FORM B10 (Official Form 10)

UNITED STATES BANKRUPTCY COURT
NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION

PROOF OF CLAIM
Chapter 11

In Re Kmart Corporation, et. al.	Case Numbers 02-802474 through 02-802498
Name of Debtor: (see attached for complete list of debtors) KMART Corporation	**Case Number:** 02-802474

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).
Mary R. Daley
905A Wadsworth,Road
Medina, Ohio 44256

- ☐ 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

If address differs from above, please complete the following:
Creditor Name
Address
City/St/Zip
Telephone. #

Your claim is scheduled as follows.
Class
Amount
This Space is for Court Use Only

Account or other number by which creditor identifies debtor

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:
May 28, 2001

3. If court judgment, date obtained:

4. Total Amount of Claim at Time Case Filed: $ In excess of $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)(__).

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
3/25/02 ML
RECEIVED 742
BY PBSI SERVICES COMPANY
02 MAR 25 PM 1:43
BANKRUPTCY

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):
03/21/02	Jack M. Arnold John Brooks Cameron & Associates

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

INSTRUCTIONS FOR PROOF OF CLAIM FORM

The instructions and definitions below are general explanations of the law. In particular types of cases or circumstances, such as bankruptcy cases that are not filed voluntarily by a debtor, there may be exceptions to these general rules

DEFINITIONS

Debtor

The person, corporation, or other entity that has filed a bankruptcy case is called the debtor.

Creditor

A creditor is any person, corporation, or other entity to whom the debtor owed a debt on the date that the bankruptcy case was filed

Proof of Claim

A form telling the bankruptcy court how much the debtor owed a creditor at the time the bankruptcy case was filed (the amount of the creditor's claim). Claims are to be mailed to Kmart Corporation, et. al. c/o Trumbull Services Company, LLC, P O. Box 426, Windsor, CT 06095

Secured Claim

A claim is a secured claim to the extent that the creditor has a lien on property of the debtor (collateral) that gives the creditor the right to be paid from that property before creditors who do not have liens on the property.

Examples of liens are a mortgage on real estate and a security interest in a car, truck, boat, television set, or other item of property. A lien may have been obtained through a court proceeding before the bankruptcy case began; in some states a court judgment is a lien. In addition, to the extent a creditor also owes money to the debtor (has a right of setoff), the creditor's claim may be a secured claim. (See also Unsecured Claim)

Unsecured Claim

If a claim is not a secured claim it is an unsecured claim. A claim may be partly secured and partly unsecured if the property on which a creditor has a lien is not worth enough to pay the creditor in full.

Unsecured Priority Claim

Certain types of unsecured claims are given priority, so they are to be paid in bankruptcy cases before most other unsecured claims (if there is sufficient money or property available to pay these claims). The most common types of priority claims are listed on the proof of claim form. Unsecured claims that are not specifically given priority status by the bankruptcy laws are classified as Unsecured Nonpriority Claims.

Items to be completed in Proof of Claim form (if not already filled in)

Court, Name of Debtor, and Case Number:
Fill in the name of the federal judicial district where the bankruptcy case was filed (for example, Northern District of Illinois), the name of the debtor in the bankruptcy case, and the bankruptcy case number.

Information about Creditor:
Complete the section giving the name, address, and telephone number of the creditor to whom the debtor owes money or property, and the debtor's account number, if any If anyone else has already filed a proof of claim relating to this debt, if you never received notices from the bankruptcy court about this case, if your address differs from that to which the court sent notice, or if this proof of claim replaces or changes a proof of claim that was already filed, check the appropriate box on the form.

1. **Basis for Claim:**
Check the type of debt for which the proof of claim is being filed. If the type of debt is not listed, check "Other" and briefly describe the type of debt. If you were an employee of the debtor, fill in your social security number and the dates of work for which you were not paid.

2. **Date Debt Incurred:**
Fill in the date when the debt first was owed by the debtor.

3. **Court Judgments:**
If you have a court judgment for this debt, state the date the court entered the judgment.

4. **Total Amount of Claim at Time Case Filed:**
Fill in the total amount of the entire claim. If interest or other charges in addition to the principal amount of the claim are included, check the appropriate place on the form and attach an itemization of the interest and charges.

5. **Secured Claim:**
Check the appropriate place if the claim is a secured claim. You must state the type and value of property that is collateral for the claim, attach copies of the documentation of your lien, and state the amount past due on the claim as of the date the bankruptcy case was filed. A claim may be partly secured and partly unsecured. (See DEFINITIONS, above).

