

Fill in this information to identify the case:

Debtor 1 Hometown Buffet, Inc.

Debtor 2 _____
(Spouse, if filing)

United States Bankruptcy Court for the: Northern District of Texas, Dallas Division

Case number 21-30724-11

E-Filed on 06/08/2021
Claim # 173

Official Form 410

Proof of Claim

04/19

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Do not use this form to make a request for payment of an administrative expense. Make such a request according to 11 U.S.C. § 503.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. **Do not send original documents;** they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed. That date is on the notice of bankruptcy (Form 309) that you received.

Part 1: Identify the Claim

1. **Who is the current creditor?** Liliana Mares Bautista
Name of the current creditor (the person or entity to be paid for this claim)

Other names the creditor used with the debtor _____

2. **Has this claim been acquired from someone else?** No
 Yes. From whom? _____

	Where should notices to the creditor be sent?	Where should payments to the creditor be sent? (if different)
3. Where should notices and payments to the creditor be sent? Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)	<p><u>Yasmin Azimi, Esq.</u> Name</p> <p><u>1401 Dove Street, Suite 450</u> Number Street</p> <p><u>Newport Beach CA 92660</u> City State ZIP Code</p> <p>Contact phone <u>(949) 222-2272</u></p> <p>Contact email <u>azimilaw@outlook.com</u></p> <p>Uniform claim identifier for electronic payments in chapter 13 (if you use one): _____</p>	<p>_____ Name</p> <p>_____ Number Street</p> <p>_____ City State ZIP Code</p> <p>Contact phone _____</p> <p>Contact email _____</p>

4. **Does this claim amend one already filed?** No
 Yes. Claim number on court claims registry (if known) _____ Filed on _____
MM / DD / YYYY

5. **Do you know if anyone else has filed a proof of claim for this claim?** No
 Yes. Who made the earlier filing? _____

Part 2: Give Information About the Claim as of the Date the Case Was Filed

6. Do you have any number you use to identify the debtor? No
 Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: _____

7. How much is the claim? \$ 16,995.00. Does this amount include interest or other charges?
 No
 Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. What is the basis of the claim? Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card. Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c). Limit disclosing information that is entitled to privacy, such as health care information.
Personal Injury/Wrongful Death

9. Is all or part of the claim secured? No
 Yes. The claim is secured by a lien on property.
Nature of property:
 Real estate. If the claim is secured by the debtor's principal residence, file a *Mortgage Proof of Claim Attachment* (Official Form 410-A) with this *Proof of Claim*.
 Motor vehicle
 Other. Describe: _____
Basis for perfection: _____
Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)
Value of property: \$ _____
Amount of the claim that is secured: \$ _____
Amount of the claim that is unsecured: \$ _____ (The sum of the secured and unsecured amounts should match the amount in line 7.)
Amount necessary to cure any default as of the date of the petition: \$ _____
Annual Interest Rate (when case was filed) _____ %
 Fixed
 Variable

10. Is this claim based on a lease? No
 Yes. Amount necessary to cure any default as of the date of the petition. \$ 0.00

11. Is this claim subject to a right of setoff? No
 Yes. Identify the property: _____

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

No

Yes. Check one:

Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).

Up to \$3,025* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).

Wages, salaries, or commissions (up to \$13,650*) earned within 180 days before the bankruptcy petition is filed or the debtor's business ends, whichever is earlier. 11 U.S.C. § 507(a)(4).

Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).

Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).

Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.

Amount entitled to priority

\$ 0.00

\$ 0.00

\$ 0.00

\$ 0.00

\$ 0.00

\$ 0.00

* Amounts are subject to adjustment on 4/01/22 and every 3 years after that for cases begun on or after the date of adjustment.

Part 3: Sign Below

The person completing this proof of claim must sign and date it. FRBP 9011(b).

If you file this claim electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what a signature is.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Check the appropriate box:

I am the creditor.

I am the creditor's attorney or authorized agent.

I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.

I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 06/08/2021
MM / DD / YYYY

Yasmin Azimi

Signature

Print the name of the person who is completing and signing this claim:

Name Yasmin Azimi
First name Middle name Last name

Title Attorney

Company Azimi Law Firm
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address _____
Number Street

City State ZIP Code

Contact phone _____ Email _____

Attachment 1 - Liliana Mares Bautista.pdf

Description -

AZIMI LAW FIRM
1401 Dove Street, Suite 450
Newport Beach, CA 92660
Telephone: (949) 222-2272
Facsimile: (949) 222-1213

March 19, 2020

Hometown Buffet Business Office
Attn: Register Agent (Lo Saechao)
455 Capital Mall Complex Ste #217
Sacramento, CA 95814

Sent Via Certified Mail

7018 3090 0001 2598 5000

7018 3090 0001 2598 5000

Re: Our Client : Liliana Mares Bautista
Date of Loss : July 30, 2019

To Whom It May Concern,

This letter shall serve as a presentation of the damages sustained by my client and a demand for an equitable settlement therefrom, in connection with, and arising from the above-captioned case. Moreover, copies of the pertinent medical reports and other relevant materials, as needed, are incorporated herein.

