results not completed today. Your record and diagnostic results are sent to your doctor.

If you cannot reach your doctor for follow up care, and/or your symptoms get worse, please call the emergency department at St Mary's Hosptial Milwaukee, at 414-291-1200, or St. Mary's Hospital Ozaukee 414-243-7373, or Columbia Hospital, at 414-961-3500.

LOW BACK PAIN

LOW BACK PAIN

GENERAL INFORMATION:

Low back pain is located in the small of the back. The pain may be related to sprained muscles or ligaments, to muscle spasms, or to herniation of a spinal disc. There are many possible causes of back pain, but the most common causes are gradual wear and tear, physical and emotional stress, and weak or tense muscles from lack of proper exercise. The pain can develop quickly or overnight and may be caused by unusual exertion such as moving furniture or heavy lifting. Low back pain can be severe, and sometimes you may be unable to move without pain.

INSTRUCTIONS:

1. During the first 24 hours, apply ice packs to your back for 10 to 20 minutes 3 to 4 times a day. Put the ice in a plastic bag and place a towel between the bag of ice and your skin.
2. After 24 hours, apply heat to your back with a heating pad set on low

Name: Beverly R Berry Age: 36 Gender: Female File: 20000727231526
Prepared: Fri, Jul 28 2000 at 01:35 by JB Page: 1 of 3
Printed by Ibex HealthData Systems

X Beverly R Berry

**ST MARY'S MILWAUKEE
DISCHARGE INSTRUCTIONS**

or a warm water bottle for 30 minutes every 3 to 4 hours. A gentle massage and warm showers may also be helpful.

3. Stay in bed for 1 to 2 days.
4. Begin normal activities as you can tolerate without causing pain.
5. Bend at the hips and knees; never bend from the waist only.
6. Sleep on a firm mattress or put a 1/2 to 1 inch piece of plywood between the mattress and box springs. Do not use a waterbed because it does not support your back correctly. Sleep with a pillow under your knees or sleep on your side with the knees bent.
7. Wear low-heeled shoes.
8. If you are overweight, losing weight will help prevent another attack.
9. Begin a program of back exercises to prevent future episodes of pain. Walking, swimming, and bicycling are good exercise. Avoid exercises that put stress on the back, such as rowing and jogging.

GO TO THE NEAREST HOSPITAL EMERGENCY DEPARTMENT IMMEDIATELY IF ANY OF THE FOLLOWING OCCUR:

1. You have shooting pains into your buttocks, groin, or legs.
2. You have difficulty urinating or lose control of bowel or bladder function.
3. You have numbness or weakness in your legs or feet.

VICODIN

This medicine is an analgesic. It is used to relieve pain. It contains Tylenol (acetaminophen). It should not be taken by anyone allergic to Tylenol (acetaminophen).

This medication usually causes considerable drowsiness and impairs judgement and coordination. It should never be used while or before driving a motor vehicle, operating machinery or engaging in any activity that requires alertness or muscular coordination. Alcohol and tranquilizers such as Valium and Xanax increase these side effects and should never be used while taking this medicine.

This medication may be habit forming. Long term use (for more than about 2 weeks) should be avoided if possible.

Common side effects are nausea, vomiting and constipation. Some nausea and a tendency to constipation are to be expected and, unless severe, are not a reason to stop this medicine. Increasing fluid intake not missing meals can decrease or eliminate the constipation.

This medication may cause inability to urinate in a person who has had a

**ST MARY'S MILWAUKEE
DISCHARGE INSTRUCTIONS**

problem difficulty urinating in the past or in a man known to have an enlarged prostate.

Higher than recommended dosage or long term use not closely supervised by a physician may cause severe, even fatal liver damage. This risk of liver damage is increased if alcohol is used excessively or regularly during treatment with this medication. This is another reason for not drinking alcohol while taking this medicine.

This medicine affects the metabolism of AZT (zidovudine) and coumadin. It should not be used for more than a short time (about 4 or 5 days) if the patient is on either or both of these medicines unless there is close supervision by a physician.

END OF INSTRUCTIONS

CONDITIONS OF TREATMENT

MEDICAL CONSENT

I request and authorize St. Mary's Hospitals, its agents and employees and my physicians, their associates and assistants (hereinafter "Physicians") who may attend to me during this hospitalization, emergency service or outpatient visit to provide and perform such medical, surgical, tests, procedures, medications, and other services and supplies which are considered advisable by my Physician for my health and well being. I understand that I will be under the direct care of my physicians or his/her designees while at the Hospital. I understand this may include, but is not necessarily limited to anesthesia, pathology, radiology services and other special services and tests, including tests for communicable diseases, ordered by my Physician. I understand that most physicians furnishing services to me including physicians working in the Emergency Department, Radiologists, Pathologists, Anesthesiologists and others are independent health care providers and not employees or agents of the Hospital. I further understand that the Hospital has educational affiliations with academic institutions and I agree to student and resident participation in my care under appropriate supervision. I also understand that the Hospital cannot guarantee the outcome of treatment provided. I further understand that the Hospital participates in research for the purpose of advancing medical education and/or knowledge utilizing anonymous pathological or diagnostic specimens and consent to the use of such specimens so long as confidentiality is maintained. I have been informed of the hospital's policy on confidentiality.

PERSONAL VALUABLES

I understand that the Hospital maintains a safe for the storage of money and valuables during hospitalization. The Hospital assumes no liability for any loss or damage to any money, jewelry, glasses, dentures, furs, or other articles of unusual value unless deposited in the safe. I further understand that I will be responsible for all articles kept in my room, that the Hospital assumes no control over personal valuables not deposited in the safe, and that no employee or agent of the Hospital is authorized to act contrary to this paragraph.

CONTROLLED SUBSTANCES, CONTRABAND

I understand that it is a policy of St. Mary's Hospital that any patient who either brings alcoholic beverages or drugs on to the unit, or uses alcoholic beverages or drugs, unless prescribed, is subject to discharge and legal action. I understand that St. Mary's Hospital staff will have access to all areas of the unit, including all areas of the room assigned to me. Any drugs, alcohol, related paraphernalia or contraband found anywhere in the unit will be confiscated. No weapons of any type are to be brought onto the hospital premises.

