FORM B10 (Official Form 10) (Rev. 4/01)

United States Bankruptcy Court Northern District of Illinois

PROOF OF CLAIM

Name of Debtor	Case Number
KMART CORPORATION	02 B 02474

NOTE: This form should not be used to make a claim for an administrative expense arising after the commencement of the case. A "request" for payment of an administrative expense may be filed pursuant to 11 U.S.C. § 503.

Name of Creditor (The person or other entity to whom the debtor owes money or property):

Celia Andrade

Name and address where notices should be sent:

c/o Bruce A. Greenberg
200 Oceangate, Suite 400
Long Beach, CA 90802-4330
Telephone number: (562) 437-2000

☐ Check box if you are aware that anyone else has filed a proof of claim relating to your claim. Attach copy of statement giving particulars.

☒ Check box if you have never received any notices from the bankruptcy court in this case

☐ Check box if the address differs from the address on the envelope sent to you by the court.

This space is for Court Use Only

Account or other number by which creditor identifies debtor:
4296

Check here if this claim ☐ replaces ☐ amends a previously filed claim, dated: _____

1. Basis for Claim

- ☐ Goods sold
- ☐ Services performed
- ☐ Money loaned
- ☒ Personal injury/wrongful death
- ☐ Taxes
- ☐ Other_____

- ☐ Retiree benefits as defined in 11 U.S.C. § 1114(a)
- ☐ Wages, salaries, and compensation (Fill out below)
  Your SS#: _____ - _____ - _____
  Unpaid compensation for services performed
  from _____ (date) to _____ (date)

2. Date debt was incurred: June 14, 2001

3. If court judgment, date obtained: N/A

4. Total Amount of Claim at Time Case Filed: $25,000.00

If all or part of your claim is secured or entitled to priority, also complete Item 5 or 6 below.

☐ Check this box if claim includes interest or other charges in addition to the principal amount of the claim. Attach itemized statement of all interest or additional charges.

5. Secured Claim.

☐ Check this box if your claim is secured by collateral (including a right of setoff).

Brief Description of Collateral:
☐ Real Estate ☐ Motor Vehicle
Other_____

Value of Collateral: $_____

Amount of arrearage and other charges at time case filed included in secured claim, if any $ _____

6. Unsecured Priority Claim.

☐ Check this box if you have an unsecured priority claim
Amount entitled to priority $ _____
Specify the priority of the claim:

- ☐ Wages, salaries, or commissions (up to $4,650),* earned within 90 days before filing of the bankruptcy petition or cessation of the debtor's business, whichever is earlier - 11 U.S.C. § 507(a)(3)
- ☐ Contributions to an employee benefit plan - 11 U.S.C. § 507(a)(4).
- ☐ Up to $2,100* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use - 11 U.S.C. § 507(a)(6).
- ☐ Alimony, maintenance, or support owed to a spouse, former spouse, or child - 11 U.S.C. § 507(a)(7).
- ☐ Taxes or penalties owed to governmental units - 11 U.S.C. § 507(a)(8).
- ☐ Other - Specify applicable paragraph of 11 U.S.C. § 507(a-____).

Amounts are subject to adjustment on 4/1/04 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.

7. CREDITS: The amount of all payments on this claim has been credited and deducted for the purpose of making this proof of claim.

8. Supporting Documents: *Attach copies of supporting documents*, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, mortgages, security agreements, and evidence of perfection of lien. DO NOT SEND ORIGINAL DOCUMENTS. If the documents are not available, explain. If the documents are voluminous, attach a summary.

9. Date-Stamped Copy: To receive an acknowledgment of the filing of your claim, enclose a stamped, self-addressed envelope and copy of this proof of claim.

This Space Is for Court Use Only

KP670

3/18/02

Date	Sign and print the name and title, if any, of the creditor or other person authorized to file this claim (attach copy of power of attorney, if any)
3-14-02	Bruce A. Greenberg, Attorney

Penalty for presenting fraudulent claim: Fine of up to $500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. §§ 152 and 3571

Southern California Permanente Medical Group

EMERGENCY DEPARTMENT RECORD

3465844

CHART REQUESTED

LOCATION	DATE	TIME REGISTERED	TRIAGE TIME	OUTPT / INPT
052	06/18/01	18:29	AM ☐ PM ☐	☐ ☐

NAME: ANDRADE, CELIA M

6917

ARRIVED ▶ ☒ WALKED ☐ WC ☐ AMB ☐ PARA AMB ☐ OTHER

ACCOMPANIED BY ▶ ☐ ALONE ☐ SPOUSE ☐ PARENT ☐ FRIEND ☐ RELATIVE

PATIENT'S ADDRESS
5678 SHULL ST SP 17
BELL GARDENS CA 90 201 - -

MED. REC. NO.: 00 000563-55-51
BIRTHDATE: 03/17/937

HOME PHONE: ~~562 927-9497~~
WORK PHONE: ~~562 927-9497~~

RELATIVE TO CONTACT / PHONE:

PRIMARY CARE CLINIC: 059
PERSONAL PHYSICIAN: SANTAMARIA,

NURSE

AGE	SEX	TEMP	BLOOD PRESSURE	PULSE	RESP	WEIGHT (Peds)
064	F	36.9	149/88	90	18	

DRUG SENSITIVITY ☐ NO ☐ YES — IF YES, SPECIFY DRUG:

LMP:

LAST TETANUS:

CURRENT MEDICATIONS:

CHIEF COMPLAINT (IF INJURY - WHERE AND HOW DID IT OCCUR?): FELL/INJ SHOULDER/NECK

Test	✓	
CBC WBC		
CBC H&H		
Lytes		
Bun/Creat		
Glucose/Acet		
Amylase		
U/A		
C&S____		
Preg Test		
CPK		
CXR		
Abd Ser/KUB		
ABG		
Peak Flow		
Pulse Ox		
EKG		

Visual Acuity OD (R)____ OS (L)_

PROVIDER

TIME OF INITIAL EXAM: 6:45 pm

HISTORY AND EXAM

Slipped & fell on wet floor of K mart 4 days ago No LOC
Now still has pain back of neck & R ankle
No neurologic changes
No neuro defic
X-ray R & C spine
No neurologic def
[illegible] R ankle swelling
C-spine -ve
R ankle N-T [illegible]
Δ Cervical Strain
Anaprox 550 mg [illegible] 20 [illegible]
[illegible]

DISABILITY ☐ NO ☐ YES — IF YES, GIVE RETURN TO WORK DATE

CONDITION AT DISCHARGE (CHECK ALL THAT APPLY)
☐ UNCHANGED ☑ ALERT/ORIENTED ☐ ON CRUTCHES ☑ DOA
☐ ASYMPTOMATIC ☐ AMBULATORY ☐ EXPIRED ☐ OTHER ▶ SPECIFY

ED PHYSICIAN:

INSTRUCTIONS TO PATIENT
☐ WRITTEN ▶
☑ VERBAL SPECIFY

DISPOSITION (CHECK ALL THAT APPLY) — SERVICE & FLOOR — DOCTOR, DATE, LOCATION, TIME — TIME
☐ RETURN PRN ☐ WORK ☐ ADMITTED ▶ ☐ REFERRED TO ▶
☐ HOME ☐ HOLDING ☐ TRANSFERRED ☐ RETURN TO

NS 7890 (5/00) WHITE - CHART PINK - PHYSICIAN GOLDENROD - EMERGENCY DEPARTMENT

KAISER PERMANENTE
Kaiser Foundation Hospitals

DOCTOR'S ORDERS

ROOM #

ADMIT TO SERVICE OF DR.

PLEASE NOTIFY REFERRING PHYSICIAN, DR.

DIAGNOSIS

EMERGENCY DEPARTMENT

CONSENT FOR

☐ SURGERY ☐ OTHER (SPECIFY)

TELEPHONE

ADMITTING DIET

0563 55 51
ANDRADE CELIA M
F 03

IMPRINT AREA

ALLERGIES

☐ NONE

DATE	TIME	TREATMENT
		VITAL SIGNS: ☐ Routine (q shift) ☐ Orthostatic BP and Pulse ☐ q ( ) minutes ☐ q ( ) hours
		DIET: NPO unless otherwise ordered
		IMAGING: (Select desired study) ☐ Chest ☐ Protable Chest ☐ Abd. Series ☐ KUB ☐ IVP ☐ C-Spine ☐ L-S Series ☐ Pelvis ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Hip ☐ Knee ☐ Ankle ☐ Foot ☐ Ultrasound ☐ CT ☐ Doppler/DVT ☐ Lung Scan ☐ Other
		LAB: (Select desired study) ☐ CBC ☐ H & H ☐ Lytes ☐ BUN ☐ Creatinine ☐ Bld Sugar ☐ Bld Ketone ☐ Amylase ☐ PT ☐ PTT ☐ CPK-MB ☐ UA ☐ UA/C&S ☐ Pregnancy Test ☐ TSH ☐ Blood Cult. x ( ) ☐ ABG FiO_2 = ( ) ☐ Type & Hold ( ) Units ☐ Type & Cross ( ) Units ☐ Rh ☐ **CCU:** CBC W/Platelets; Lytes; BUN; Creat-Serum; Glucose-Random; CPK-M ☐ **GI Bleed:** CBC; PT; PTT; Electrolytes; BUN; Creatinine; Glucose; Calcium; Amylase; Phosphorus; Alk-Phos; AST; ALT; Type/Screen ☐ **Kidney Stone:** CBC w/Platelets; UA; Urine Culture; BUN; Creat-Serum; Calcium; Uric Ac Pregnancy Test, as applicable ☐ **Liver Function Test:** Quick Pro-Time; PTT; Calcium; Amylase; Total Protein; Alk-Phos AST; ALT; LDH; Bilirubin; Gamma GT ☐ Other
		PROCEDURES: (Select desired procedure) ☐ EKG ☐ NG ☐ Foley ☐ In & Out Cath ☐ Other ☐ Cardiac Monitor ☐ BP/P Monitor ☐ Pulse Oximeter ☐ Peak Flow
		OXYGEN THERAPY: O2 ( ) Liters/Min. ☐ N/C ☐ Mask ☐ Other:
		MEDICATION: ☐ Albuterol ( ) ml + NS ( ) ml HHN ☐ NTG ( ) mg SL q ( ) min. x ( ) ☐ Pain Medication:
		INTRAVENOUS: ☐ Hep-Lok
		OTHER ORDERS:
		NURSE SIGNATURE: **PHYSICIAN SIGNATURE:**