FACTS REGARDING LIABILITY

Under Civil Code, section 1714(a), "Everyone is responsible not only for the result of their willful acts but also for an injury occasioned to another by want of ordinary care of skill in the management of his/her property or person, except so far as the latter has, willfully or by want of ordinary care brought the injury upon themselves."

No issue of liability surfaces. On July 30, 2019 approximately around 5:45 p.m. my client Ms. Liliana Mares Bautista was visiting your restaurant (Hometown Buffet) located at 127 West Valley Blvd., in the city of Rialto. As my client was walking in the buffet section she slipped on a greasy floor, forcing her to grab the plate stand and put all her weight to the left side of her body to maintain her balance and not fall, causing her various injuries. Because of the intensity of this incident, my client had to seek medical attention and treatment.

I am whole heartedly confident that you will agree with me that liability rests complete with your restaurant. I am confident that you will concur that your restaurant was negligent in one or more of the following ways: 1) By failing to maintain safe and proper condition on your property and premises. 2) By negligently maintaining the premises by allowing the unattended greasy floor to remain where any patron, including my client could easily slipped and fall. 3) Your restaurant negligently failed to inspect the premises for dangerous conditions such as the presence of a greasy floor when your restaurant knew or in the exercise of reasonable care,

should have known that such dangerous conditions can greatly increase the risk that customers, including my client would slip and fall. 4) Your restaurant failed to warn my client of the aforementioned dangerous condition when it knew, or in the exercise or reasonable care should have known it existed. Rather than continue with a laundry list of theories of liability, I will defer to your prudent judgment and ability to realize that liability is reasonably certain. Therefore, I will proceed directly to damages.

INJURIES AND MEDICAL TREATMENT

Attached to this letter are the medical records, reports and bills. I will not itemize the medical billings that have already been done by the health care provider.

SETTLEMENT DEMAND

The previously referred to attachments to this letter provide you with sufficient documentation to reasonably evaluate this claim. It is evident that your restaurant is civilly culpable for my client's damages, of whatever nature, and that the insurance coverage provided to you must be used to compensate my client's losses. The past money expenditures in my client's claim are itemized as follows:

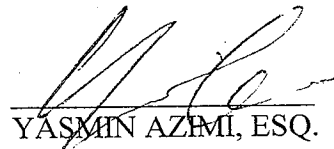
Family Chiropractic Center	\$3,491.00
Simon Medical Imaging	<u>\$ 744.00</u>
Total Damages:	\$4,235.00

I am taking this opportunity to present my client's settlement demand for \$16,995.00 in an effort to settle this claim without having compounded more expenses. The litigation costs which stand to be saved on both sides are quite large. It is my opinion that the assessment of my client's personal injury damages represents a conservative, fair and equitable evaluation.

The liability and damages are now known to you. Please consider this settlement carefully, so we may begin negotiations. In your response please provide a breakdown of the reasonable medicals and general damages considered.

Very truly yours,

AZIMI LAW FIRM



YASMIN AZIMI, ESQ.

Attorney at Law

YA: cmh

Enclosures: As Stated

CC:

Hometown Buffet Executive Office
Capitol Corporate Services, Inc.
206 E. 9th St. Ste# 1300
Austin, TX 78701

CC:

Hometown Buffet, Inc.
Capitol Corporate Services, Inc.
1460 Buffet Way.
Eagan, MN 55121

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Hometown Buffet Corporation
Attn: Cheryl Roberts & John Robinson
P.O. Box 1831
Austin, TX 78767

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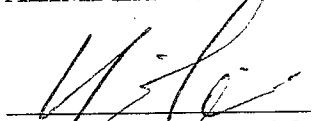
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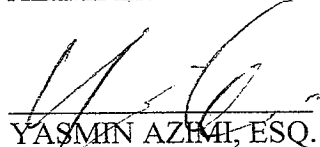
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Please note, we have moved and as of February 17, 2020 our new office address is what is indicated above. Enclosed please find our demand and updated W-9 form. Please adjust the file/claim and company directory.

Thank you for your courtesy and cooperation in this matter.

Very truly yours,
Azimi Law Firm



11/26/2019

Law Offices of Azimi Law Firm
2171 Campus Dr. Ste 200
Irvine, Ca. 92612

Patient: Bautista, Liliana
Date of Birth: 11/13/1973

Date of Injury: 7/30/2019
Date of Initial Examination: 7/31/2019
Date of Final Examination: 11/20/2019

To Whom It May Concern,

The following is a report, respectfully submitted with the permission of the above-referenced-patient, regarding injuries sustained in a personal injury dated 7/30/2019.

Ms. Bautista was the victim of a personal injury at Hometown Buffet caused by their negligence. The patient states that as she slipped backwards and fell, she attempted to prevent her fall by grabbing onto a handrail. The fall resulted in injuries to Ms. Bautista. Ms. Bautista was not rendered unconscious, but was severely shaken, stunned and in immediate pain. The patient did not receive medical attention at the scene of the injury nor was taken to the E.R.

Due to persistent symptoms the patient subsequently consulted this office for a full evaluation and for treatment of the injuries which occurred as a result of the accident dated above.