6. **Unsecured Priority Claim:**
Check the appropriate place if you have an unsecured priority claim, and state the amount entitled to priority. (See DEFINITIONS, above). A claim may be partly priority and partly nonpriority if, for example, the claim is for more than the amount given priority by the law. Check the appropriate place to specify the type of priority claim.

7. **Credits:**
By signing this proof of claim, you are stating under oath that in calculating the amount of your claim you have given the debtor credit for all payments received from the debtor.

8. **Supporting Documents:**
You must attach to this proof of claim form copies of documents that show the debtor owes the debt claimed or, if the documents are too lengthy, a summary of those documents. If documents are not available, you must attach an explanation of why they are not available.

LIST OF DEBTORS, CASE NUMBERS AND TAX IDENTIFICATION NUMBERS:

DEBTOR	CASE NUMBER	TAX ID NUMBER
KMART CORPORATION OF ILLINOIS, INC.	02-B02462	37-0916029
KMART OF INDIANA	02-B02463	38-3413374
KMART OF PENNSYLVANIA LP	02-B02464	38-3469157
KMART OF NORTH CAROLINA LLC	02-B02465	38-3469154
KMART OF TEXAS LP	02-B02466	38-3469160
BLUELIGHT.COM LLC	02-B02467	77-0529022
BIG BEAVER OF FLORIDA DEVELOPMENT LLC	02-B02468	38-0729500
TC GROUP I LLC	02-B02469	38-2332504
KMART MICHIGAN PROPERTY SERVICES LLC	02-B02470	38-3384536
KMART FINANCING I	02-B02471	38-6667809
TROY CMBS PROPERTY LLC	02-B02472	38-3334610
BIG BEAVER DEVELOPMENT CORPORATION	02-B02473	38-2834722
KMART CORPORATION	02-B02474	38-0729500
BIG BEAVER OF GUAYNABO DEVELOPMENT CORPORATION	02-B02475	38-3225644
BIG BEAVER OF CAGUAD DEVELOPMENT CORPORATION	02-B02476	38-3053789
BLUELIGHT COM INC	02-B02477	77-0527034
KMART HOLDINGS INC	02-B02478	38-3293882
KMART OF AMSTERDAM NY DISTRIBUTION CENTER	02-B02479	38-3626487
KMART STORES OF INDIANA INC.	02-B02480	38-2831604
KMART OF MICHIGAN INC.	02-B02481	38-3551696
KMART STORES OF TNCP INC.	02-B02482	38-2305127
KMART OVERSEAS CORPORATION	02-B02483	31-0972999
JAF INC.	02-B02484	38-2970528
VTA INC.	02-B02485	51-0331035
BIG BEAVER OF CAGUAS DEVELOPMENT CORP II	02-B02486	38-3175257
BIG BEAVER OF CAROLINA DEVELOPMENT	02-B02487	38-3175256
KMART PHARMACIES INC.	02-B02488	38-1978255
BUILDERS SQUARE INC.	02-B02489	74-2259917
KMART INTERNATIONAL SERVICES INC.	02-B02490	38-2331210
SOURCING & TECHNICAL SERVICES INC.	02-B02491	22-3004708
KMART PHARMACIES OF MINNESOTA INC.	02-B02492	38-3351987
STI MERCHANDISING INC.	02-B02493	38-2760188
KMART CMBS FINANCING INC.	02-B02494	38-3334553
KLC INC.	02-B02495	75-2490839
PMB INC.	02-B02496	75-1371063
ILJ INC.	02-B02497	92-0132179
KBL HOLDINGS INC.	02-B02498	N/A

Kmart Customer Incident Information

Store Stamp

Dear Kmart Customer,

We want you to have a positive experience every time you visit our store. If you have experienced an accident or loss of any kind while visiting us, please provide the information requested below. This information will help us meet our goal of continuous improvement in the operation of our store. It will also help us in contacting you to make sure we are providing the service you expect.

Please take the white copy of this document for your records. If after leaving the store you wish to provide further information or have any questions about your incident, please call our Store Team Manager.

We are sorry you had an unpleasant experience while our guest. We look forward to serving you better in the future.

Sincerely, Kelly Toy

Your Kmart Store Management

Store Phone Number: (330) 722-1127 EXT. 606

TO BE COMPLETED BY CUSTOMER:

Customer name: MARY R. DALEY Customer's Street Address: 905 A WADSWORTH Rd.