DISPENSING BY NON-PROPRIETARY N
IS AUTHORIZED UNLESS CHECKED H

RR 0420 (4 01)

"DO NOT WRITE IN THIS AREA"

BLUE - CHART YELLOW - ATTACH TO CLINIC PROCESSING RECORD (CPR)

Kaiser Bellf
Medical Cente
Emergency Departmer

0563 55 51

ANDRADE CELIA 9400 E. Rosecrans Ave., Bellflower, CA 90
(562) 461-3

EDS

EMERGENCY SERVICE
AFTER CARE INSTRUCTION SHEET

Patient Name

Date of Service 6/18/01

Diagnosis CERVICAL STRAIN, (R) ANKLE STRAIN

TREATMENT RENDERED

___ Sutured
___ X-Ray
___ EKG
___ Lab Test
___ Tetanus Booster
___ Hypertet & Tetanus Booster
___ Medication
✓ Exam & Evaluation

GENERAL INSTRUCTIONS:

___ Keep dressing clean and dry
✓ Keep injured part elevated as much as possible (above the level of the heart) for_____ days.
___ Ice (intermittently) to injured area for_____hr(s).
___ No weight bearing
___ Re-wrap ace bandage if too loose or too tight
___ Crutches as needed (they are sold to you)
✓ Take prescription(s) as directed

___ Watch for signs of possible infection, such as red streaks, redness, swelling, and/or heat of the injured area. Contact your M.D. immediately if these occur.

COOLING MEASURES FOR FEVER

Check temperature every _____ hours

___ Encourage force fluid _____ dress lightly _____ cover lightly

Give _____ Aspirin/Tylenol every _____ hours for temperature over _____ and cool sponge baths.

Within the next 2-3 days, please check with your M.D. for:

___ Exam & re-evaluation IF WORSE
___ Wound evaluation in 24 - 48 hours
___ Removal of sutures in _____ days
___ Further treatment of the condition which brought you here
___ You will need re-evaluation by your M.D. or "compensation M.D." prior to returning to work and/or school
___ **Do not drive, ride a bicycle or operate any machinery while taking narcotic medications.**

Referred to: Surgical Urgent Care
Physician: Imperial Clinic
Address: Building C - Room 228
Phone No.: 1-800-823-4040

FOR KAISER DOCTOR APPOINTMENT CENTER PLEASE CALL 1-800-823-4040 OR CALL L.A. COUNTY MEDICAL ASSOCIATION FOR A PHYSICIAN REFERRAL (PHONE (213) 683-9900)

I hereby acknowledge receipt of above printed instructions:

Signature Celia Andrade
(circle one) RN / M D

INSTRUCTIONS FOR PATIENTS WITH HEAD INJURIES:

Although no evidence of any serious injury is found at this time, contact physician immediately if any of the following conditions occur. If unable to your physician, return to the Emergency department at once, day or nig

1. Increase drowsiness
2. Persistent or increasingly severe headache
3. Persistent vomiting
4. Stiffness of neck
5. Drainage of blood or clear fluid from ear or nose.
6. Weakness of limbs or loss of coordination
7. Convulsions (fits)

_____ Your bood pressure was elevated today.
Please follow-up with your regular doctor for a recheck.

SPECIFIC INSTRUCTIONS:

___ Back/Neck Pain
___ Croup
___ Crutch Training
___ Eye Injuries
___ Febrile Seizure
___ Fever
___ Fracture/Sprain
___ Other
___ Head Injury
___ Hepatitis
___ Nose Bleed
___ Temperature
___ Threatened Miscarriage
___ UTI
___ Vomiting & Diarrhea

___ **OTHER SPECIFIC INSTRUCTIONS:**

- HEAT AS TOLERATED TO PAINFUL REGION

**** RETURN IMMEDIATELY IF YOUR CONDITION WORSENS.***

___ **Important Notice:**

Your x-ray has been read on a preliminary basis. An official revi be made by the Radiologist.

PLEASE NOTE: **Treatment given in the Emergency S is offered as emergency first care (**

Follow-up treatment by a physician may be important fo safety. You are urged to follow carefully the instructions on this sheet. If your condition worsens, return to the Emer Department or see your doctor immediately.

Kaiser Bellflower
Medical Center
Emergency Department

comp

ANDRADE CELIA M

EMERGENCY DEPARTMENT

TIME IN:	NAME:	AGE:	DATE:	TRIAGE TIME:
18:15	Andrade, Celia	64	6/18/01	18:20

INITIAL COMPLAINT/SUBJECTIVE: Slip & fall. Fell on the floor last Thursday. pain @ shoulder, neck, arm "—6

SEX: ☐ M ☒ F | Advance Directive: ☐ Yes ☒ No ☐

IMPAIRMENT: ☐ Vision ☐ Hearing ☐ Speech none

OBJECTIVE FINDINGS: Pt able to sit upright w/o difficulty. Pt requesty Chro practice Services. NAD distress.

General Appearance: ☒ No Distress ☐ Distress | OK to Wait: ☐ Yes | TIME | INITIAL | GLASGOW COMA | Eyes 4 | Motor 6 | Verbal 5

Admitted via: ☐ W/C ☐ Stretcher ☒ Walking ☐ Carried | ☐ EMS - Sequence # ____

Accompanied by: husband | Language Spoken: English. | Chief Historian: self

Pre Hospital Care: none | Immunization Status: unk | LAST TETANUS: unk

BP	PULSE	RESP.	TEMP.	O_2 SAT RA	O_2	INITIAL
143/88	80	18.	36.9	96		KK

ORTHOSTATIC V/S: TIME____ ○— BP____ P____

WEIGHT 145lb ♀ BP____ P____

ALLERGIES: ☒ NKA

MED/DOSE ☒ NONE

INITIAL PAIN LEVEL
Site (R) Shoulder
Provoked movement.
Quality throbbing
Radiation neck, arm
Severity 10/10
Time x 4 days

PAIN SCALES
0 1 2 3 4 5 6 7 8 9
no pain | mild pain | moderate pain | severe pain

MEDICAL HISTORY

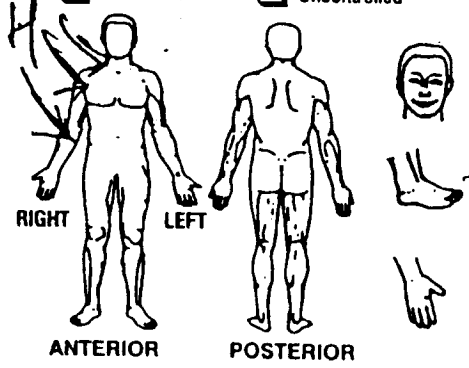
☐ Heart Disease	☐ GI Disease
☐ Hypertension	☐ Rheumatology
☐ Respiratory Disorder	☐ Diabetes Mellitus
☐ GU Disease	☐ Neuro Disorder
☐ Mental Illness	☐ Seizures
☐ Immune Disorder	☐ Sickle Cell
☐ Cancer	☐ Hepatitis
	☐ CVA

Other: None

INJURY/LACERATION LABEL AND SHADE AREAS INVOLVED

☐ N/A BLEEDING: ☐ Controlled ☐ Uncontrolled

A – ABRASIONS
B – BRUISE
C – BURNS
D – FOREIGN BODY
E – LACERATION
F – PUNCTURE
G – POSSIBLE FX
H – C/O PAIN
I – REDDENED
J – HEMATOMA
K – AVULSION
L – OTHER



PEDS: DEVELOPEMENT: ☐ Age Appropriate ☐ Delayed
ACITIVITY: ☐ Playful ☐ Irritable
FEVER: Days:____

SKIN: ☐ Rash ☐ Edema ☐ Diaphoretic ☐ Warm ☐ Cool ☐ Abn/Color: ____ ☒ WNL ☐ Other____

ENT: ☐ Stridor ☐ Visual Changes ☐ Eye Pain ☐ OD ☐ Contacts ☐ Ear R/L ☐ Throat ☐ OS ☒ WNL ☐ Other____ ☐ OU

NEURO PSY: ☐ Suicidal ☐ Homicidal ☐ Lethargic ☐ A & O ☐ Confused ☐ Headache ☐ Hearing Voices ☐ Motor Dysfunction ☐ Other____ ☐ WNL

GI: ☐ Abdominal Pain ☐ Location ____ ☒ WNL ☐ Timing ____ ☐ Nausea/Vomit ____ ☐ Bleeding ☐ Diarrhea ____ Emesis ____ ☐ Other____ Rectal ____