RELEASE OF INFORMATION

ST. MARYS' HOSPITALS AND ITS AFFILIATES WILL GIVE INFORMATION FROM MY MEDICAL RECORD TO ANY AND ALL PUBLIC AND PRIVATE HEALTH CARE INSURERS, REIMBURSEMENT AGENCIES, 3RD PARTY PAYORS, AND FUNDING SOURCES PROVIDING HEALTH CARE INSURANCE OR REIMBURSEMENT FOR LEGITIMATE PURPOSES OF PAYMENT OF MY BILL. I understand that such information may include diagnosis and treatment for physical and/or mental illness including alcohol and drug abuse, developmental disabilities, and/or AIDS/HIV related disorders. This authorization may be revoked in writing at any time except to the extent that releases have already been made, and will expire without express revocation whenever legal or contractual obligations or the evaluation or treatment referred to above have been performed, and in no case shall it remain in effect for more than one year. I understand that I may inspect my medical records upon reasonable notice. I may receive copies of my medical records at my own expense. I hereby authorize the Hospital to disclose information requested by manufacturers of devices which require tracking under federal law.

ASSIGNMENT OF BENEFITS

I hereby authorize, request and assign payment directly to St. Marys' Hospitals and physicians by all insurance carriers and social security administrators with whom I have coverage or from whom benefits are, or may become, payable to me, including settlements or judgements flowing from an occurrence for which I am receiving treatment. I understand that independent health care providers may not participate in all insurance programs recognized by the Hospital which may result in a separate bill. I agree to pay to the Hospital and Physician(s) all charges not paid by my insurance plan.

MEDICARE CERTIFICATION

I certify that the information given by me in applying under Title XVIII(18) of the Social Security Act is correct and authorize release of any information needed to act on this request. I request that payment of authorized benefits be made in my behalf. I assign payment for the unpaid charges of the Physician(s) for whom the Hospital is authorized to bill in connection with its services. I understand I am responsible for any health insurance deductibles and percentages of the remaining reasonable charges.

THE UNDERSIGNED HAS READ AND UNDERSTANDS THE ABOVE

Signature of Patient or

Patient's Legal Representative - if patient unable to sign

Relationship to Patient

Date

Time

Signature of Witness

[Handwritten signatures and text]
Signature of Patient or Patient's Legal Representative - if patient unable to sign: *[Signature]*
Relationship to Patient: *Niece*
Date: *7/28*
Time: *00:55*
Signature of Witness: *W Wright*

SELECTED DETAIL DATA

SVC FAC: M070 08/22/00 1138

PT NO: 105854021 BERRY , BEVERLY R MR NO: 000000109341 ACCT TYPE: O
 REG: 07/27/00 DSCH: FC: G PT: E EXP IND: ACCT BAL: 174.92

----- PAGE NO: 1

TOT CHGS T13 V PT BAL
 174.92 174.92 .00

SVC	POST	SVC CD	INS	CD-DESCRIPTION/COMMENT-REF	DATE	AMOUNT
072700	072800	45521001	54	E/R LEVEL III MODERATE		165.00
072800	072900	65575612	06	VICODIN 5/500 TAB		4.96
072800	072900	65575612	06	VICODIN 5/500 TAB		4.96

 ! (PF14) SEL PT ! (PF3) SELECT DTL
 ! (PF15) RETURN TO PT OVERVIEW ! (PF10) ACCT CMNTS PF16 D/E _____

PAQDTL01

MAKE CHECKS PAYABLE TO

INFINITY HEALTHCARE PHYSICIANS, S.C.
1251 W GLEN OAKS LANE
MEQUON, WI 53092-3378

DATE
08/17/2000

ACCOUNT NO.
8-1473081

PROFESSIONAL SERVICES
FOR BEVERLY BERRY
BY KATHLEEN SCHNEIDER M.D.
AT ST MARYS HOSPITAL - MKE

BEVERLY BERRY
5867 N 37TH ST
MILWAUKEE, WI 53209

QUESTIONS REGARDING THIS STATEMENT?
PLEASE CALL 414-290-6720 OR TOLL FREE
888-290-6720, MONDAY THROUGH FRIDAY
9 AM to 3 PM.

- CHANGE OF ADDRESS INFORMATION ON REVERSE SIDE

- MASTERCARD / VISA PAYMENTS - SEE REVERSE SIDE

DETACH HERE AND RETURN UPPER PORTION WITH PAYMENT

DATE	DESCRIPTION	AMOUNT
07/27/2000	LEVEL 4: EVALUATION (CPT:99284)	\$202.00
07/27/2000	NIGHT SVCS, 11PM-7AM (CPT:99052)	\$15.00
	PAYMENT DUE by 08/31/2000----->	\$217.00

THESE CHARGES ARE FOR EMERGENCY PHYSICIAN SERVICES ONLY. THEY ARE NOT INCLUDED IN YOUR HOSPITAL BILL.

INFINITY HEALTHCARE PHYSICIANS, S.C.
1251 W GLEN OAKS LANE
MEQUON, WI 53092-3378

8-1473081

TAX ID# 39-1861457

dgilbert

PROGRESS NOTES

mvt 7/27/00

NAME Berny, Beverly

DATE OF BIRTH

PG#



DATE - TIME HT CPT CODE WT

BMI

BP

P ALLERGIES

36

7/31/00

Pts of end of 7/27/00... 136/84... 93/64... 8/10... 10/30/00... 7/31/00... 8/14/00... 8/28/00... 9-11-00... 9-25-00... 9-27-00... 10-18-00... 10/30/00

8-14-00

Pts of end of 7/27/00... 136/84... 93/64... 8/10... 10/30/00... 7/31/00... 8/14/00... 8/28/00... 9-11-00... 9-25-00... 9-27-00... 10-18-00... 10/30/00

8-28-00

Pts of end of 7/27/00... 136/84... 93/64... 8/10... 10/30/00... 7/31/00... 8/14/00... 8/28/00... 9-11-00... 9-25-00... 9-27-00... 10-18-00... 10/30/00

9-11-00

Pts of end of 7/27/00... 136/84... 93/64... 8/10... 10/30/00... 7/31/00... 8/14/00... 8/28/00... 9-11-00... 9-25-00... 9-27-00... 10-18-00... 10/30/00

9-25-00

Pts of end of 7/27/00... 136/84... 93/64... 8/10... 10/30/00... 7/31/00... 8/14/00... 8/28/00... 9-11-00... 9-25-00... 9-27-00... 10-18-00... 10/30/00

9-27-00

Pts of end of 7/27/00... 136/84... 93/64... 8/10... 10/30/00... 7/31/00... 8/14/00... 8/28/00... 9-11-00... 9-25-00... 9-27-00... 10-18-00... 10/30/00

10-18-00

Pts of end of 7/27/00... 136/84... 93/64... 8/10... 10/30/00... 7/31/00... 8/14/00... 8/28/00... 9-11-00... 9-25-00... 9-27-00... 10-18-00... 10/30/00

10/30/00

Pts of end of 7/27/00... 136/84... 93/64... 8/10... 10/30/00... 7/31/00... 8/14/00... 8/28/00... 9-11-00... 9-25-00... 9-27-00... 10-18-00... 10/30/00

ONCE-A-DAY ARICEPT (donepezil HCl) 5-MG AND 10-MG TABLETS

For patients with mild to moderate Alzheimer's disease.