City: MEDINA State: OHIO Zip: 44256 Phone: (330) 725-7015

Customer's employer: Customer's sex: FEMALE

Customer's Date of Birth: 1-24-53 Customer's Social Security Number: 274-54-8180

If injury to a child: Child's name: N/A Child's age: N/A Parent's name: N/A

Customer's Description of Incident:

Date of incident: 5-28-01 Location of incident: PRODUCE DEPT.

Time of incident: 1355 What happened? CUSTOMER WAS LAYING ON FLOOR AND UNABLE TO WRITE OUT STATEMENT. CUSTOMER STATED SHE WAS [redacted] PUSHING A SHOPPING CART AND SLIPPED ON A CHERRY THAT WAS ON THE FLOOR. SHE STATED SHE FELL ON HER RIGHT SIDE & HIT HER HEAD ON A RACK

Do you wish to be contacted? YES Date reported: 5-28-01 Signature of Customer: UNABLE TO SIGN

White copy - for Customer

code (37) 094-4699-115 9/98

Kelly Toy

IN THE COURT OF COMMON PLEAS
MEDINA COUNTY, OHIO

MARY R. DALEY, **905 A Wadsworth Road** **Medina, Ohio 44256**	)	**CASE NO.**
	)	
	)	**JUDGE**
Plaintiff,	)	
	)	
vs.	)	
	)	
KMART CORPORATION **Store 3786** **1105 N. Court Street**	)	**PRAECIPE**
	)	
and	)	
	)	
JOHN DOE, **Address Unknown**	)	
	)	
and	)	
JOHN DOE **Address Unknown**	)	
	)	
and	)	
JOHN DOE **Address Unknown**	)	
	)	
Defendants.	)	

TO THE CLERK:

Please serve a copy of the Complaint upon the Defendants by certified mail, return receipt requested.

Respectfully submitted,

JOHN BROOKS CAMERON #0055800
Attorney for Plaintiff
247 East Smith Road
Medina, Ohio 44256
Phone: (330) 722-8989
Fax: (330) 722-5877

IN THE COURT OF COMMON PLEAS
MEDINA COUNTY, OHIO

MARY R. DALEY, **905 A Wadsworth Road** **Medina, Ohio 44256**	)	**CASE NO.**
	)	**JUDGE**
Plaintiff,	)	**COMPLAINT**
vs.	)	**(Jury Demand Endorsed Herein)**
KMART CORPORATION **Store 3786** **1105 N. Court Street** **Medina, Ohio 44256**	)	
and	)	
JOHN DOE, **Address Unknown**	)	
and	)	
JOHN DOE **Address Unknown**	)	
and	)	
JOHN DOE **Address Unknown**	)	
Defendants.	)	

COUNT ONE

1. Now comes the Plaintiff, Mary Daley, and for her cause of action she states that at all times material hereto, Defendant Kmart Corporation, owned, operated, managed and maintained a Super Kmart store located at 1105 North Court Street, in the City of Medina, County of Medina, and State of Ohio.

2. Plaintiff further states that Defendant Kmart Corporation presented the aforementioned store to the general public as being safe and secure and without any notification of any hazards.

3. On or about the 28th day of May, 2001, at approximately 1:55 p.m. plaintiff was a business invitee, shopping for goods to purchase.

4. Defendant maintains many aisles in its store for use by its customers inspecting and selecting merchandise. The store includes a produce section.

5. Defendant had a duty to keep and maintain its store, including the floor in the produce section, in a reasonably safe condition for customers.

6. It was further defendant's duty not to create or to allow to exist a dangerous condition, or if such condition existed, to give notice or warning to customers and potential customers in the store.

7. Defendant breached this duty by failing to keep and maintain the floor of its aisles in a reasonably safe condition or give notice or warn the plaintiff that produce, i.e. a cherry/cherries, was on the floor, and as a result caused plaintiff who was pushing a cart to slip and fall on her right side, striking her head on a display rack.

8. Defendant's negligence was the direct and proximate cause of plaintiff's accident and injuries to her right side and head for which she is entitled to recover damages.

9. Plaintiff further states that as a direct and proximate result of the

negligence of the Defendants, she suffered personal injury resulting in her pain, suffering and disability and for which she was required to seek medical attention at her expense. Plaintiff has incurred expenses for medical treatment and care in an amount exceeding Four Thousand Nine Hundred Ninety Dollars ($4,990.00).

10. Further, Plaintiff believes and therefore avers that her injuries are permanent in nature and that she will experience pain, suffering and disability into the indefinite future and will require future medical care and attention at her expense.