CARDIO-PULMONARY CHEST PAIN:
☐ Dyspnea ☐ Cough ☒ WNL ☐ Retractions ☐ Peds Asthma

GU: ☐ Pain Where ____ ☒ WNL

Kaiser Bellflower Medical Center
Emergency Department

C 53 55 51 F
ANDRADE CELIA M

DATE: 6/14/01

SOCIAL ASSESSMENT

Does this patient have any cultural factors that need to be considered as part of their care? ☐ No ☐ Yes:
Does this patient have any spiritual/religious factors that need to be considered as part of their care? ☐ No ☐ Yes:
Does this patient have any learning barriers factors that need to be considered as part of their care? ☐ No ☐ Yes:

NURSING DIAGNOSIS

INITIATED Number	Time	Initials	(NUMBER BY PRIORITY)				DISCONTINUED Number	Time	Initials
1	1800	[illegible]	__ Airway Clearance (ineffective)	1 Comfort, Alterations in	__ Hyperthermia (fever)	__ Non Compliance	1	1945	[illegible]
			__ Anxiety	__ Communication impaired	__ Infection potential	__ Self care deficit			
			__ Breathing Patterns (ineffective)	__ Coping (ineffective)	__ Injury, potential	__ Skin Intergrity impaired			
			__ Cardiac Output, Decreased	__ Fluid Volume, Alterations in	__ Knowledge deficit	__ Thought process, Alterations in			
			__ Other	__ Gas Exchange, Impaired	__ Mobility impaired	__ Tissue Perfusion, Alterations in			
					__ Other				

DIAGNOSTIC TESTS

EKG: ABG: Other: MD EVAL. TIME:
Lab: Time Drawn: X-Ray: Time Portable done: Departure Time: Return Time:

INTERVENTIONS

Time	IV Solutions/Amt.	Needle Gauge	Rate	Site	Initial

INTAKE: P.O. ____ IV ____ TOTAL ____

OUTPUT: Urine ____ BM ____ Other ____ TOTAL ____

GLASGOW COMA

Time	Eyes	Motor	Verbal	Total
1800	4	6	5	15

NEUROLOGICAL ✓

Time	Pupils (Right)	Pupils (Left)	R Arm/Leg	A

Time:	B/P	P	RR	Temp	O2 Sat	Rhythm	Pain
1900	137/82	71	20				0

O_2 Sat: RA: ____ O_2: ____ L/min via: ☐ N/C ☐ Ma

Time	Medications/Route	Site	Time	Response	In

NURSE NOTES

☐ S/R ↑X 2 ☐ Instructed in Call Bell Use ☐ Bed Low & Locked

Time	
1800	Ambulate to bed 20. [illegible]
1945	FROM. [illegible] Ambulates [illegible]
	difficulty [illegible] WNL. [illegible]
	[illegible] verbalized understanding [illegible]
	[illegible] ambulating [illegible] Discharged [illegible]

☐ See Supplemental Narrative

End of Visit Summation (EOVS) → (i.e. stable, improving, goals met, absence of complications):
FROM. [illegible] WNL. Ambulate [illegible] difficulty [illegible]

☐ Tolerating PO Fluids ☐ Voiding ☑ Pain Controlled 0/10

☐ Discharge with reponsible adult NAME TIME 1945 INITIAL [illegible]

ACUITY 1 2 3 4 5

DISCHARGE/TRANSFER/ADMISSION

DISCHARGE TO	VALUABLES/CLOTHING	CONTINUE OF CARE	ACCOMPANIED BY	MODE	POLICE
☑ Home	☐ None	☐ Transfer pack completed	☐ Self	☐ Iwr	☐ [illegible]

STAT

KAISER PERMANENTE®

BELLFLOWER

DEPARTMENT OF MEDICAL IMAGING
DIAGNOSTIC X-RAY CONSULTATION

***
* S
***

DATE REQUEST INITIATED	DATE EXAM PERFORMED
06/18/01 18:51	6-18-01

ANDRADE, CELIA M
00 000563-55-51
052 2 03/17/937 064 1
06/18/01

ALLERGIES

ISOLATION TYPE UNIVERSAL PRECAUTIONS

ONSET LNMP

IND.	MEDI-CARE	NON MEMBER	MEDI-CAL	KFHP
AREA	WAT3	RM WAT3	BED 04	EXT.
NURSE	SHULER	UNUVA		

TYPE OF EXAM			ORDER #	CPT CODE	AMOUNT
SPINE, CERVICAL, LIMITED	(*)	000007204000	0001	72040	
ANKLE, RIGHT COMPLETE	(*)	000007360098	0002	73610	

REASON FOR EXAM/ PERTINENT CLINICAL INFORMATION R/O FX

RESTRAINTS N ORD MD CODE: YIUCH DEPT SU LOC

SPECIAL INSTRUCTIONS PT IN THE WAITING AREA OF X-RAY

☐ CHECK WITH RADIOLOGIST FOR VIEWS ☐ HAVE RADIOLOGIST CHECK FILMS BEFORE PATIENT LEAVES

NO. OF FILMS: 14.____ 10.2 ____ 11.____ 8.____ OCC. ____

TECHNOLOGIST'S NOTES: C 7,T1 INITIALS

PATIENT ADMITTED YES ☐ NO ☐

PATIENT ADDRESS 5678 SHULL ST SP 17 BELL GARDENS CA 90201

HM. PHONE 562 927[illegible]

WK. PHONE 562 9279497

MODE OF TRANSPORTATION WHEELCHAIR

REQUESTING M.D. YIU, CHUN

TYPED NAME	MEDICAL RECORD NUMBER	CALL STAT REPORT TO EXT. MD	SEND COPY OF REPORT TO

TO BE USED ONLY BY RADIOLOGIST

( ) NO SIGNIFICANT ABNORMALITY

( ) NO CHANGE SINCE __/__/__

RADIOLOGIST: _____, M.D.

PERSONAL MD: SANTAMARIA, MARGARITA

PRELIM READING
(X) NEGATIVE
( ) POSITIVE FINDINGS_____

_____ DR'S INIT.__

ANDRADE, CELIA M. 000005635551 F DOB: 03/17/37 EXAM: 06/18/01 YIU
CERVICAL SPINE:

There is a mild degree of narrowing of the disc space seen between C3-4 region and moderate degree of degenerative disc disease seen between C4 to C7 with spurring and osteophyte formation. There is no evidence of fracture or dislocation.

KANAGAL SAPPA, M.D.

KS/jb D: 06/20/01 T: 06/21/01

KAISER FOUNDATION HOSPITALS
FILE 54602
LOS ANGELES, CA 90074-4602
888-512-6217

3 PATIENT CONTROL NO. 65158354

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I.D.	10 L-R D.	11
94-1105628	061801	061801					

12 PATIENT NAME	13 PATIENT ADDRESS
ANDRADE, CELIA M	5678 SHULL ST SP 17 BELL GARDENS CA 902

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24-30 CONDITION CODES	31
03171937	F	M							5635551		

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
05	061401										A B C

ANDRADE, CELIA M
5678 SHULL ST SP 17

BELL GARDENS CA 90201

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
250	PHARMACY	99070	061801	1	40 99		
001	TOTAL				40 99		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DATE	56
JUAN J. DOMINGUEZ,ESQ.		Y	Y			

57 DUE FROM PATIENT

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
K-MART CARSON, CALIF.	15	UNKNOWN		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

OTHER DIAG. CODES 67 CODE	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE
8470	71947									

78 P.C.	79	PRINCIPIL PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
9							

OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID	83 OTHER PHYS. ID	OTHER PHYS. ID

84 REMARKS
JUAN J. DOMINGUEZ,ESQ.
3250 WILSHIRE BLVD., 12TH FLOOR
LOS ANGELES CA 90010-1502
ATTENTION: GONZALO TRUJILLO

85 PROVIDER REPRESENTATIVE
X

86 DATE
12/2

KAISER FOUNDATION HOSPITAL
FILE 54602
LOS ANGELES, CA 90074-460
888-512-6217

PATIENT CONTROL NO. 65158354

25 FED. TAX NO.	26 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I.D.	10 L-R D.	11
94-1105628	061401	061801					

12 PATIENT NAME: ANDRADE, CELIA M

13 PATIENT ADDRESS: 5678 SHULL ST SP 17 BELL GARDENS CA 902

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	25	26	27	28	29	30	31
03171937	F								5635551								

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36	37 OCCURRENCE SPAN CODE	FROM	THROUGH
05	061401										

ANDRADE, CELIA M
5678 SHULL ST SP 17

BELL GARDENS CA 90201

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
320	DX X-RAY	7204027	061801	1	190 00		
450	EMERG ROOM	99283	061801	1	270 00		
972	PRO FEE-RAD-DX	7204026	061801	1	73 00		
981	PRO FEE-ER	99283	061801	1	165 00		
001	TOTAL				698 00		

RECEIVED
DEC 18 1998

MEDICAL RECORDS ATTACHED

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DATE	56
JUAN J. DOMINGUEZ,ESQ.		Y	Y			

57 DUE FROM PATIENT

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
K-MART CARSON, CALIF.	15	UNKNOWN		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

	OTHER DIAG. CODES 67 CODE	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE
	8470	71947									

79 P.C.	80 PRINCIPLE PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
9			A		
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID
	C		D		

84 REMARKS: JUAN J. DOMINGUEZ,ESQ.
3250 WILSHIRE BLVD., 12TH FLOOR
LOS ANGELES CA 90010-1602
ATTENTION: GONZALO TRUJILLO

OTHER PHYS. ID

85 PROVIDER REPRESENTATIVE: X

86 DATE: 12/17

UB-92 (HCFA 1450) NUCC 1.0 (10/94)