Please see accompanying brief summary.



Marketed by Eisai Inc. Teaneck, NJ 07666



Manufactured and Distributed/Marketed by U.S. Pharmaceuticals New York, NY 10017

THERAPY TO REMEMBER™

EL236896

ARICEPT™ is a trademark of Eisai Co., Ltd.

MADE IN USA

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April 1997



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

JULY 31, 2000

COMPREHENSIVE OFFICE VISIT

RE: BEVERLY BERRY

DOI: 7-27-00

Patient being seen by me at this time is a 36 year old female who was injured in an accident that occurred on 7-27-00. She states that she was driving her car and proceeding on an off-ramp at Silver Spring to Teutonia when a truck to her right tried to make a left turn and hit her vehicle in the left rear and forcing it forward and she struck some other objects as well and part of a bridge. She was significantly shaken up but fortunately was wearing her seat belt. She did not suffer immediate pain but later noted much discomfort and was seen in the Emergency Room at St. Mary's Hospital. At the hospital she complained of pain in the dorsal area and low back and she also had a headache. She was examined and discharged on Vicodin. Unfortunately her problems have persisted. I had treated her in the past and she decided to return to my clinic for evaluation and cares at this time.

CHIEF COMPLAINTS: Pain in the upper and lower back and neck and stiffness in the upper extremities. She notes the headaches are markedly diminished. She denies any neurological manifestations such as bowel or bladder problems, dizziness or visual disturbances.

PAST MEDICAL HISTORY: Significant for several MVAs in the past with injuries that resolved. She denies any chronic pain or significant illnesses.

FAMILY HISTORY: Single with 2 children.

SOCIAL HISTORY: Tobacco 1/2pk a day, alcohol occasionally.

SCHOOLING: 11th grade.

WORK HISTORY: Unemployed.

EXAMINATION reveals a well developed, well nourished, alert, oriented female in some musculoskeletal distress. Gait is within normal limits with normal heel, toe and squat. Low back discomfort is noted with these maneuvers however.

LOWER EXTREMITIES show full range of motion of the knees, ankles and feet with no problems noted.

BEVERLY BERRY

PAGE 2

7-31-00

UPPER EXTREMITIES show full range of motion of the shoulders, elbows and hands. Much discomfort is noted in the shoulders and upper back but the upper extremity joints themselves are fully functional. Grasp is excellent bilaterally. Negative Tinel, Phalen and Compression tests bilaterally.

CHEST & ABDOMEN: Unremarkable.

HEENT EVALUATION: Unremarkable, with the exception of stiffness in the dorsal area with ranging of the neck.

BACK EVALUATION: Stiffness and discomfort are noted in the dorsal area. The neck itself shows normal ranges. Spurling's test is negative. Discomfort is noted on palpation of the mid dorsal and lumbar paraspinals. Increased lordotic curvature noted. Thoracolumbar ranges are poor. Flexion at most is 75 degrees with fingers 1 ft. from the floor. Extension is 10 degrees. Side bending and rotation are diminished with low back pain. No radicular pain is noted. Much localized pain is noted in the low back.

HIP EVALUATION: Full range of motion. Negative Faber test. Straight leg and reversed straight leg both produce low back pain but no radicular pain.

NEUROLOGICALLY: Grossly intact.


IMPRESSION:

- 1). Sprain of the dorsal area.
- 2). Sprain of the lumbar area.
- 3). Myositis in the upper extremities.
- 4). Resolving post-concussion type headaches.

RECOMMENDATIONS:

- 1). Physical therapy and exercising.
- 2). Parafon Forte q.i.d..
- 3). Naprosyn 500mg b.i.d..

We'll initiate therapy at this time and I will re-evaluate her in several weeks.


E. B. Zussman, D.O.
Physiatrist

EBZ/cmz

CAPITOL REHAB CLINIC
 7220 W. CAPITOL DRIVE
 MILWAUKEE, WI. 53216
 (414) 464-4888 FAX 464-1850

DATE: 7-31-00

NAME: Beverly Berry

The above named patient was scheduled for a doctor's/therapy appointment on _____ at _____. The patient left the clinic at _____.

The patient is physically capable of the following:

PHYSICAL DEMAND LEVEL	0-33% OCCASIONAL	34-66% FREQUENT	67-100% CONTINUOUS
-MAY PUSH, PULL OR CARRY UNDER _____ LBS.	<u>50lbs</u>	<u>20lbs</u>	<u>10lbs</u>
-MAY LIFT UNDER _____ LBS.	<u>50lbs</u>	<u>20lbs</u>	<u>10lbs</u>
-MAY SQUAT OR CRAWL.	_____	<u>X</u>	_____
-MAY BEND OR TWIST AT THE WAIST.	_____	<u>X</u>	_____
-MAY CLIMB OR REACH ABOVE SHOULDER HT.	_____	_____	<u>X</u>
-MAY USE THE RIGHT/LEFT HAND.	_____	_____	<u>X</u>
-TO WORK _____ HOURS A DAY. TO WORK _____ DAYS PER WEEK.			

The patient is incapacitated from _____ through _____.

A determination of physical capabilities status will be made on 8/14/00 when the patient sees the doctor again.

(EB)

If you have any questions, please feel free to contact this office at (414) 464-4888.

E.B. Zussman, D.O.
 (EB)

BEVERLY BERRY
DOI: 7-27-00
TODAY: 8-14-00

Patient being seen by me at this time for an update evaluation of multiple injuries secondary to an accident that occurred on 7-27-00. She was first seen by me on 7-31-00 at which time I examined her and noted injuries to the dorsal and lumbar area and she also had post-concussion type headaches and generalized aches and pains. I started her on therapy and medication at that time. At present she is doing fair. She still has discomfort in the above mentioned areas but she has no new complaints and is managing with her daily activities.

EXAMINATION reveals a well developed, well nourished, alert, oriented female with residual musculoskeletal complaints. Gait is within normal limits with normal heel, toe and squat. Low back discomfort is noted with these maneuvers however.

LOWER EXTREMITIES show full range of motion of the knees, ankles and feet with no problems noted other than some stiffness.

UPPER EXTREMITIES show full range of motion of the shoulders, elbows and hands but stiffness is noted. Grasp is intact. Negative Tinel, Phalen and Compression tests.