WHEREFORE, Plaintiff, Mary Daley, demands judgment against Defendants, in an amount exceeding Twenty Five Thousand Dollars ($25,000.00), and jointly or severally in an amount suitable to compensate her for her injuries and losses together with his costs incurred herein, along with any other relief which this Court deems appropriate.

Respectfully submitted,

JOHN BROOKS CAMERON #0055800
Attorney for Plaintiff
247 East Smith Road
Medina, Ohio 44256
Phone: (330) 722-8989
Fax: (330) 722-5877

JURY DEMAMD

A trial by jury is hereby demanded in this action by the maximum number of

jurors permitted by law.

JOHN BROOKS CAMERON #0055800
Attorney for Plaintiff

PRELIMINARY CLIENT AUDIT
MEDICAL EXPENSES

PROVIDER	AMOUNT
MEDINA GENERAL HOSPITAL PO BOX 75600 CLEVELAND, OHIO 44101-4755	$2,810.75
NORTHEAST OHIO EMERGENCY AFFILIATES 21755 BROOKPARK ROAD CLEVELAND, OHIO 44126	$ 162.00
RADIOLOGY PROFESSIONAL 15666 SNOW RD, SUITE 204 BROOKPARK, OHIO 44142-2351	$ 467.00
DR MARK MUSGRAVE, CRYSTAL CLINIC 4015 MEDINA RD, SUITE 90 MEDINA, OHIO 44256	$ 612.00
OHIO PAIN SERVICES 970 EAST WASHINGTON STREET SUITE 203 MEDINA, OHIO 44256	$ 599.00
MEDINA LIFE SUPPORT TEAM PO BOX 16211 ROCKY RIVER, OHIO 44116	$ 340.00

MEDICAL EXPENSES FOR THIS ACCIDENT $ 4,990.75

TOTAL EXPENSES FOR THIS ACCIDENT ... $ 4,990.75

MEDINA GENERAL HOSPITAL — EMS REPORT

1000 EAST WASHINGTON STREET
MEDINA, OHIO 44256-2170

DEPT. LST

TIMES	
RECEIVED	1353
ENROUTE	1353
ON SCENE	1354
ENROUTE	1421
ARRIVE	1430
IN SERVICE	

SQUAD: X

RUN NO. 01-1569
DATE 4 MAY 01
UNIT M1
MEDIC
LEVEL OF RESPONSE B I (P)
MILEAGE START 0.0 END 3.1

LOCATION OF RESPONSE: 1105 N. COURT
RUN ZONE: 19 RES. ZONE: 19 INV. TRANS. MED TRANS LAW ENF. MUT AID OTHER MEDICAL TRAUMA X

PATIENT NAME: MARY BALEY
PATIENT ADDRESS: 905 A WADSWORTH RD. MEDINA
AGE: 98 D.O.B. 1/24/53 SEX: F RACE: W B O
PATIENT PHONE: (330) 725-7051
PATIENT S.S.#: 274 54 8180
PARENT / NEAREST RELATIVE
PHONE
FAMILY PHYSICIAN: MEAKUM
E.R. PHYSICIAN: DUNCAN
RECEIVING FACILITY: MGH
ADDITIONAL INFO-INSURANCE

CHIEF COMPLAINT (L) SHOULDER PAIN + (R) HIP PAIN 2° FALL

HISTORY OF EVENT

PT. SLIPPED AND FELL IN THE PRODUCE DEPT. OF K-MART. PT. STATES SHE WAS NOT DIZZY BEFORE THE FALL. SHE STATES SHE WAS LEANING ON A CART WHEN SOMEONE MOVED THE CART. PT. DENIES LOSING CONSCIOUSNESS. SHE STATES SHE HIT HER HEAD ON THE CART AS SHE FELL. PT. DENIES HA, LOC NECK OR BACK PAIN. CC IS PAIN (L) SHOULDER AND ARM AND (R) HIP. PT. COMPLAINS OF NUMBNESS & TINGLING IN HER LEFT HAND.