KAISER FOUNDATION HOSPITA
FILE 54602
LOS ANGELES, CA 90074-460
888-512-6217

3 PATIENT CONTROL NO. 65158354

25 FED. TAX NO.	26 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I.D.	10 L-R D.	11
94-1105628	061401	061801					

12 PATIENT NAME: ANDRADE, CELIA M

13 PATIENT ADDRESS: 5678 SHULL ST SP 17 BELL GARDENS CA 902

14 BIRTHDATE	15 SEX	16 MS	17 DATE	ADMISSION 18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
03171937	F								5635551								

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
05	061401										A
											B
											C

ANDRADE, CELIA M
5678 SHULL ST SP 17

BELL GARDENS CA 90201

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a						
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
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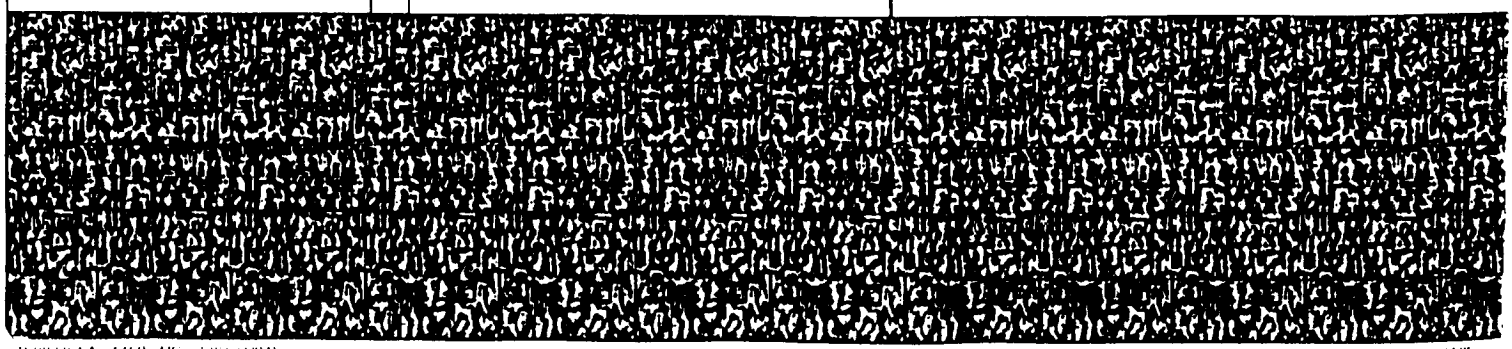
981	PRO FEE-ER	99283	061801	1	155 00		
001	TOTAL				698 00		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DATE	56
JUAN J. DOMINGUEZ, ESQ.		Y	Y			

57 DUE FROM PATIENT

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
K-MART CARSON, CALIF.	15	UNKNOWN		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION



DG PT-O FC-36 PAYOR-01 001 BT-C DRG- M/B-

KAISER PERMANENTE®
Southern California Permanente Medical Group
Kaiser Foundation Hospitals

DETAIL BILL
KAISER PERMANENTE
FILE 54602
LOS ANGELES, CA 90074-4602
PHONE 888-512-6217
HOURS: 8:00AM - 5:00PM

BILL DATE 12/22/01
FC:36 LAST DATE 12/12/01

ACCT#: 65158
MRN#: 5635
BILL TYPE: C

ANDRADE, CELIA M

GUARANTOR NAME/ADDRESS
ANDRADE, CELIA M
5678 SHULL ST SP 17

BELL GARDENS CA 90201

INSURANCE CO.
JUAN J. DOMINGUEZ,ESQ.

ICD9: 8470

POLICY NO.
UNKNOWN

SS#:
DOI: 06/14/01

DATE	QTY	DESCRIPTION	CPT4	MODS	TOTAL CHARG
06/18/01	1	PHARMACY CHARGES	99070		40.9
		20 NAPROXEN SODIUM 550MG TABS			

KAISER PERMANENTE
FILE 54602
LOS ANGELES, CA 90074-4602

SUBTOTAL CURRENT CHARGES	40.9
SUBTOTAL ADJUSTMENTS	.0
SUBTOTAL PAYMENTS	.0
PREVIOUS BALANCE FORWARD	698.0
TOTAL DUE	738.9

ACCOUNT NO. PATIENT NAME
65158354 ANDRADE, CELIA M

PAGE 001 FC-36

TO ASSURE PROPER CREDIT, PLEASE WRITE ACCOUNT NUMBER ON YOUR CHECK
AND RETURN THIS PORTION WITH YOUR PAYMENT

PT-U FC-36 PAYOR-01 [illegible] BI-U DRG- M/B-

KAISER PERMANENTE®
Southern California Permanente Medical Group
Kaiser Foundation Hospitals

DETAIL BILL
KAISER PERMANENTE
FILE 54602
LOS ANGELES, CA 90074-4602
PHONE 888-512-6217
HOURS: 8:00AM - 5:00PM

FC:36

BILL DATE 12/12/01

ACCT#: 6515
MRN#: 563
BILL TYPE: O

ANDRADE, CELIA M

GUARANTOR NAME/ADDRESS
ANDRADE, CELIA M
5678 SHULL ST SP 17

BELL GARDENS CA 90201

INSURANCE CO.
JUAN J. DOMINGUEZ,ESQ.

ICD9: 8470

POLICY NO.
UNKNOWN

SS#:
DOI: 06/14/01

DATE	QTY	DESCRIPTION	CPT4	MODS	TOTAL CHAR
06/18/01	1	EMERGENCY ROOM - LEVEL 3	99283		270.
06/18/01	1	EMERGENCY DEPT VISIT	99283		165.
06/18/01	1	SPINE, CERVICAL; ANTEROPOST TC	72040	27	190.
06/18/01	1	SPINE, CERVICAL; ANTEROPOST PC	72040	26	73.

File
01061116

KAISER PERMANENTE
FILE 54602
LOS ANGELES, CA 90074-4602

ACCOUNT NO. PATIENT NAME
65158354 ANDRADE, CELIA M

SUBTOTAL CURRENT CHARGES	698.(
SUBTOTAL ADJUSTMENTS	.(
SUBTOTAL PAYMENTS	.(
PREVIOUS BALANCE FORWARD	.(
TOTAL DUE	698.(

PAGE 001 FC-36

TO ASSURE PROPER CREDIT, PLEASE WRITE ACCOUNT NUMBER ON YOUR CHECK
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DD PT-O FC-36 PAYOR-01 OC BT-O DRG- M/B-

KAISER PERMANENTE®
Southern California Permanente Medical Group
Kaiser Foundation Hospitals

DETAIL BILL
KAISER PERMANENTE
FILE 54602
LOS ANGELES, CA 90074-4602
PHONE 888-512-6217
HOURS: 8:00AM - 5:00PM

FC:36

BILL DATE 12/12/01

ACCT#: 65158
MRN#: 563
BILL TYPE: O

ANDRADE, CELIA M

GUARANTOR NAME/ADDRESS
ANDRADE, CELIA M
5678 SHULL ST SP 17

BELL GARDENS CA 90201

INSURANCE CO.
JUAN J. DOMINGUEZ,ESQ.

ICD9: 8470

POLICY NO.
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06/18/01	1	EMERGENCY ROOM - LEVEL 3	99283		270.(
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06/18/01	1	SPINE, CERVICAL; ANTEROPOST TC	72040	27	190.(
06/18/01	1	SPINE, CERVICAL; ANTEROPOST PC	72040	26	73.(

KAISER PERMANENTE
FILE 54602
LOS ANGELES, CA 90074-4602

SUBTOTAL CURRENT CHARGES	698.
SUBTOTAL ADJUSTMENTS	.
SUBTOTAL PAYMENTS	.
PREVIOUS BALANCE FORWARD	.
TOTAL DUE	698.

ACCOUNT NO. PATIENT NAME
65158354 ANDRADE, CELIA M

PAGE 001 FC-36

TO ASSURE PROPER CREDIT, PLEASE WRITE ACCOUNT NUMBER ON YOUR CHECK
AND RETURN THIS PORTION WITH YOUR PAYMENT

FAMILY HEALTH GROUP

9838 S. Paramount Blvd.
Downey, CA 90240
(562) 928-2509
Fax (562) 927-0928

Juan J. Dominguez
Attorney at Law
3250 Wilshire Blvd.
Penthouse
Los Angeles, CA. 90010

Patient's Name: Andrade, Celia
Date of Accident: June 12, 2001

FINAL MEDICAL REPORT

Dear Mr. Dominguez:

The following is a complete medical report and itemization of charges for services rendered for the above-named patient, for injuries sustained as a result of an involvement in a slip and fall accident.

The findings of the initial examination along with the patient's subsequent course of treatment are included in the following report:

The historical information used in this report was provided by the patient at the time of the initial examination. I believe it to be an accurate representation of the events as they occurred.

HISTORY OF THE CURRENT TRAUMA

The patient stated that at the time of the accident she was at KMart in the city of Carson. While walking she suddenly slipped and fell on the floor, due to some hand cleaner liquid that was on the floor. Ms. Andrade tried to get up, but she slipped and fell on the floor again.

She denied any bleeding from her nose or ears. She did not suffer amnesia or loss of consciousness, but she felt an immediate pain over her neck and upper back. She was also nervous, confused and scared following the accident. There were emergency services rendered at the scene of the accident. She was transported via ambulance to Kaiser Hospital where she was examined, x-rays were obtained, medication given and released on the same day.

Because her symptoms failed to subside, she presented herself to this office on June 18, 2001 for evaluation and treatment.