CHEST & ABDOMEN: Unremarkable.

BACK EVALUATION: Upper and lower back are still with stiffness and discomfort noted but the neck itself shows fairly normal ranges and Spurling's test is negative. No radicular pain is noted in the neck or low back.

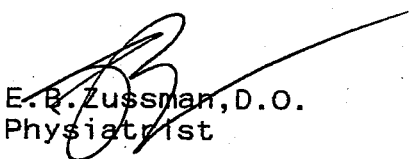
HIP EVALUATION: Full range of motion. Negative Faber test. Straight leg and reversed straight leg both produce low back pain but no radicular pain.

IMPRESSION: -Residual sequelae of injuries of 7-27-00.

RECOMMENDATIONS:

- 1). Continue with therapy.
- 2). I will re-evaluate her in 2 weeks.

EBZ/cmz


E. B. Zussman, D.O.
Physiatrist

CAPITOL REHAB CLINIC
 7220 W. CAPITOL DRIVE
 MILWAUKEE, WI. 53216
 (414) 464-4888 FAX 464-1850

DATE: 8/14/00

NAME: Beverly Berry

The above named patient was scheduled for a doctor's/therapy appointment on _____ at _____. The patient left the clinic at _____.

The patient is physically capable of the following:

PHYSICAL DEMAND LEVEL	0-33% OCCASIONAL	34-66% FREQUENT	67-100% CONTINUOUS
-MAY PUSH, PULL OR CARRY UNDER _____ LBS.	<u>50 lbs</u>	<u>20 lbs</u>	<u>10 lbs</u>
-MAY LIFT UNDER _____ LBS.	<u>50 lbs</u>	<u>20 lbs</u>	<u>10 lbs</u>
-MAY SQUAT OR CRAWL.	_____	<u>X</u>	_____
-MAY BEND OR TWIST AT THE WAIST.	_____	<u>X</u>	_____
-MAY CLIMB OR REACH ABOVE SHOULDER HT.	_____	_____	<u>X</u>
-MAY USE THE RIGHT/LEFT HAND.	_____	_____	<u>X</u>
-TO WORK _____ HOURS A DAY. TO WORK _____ DAYS PER WEEK.	_____	_____	<u>X</u>

The patient is incapacitated from _____ through _____.

A determination of physical capabilities status will be made on 8-28-00 when the patient sees the doctor again.

If you have any questions, please feel free to contact this office at (414) 464-4888.

E. B. Zussman D.O.
 (R.T.)

BEVERLY BERRY
DOI: 7-27-00
TODAY: 8-28-00

Patient being seen by me at this time for an update evaluation of multiple injuries secondary an accident that occurred on 7-27-00. She was last seen by me on 8-14-00 and continued with therapies. At present she has a new problem of pain in the right supraspinatus, which seems to have extended from the dorsal problems that she was having. Her low back is also with much stiffness and discomfort. She is managing with her daily activities but does so with discomforts. She notes a decreased ability to use her right upper extremity because of the pain in the right supraspinatus.

EXAMINATION reveals a well developed, well nourished, alert, oriented female with residual musculoskeletal complaints. Gait is within normal limits with normal heel, toe and squat. Low back discomfort is noted with these maneuvers however.

LOWER EXTREMITIES show full range of motion of the knees, ankles and feet with no problems noted.

UPPER EXTREMITIES show full range of motion of the left shoulder and both elbows and hands with no problems noted and grasp is excellent. Right shoulder ranges are decreased with much pain in supraspinatus, palpation of which reveals tenderness, ropiness and positive Jump signs, indicating underlying muscle spasming. The upper extremity joints themselves are otherwise fully functional.

CHEST & ABDOMEN: Unremarkable.

BACK EVALUATION: The neck itself shows full range of motion but there is discomfort into the right shoulder. Spurling's test is negative. The mid and low back are with much discomfort on deep palpation. Thoracolumbar ranges are fair. Flexion is 80 degrees and extension is 10 degrees. Side bending and rotation are with low back pain but no radicular component.

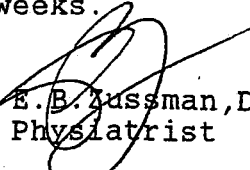
HIP EVALUATION: Full range of motion. Negative Faber test. Straight leg and reversed straight leg are both with low back discomfort but no radicular pain.

The remainder of the evaluation is unremarkable.

IMPRESSION: -Residual sequelae of injuries of 7-27-00.

RECOMMENDATIONS:

- 1). Continue with therapies + start treatment to the right supraspinatus. I may consider injecting the right supraspinatus in the near future.
- 2). I will re-evaluate her in several weeks.


E. B. Zussman, D.O.
Physiatrist

EBZ/cmz

CAPITOL REHAB CLINIC
7220 W. CAPITOL DRIVE
MILWAUKEE, WI. 53216
(414) 464-4888 FAX 464-1850

DATE: 8/28/00


NAME: BARRY BERRY

The above named patient was scheduled for a doctor's/therapy appointment on _____ at _____. The patient left the clinic at _____.

The patient is physically capable of the following:

PHYSICAL DEMAND LEVEL	0-33% OCCASIONAL	34-66% FREQUENT	67-100% CONTINUOUS
-MAY PUSH, PULL OR CARRY UNDER _____ LBS.	<u>50#</u>	<u>20#</u>	<u>10#</u>
-MAY LIFT UNDER _____ LBS.	<u>50#</u>	<u>20#</u>	<u>10#</u>
-MAY SQUAT OR CRAWL.	_____	<u>X</u>	_____
-MAY BEND OR TWIST AT THE WAIST.	_____	<u>X</u>	_____
-MAY CLIMB OR REACH ABOVE SHOULDER HT.	_____	_____	<u>X</u>
-MAY USE THE RIGHT/LEFT HAND.	_____	_____	<u>X</u>
-TO WORK <u>8</u> HOURS A DAY. TO WORK <u>5</u> DAYS PER WEEK.	_____	_____	_____

The patient is incapacitated from _____ through _____.

A determination of physical capabilities status will be made on 9-11-02 when the patient sees the doctor again. 

If you have any questions, please feel free to contact this office at (414) 464-4888.

E. B. [Signature] D.O.M.

BEVERLY BERRY
DOI: 7-27-00
TODAY: 9-11-00

Patient being seen by me at this time for an update evaluation of multiple injuries secondary to an accident that occurred on 7-27-00. She was last seen by me on 8-28-00 and continued with therapies. At present these problems seem to be diminishing and the additional therapies seem to be helping greatly. I had considered injections but it doesn't seem necessary at this time. She's managing with her daily activities and is working with no significant problems, only minimal discomforts. She notes her headaches have markedly diminished.