Initial Subjective Complaints:

Neck Pain: The pain was daily and constant throughout the day. The pain was described as burning pain, rated 7-9 on a 1-10 scale and was made worse with activities of daily living and movement. The pain radiated into the right shoulder and arm. The pain had not improved since the initial injury.

Low Back Pain: The pain was daily and constant throughout the day. The pain was described as burning pain, rated 7-9 on a 1-10 scale and was made worse with activities of daily living and movement. The pain radiated into the right leg. The pain had not improved since the initial injury.

Re: Bautista, Liliana

Work History/Disability:

The patient was employed at the time of the fall and did not miss any time from work, but continued to work under duress as a result of their injuries.

Past Medical History:

Ms. Bautista's previous medical history is non-contributory to the present injuries.

Physical Examination:

The patient is a 46 year old, female. Observation of Ms. Bautista revealed the patient to be cooperative and alert, with no apparent physical deformities. The patient is 5'1" and weighs 150 lbs.

Palpation:

Aberrant motion and a loss of inter-segmental function were noted within the cervical and lumbar spines. Digital palpation revealed palpable tenderness within the cervical and lumbar spines and musculature. Muscle spasms within the paravertebral muscles of the cervical and lumbar spines were noted.

Cervical Active Ranges of Motion:

Motion		Actual / Normal	Pain	Location
Flexion	:	60 / 60 degrees	+	cervical spine
Extension	:	50 / 50 degrees	+	cervical spine
Right Lateral Bending	:	40 / 40 degrees	+	cervical spine
Left Lateral Bending	:	40 / 40 degrees	+	cervical spine
Right Rotation	:	80 / 80 degrees	+	cervical spine
Left Rotation	:	80 / 80 degrees	+	cervical spine

Dorso-lumbar Active Ranges of Motion:

Motion		Actual / Normal	Pain	Location
Flexion	:	90 / 90 degrees	+	Lumbar spine
Extension	:	30 / 30 degrees	+	Lumbar spine

Re: Bautista, Liliana

Right Lateral Bending	:	20 / 20 degrees	+	Lumbar spine
Left Lateral Bending	:	20 / 20 degrees	+	Lumbar spine
Right Rotation	:	30 / 30 degrees	+	Lumbar spine
Left Rotation	:	30 / 30 degrees	+	Lumbar spine

Orthopedic Examination:

Multiple positive musculoskeletal findings, within the cervical and lumbar spine, were noted during the examination. Please see examination findings.

Radiographic Examination:

8/5/2019

In order to rule out post-traumatic osseous pathology and to evaluate for ligament instability films were taken of the cervical spine. The films were taken at SimonMed San Bernardino. There are no apparent fractures, osseous pathology, or congenital bony abnormalities noted.

Examination of the cervical films indicates a mild dextroscoliosis. A mild asymmetry of the cervical spine can be seen as a typical sequel of cervical injury. A copy of the report has been included for your perusal.

Diagnosis

Cervical

M48.32	Traumatic spondylopathy, cervical region
S13.4XXA	Sprain of ligaments of cervical spine, initial encounter
S16.1XXA	Strain of muscle, fascia and tendon at neck level, initial encounter
M99.01	Segmental and somatic dysfunction of cervical region
M54.2	Cervicalgia

Lumbar/Sacral

M48.36	Traumatic spondylopathy, lumbar region
M99.03	Segmental and somatic dysfunction of lumbar region
S33.5XXA	Sprain of ligaments of lumbar spine, initial encounter
S39.012A	Strain of muscle, fascia and tendon of lower back, initial encounter
M99.04	Segmental and somatic dysfunction of sacral region
S33.6XXA	Sprain of sacroiliac joint, initial encounter
M54.5	Low back pain

Re: Bautista, Lilitana

Thoracic

M48.34 Traumatic spondylopathy, thoracic region
S23.3XXA Sprain of ligaments of thoracic spine, initial encounter
M99.02 Segmental and somatic dysfunction of thoracic region
M54.6 Pain in thoracic spine

Treatment:

After completing an initial consultation and examination, a treatment plan was prescribed to return the patient to a pre-injury status and to minimize the possibility of future permanent residuals and impairment. Treatment consisted of Chiropractic adjustments to the injured areas. Ms. Bautista demonstrated gradual improvements to the injured areas with the treatment that was provided.

Discussion:

Ms. Bautista presented to this office following a personal injury dated 7/30/2019. The patient's subjective complaints and objective findings are indicative of soft tissue damage and injury. Furthermore, it is my professional opinion, after considering all the examination findings, that the injuries are consistent with the described mechanism of injury and are therefore the result of the personal injury dated above.

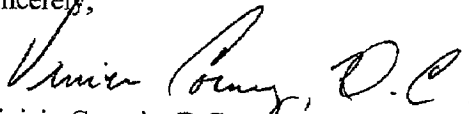
At the time of the final examination on 11/20/2019 the patient continued to complain of occasional mild neck and low back pain. Cervical and Lumbar ranges of motion were within normal limits.