PRESENTING CHIEF COMPLAINTS

On the day of her initial examination, the patient presented with the following subjective symptomatology:

1. Posterior neck pain and stiffness.

2. Upper back and interscapular pain and stiffness.

3. Multiple bruises and swelling of the right forearm.

4. Mild bruise on the anterior compartment of the right lower leg.

PAST MEDICAL HISTORY

Major Illnesses:	None
Surgical History:	None
Fractures:	None
Allergies:	None
Current Medication:	None
Previous Accident:	None

INITIAL PHYSICAL EXAMINATION

A comprehensive physical examination was accomplished on June 21, 2001, and revealed the patient to be a well-developed and nourished female.

At the time of the examination the patient was alert, cooperative, and well oriented. She was in mild distress due pain.

SKIN: Warm. No evidence of abrasions, lacerations, contusions or hematomas; other than those indicated in the present injury. No active dermatoses.

HEAD: The head was normocephalic and atraumatic. The scalp was intact, without lacerations or hematomas.

EYES: Examination of the eyes revealed the pupils to be round and regular with consensual reaction to light and accommodation.

EARS: External auditory canals were non-tender and non-inflamed. Tympanic membranes were clear bilaterally. Auditory canals were patent.

INITIAL PHYSICAL EXAMINATION (CON'T):

NOSE: The nose was not traumatic, without deformity. Nares were patent, bilaterally, with no evidence of acute or recent bleeding. No sinus tenderness.

FACE: Facial bones were intact without deformity or tenderness.

MOUTH AND OROPHARYNX: Normal mucous membranes were present without lesions. The tongue was in midline. The pharynx was clear. Normal swallow mechanism and gag reflex were noted.

NECK: The trachea was located in midline. There was no adenopathy or thyromegaly. Carotid pulses were normal.

HEART: Sounds were of good quality. There was no murmur, rub or gallop present. There was no clinical cardiomegaly.

CHEST: The chest was symmetrical without evidence of increased tenderness over the rib cage, costal cartilage, or over the sternum. Breathing was quiet and not labored.

ABDOMEN: The abdomen was soft and non-tender, with no organomegaly or masses palpable. The bowel sounds were normal.

PULMONARY: Breath sounds were bronchovesicular in quality. No dullness or changes in tactile fremitus was noted. Lungs were clear to percussion and auscultation.

MUSCULOSKELETAL: There were no muscle spasm, stiffness, deformity or limitation in range of motion in any areas other than those indicated in the present injury description.

MUSCULO-SKELETAL EXAMINATION

CERVICAL SPINE:

Slow movements and a decreased curvature were noted. Motion palpation revealed 2/5+ tenderness over the bony structures of the cervical spine at C1-C7 spinous processes. Palpation of the anterior and posterior soft tissue revealed moderate tenderness and myospasm over the paraspinal structures and the ligamentum nuchae, as well as over the sub-occipital muscles. Range of motion was restricted and painful in all planes. Distraction, Shoulder Depression, Foramina Compression and Hyper Extension Compression tests were all positive.

CERVICAL SPINE (CON'T):

ROM:	NORMAL	TEST	PAIN
Forward Flexion	45	35	+2/5
Extension	55	40	+2/5
Rt. Lateral Flexion	60	50	+2/5
Lt. Lateral Flexion	60	50	+2/5
Lt. Lateral Rotation	70	55	+2/5
Rt. Lateral Rotation	70	60	+2/5

THORACIC SPINE:

There is normal kyphosis of the thoracic spine. No evidence of scoliosis. There is no evidence of scarring. There is diffuse mid line tenderness to palpation. There are spasms of the paraspinous muscles of the thoracic spine. There is +2 tenderness to palpation along paraspinal muscles of the thoracic spine, particularly along both rhomboid muscles. There are myofascial trigger points. There is no rib tenderness.

LUMBAR SPINE:

There is a normal lumbar lordosis with no evidence of significant scoliosis. There is no evidence of tenderness to paraspinal muscle palpation, bilaterally. Pressure applied to the apex of the sacrum, with the patient in a prone position, produced no discomfort, bilaterally. The lower extremities were not functionally impaired and there was no gross evidence of comparative atrophy noted. Ranges of motion of the lumbar spine were performed slowly and without significant tenderness or discomfort. The patient is able to get the fingers to the floor during forward flexion with the knees extended. Extension, right and left lateral flexion and right and left rotation were within normal limits. Kemp signs were negative bilaterally. Straight Leg, Lasegue's, Braggard's, Goldwaith, and Soto Hall tests were negative, bilaterally. Pinwheel test on the lower extremities proved negative left and negative right. Patellar and Achilles tendon reflexes were within normal limits.

UPPER EXTREMITIES:

The shoulder girdles were level. There is evidence of two bruises measuring about 2x3cm and 1x2in in the anterior compartment of right forearm. These bruises appear to be healing well. There were no abnormalities/deformities noted on gross examination of both upper extremities. There was no arm length discrepancies noted. The ranges of motion were full and painless in all planes.

RECOMMENDATIONS FOR TREATMENT

Due to the marked pain and sprain injuries sustained as a consequence of the previously described trauma, the patient was provided with complete instructions regarding home care, which incorporated the use of local moist heat, maximal rest and reduced physical activity, as well as stretching exercises to be performed at home on a daily basis. The course of treatment, which was discussed and recommended to the patient, consisted of a combination modalities addressed to alleviate pain by improving circulation and lessening muscular spasm, and thus regains normal function and full mobility.

Furthermore, the patient was advised to the necessity of returning at periodic intervals during the treatment program for follow-up examinations, so that the response, or lack thereof to the therapy treatment could be determined and changes be made in the therapy regimen, if necessary.

CLINICAL COURSE

After a comprehensive evaluation, including a complete medical and surgical history, as well as a physical examination, and the nature and extent of injuries were thoroughly discussed with the patient, she received her treatment.

Ms. Andrade has been suffering and trying to recuperate from the after effects of a slip and fall. She has made satisfactory improvement, obtaining progressive, general relief of symptoms and when last seen on her last treatment, she stated that she felt much better, in comparison to a month ago. Upper back pain, right forearm bruises and left lower extremity bruises have now resolved. She did complain however, of some residual muscle tension and episodic aggravations of pain in her neck and upper back. Stress, increased physical activity or after continuous repetitive movements, the tension developed into an actual pain requiring treatment and rest.

However, it was felt that sufficient significant improvement in symptomatology had been achieved; that a plateau in her treatment had been obtained and in view of the progress thus far obtained, she was advised to discontinue her treatment.

It was felt that the patient had attained the maximum benefit of conservative management and she was discharged from medical care at this time. She was advised to return to this office should she experience aggravation of her symptoms that cannot be controlled with home management.

DISCUSSION AND RECOMMENDATIONS:

Ms. Andrade has suffered injury involving her cervical spine, thoracic spine, right forearm, lowerleg regions, secondary to a slip and fall accident that occurred on June 12, 2001. Please refer to the opening paragraphs of this report for a detailed explanation of the mechanisms of injury and developing symptoms, which continue to plague the patient to the present time, prompting her presentation to this office on the above-noted date, for initial evaluation and appropriate treatment.

MUSCULO-SKELETAL EXAMINATION (CON'T)

LOWER EXTREMITIES:

The pelvis was level. There is evidence of bruise measuring about 3x4cm on the anterior compartment of the right lower leg this bruise appears to be healing well. There were no other abnormal findings noted on gross examination of both lower extremities. There was no muscle atrophy or hypertrophy noted. There was no leg length discrepancies noted. The ranges of motion were within normal limits and painless in all planes. Range of motion of the right ankle was full without pain.

NEUROLOGICAL EXAMINATION

Sensorium:

She was alert and responsive, and well oriented to time, place and person.

Cranial Nerves:

The cranial nerves were examined in a sequential manner and found to be essentially within normal limits.

Deep Tendon Reflexes:

There was no elicitation of pathological reflexes. Deep tendon reflexes of the upper and lower extremities were present, and were active and symmetrical bilaterally.

Coordination:

On coordination testing, good finger-nose, heel-shin, and rapid alternating movements of the hands and feet tests were all normal.

DIAGNOSTIC IMPRESSIONS

1. Acute traumatic cervical strain/sprain.
2. Acute traumatic thoracic spine strain/sprain with myofascitis.
3. Multiple right forearm contusion with bruises.
4. Left lower extremity contusion with bruises.

DISCUSSION AND RECOMMENDATIONS (CON'T):

On initial presentation to this office, the patient was in an acute stage of discomfort, demonstrating signs and symptoms consistent with the described mechanisms of injury and above-rendered diagnostic impression.

The slip and fall accident has resulted in musculoligamentous stretch and strain-type injury involving the spine, as well as soft tissue contusion, as described in the physical examination section of this report. Skeletal malalignment and stretch injury affecting the normal biochemical positioning was also apparent.

As stated, the patient was initially seen and evaluated in this office by the undersigned on June 12, 2001, in order to clearly elucidate the nature and extent of her injuries, arising from the subject slip and fall accident. Following comprehensive evaluation of the patient at that time, it was felt that Ms. Andrade could very well benefit from a course of conservative treatment, and accordingly, by her request, she was started on an intensive course of multi modality conservative care, consisting of hot packs, ultrasound, and electrical muscle stimulation. In conjunction with chiropractic manipulative therapy directed toward the involved areas.

The patient was also instructed in home strengthening and stretching exercises of the involved muscle groups, in attempts to increase functional status and endurance.

Following initial presentation to this office on June 18, 2001, the patient's progress in recovery was monitored at regular intervals. The patient's progress was slow but steady, with occasional tightness and spasming of the traumatized musculoligamentous-tendinous structures on exertion.

Although substantially improved at the time of discharge, the patient continued to experience a degree of residual discomfort involving her neck and back, especially noted following periods of strenuous or repetitive activity.