EXAMINATION reveals a well developed, well nourished, alert, oriented female with some residual discomforts.

LOWER EXTREMITIES: Gait is within normal limits with normal heel, toe and squat. Range of motion of the knees, ankles and feet are full with no problems noted.

UPPER EXTREMITIES show full range of motion of the shoulders, elbows and hands. Some discomfort is still noted in the shoulder but it's improving.

BACK EVALUATION: Upper and lower back are still with some stiffness but improvement is noted. No problems are noted in the neck and Spurling's test is negative.

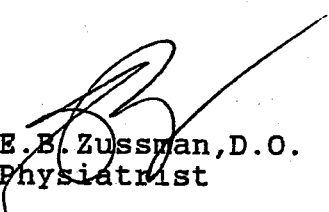
CHEST & ABDOMEN: Unremarkable.

IMPRESSION: -Improving sequelae of injuries of 7-27-00.

RECOMMENDATIONS:

- 1). Decrease therapy to once weekly.
- 2). I will re-evaluate her in several weeks.

EBZ/cmz


E. B. Zussman, D.O.
Physiatrist

CAPITOL REHAB CLINIC
7220 W. CAPITOL DRIVE
MILWAUKEE, WI. 53216
(414) 464-4888 FAX 464-1850

DATE: 9/11/00

NAME: Beverly Berry

The above named patient was scheduled for a doctor's/therapy appointment on _____ at _____. The patient left the clinic at _____.

The patient is physically capable of the following:

PHYSICAL DEMAND LEVEL	0-33% OCCASIONAL	34-66% FREQUENT	67-100% CONTINUOUS
-MAY PUSH, PULL OR CARRY UNDER _____ LBS.	<u>50[#]</u>	<u>20[#]</u>	<u>10[#]</u>
-MAY LIFT UNDER _____ LBS.	<u>50[#]</u>	<u>20[#]</u>	<u>10[#]</u>
-MAY SQUAT OR CRAWL.	_____	<u>X</u>	_____
-MAY BEND OR TWIST AT THE WAIST.	_____	<u>Y</u>	_____
-MAY CLIMB OR REACH ABOVE SHOULDER HT.	_____	_____	<u>X</u>
-MAY USE THE RIGHT/LEFT HAND.	_____	_____	<u>X</u>
-TO WORK <u>8</u> HOURS A DAY. TO WORK <u>5</u> DAYS PER WEEK.			

The patient is incapacitated from - through -.

A determination of physical capabilities status will be made on 9/25/00 when the patient sees the doctor again. (E)

If you have any questions, please feel free to contact this office at (414) 464-4888.

E. B. Zussman D.O.
(R.I.)

BEVERLY BERRY
DOI: 7-27-00
TODAY: 9-27-00

Patient being seen by me at this time for an update evaluation of injuries secondary to an accident that occurred on 7-27-00. She was last seen by me on 9-11-00 and continued with therapy once weekly. At present she is much improved. She has occasional stiffness but aside from that has no complaints. She is managing with her daily activities and now works and does so without any significant problems, other than the occasional stiffness.

EXAMINATION reveals a well developed, well nourished, alert, oriented black female in no distress.

GAIT is within normal limits with normal heel, toe squat.

LOWER EXTREMITIES show full range of motion of the knees, ankles and feet with no problems noted and strengths are excellent.

UPPER EXTREMITIES show full range of motion of the shoulders, elbows and hands with no problems noted and strengths are excellent.

BACK EVALUATION: Upper back and neck shows normal range of motion with only minimal stiffness noted. Low back shows full range of motion with no problems noted.

HIP EVALUATION: Full range of motion with no problems noted.

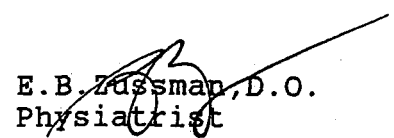
HEENT EVALUATION: Unremarkable.

CHEST & ABDOMEN: Unremarkable.

IMPRESSION: -Improved sequelae of injuries of 7-27-00 with only minimal residual stiffness.

RECOMMENDATIONS:

- 1). Discontinue therapy at this time.
- 2). Continue with home cares and exercises.
- 3). I will re-evaluate her in several weeks. If she's doing well at that time I may consider discharging her.
- 4). If she has any problems in the interim she was instructed to contact me.


E. B. Zussman, D.O.
Physiatrist

EBZ/cmz

CAPITOL REHAB CLINIC
7220 W. CAPITOL DRIVE
MILWAUKEE, WI. 53216
(414) 464-4888 FAX(414)464-1850

DATE ISSUED: 9/27/10

Please excuse Beverly Berry from work/school from
_____ through _____.

Please excuse _____ from work/school on
_____ as he/she had a doctor's/therapy appointment
scheduled at _____. The patient left the clinic at _____.

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 9/27/10 WITH NO RESTRICTIONS.
3. 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 SQUATTING OR CRAWLING.
- 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.
- 10 MINUTE REST BREAK FOR EVERY HOUR WORKED.
- TO WORK _____ HOURS A DAY.
- NO PARTICIPATION IN GYM CLASS.

A determination of work/school status will be made on 10-18-10 when the patient sees the doctor again.

If you have any questions, please feel free to contact this office at
(414) 464-4888.

E. B. Zussman D.O.
(Signature)



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

OCTOBER 30, 2000

DISCHARGE SUMMARY
BEVERLY BERRY
DOI: 7/27/00

Patient being seen at this time for final evaluation of injuries sustained in an accident on 7/27/00. She was first seen by me on 7/31/00 at which time I noted she suffered injuries to the dorsal and lumbar areas. She also had post concussion type headaches and sprains of the extremities, especially right shoulder. She was started on therapies and medications. She has shown slow steady improvement since that time and we were eventually able to decrease therapies and stop them entirely at the end of September. I did have her continue home cares and medications. She has continued to show slow steady improvement since that time. At present, she is relatively asymptomatic. Patient is doing all of her daily activities with no complaints and feels she is ready to be discharged.

EXAMINATION reveals a well developed, well nourished, alert, oriented black female in no distress.

GAIT is within normal limits with normal heel, toe and squat. No problems are noted in the knees, ankles or feet.

UPPER EXTREMITIES show full range of motion of the shoulders, elbows and hands with no problems noted and grasp is excellent bilaterally. Negative Speedy, Yerguson and Appley tests.

BACK EVALUATION shows full ranges of motion of the upper and lower back with no problems noted.

HIP EVALUATION shows full ranges of motion. Negative Faber test.