Prognosis:

Ms. Bautista prognosis is fair. Ms. Bautista progressed under the treatment that was provided. However, it must be understood that there has been a general weakening of the soft tissues in the areas of concern which predisposes the patient to further injury and loss from trauma which would have otherwise been inconsequential. Also contributing to the aforementioned effects is the dextroscoliosis seen on the cervical spine films. Future impairments and residuals such as scar tissue, muscle weakness, limited range of motion, and loss of functional capacity are expected and will have to be evaluated with future exacerbations. When symptomatic exacerbations are experienced, care should be sought after on an as-needed basis for pain control and to prevent further loss of function. Literature indicates that problems of this nature may continue for months, years, or indefinitely.

If you should have any further questions regarding this matter, please do not hesitate to contact me.

Sincerely,


Vinicio Cornejo, D.C.

Initial Consultation

Patient Name: Liliana Bautista

Date: JUL 31 2019

CHIEF COMPLAINT

Neck Mid Back Low Back Headaches Shoulder Knee
 Right Left

Other: _____

DATE OF ONSET: 7/30/19 Gradual Chronic Insidious

CAUSE

MVA Rear End Front End Head-on Side Impact (Passenger)
(Driver) Treatment at Scene E.R. Ambulance Car Urgent
Care Primary Care Physician Loss of Consciousness Y N

Other/Add. Detail: Slip and fall, at a hometown buffet.

PRIOR EPISODES: Y N

SYMPTOMS

FREQUENCY
 Daily x Week x Month x Year
 Constant (100%) Frequent (75%) Off/On (50%) Occasional (25%)

TYPE/CHARACTER
 Sharp Dull Ache Burning Tension Dull to Sharp N&T

Other: _____

INTENSITY
1 2 3 4 5 6 7 8 → 9 10
 Mild Moderate Severe

AGGRAVATED
 Sitting Standing Bending Lifting Carrying Movement ADL's

Other: _____ Duration: _____

RELIEF
 Rest Sitting Standing Walking Movement Activity

Medication Exercise Other: _____

RADIATING PAIN Y N
 Shoulder Shld. Blade Arm Hand Glute Leg Foot
 Right Left

Other: _____

PROGRESS
 Better No Change Worse

MEDS: Y N

Types: TBP.

COMPLAINT

Neck Mid Back Low Back Headaches Shoulder Knee
 Right Left

Other: Back

DATE OF ONSET: _____ Gradual Chronic Insidious

CAUSE

PRIOR EPISODES: Y N

SYMPTOMS

FREQUENCY
 Daily x Week x Month x Year
 Constant (100%) Frequent (75%) Off/On (50%) Occasional (25%)

TYPE/CHARACTER
 Sharp Dull Ache Burning Tension Dull to Sharp N&T

Other: _____

INTENSITY
1 2 3 4 5 6 7 8 → 9 10
 Mild Moderate Severe

AGGRAVATED
 Sitting Standing Bending Lifting Carrying Movement ADL's

Other: _____ Duration: _____

RELIEF
 Rest Sitting Standing Walking Movement Activity

Medication Exercise Other: _____

RADIATING PAIN Y N
 Shoulder Shld. Blade Arm Hand Glute Leg Foot
 Right Left

Other: _____

PROGRESS
 Better No Change Worse

MEDS: Y N

Types: _____

NAME Bautista, Liliana DATE _____ DR _____
 X-RAY STUDY _____

MOTOR	L		R		SITTING	SUPINE
	L	R	L	R		
Deltoid C5						
Wrist Extensor C6						
Wrist Flexor C7						
Finger flexor C8						
Interossei T1						

MOTOR	L		R		SITTING	SUPINE
	L	R	L	R		
Quad L3-4						
EHL L5						
Peronei S1						

Cervical Motion Studies

	Norm	Pass	Pain	Location
Flexion	60			
Extension	50			
R Lat. Flex	40			
L Lat. Flex	40			
R Rotation	80			
L Rotation	80			

Dorso-Lumbar Motion Studies

	Norm	Pass	Pain	Location
Flexion	90			
Extension	30			
R Lat. Flex	20			
L Lat. Flex	20			
R Rotation	30			
L Rotation	30			

JAMAR 0 Pinwheel _____
 Height 5' Weight 150 BP 123/90

MAJOR COMPLAINTS: _____

STANDING
 Kemp's _____

PRONE
 Leg Length _____
 Derifield _____
 Ely's _____
 Yeoman's _____
 Hibbs _____
 S/I Comp. _____

Posture Analysis

	MS	L	R	MS
AT				
AX				
SC				
CC				
CC				
CC				
T1				
T2				
T3				
T4				
T5				
T6				
T7				
T8				
T9				
T10				
T11				
T12				
L1				
L2				
L3				
L4				
L5				
SAC				
RIU				
RIU				
COX				

DATE _____ DR _____

MOTOR	L		R		SITTING	SUPINE
	L	R	L	R		
Deltoid C5						
Wrist Extensor C6						
Wrist Flexor C7						
Finger flexor C8						
Interossei T1						