On August 22, 2001 Ms. Andrade was released from further active medical care through this office, having reached a stationary plateau in her recovery phase. It was felt that she had derived maximal benefit from intensive conservative treatment that had been provided through this facility.

The aforementioned June 12, 2001 accident has resulted in overstretching of muscles tendons and ligaments of the above-described areas, causing fibrous tearing of the associated soft-tissue support structures, leading to hemorrhage, and escape of fluids into the surrounding tissues. The body tends to heal the damage areas by forming granulation fibers, which in due process, is replaced by scar tissue, being substantially more friable than the previously healthy tissues.

It is anticipated that the patient will experience periodic exacerbative episodes of painful musculo-skeletal symptoms from time to time, depending on activity level. During these periods, the patient may well require future medical treatment, including re-evaluation, physiotherapeutic/chiropractic modalities, as indicated, lower back support, firm sleep support, and appropriate oral medications, as may be deemed necessary, on a symptomatic and supportive basis.

MUSCULO-SKELETAL EXAMINATION (CON'T)

Lifestyle modification to prevent re-injury or aggravation to the aforementioned traumatized regions was also discussed, particularly sleeping positions, taking time for interval rests, as necessary, and generalized graded exercise program.

The patient was further advised to exercise caution in performance of daily activities for the foreseeable future, including hobbies and recreational pursuits, to reduce the possibility of recurrent painful symptoms.

It is felt that the above-described symptoms and need for treatment are solely attributable to the slip and fall accident that occurred on June 12, 2001.

Although no further appointments have been scheduled through this office at this time, we would be pleased to re-evaluate the patient at an appropriate future date, if indicated.

PROGNOSIS

One should keep in mind that unstable joints and ligamentous structures, which are secondary to trauma can result in a variety of further sequelae and reoccurrence of symptomatology referable to the injured regions. Moreover, any further microtrauma to the insulted tissues could result in increased symptomatology expressed as ligamentous instability, and thus she might be in need of an added complete course of therapy. Therefore, her prognosis is considered guarded.

The patient understands this and will return at once should any such problems arise. Otherwise, she should continue to do well.

DISCLOSURE

The above report is for assessment of the injury noted within the application, and is not to be construed as a complete physical examination for general health purposes. Only these symptoms, which are believed to have been involved in, the injury, or that might relate to the injury, have been assessed/discussed.

Very truly yours,

Paul J. Lopez, D.C.

PJL/TL/la

ITEMIZED STATEMENT

JUAN J DOMINGUEZ
LAW OFFICE
3250 WILSHIRE BLVD SUITE 2200
LOS ANGELES CA 90010

CLAIM NO:
ADJUSTER:

EMPLOYER:

PATIENT:
CELIA ANDRADE 8349 PI
5678 SHULL ST
BELL GARDENS CA 90201

BIRTHDAY:
03 17 37
SEX:F
RELATIONSHIP:

INSURED:

I.D.#
GROUP:

OTHER INSURANCE:

WORK INJURY: NO

INSUREDS ADDRESS:

AUTO ACCIDENT: YES

RELEASE OF INFORMATION:ON FILE

ASSIGNMENT OF BENEFITS: ON FILE

ILLNESS/ACC DATE:06 12 2001

FIRST TREATMENT:

DIAGNOSIS:
847 1 THORACIC SPRAIN/STRAIN
847 0 CERVICAL SPRAIN OR STRAIN

DATE	DESCRIPTION	PROC CODE	AMOUNT
06-21-2001	INITIAL EXAM	99243	150.00
06-22-2001	ELECT STIM	97014	35.00
06-22-2001	HOT/COLD PACK	97010	30.00
06-23-2001	MANIP 1 TO 2 REGIONS	98940	40.05
06-23-2001	ELECT STIM	97014	35.00
06-23-2001	HOT/COLD PACK	97010	30.00
06-23-2001	ULTRASOUND	97128	28.00
06-25-2001	ELECT STIM	97014	35.00
06-25-2001	HOT/COLD PACK	97010	30.00
06-26-2001	MANIP 1 TO 2 REGIONS	98940	40.05
06-26-2001	ELECT STIM	97014	35.00
06-26-2001	HOT/COLD PACK	97010	30.00
06-27-2001	ELECT STIM	97014	35.00
06-27-2001	HOT/COLD PACK	97010	30.00
06-28-2001	MANIP 1 TO 2 REGIONS	98940	40.05
06-28-2001	ELECT STIM	97014	35.00
06-28-2001	HOT/COLD PACK	97010	30.00
06-29-2001	ELECT STIM	97014	35.00

Continued...

09 17 01

Acct No 8349

Family Health Group
9838 S Paramount Blvd
Downey, CA 90240-3804
(562)928-2509

ITEMIZED STATEMENT

JUAN J DOMINGUEZ
LAW OFFICE
3250 WILSHIRE BLVD SUITE 2200
LOS ANGELES CA 90010

CLAIM NO:
ADJUSTER:

EMPLOYER:

PATIENT:
CELIA ANDRADE 8349 PI
5678 SHULL ST
BELL GARDENS CA 90201

BIRTHDAY: 03 17 37
SEX:F
RELATIONSHIP:

INSURED:
I.D.#
GROUP:

OTHER INSURANCE:

WORK INJURY: NO
AUTO ACCIDENT: YES

INSUREDS ADDRESS:

RELEASE OF INFORMATION:ON FILE

ASSIGNMENT OF BENEFITS: ON FILE

ILLNESS/ACC DATE:06 12 2001

FIRST TREATMENT:

DIAGNOSIS:
847 1 THORACIC SPRAIN/STRAIN
847 0 CERVICAL SPRAIN OR STRAIN

DATE	DESCRIPTION	PROC CODE	AMOUNT
06-29-2001	HOT/COLD PACK	97010	30.00
06-30-2001	MANIP 1 TO 2 REGIONS	98940	40.05
06-30-2001	MASSAGE	97124	38.00
06-30-2001	MECHANICAL TRACTION	97012	35.00
06-30-2001	HOT/COLD PACK	97010	30.00
07-02-2001	ELECT STIM	97014	35.00
07-02-2001	HOT/COLD PACK	97010	30.00
07-05-2001	MANIP 1 TO 2 REGIONS	98940	40.05
07-05-2001	ELECT STIM	97014	35.00
07-05-2001	HOT/COLD PACK	97010	30.00
07-06-2001	ELECT STIM	970141	35.00
07-07-2001	ELECT STIM	97014	35.00
07-07-2001	HOT/COLD PACK	97010	30.00
07-09-2001	ELECT STIM	97014	35.00
07-09-2001	HOT/COLD PACK	97010	30.00
07-10-2001	MANIP 1 TO 2 REGIONS	98940	40.05
07-10-2001	MASSAGE	97124	38.00
07-10-2001	MECHANICAL TRACTION	97012	35.00

Continued...

09 17 01

Acct No 8349

Family Health Group
9838 S Paramount Blvd
Downey, CA 90240-3804
(562)928-2509

ITEMIZED STATEMENT

JUAN J DOMINGUEZ
LAW OFFICE
3250 WILSHIRE BLVD SUITE 2200
LOS ANGELES CA 90010

CLAIM NO:
ADJUSTER:

EMPLOYER:

PATIENT:
CELIA ANDRADE 8349 PI
5678 SHULL ST
BELL GARDENS CA 90201

BIRTHDAY:
03 17 37
SEX:F
RELATIONSHIP:

INSURED:

I.D.#
GROUP:

OTHER INSURANCE:

WORK INJURY: NO

AUTO ACCIDENT: YES

INSUREDS ADDRESS:

RELEASE OF INFORMATION:ON FILE

ASSIGNMENT OF BENEFITS: ON FILE

ILLNESS/ACC DATE:06 12 2001

FIRST TREATMENT:

DIAGNOSIS:
847 1 THORACIC SPRAIN/STRAIN
847 0 CERVICAL SPRAIN OR STRAIN

DATE	DESCRIPTION	PROC CODE	AMOUNT
07-10-2001	HOT/COLD PACK	97010	30.00
07-11-2001	ELECT STIM	97014	35.00
07-11-2001	HOT/COLD PACK	97010	30.00
07-16-2001	MANIP 1 TO 2 REGIONS	98940	40.05
07-16-2001	ELECT STIM	97014	35.00
07-16-2001	HOT/COLD PACK	97010	30.00
07-18-2001	ELECT STIM	97014	35.00
07-18-2001	HOT/COLD PACK	97010	30.00
07-20-2001	MYO. RELEASE/SFT TISSUE	97250	44.28
07-20-2001	ELECT STIM	97014	35.00
07-20-2001	HOT/COLD PACK	97010	30.00
07-23-2001	MANIP 1 TO 2 REGIONS	98940	40.05
07-23-2001	ELECT STIM	97014	35.00
07-23-2001	HOT/COLD PACK	97010	30.00
07-25-2001	ELECT STIM	97014	35.00
07-25-2001	HOT/COLD PACK	97010	30.00
07-27-2001	MASSAGE	97124	38.00
07-27-2001	MECHANICAL TRACTION	97012	35.00

Continued...