CHEST & ABDOMEN: Unremarkable.

NEUROLOGICAL EVALUATION: Grossly intact. Deep tendon reflexes are full and functional.

HEENT evaluation is unremarkable.

IMPRESSION: Improved sequelaes of injuries of 7/27/00.

RECOMMENDATIONS: Patient is being discharged from my service at this time in improved condition.


E. B. Zussman, D.O.
Physiatrist

EBZ/dff

CAPITOL REHAB CLINIC
7220 W. CAPITOL DRIVE
MILWAUKEE, WI. 53216
(414) 464-4888 FAX(414)464-1850

DATE ISSUED: 10/30/10

Please excuse Beverly Berry from work/school from
_____ through _____.

Please excuse _____ from work/school on
_____ as he/she had a doctor's/therapy appointment
scheduled at _____. The patient left the clinic at _____.

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 10-30-10 WITH NO RESTRICTIONS.
3. 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 SQUATTING OR CRAWLING.
- 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.
- 10 MINUTE REST BREAK FOR EVERY HOUR WORKED.
- TO WORK _____ HOURS A DAY.
- NO PARTICIPATION IN GYM CLASS.

A determination of work/school status will be made on _____
when the patient sees the doctor again.

~~10/30/10~~ Discharged
RE

If you have any questions, please feel free to contact this office at
(414) 464-4888.

E. B. Zussman D.O.

(R.D.)

OTHER THERAPY INTAKE FORM

MVA W/C DOI 7-27-00

PT. NAME: Beverly Berry PHYSICIAN Dr Zussman

Hx. of injury: She states she was traveling in the (L) lane when a truck in the (R) lane turned into the (L) lane. She was in & struck the rear passenger side of her vehicle.

DRIVER PASSENGER: Front Rear SEAT BELT: On Off

Other Rx r/t injury: She reports going to St Man's ER the same day where she was examined, given ice packs, meds, & was released. No X-rays were taken.

Medications: Vicodin, Ibuprofen

PAIN: (1-10) 7-8 Sharp Dull Achy Tight Sore Throbbing
Pulling Burning Stiff Other
Numbness/Tingling Denies Blurred Vision/Dizziness Denies H/A "Mild"

Lacerations/Bruises Reported/ Observed: Denies
Edema: Reported/Observed: Denies

ADL STATUS: Child Care Personal Hygiene I Household tasks I
Overhead Dress Assist L.E. Dress I Other

PAST MEDICAL HX. Operations: Denies ^{error} "Tubes tied"
Illnesses: Denies
Pregnancy: Denies

INCREASES PAIN: Neck Motion Reaching Walking Sitting Standing
Back Motions flex, ext Other

DECREASES PAIN: Medication Lying Down Heat Ice Other Nothing

THER EX. sub stretch, shld rounding - good tol.

WORK STATUS: Return to Work: Off of Work:
Light Duty/ Other: May do med work
Occupation: unemployed George Wehbs as of 9/20

M. Spahn PTA ^{error} 7-31-00
THERAPIST SIGNATURE DATE

PT. NAME:

Beverly Berry

DOI: 7-27-00

	7-31-00	8-3-00	8-7-00	8-10-00	8-14-00	8-18-00	8-21-00	8-25-00	8-28-00	8-31-00	9-5-00	9-11-00
THE EX: TRUNK												
BACK												
SEATED LOW BACK (SLB)	X	X	X	X	X	X	X	X	X	X	X	X
WILLIAMS PELVIC TILT (PT)		X	X	X	X	X	X	X	X	X	X	X
SINGLE KNEE TO CHEST (SKTC)		X	X	X	X	X	X	X	X	X	X	X
DOUBLE KNEE TO CHEST (DKTC)		X	X	X	X	X	X	X	X	X	X	X
TRUNK ROTATION		X	X	X	X	X	X	X	X	X	X	X
HAMSTRING STRETCH			X	X	X	X	X	X	X	X	X	X
GLUTEAL SETS				X	X	X	X	X	X	X	X	X
MCKENZIES PRONE ON ELBOWS(POE)					X	X	X	X	X	X	X	X
ALTERNATE ARM/LEG										X	X	X
STATIONARY BIKE												
TREADMILL												
BACK VIDEO TAPES												
REHABILITATOR BACK EXTENSION												
ABDOMINAL CURLS												
CERVICAL												
NECK ROM												
CHIN TUCKS												
CAUDAL GLIDES								X				
UPPER TRAP STRETCH												
LEVATOR STRETCH												
NECK STRETCH												
ACTIVE RESISTIVE ROM												

Unable to stay - antherapist.

PT. NAME:

Beverly Berry

DOI: 7-27-00

THER EX: TRUNK

7-31-00	8-3-00	8-7-00	8-10-00	8-14-00	8-18-00	8-21-00	8-25-00	8-28-00	8-31-00	9-5-00	9-20-00
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RIB CAGE

HOOKED EXTREMITY FLEXION

TRUNK ROTATION

CHEST EXPANSION

WAND FLEXION

WAND ABDUCTION

CORNER STRETCH

MID-BACK SCAPULAR

SHOULDER ROUNDING

TRUNK ROTATION

HORIZONTAL ADDUCTION

CAT AND CAMEL

MID-BACK STRETCH

MID-BACK ROTATION

CHEST EXPANSION W/THERABAND

RHOMBOID STRENGTHENING

REHABILITATOR

X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X
			X	X	X	X	X	X	X	X	X
			X	X	X	X	X	X	X	X	X

PT. NAME: Beverly Berry

DOI: 72700

THER EX: UE

R--RIGHT L--LEFT B--BILAT.