MOTOR	L		R		SITTING	SUPINE
	L	R	L	R		
Quad L3-4						
EHL L5						
Peronei S1						

Cervical Motion Studies

	Norm	Pass	Pain	Location
Flexion	60			
Extension	50			
R Lat. Flex	40			
L Lat. Flex	40			
R Rotation	80			
L Rotation	80			

Dorso-Lumbar Motion Studies

	Norm	Pass	Pain	Location
Flexion	90			
Extension	30			
R Lat. Flex	20			
L Lat. Flex	20			
R Rotation	30			
L Rotation	30			

JAMAR _____ Pinwheel _____
 Height _____ Weight _____ BP _____

MAJOR COMPLAINTS: _____

STANDING
 Kemp's _____

PRONE
 Leg Length _____
 Derifield _____
 Ely's _____
 Yeoman's _____
 Hibbs _____
 S/I Comp. _____

Posture Analysis

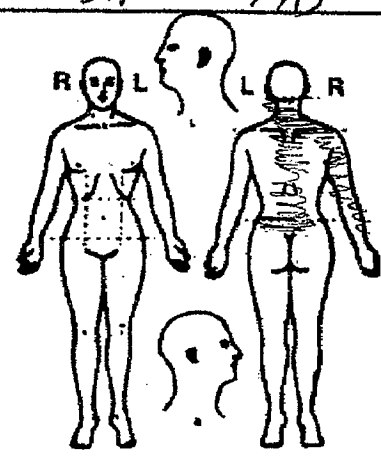
	MS	L	R	MS
AT				
AX				
SC				
CC				
CC				
CC				
T1				
T2				
T3				
T4				
T5				
T6				
T7				
T8				
T9				
T10				
T11				
T12				
L1				
L2				
L3				
L4				
L5				
SAC				
RIU				
RIU				
COX				

NAME Bautista Liliama
 4x 3x 5 2x 5 1x 5

S.C.C. _____
 ROOM _____

7230

DIAGNOSIS	TECHNIQUE	L M H		
		L	M	H
Cervical M48.32 S13.4XXT S16.1XXT	C/S (B)		+	(B)
Lumbar M48.32 M99.03 S33.5XXA	T/S and		(C)	Shd P/200
Thoracic M48.34 S23.3XXA M99.07	A/S S.P			FID
Major Complaint & Symptoms				
	Left	Seg.	Right	
		Occ		
		C1		
		2		
		3		
		4		
		5		
		6		
		7		
		D1		
		2		
		3		
		4		
		5		
		6		
		7		
		8		
		9		
		10		
		11		
		12		
	L1	Exercise		Temporary Disability
	2	Piriformis		
	3	Hamstring		
	4	Shd Wall ROM		
	5	Wall Angels		
	Sac	Plank		
	Ril			
	L1	C/S Stretch		Leg Lifts/Supports
	Coc	Sup Bridge 21 1-ex		
	Short Leg	Balance		



DATE	S.O.A.P.	C.M.T.	P.T.
JUL 31 2019	Consent given		
08/01/2019	Heat pack & EMS		HP/MS
AUG 05 2019	Heat pack & EMS		LLTS
AUG 06 2019	Heat pack & EMS		HP/MS/LS
AUG 09 2019	Heat pack & EMS		HP/MS/LS
AUG 13 2019	Heat pack & EMS		HP/MS/LS
AUG 15 2019	Heat pack & EMS		HP/MS/LS
AUG 16 2019	Heat pack & EMS		HP/MS/LS
AUG 22 2019	C/O LS (P)		HP/MS/LS
AUG 28 2019	Cons. to exp @ in @ am		HP/MS/LS
AUG 30 2019	Heat pack and EMS		HP/MS/LS
SEP 03 2019	Heat pack and EMS		HP/MS/LS
SEP 05 2019	C/O LS (P)		HP/MS/LS
SEP 06 2019	Cons. to exp @ in @ am		
SEP 09 2019	C/O LS (P) is feeling better. Mech Traction		HP/MS/LS
SEP 11 2019	C/O LS (P)		HP/MS/LS
SEP 13 2019	C/O LS (P) is feeling better.		HP/MS/LS
SEP 16 2019	C/O LS (P) Mech Traction		HP/MS/LS
SEP 18 2019	LS feeling better.		HP/MS/LS
SEP 20 2019	Heat pack & EMS		HP/MS/LS
SEP 25 2019	out 7 MRI of CS & LS		

Atty/Ins. Co. _____ F.L. _____ V.L. _____

Bautista, Liliana.