PMH IDDM

MEDICATIONS 70/30 NOVOLIN 35 units am / 32 units pm

ALLERGIES / Rxn Prozac, Imitrex, Codeine, PCN, Delantin, Sulfa, Estrogen, Zantac, Naproxen, Naprocilin

L.O.C.	AIRWAY	TIME	POS	BP	PULSE	RESP.	GCS	EYES
☑ Alert	☑ Patent ☐ Obstructed	1407		170/102	98	20	15	Round Yes ☐ No ☐
☐ Oriented x3 x2 x1	BREATHING							Equal Yes ☐ No ☐
☐ Verbal	☑ Present ☐ Absent							Reacts Yes ☐ No ☐
☐ Pain	QUALITY							
☐ Unresponsive	☑ Normal ☐ Deep ☐ Shallow							
☑ Appropriate	LUNGS							
☐ Inappropriate								

CIRCULATION	COLOR
SKIN	☑ Normal ☐ Cyanotic
☑ Warm ☑ Dry	☐ Pale ☐ Jaundiced
☐ Cool ☐ Moist	☐ Flushed ☐ Mottled
☐ Hot	CAP REFILL ☐ 2 Sec ☐ Delayed

PHYSICAL EXAM
- (-) LOSS OF CONSCIOUSNESS
- (-) RESP. DISTRESS
- (-) NECK OR BACK PAIN
- (+) (L) SHOULDER PAIN (+) POP (L) SHOULDER (L) HUMERUS
- (+) (R) HIP PAIN (+) POP
- (+) SOFT NONTENDER NONDISTENDED
- (-) EVIDENCE OF ANY OTHER TRAUMA
- (-) NAUSEA

MSP X 4 Before ✓ After ✓ INTACT

TREATMENT

Hx 2° EXAM, SPINAL IMMOBILIZATION

☐ O_2 L/M	☐ COMBTUBE	SIZE	IV SIZE	TIME	BB CC HI STRAPS 1/2
☐ NC ☐ MASK	☐ ET TUBE	TIME	SITE	BY	☐ Monitor Applied ☐ 12 Lead Taken
☐ NASAL AIRWAY	☐ SUCTION	BY	NS KVO WO	cc / hR	☐ EKG Attached ☐ AED ☐ Sent
☐ ORAL AIRWAY	☐ BVM	PULSE OX RM AIR 100	☐ MEDICATION GIVEN		RHYTHM
	☐ CPR	PULSE OX POST O_2	☐ BLOOD DRAW	GLUCOSE 144	

☐ Cellular ☐ Med. Rad.	Hospital Contacted	Time	Disp.	Transported By	Transport Position	Personnel	Cert.
☐ Telephone ☐ Protocol	MGH	1423	II	LST	— O	SCHLABACH	EMT-P
SUPPLEMENT ATTACHED ☐	VALUABLES: ☐ WITH PT ☐ FAMILY ☐ AT HOME					CORVETT	EMT-P

COMMENTS / CHANGES

☐ REFUSAL SIGNED

Recorder Mary Corvett

HOSPITAL

DALEY MARY R
ACCT# - 0258000
MEDRC# - 000010798
274-54-8180 1/24/1953
5/28/01 POOL, LOREN, M.D.

PATIENT IDENTIFICATION

MEDINA GENERAL HOSPITAL

1000 East Washington Street Medina, OH 44256
725-1000 • 225-8555 • 336-1000

EMERGENCY DEPARTMENT REGISTRATION FORM

PATIENT INFORMATION

*** EMERGENCY ***

Name DALEY MARY R
Address 905 A WADSWORTH RD
City MEDINA State OH Zip 44256 Phone 330 725-7015
Sex F Race W Marital Status D Birth Date 1/24/1953 Age 048Y Soc.Sec.# 274-54-8180 F/C S Religion 03
Room Bed Admit/Reg Date 5/28/01 Time 14:34 Med. Serv. EMR Admit. Cat. Clerk BOHP Last Admit 2/24/93
Attending Physician POOL, LOREN, M.D. 738 Referring Physician/PCP MEACHAM, MARK H., M.D. 30095
Admitting Diagnosis/Patient States L SHOULDER PAIN & R HIP PAIN SECOND TO FALL AT K-MART N COURT
EM Time Discharged Date Discharged
Brought in by SQUAD Mode of Arrival

GUARANTOR AND FINANCIAL INFORMATION

Name DALEY MARY R
Address 905 A WADSWORTH RD Patient's Relationship SF
City MEDINA State OH Zip 44256 330 725-7015
Guarantor Employer UNEMPLOYED Phone
Employer Address City State OH Zip Phone
Patient Employer UNEMPLOYED Occupation UNEMPLOYED
Employer Address City State OH Zip Phone
Occurence Code 05 Date 5/28/01 Occurence Code Date Occurence Code Date

EMERGENCY INFORMATION

Nearest Relative DALEY,KRISTA Patient's Relationship CH
Address 905 A WADSWORTH RD City MEDINA State OH Zip 44256 Phone 330 725-7015
Emergency Contact ESTEP, BECKY Patient's Relationship FR
Address City State Zip Phone 330 925-2973