8-31-00
9-5-02
9-20-02

(R) (L) (B)

SHOULDER

PASSIVE HORIZONTAL STRETCH

X X X

WAND ROM FLEX ABD

IR / ER

FINGER LADDER FLEX

ABD

SHOULDER WHEEL FLEX ABD

TRICEP STRETCH

SHOULDER LADDER

PNF D1 THERABAND

D2 THERABAND

THERABAND PLAINS FLEX/EXT

ABD/ADD

WEIGHTED PLAINS FLEX/EXT

ABD/ADD

SIDELYING IR/ER

ELBOW

WAND ROM FLEX/EXT

FOREARM PRONATION/SUPINATION

EXTENSOR STRETCH

PADDED GRIPPER

THERABAND FLEX/EXT

PRON/SUP

BICEP CURLS WEIGHTED

WEIGHTED PRON/SUP

TRICEP STRENGTHENING

PT. NAME:

B. Berry

DOI:

7-27-00

	<i>20 Feb</i>																		
THE EX: TRUNK																			
BACK																			
SEATED LOW BACK (SLB)	X																		
WILLIAMS PELVIC TILT (PT)	X																		
SINGLE KNEE TO CHEST (SKTC)	X																		
DOUBLE KNEE TO CHEST (DKTC)	X																		
TRUNK ROTATION	X																		
HAMSTRING STRETCH	X																		
GLUTEAL SETS	X																		
MCKENZIES PRONE ON ELBOWS(POE)	X																		
ALTERNATE ARM/LEG	X																		
STATIONARY BIKE																			
TREADMILL																			
BACK VIDEO TAPES																			
REHABILITATOR BACK EXTENSION																			
ABDOMINAL CURLS																			
CERVICAL																			
NECK ROM																			
CHIN TUCKS																			
CAUDAL GLIDES																			
UPPER TRAP STRETCH																			
LEVATOR STRETCH																			
NECK STRETCH																			
ACTIVE RESISTIVE ROM																			

-CAPITOL REHAB CLINIC-
PHYSICAL & OCCUPATIONAL THERAPY RECORD

NAME: B. Berry

Pain Codes: ↑:Increased ↓:Decreased ∅:None NoΔ:No Change S:Sharp
H/A:Headache S/A:Soreness/Stiffness/Aching N:Numbness T:Tingling

		(As Per Pt)	
date	Area(s) being Rx'd	Pain Code	
9/20/0	Suprofen umlas driat	/	

COMMENTS:

RX Received This Date: TP @ Suprofen
umlas, HPS - 10ml, 20ml
R. Shole n
Modality Tolerance: can

TherEx Added/Tolerance:
Completed as instructed
[Signature]

		(As Per Pt)	
date	Area(s) Being Rx'd	Pain Code	
		/	

COMMENTS:

RX Received This Date: _____
Modality Tolerance: _____
TherEx Added/Tolerance: _____

		(As Per Pt)	
date	Area(s) Being Rx'd	Pain Code	
		/	

COMMENTS:

RX Received This Date: _____
Modality Tolerance: _____
TherEx Added/Tolerance: _____

		(As Per Pt)	
date	Area(s) Being Rx'd	Pain Code	
		/	

COMMENTS:

RX Received This Date: _____
Modality Tolerance: _____
TherEx Added/Tolerance: _____

-Capitol Rehab Clinic-
Physical & Occupational Therapy Treatment Plan

Name: Beverly Berry Date: 7-31-00

Modalities: ES&HP lumbar, HP dorsal, ther ex

Short Term Goals

Goals Set | Goals Met

- | | | | |
|----------|--|----------------|--|
| <u>X</u> | | <u>X</u> | Pt. will report less discomfort/pain than on initial visit. |
| <u>X</u> | | <u>X</u> | Pt. will demonstrate increased AROM throughout injured body parts with ease. |
| <u>X</u> | | <u>X</u> | Pt. will report ability to complete own ADL's and light/moderate household tasks independently. |
| _____ | | _____ | Pt. will comply with treatment regimen at home daily. |
| <u>X</u> | | <u>X</u> | Pt. will comply with home exercising and demonstrate correctly in in this clinic. |
| _____ | | _____ | Pt. will report little to no difficulties with job when on light duty. |
| _____ | | _____ | Pt. will report little to no difficulties with job when on full/unrestricted duties. |
| <u>X</u> | | <u>ongoing</u> | Pt. will demonstrate understanding and knowledge of proper body mechanics with all activities. |
| _____ | | _____ | Pt. will demonstrate good understanding and use of all splints, braces or adaptive equipment issued. |

Long Term Goals

- | | | | |
|----------|--|----------------|---|
| <u>X</u> | | <u>ongoing</u> | Pt. will obtain knowledge useful in decreasing/eliminating pain and proper body mechanics and exercises to aid in physical status to increase functional independence as prior to injury. |
|----------|--|----------------|---|

E.B. Zussman, D.O. Physiatrist

Jordan D. Mandel, M.D. Physiatrist

M. Spath PTA

Therapist's Signature

NAME: Beverly Berry

DOI: 7-8-10

Injury as a result of: 7-31-

Frequency of Treatment:

3x1wk X
2x1wk _____
1x1wk X
Daily _____

W/C _____
MVA X
FALL _____
OTHER _____

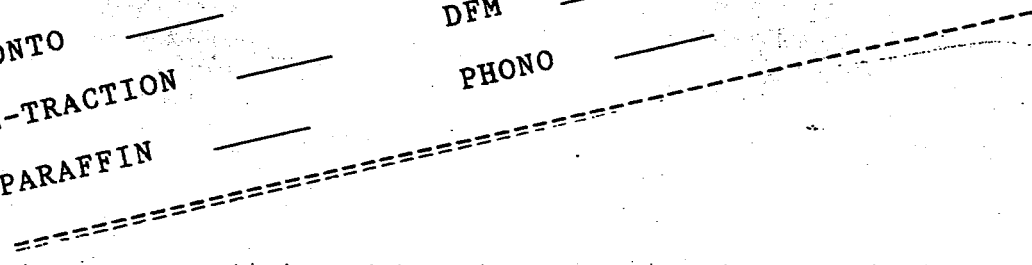
8-10
8-28
9-1
9

-TYPE OF TREATMENT-

ES & HP X
COLD PACK _____
WHIRLPOOL _____
ULTRASOUND _____
IONTO _____
C-TRACTION _____
PARAFFIN _____

OT EVAL _____
TENS UNIT _____
TPI 1st _____
S & S _____
ICE PROBE X
DFM _____
PHONO _____

DIATHERMY
T-TRACTION
FLUIDO
WHP EVAL
WHP _____



MAKE CHECKS PAYABLE TO:

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

Account #	004356-00

STATEMENT

RETURN UPPER PORTION OF
 STATEMENT WITH PAYMENT

NOTE: Charges and payments not appearing on this statement will appear on next month's statement