DATE	S.O.A.P.	C.M.T.	P.T.
	Flu w/ +ve & (B)		
SEP 27 2019	W/ exam ES: TS = 28		
OCT 1 2019	C/O (R) Shoulder pain		
OCT 03 2019			HIP/MS/RS
OCT 04 2019	C/O (R) Shoulder pain		
OCT 10 2019	Treat back and EMS		HIP/MS/RS
OCT 16 2019			CT
OCT 25 2019	W/ feeling better		
NOV 01 2019	Exam (B) - N MS = 23		HIP/MS/RS
NOV 07 2019	C/O (R) - (B) - (B) - (B)		
NOV 20 2019	Final exam. of the C8 and L5 C5 and L5 feeling better.		HIP/MS/RS

Billing Statement

Family Chiropractic Center
 Cornejo Chiropractic, Inc 237 N Riverside Ave
 Rialto, CA 92376
 909-874-6640

Statement No: 102306
 Statement Date: 12/5/2019

Patient: **Bautista, Liliana**
 608 E Wilson St
 Rialto, CA 92376
 7230

Bill To: **Bautista, Liliana**
 608 E Wilson St
 Rialto, CA 92376

Date of Service	Visit ID	Procedure	Charge	Insurance Payment	Patient Payment	Adjustment	Balance
07/31/2019	258398859	99203	\$200.00	\$0.00	\$0.00	\$0.00	\$200.00
07/31/2019	258398859	99213	\$65.00	\$0.00	\$0.00	\$0.00	\$65.00
07/31/2019	258398859	97010	\$25.00	\$0.00	\$0.00	\$0.00	\$25.00
07/31/2019	258398859	97014	\$30.00	\$0.00	\$0.00	\$0.00	\$30.00
08/01/2019	258652459	98941	\$49.00	\$0.00	\$0.00	\$0.00	\$49.00
08/01/2019	258652459	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/01/2019	258652459	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/01/2019	258652459	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/05/2019	258867010	99213	\$65.00	\$0.00	\$0.00	\$0.00	\$65.00
08/05/2019	258867010	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/05/2019	258867010	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/05/2019	258867010	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/06/2019	259120873	99213	\$65.00	\$0.00	\$0.00	\$0.00	\$65.00
08/06/2019	259120873	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/06/2019	259120873	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/06/2019	259120873	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/09/2019	259418091	98941	\$49.00	\$0.00	\$0.00	\$0.00	\$49.00
08/09/2019	259418091	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/09/2019	259418091	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/09/2019	259418091	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/13/2019	259851112	99213	\$65.00	\$0.00	\$0.00	\$0.00	\$65.00
08/13/2019	259851112	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00

Comments:

Billing Statement

Family Chiropractic Center
 Cornejo Chiropractic, Inc 237 N Riverside Ave
 Rialto, CA 92376
 909-874-6540

Statement No: 102306
 Statement Date: 12/5/2019

Patient: Bautista, Liliana
 608 E Wilson St
 Rialto, CA 92376
 7230

Bill To: Bautista, Liliana
 608 E Wilson St
 Rialto, CA 92376

Date of Service	Visit ID	Procedure	Charge	Insurance Payment	Patient Payment	Adjustment	Balance
08/13/2019	259851112	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/13/2019	259851112	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/15/2019	260158495	98940	\$47.00	\$0.00	\$0.00	\$0.00	\$47.00
08/15/2019	260158495	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/15/2019	260158495	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/15/2019	260158495	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/16/2019	261405829	98940	\$47.00	\$0.00	\$0.00	\$0.00	\$47.00
08/16/2019	261405829	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/16/2019	261405829	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/16/2019	261405829	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/22/2019	260818029	98940	\$47.00	\$0.00	\$0.00	\$0.00	\$47.00
08/22/2019	260818029	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/22/2019	260818029	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/22/2019	260818029	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/28/2019	261441939	98941	\$49.00	\$0.00	\$0.00	\$0.00	\$49.00
08/28/2019	261441939	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/28/2019	261441939	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/28/2019	261441939	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/30/2019	261703638	99213	\$65.00	\$0.00	\$0.00	\$0.00	\$65.00
08/30/2019	261703638	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/30/2019	261703638	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
08/30/2019	261703638	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00

Comments:

Billing Statement

Family Chiropractic Center
 Cornejo Chiropractic, Inc 237 N Riverside Ave
 Rialto, CA 92376
 909-874-6640

Statement No: 102306
 Statement Date: 12/5/2019

Patient: Bautista, Liliana
 608 E Wilson St
 Rialto, CA 92376
 7230

Bill To: Bautista, Liliana
 608 E Wilson St
 Rialto, CA 92376

Date of Service	Visit ID	Procedure	Charge	Insurance Payment	Patient Payment	Adjustment	Balance
09/03/2019	261932272	99213	\$65.00	\$0.00	\$0.00	\$0.00	\$65.00
09/03/2019	261932272	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/03/2019	261932272	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/03/2019	261932272	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/05/2019	262228518	99213	\$65.00	\$0.00	\$0.00	\$0.00	\$65.00
09/05/2019	262228518	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/05/2019	262228518	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/05/2019	262228518	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/06/2019	262354884	98941	\$49.00	\$0.00	\$0.00	\$0.00	\$49.00
09/06/2019	262354884	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/06/2019	262354884	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/06/2019	262354884	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/09/2019	262566334	99213	\$65.00	\$0.00	\$0.00	\$0.00	\$65.00
09/09/2019	262566334	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/09/2019	262566334	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/09/2019	262566334	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/11/2019	262860520	98941	\$49.00	\$0.00	\$0.00	\$0.00	\$49.00
09/11/2019	262860520	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/11/2019	262860520	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/11/2019	262860520	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/13/2019	263134700	99213	\$65.00	\$0.00	\$0.00	\$0.00	\$65.00
09/13/2019	263134700	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00