09 17 01

Acct No 8349

Family Health Group
9838 S Paramount Blvd
Downey, CA 90240-3804
(562)928-2509

ITEMIZED STATEMENT

JUAN J DOMINGUEZ
LAW OFFICE
3250 WILSHIRE BLVD SUITE 2200
LOS ANGELES CA 90010

CLAIM NO:
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EMPLOYER:

PATIENT:
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5678 SHULL ST
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BIRTHDAY:
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AUTO ACCIDENT: YES

INSUREDS ADDRESS:

RELEASE OF INFORMATION:ON FILE

ASSIGNMENT OF BENEFITS: ON FILE

ILLNESS/ACC DATE:06 12 2001

FIRST TREATMENT:

DIAGNOSIS:
847 1 THORACIC SPRAIN/STRAIN
847 0 CERVICAL SPRAIN OR STRAIN

DATE	DESCRIPTION	PROC CODE	AMOUNT
07-27-2001	HOT/COLD PACK	97010	30.00
07-30-2001	ELECT STIM	9701411	35.00
08-01-2001	ELECT STIM	97014	35.00
08-01-2001	HOT/COLD PACK	97010	30.00
08-03-2001	ELECT STIM	97014	35.00
08-03-2001	HOT/COLD PACK	97010	30.00
08-06-2001	MASSAGE	97124	38.00
08-06-2001	MECHANICAL TRACTION	97012	35.00
08-06-2001	HOT/COLD PACK	97010	30.00
08-08-2001	ELECT STIM	97014	35.00
08-08-2001	HOT/COLD PACK	97010	30.00
08-10-2001	ELECT STIM	97014	35.00
08-10-2001	HOT/COLD PACK	97010	30.00
08-13-2001	MANIP 1 TO 2 REGIONS	98940	40.05
08-13-2001	ELECT STIM	97014	35.00
08-13-2001	HOT/COLD PACK	97010	30.00
08-15-2001	ELECT STIM	97014	35.00
08-15-2001	HOT/COLD PACK	97010	30.00

Continued...

09 17 01

Acct No 8349

Family Health Group
9838 S Paramount Blvd
Downey, CA 90240-3804
(562)928-2509

ITEMIZED STATEMENT

JUAN J DOMINGUEZ
LAW OFFICE
3250 WILSHIRE BLVD SUITE 2200
LOS ANGELES CA 90010

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BELL GARDENS CA 90201

BIRTHDAY: 03 17 37
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RELATIONSHIP:

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I.D.#
GROUP:

OTHER INSURANCE:

WORK INJURY: NO
AUTO ACCIDENT: YES

INSUREDS ADDRESS:

RELEASE OF INFORMATION:ON FILE

ASSIGNMENT OF BENEFITS: ON FILE

ILLNESS/ACC DATE:06 12 2001

FIRST TREATMENT:

DIAGNOSIS:
847 1 THORACIC SPRAIN/STRAIN
847 0 CERVICAL SPRAIN OR STRAIN

DATE	DESCRIPTION	PROC CODE	AMOUNT
08-17-2001	ELECT STIM	97014	35.00
08-17-2001	HOT/COLD PACK	97010	30.00
08-20-2001	MASSAGE	97124	38.00
08-20-2001	MECHANICAL TRACTION	97012	35.00
08-20-2001	HOT/COLD PACK	97010	30.00
08-22-2001	FINAL REPORT	99215	125.00
08-22-2001	FINAL EXAM	99243	150.00
		TOTAL	3002.73

DATE:09 17 01

Family Health Group

Family Health Group

Employer ID No
95-4575544
Social Sec No
N/A

Family Health Group
9838 S Paramount Blvd
Downey, CA 90240-3804
(562)928-2509

Venus
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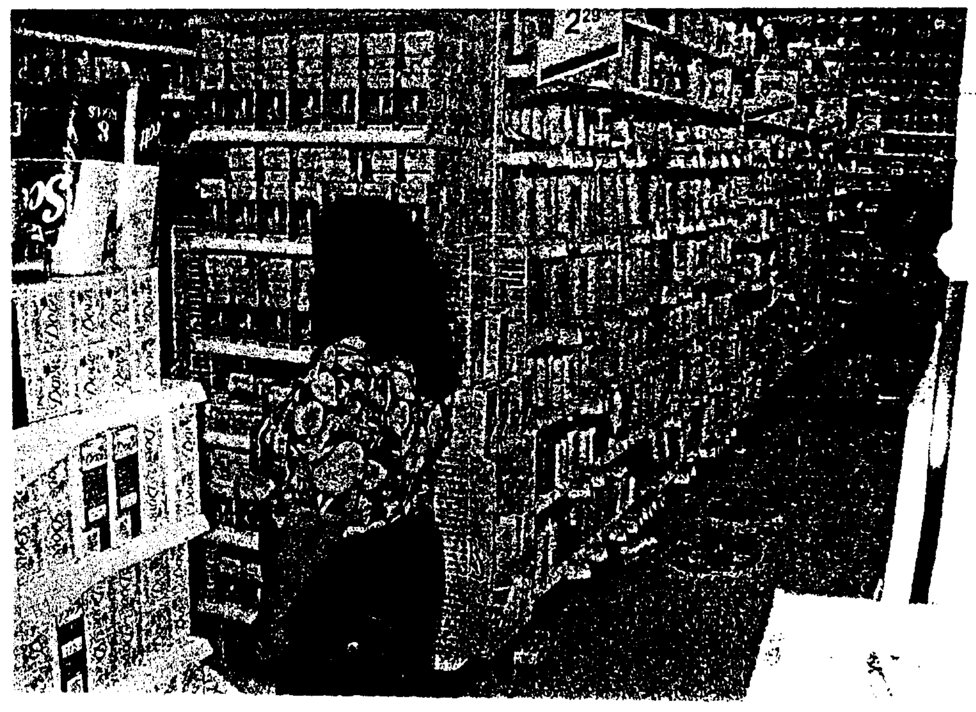
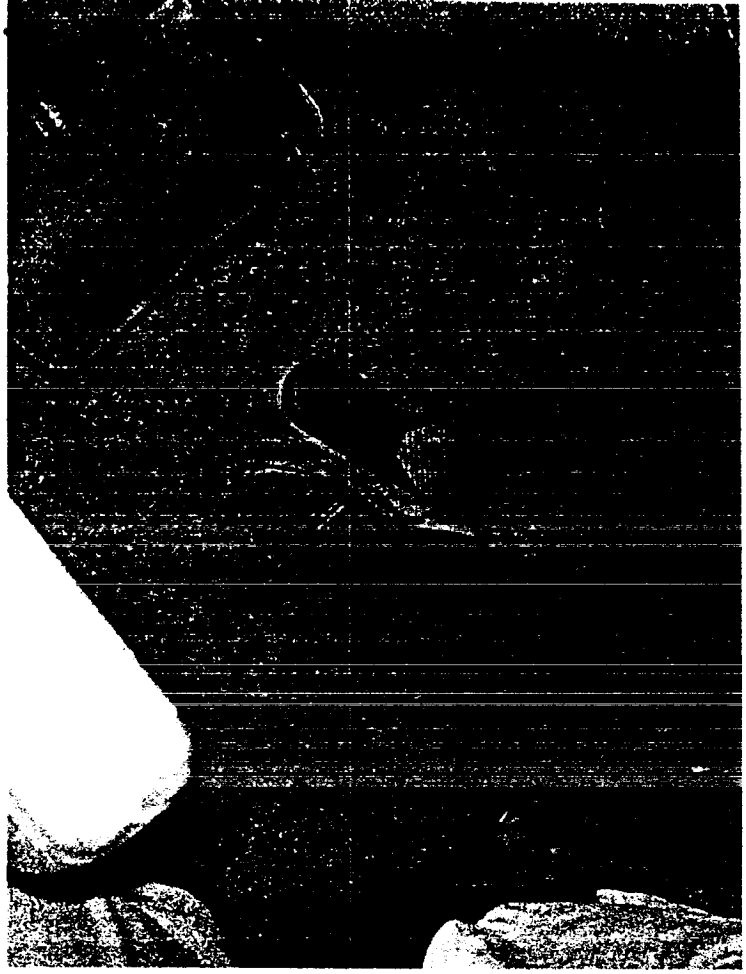
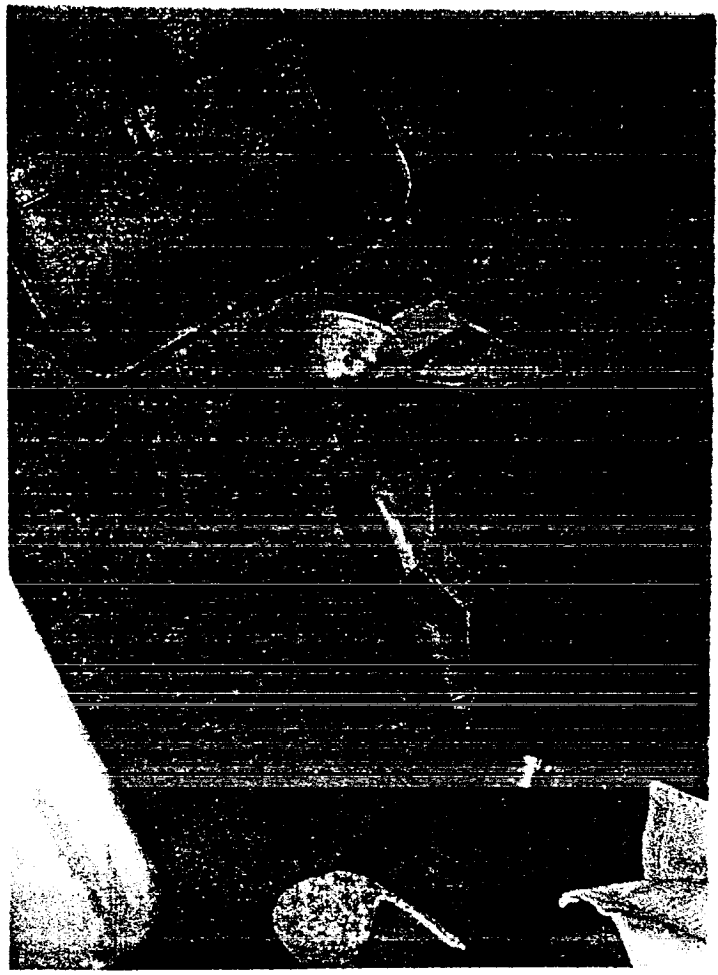
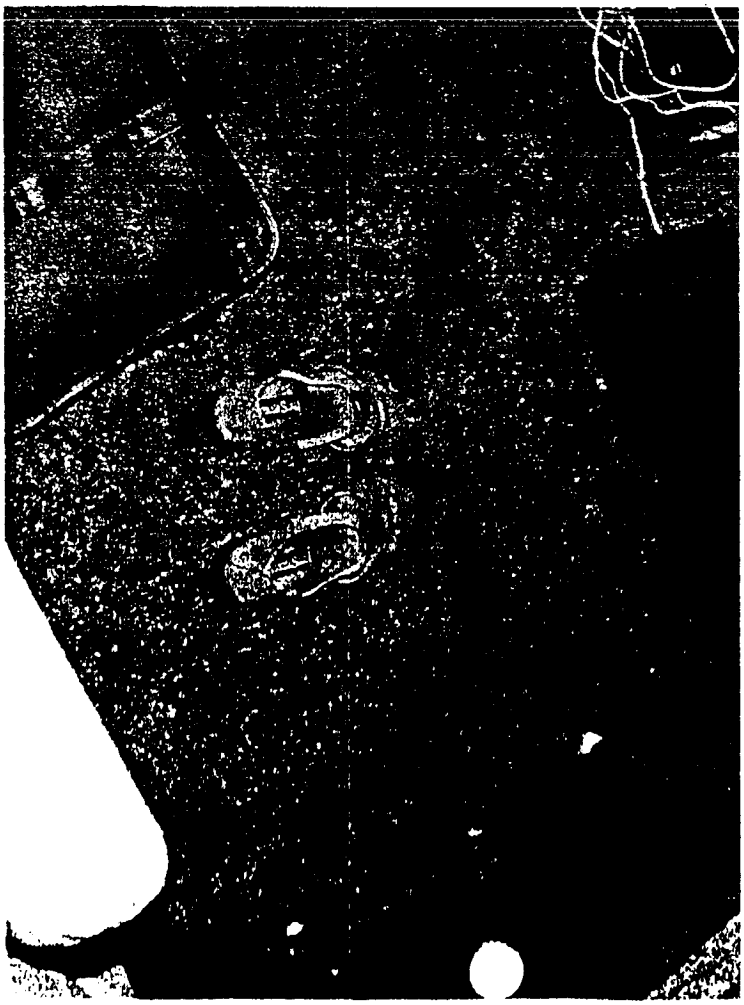
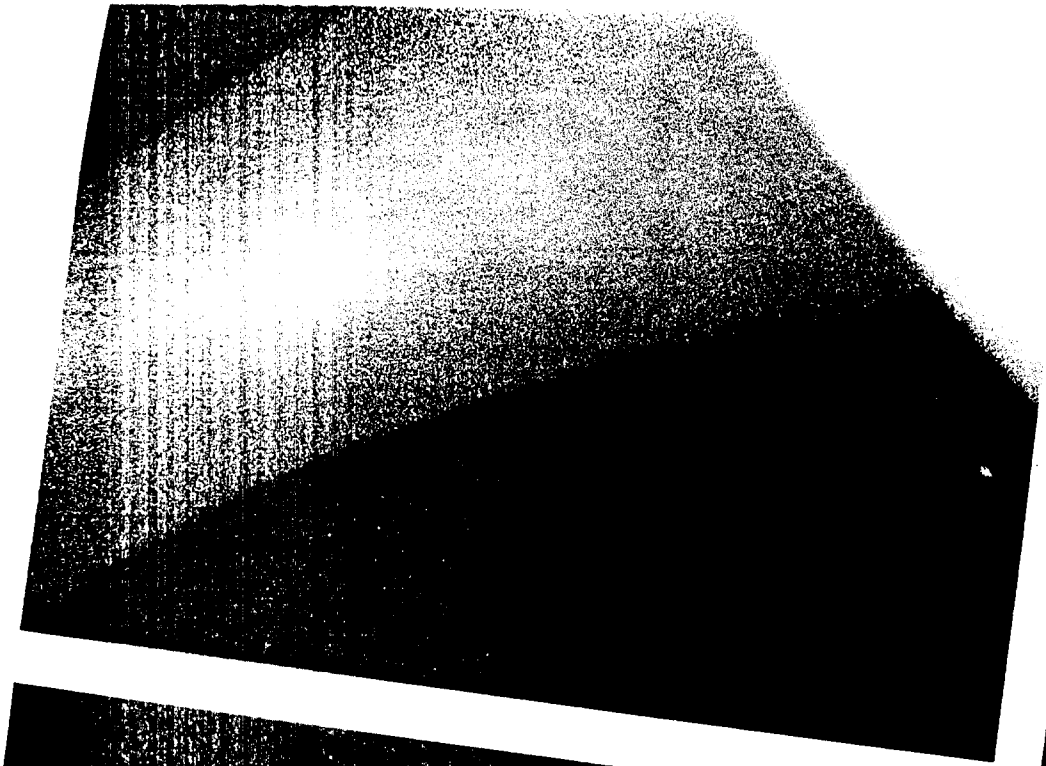
Celina Andrade 6/1/14