~~BEVERLY BERRY~~
 5867 N. 37TH ST.
 MILWAUKEE, WI 53209

SHOW AMOUNT
 PAID HERE \$

PATIENT'S NAME		
BEVERLY BERRY		
CLOSING DATE	PAGE NO.	NEW BALANCE
11/15/00	01	\$ 2475.00

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

DATE	EXPLANATION OF ACTIVITY	PROC. CODE	DIAG. CODE	CHARGES & DEBITS	PAYMENTS & CREDITS
07/31/00	EBZ ELECTRICAL STIMULATION			40.00	
07/31/00	EBZ HOT PACKS			40.00	
07/31/00	EBZ THERAPEUTIC EXERCISE 15 MIN			60.00	
07/31/00	EBZ COMPREHENSIVE OFFICE VISIT			200.00	
08/03/00	EBZ ELECTRICAL STIMULATION			40.00	
08/03/00	EBZ HOT PACKS			40.00	
08/03/00	EBZ THERAPEUTIC EXERCISE 15 MIN			60.00	
08/07/00	EBZ ELECTRICAL STIMULATION			40.00	
08/07/00	EBZ HOT PACKS			40.00	
08/07/00	EBZ THERAPEUTIC EXERCISE 15 MIN			60.00	
08/10/00	EBZ ELECTRICAL STIMULATION			40.00	
08/10/00	EBZ HOT PACKS			40.00	
08/10/00	EBZ THERAPEUTIC EXERCISE 15 MIN			60.00	
08/14/00	EBZ ELECTRICAL STIMULATION			40.00	
08/14/00	EBZ HOT PACKS			40.00	
08/14/00	EBZ THERAPEUTIC EXERCISE 15 MIN			60.00	
08/14/00	EBZ EST. PT. INTERMEDIATE OFFIC			85.00	
08/18/00	EBZ ELECTRICAL STIMULATION			40.00	
08/18/00	EBZ HOT PACKS			40.00	
08/18/00	EBZ THERAPEUTIC EXERCISE 15 MIN			60.00	

STATEMENT CLOSING DATE	DATE OF LAST PAYMENT	AMT. OF LAST PAYMENT	OVER 30 DAYS	OVER 60 DAYS	OVER 90 DAYS	OVER 120 DAYS	CHARGES & DEBITS	PAYMENTS & CREDITS
11/15/00	**/**/**	0.00	235.00	1130.00	985.00	0.00	2475.00	0.00

CAPITOL REHABILITATION CLINIC, 7220 WEST CAPITOL DRIVE, MILWAUKEE, WI 53216, (414) 464-4888

PLEASE PAY THIS AMOUNT 

2475.00

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

Account # 004356-00

STATEMENT
 RETURN UPPER PORTION OF
 STATEMENT WITH PAYMENT

NOTE: Charges and payments not appearing on this statement will appear on next month's statement.

BEVERLY BERRY
 5867 N. 37TH ST.
 MILWAUKEE, WI 53209

SHOW AMOUNT PAID HERE \$


PATIENT'S NAME
 BEVERLY BERRY
 CLOSING DATE 11/15/00 PAGE NO. 02 NEW BALANCE \$ 2475.00

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

DATE		EXPLANATION OF ACTIVITY	PROC. CODE	DIAG. CODE	CHARGES & DEBITS	PAYMENTS & CREDITS
08/21/00	EBZ	ELECTRICAL STIMULATION			40.00	
08/21/00	EBZ	HOT PACKS			40.00	
08/21/00	EBZ	THERAPEUTIC EXERCISE 15 MIN			60.00	
08/25/00	EBZ	ELECTRICAL STIMULATION			40.00	
08/25/00	EBZ	HOT PACKS			40.00	
08/25/00	EBZ	THERAPEUTIC EXERCISE 15 MIN			60.00	
08/28/00	EBZ	HOT PACKS			40.00	
08/28/00	EBZ	ICE MASSAGE			50.00	
08/28/00	EBZ	THERAPEUTIC EXERCISE 15 MIN			60.00	
08/28/00	EBZ	EST. PT. INTERMEDIATE OFFIC			85.00	
08/31/00	EBZ	HOT PACKS			40.00	
08/31/00	EBZ	ICE MASSAGE			50.00	
08/31/00	EBZ	THERAPEUTIC EXERCISE 15 MIN			60.00	
09/05/00	EBZ	HOT PACKS			40.00	
09/05/00	EBZ	ICE MASSAGE			50.00	
09/05/00	EBZ	THERAPEUTIC EXERCISE 15 MIN			60.00	
09/11/00	EBZ	HOT PACKS			40.00	
09/11/00	EBZ	ICE MASSAGE			50.00	
09/11/00	EBZ	EST. PT. INTERMEDIATE OFFIC			85.00	
09/20/00	EBZ	HOT PACKS			40.00	

STATEMENT CLOSING DATE	DATE OF LAST PAYMENT	AMT. OF LAST PAYMENT	OVER 30 DAYS	OVER 60 DAYS	OVER 90 DAYS	OVER 120 DAYS	CHARGES & DEBITS	PAYMENTS & CREDITS
11/15/00	**/**/**	0.00	235.00	1130.00	985.00	0.00	2475.00	0.00

CAPITOL REHABILITATION CLINIC, 7220 WEST CAPITOL DRIVE, MILWAUKEE, WI 53216, (414) 464-4888

PLEASE PAY THIS AMOUNT  2475.00

MAKE CHECKS PAYABLE TO:
 CAPITOL REHABILITATION CLINIC
 7220 WEST CAPITOL DRIVE
 MILWAUKEE, WISCONSIN 53216
 (414) 464-4888
 FAX (414) 464-1850

Account #	004356-00

STATEMENT
 RETURN UPPER PORTION OF
 STATEMENT WITH PAYMENT

NOTE: Charges and payments not appearing on this statement will appear on next month's statement.

BEVERLY BERRY
 5867 N. 37TH ST.
 MILWAUKEE, WI 53209

SHOW AMOUNT PAID HERE \$

PATIENT'S NAME BEVERLY BERRY		
CLOSING DATE 11/15/00	PAGE NO. 03	NEW BALANCE \$ 2475.00

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

DATE		EXPLANATION OF ACTIVITY	PROC. CODE	DIAG. CODE	CHARGES & DEBITS	PAYMENTS & CREDITS
09/20/00	EBZ	ICE MASSAGE			50.00	
09/20/00	EBZ	THERAPEUTIC EXERCISE 15 MIN			60.00	
09/27/00	EBZ	EST. PT. INTERMEDIATE OFFIC			85.00	
10/30/00	EBZ	EST. PT. EXTENDED OFFICE VI			125.00	

STATEMENT CLOSING DATE	DATE OF LAST PAYMENT	AMT. OF LAST PAYMENT	OVER 30 DAYS	OVER 60 DAYS	OVER 90 DAYS	OVER 120 DAYS	CHARGES & DEBITS	PAYMENTS & CREDITS
11/15/00	**/**/**	0.00	235.00	1130.00	985.00	0.00	2475.00	0.00

CAPITOL REHABILITATION CLINIC, 7220 WEST CAPITOL DRIVE, MILWAUKEE, WI 53216, (414) 464-4888

PLEASE PAY THIS AMOUNT 

2475.00