Comments:

Billing Statement

Family Chiropractic Center
 Cornejo Chiropractic, Inc 237 N Riverside Ave
 Rialto, CA 92376
 909-874-6640

Statement No: 102306
 Statement Date: 12/5/2019

Patient: Bautista, Liliana
 608 E Wilson St
 Rialto, CA 92376
 7230

Bill To: Bautista, Liliana
 608 E Wilson St
 Rialto, CA 92376

Date of Service	Visit ID	Procedure	Charge	Insurance Payment	Patient Payment	Adjustment	Balance
09/13/2019	263134700	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/13/2019	263134700	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/16/2019	263345652	99213	\$65.00	\$0.00	\$0.00	\$0.00	\$65.00
09/16/2019	263345652	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/16/2019	263345652	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/16/2019	263345652	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/18/2019	263654343	98940	\$47.00	\$0.00	\$0.00	\$0.00	\$47.00
09/18/2019	263654343	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/18/2019	263654343	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/18/2019	263654343	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/20/2019	263920891	99213	\$65.00	\$0.00	\$0.00	\$0.00	\$65.00
09/20/2019	263920891	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/20/2019	263920891	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/20/2019	263920891	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/23/2019	264146152	99213	\$65.00	\$0.00	\$0.00	\$0.00	\$65.00
09/23/2019	264146152	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/23/2019	264146152	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/23/2019	264146152	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/25/2019	264447334	98941	\$49.00	\$0.00	\$0.00	\$0.00	\$49.00
09/25/2019	264447334	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/25/2019	264447334	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
09/25/2019	264447334	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00

Comments:

Billing Statement

Family Chiropractic Center
Cornejo Chiropractic, Inc 237 N Riverside Ave
Rialto, CA 92376
909-874-6640

Statement No: 102306
 Statement Date: 12/5/2019

Patient: Bautista, Liliana
608 E Wilson St
Rialto, CA 92376
7230

Bill To: Bautista, Liliana
608 E Wilson St
Rialto, CA 92376

Date of Service	Visit ID	Procedure	Charge	Insurance Payment	Patient Payment	Adjustment	Balance
10/03/2019	265497535	98941	\$49.00	\$0.00	\$0.00	\$0.00	\$49.00
10/03/2019	265497535	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
10/03/2019	265497535	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
10/03/2019	265497535	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
10/03/2019	265497535	98943	\$34.00	\$0.00	\$0.00	\$0.00	\$34.00
10/04/2019	265497943	99213	\$65.00	\$0.00	\$0.00	\$0.00	\$65.00
10/04/2019	265497943	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
10/04/2019	265497943	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
10/04/2019	265497943	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
10/10/2019	266160520	98940	\$47.00	\$0.00	\$0.00	\$0.00	\$47.00
10/10/2019	266160520	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
10/10/2019	266160520	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
10/10/2019	266160520	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
10/25/2019	267849397	99213	\$65.00	\$0.00	\$0.00	\$0.00	\$65.00
10/25/2019	267849397	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
10/25/2019	267849397	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
10/25/2019	267849397	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
11/01/2019	268621249	98940	\$47.00	\$0.00	\$0.00	\$0.00	\$47.00
11/01/2019	268621249	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
11/01/2019	268621249	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
11/01/2019	268621249	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
11/20/2019	270785212	98940	\$47.00	\$0.00	\$0.00	\$0.00	\$47.00

Comments:

Billing Statement

Family Chiropractic Center
Cornejo Chiropractic, Inc 237 N Riverside Ave
Rialto, CA 92376
909-874-6640

Statement No: 102306
Statement Date: 12/5/2019

Patient: Bautista, Liliana
608 E Wilson St
Rialto, CA 92376
7230

Bill To: Bautista, Liliana
608 E Wilson St
Rialto, CA 92376

Date of Service	Visit ID	Procedure	Charge	Insurance Payment	Patient Payment	Adjustment	Balance
11/20/2019	270785212	97012	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
11/20/2019	270785212	97010	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
11/20/2019	270785212	97014	\$20.00	\$0.00	\$0.00	\$0.00	\$20.00
Please Remit This Amount						Balance Due Total:	\$3,491.00

Comments:



SimonMed™
See Tomorrow Today

Patient Name:	Bautista, Liliana	Accession Number:	27134049
Patient ID:	4109149	Location:	SimonMed California San Bernardino
Gender:	Female	Exam Date:	August 5, 2019 16:23
Date of Birth:	November 13, 1973	Modality:	CR
Referring Physician:	Cornejo, Vinicio	Report Status:	Final

CERVICAL SPINE 2-3 VIEWS

INDICATION: Neck pain for 8 days.

COMPARISON: No prior studies are available for comparison.

TECHNIQUE: Three views of the cervical spine.

FINDINGS: There is mild spinal asymmetry/dextroscoliosis of the cervical spine, apex to the right at C3, less than 10 degrees.