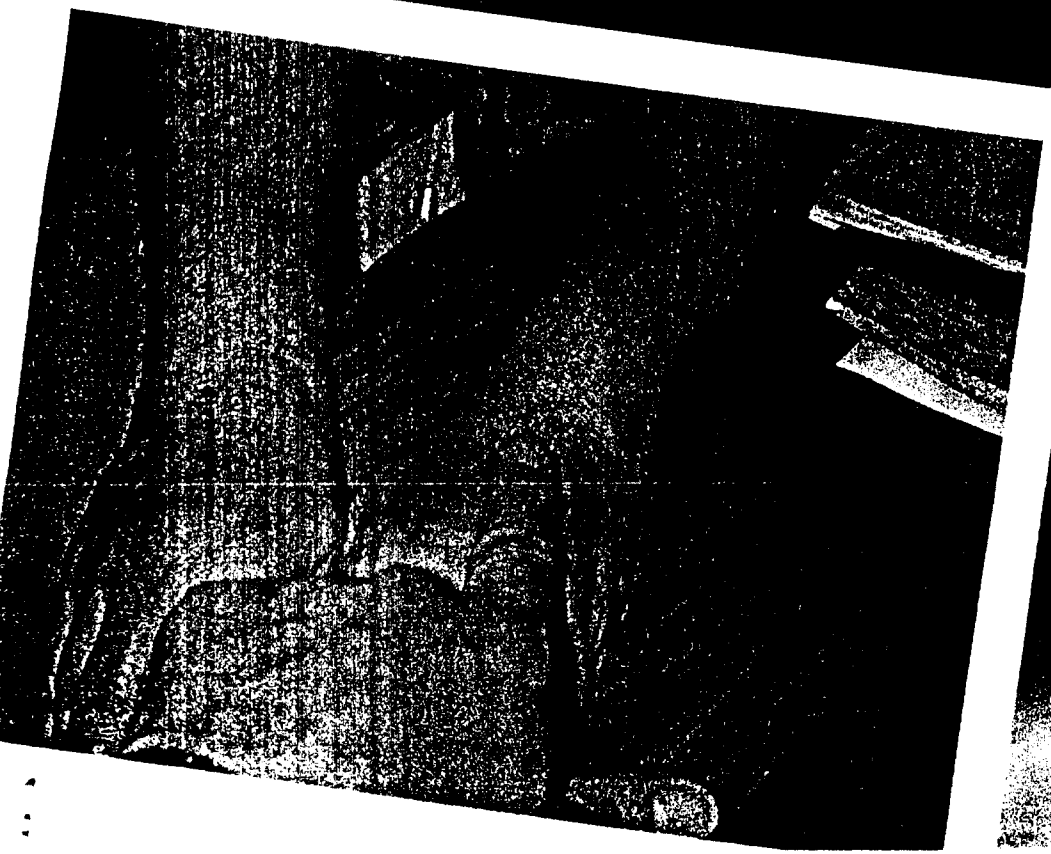









Celia ANDRADE



PROOF OF SERVICE BY MAIL

I, the undersigned, am a citizen of the United States, a resident of the County of Los Angeles, State of California, over the age of eighteen years, and not a party to the within action; my business address is 200 Oceangate, Suite 400, Long Beach, CA 90802-4330.

On March 14, 2002, I served the foregoing document described as: **PROOF OF CLAIM**. Said document was served on the interested party(ies) in this action by placing a true copy thereof, enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at Long Beach, California, addressed as follows:

Kmart Corp., c/o Trumbull Services, P.O. Box 426, Windsor, CT 06095

John Wm. Butler, Jr., Esq., Skadden, Arps, Slate, Meagher & Flom, 333 W. Wacker Dr., Suite 2100, Chicago, IL 60606

I am "readily familiar" with the firm's practice of collection and processing correspondence for mailing. Under that practice, it would be deposited with the United States Postal Service on that same day with postage thereon fully prepaid at Long Beach, California in the ordinary course of business.

I declare under penalty of perjury under the laws of the Unites States of America that the foregoing is true and correct.

Executed on March 14, 2002, at Long Beach, CA.

Susan A. Kamilar

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