There is no fracture or dislocation. The prevertebral soft tissues are unremarkable. There is no other evidence for osteophyte formation or degenerative change. The intervertebral disc spaces are normal in height and configuration. The dens is intact. There is no suspicious sclerotic or lytic lesion.

IMPRESSION:

1. There is mild spinal asymmetry/dextroscoliosis of the cervical spine, apex to the right at C3, less than 10 degrees.
2. There is no other evidence for osteophyte formation or degenerative change.
3. If there is clinical concern for acute disc herniation, recommend MRI of the cervical spine.

Reported by: Avery Knapp M.D.

Electronically signed by: Avery Knapp M.D. on Aug 08, 2019 @ 17:46

Relevant Clinical Information

1) ORDER= VERIFIED \.br2) PT SIGNS AND SYMPTOMS (When and how long)= NECK AND LOW BACK PAIN X 8 DAYS \.br3) BODY LOCATION AND WHICH SIDE OR QUADRANT= C SPINE, L SPINE \.br4) INJURY (Specific dates, time, and what pt was doing when injury occurred)=8 DAYS AGO, PT



SimonMed™
See Tomorrow Today

Patient Name:	Bautista, Liliana	Accession Number:	27134050
Patient ID:	4109149	Location:	SimonMed California San Bernardino
Gender:	Female	Exam Date:	August 5, 2019 16:23
Date of Birth:	November 13, 1973	Modality:	CR
Referring Physician:	Cornejo, Vinicio	Report Status:	Final

LUMBOSACRAL SPINE 2-3 VIEWS

INDICATION: Low back pain for 8 days.

TECHNIQUE: Three views of the lumbar spine.

COMPARISON: No prior studies are available for comparison.

FINDINGS: There is no fracture or dislocation. The alignment is unremarkable. There is no other evidence for osteophyte formation or degenerative change. There is no suspicious sclerotic or lytic lesion.

IMPRESSION:

1. Normal examination.
2. No other evidence for osteophyte formation or degenerative change.
3. If there is clinical concern for acute disc herniation, recommend MRI of the lumbar spine.

Reported by: Avery Knapp M.D.
Electronically signed by: Avery Knapp M.D. on Aug 08, 2019 @ 17:48

Relevant Clinical Information

1) ORDER= VERIFIED \.br2) PT SIGNS AND SYMPTOMS (When and how long)= NECK AND LOW BACK PAIN X 8 DAYS \.br3) BODY LOCATION AND WHICH SIDE OR QUADRANT= C SPINE, L SPINE \.br4) INJURY (Specific dates, time, and what pt was doing when injury occurred)=8 DAYS AGO, PT



AZIMI LAW FIRM
2171 CAMPUS DR STE 200
IRVINE CA 92612-1472

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 11131973	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) BAUTISTA LILIANA		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME	
3. PATIENT'S BIRTH DATE (MM/DD/YY) 11/13/1973 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) SAME	
5. PATIENT'S ADDRESS (No., Street) 608 E WILSON ST		8. RESERVED FOR NUCC USE	
CITY RIALTO STATE CA		CITY STATE	
ZIP CODE 92376 TELEPHONE (Include Area Code) (909) 543-5793		ZIP CODE TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
11. INSURED'S POLICY GROUP OR FECA NUMBER		11. INSURED'S DATE OF BIRTH (MM/DD/YY) 11/13/1973 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
a. INSURED'S DATE OF BIRTH (MM/DD/YY) 11/13/1973 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		b. OTHER CLAIM ID (Designated by NUCC)	
c. INSURANCE PLAN NAME OR PROGRAM NAME AZIMI LAW FIRM		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED **SIGNATURE ON FILE** DATE **082619**

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM/DD/YY QUAL.		15. OTHER DATE MM/DD/YY QUAL.		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM/DD/YY TO MM/DD/YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN VINICIO CORNEJO		17a. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM/DD/YY TO MM/DD/YY	
17b. NPI 1669584165		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES		22. RESUBMISSION CODE ORIGINAL REF. NO.	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0		23. PRIOR AUTHORIZATION NUMBER	
A. M54.2 B. M54.5 C. D. E. F. G. H. I. J. K. L.		24. A. DATE(S) OF SERVICE From MM/DD/YY To MM/DD/YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER		F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #	

1	2	3	4	5	6	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
08052019	08052019	11	72040		A	372.00	1.0		NPI	1255594289
08052019	08052019	11	72100		B	372.00	1.0		NPI	1255594289
									NPI	
									NPI	
									NPI	
									NPI	

25. FEDERAL TAX I.D. NUMBER 943292479 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. Z5RFS7L		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 744.00		29. AMOUNT PAID \$ 0.00		30. Rsvd for NUCC Use 744.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) AVERY KNAPP JR MD				32. SERVICE FACILITY LOCATION INFORMATION SIMONMED IMAGING SAN BERNA 225 WEST HOSPITALITY LN ST SAN BERNAR, CA 92408-3244				33. BILLING PROVIDER INFO & PH # (866) 282-7905 HEALTH DIAGNOSTICS OF CALIFOR PO BOX 207465 DALLAS, TX 75320-7465			
SIGNED 082619 DATE				a. 1104321959				b.			