INSURANCE INFORMATION

Card Copied: ☐

PRIMARY:
Co.# Plan# Certificate Group
Plan Name Pre Cert Phone# Benefit Verif. Phone#
City State Zip
Subscriber's Name Birth Date Employer
Address City State Zip Phone

SECONDARY:
Co.# Plan# Certificate Group
Plan Name Pre Cert Phone# Benefit Verif. Phone#
Address City State Zip
Subscriber's Name Birth Date Employer
Address City State Zip Phone

TERTIARY:
Co.# Plan# Certificate Group
Plan Name Pre Cert Phone# Benefit Verif. Phone#
Address City State Zip
Subscriber's Name Birth Date Employer
Address City State Zip Phone

719.41 922.3 923.10 924.01 E555.9 250.00 V1640 ...

Date of Original/Revision: 9/97
Distribution: Medical Records
JetForm-errop
Form Number: 2055

MEDICAL RECORDS ORIGINAL

025600 5/25/01 1434

EMERGENCY DEPARTMENT NURSING ASSESSMENT RECORD

STAMPER: 10798 ... MARK H. 273360980
ROOM: 6

ARRIVED: ☐ WALK ☐ CARRY ☐ W/C ☐ CART ______
☐ BACKBOARD ☐ C-COLLAR ☐ HEAD IMMOBILIZER ☐ SPLINT
REMOVED BY ______ TIME ______
INFORMANT: ☐ SELF ☐ PARENT ☐ SPOUSE ☐ OTHER ______

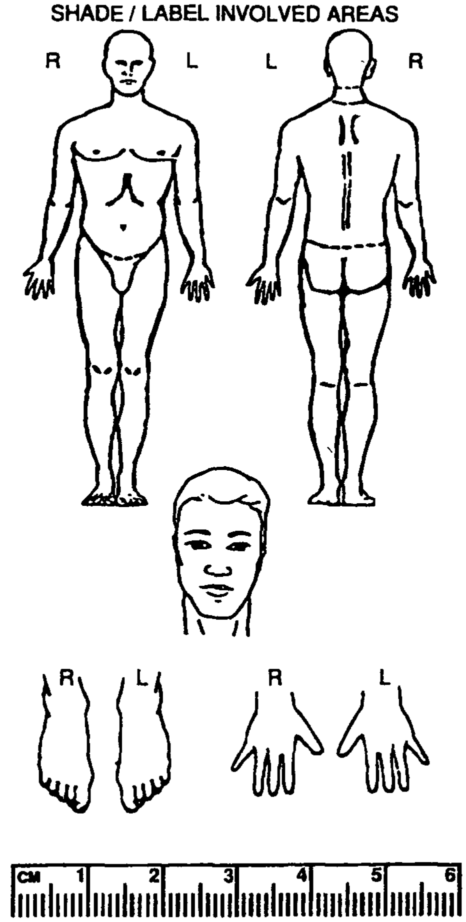
ACCIDENT - ☐ MVA ☐ OTHER
DATE: ______ TIME: ______
SITE: ______
POLICE AT SCENE ______

NOTIFICATION
☐ POLICE ______
☐ RELATIVE ______
☐ CLERGY ______
BY WHOM: ______ TIME: ______

INITIAL COMPLAINT/TRIAGE

TIME 1425 Slipped & fell at a store, Hit Rt thigh/head on a cart fell onto Rt hip c/o pain Rt hip + (L) shoulder area No LOC

SHADE / LABEL INVOLVED AREAS



ALLERGIES
Prevacid, Zantac, Sulfa, ... Codeine, Ethrane, Dilantin, Toradol, Imitrex, Advil, Benadryl

LAST TETANUS ______
WEIGHT ______ LMP ______

T	P	R	BP
97.2	91	20	103/65

HEALTH HISTORY ☐ SMOKER ______ ETOH USE ______
☐ ASTHMA ☐ DIABETES ☐ SEIZURES ☐ HYPERTENSION
☐ TUBERCULOSIS ☐ CARDIAC ______
☐ OTHER ______

FAMILY HX ______
LIVING ENVIRONMENT ☐ WITH FAMILY ☐ ALONE ☐ NSG HOME
☐ ASSISTED LIVING ☐ OTHER

CURRENT MEDICATIONS

MEDICATION & DOSAGE	LAST DOSE	MEDICATION & DOSAGE	LAST DOSE
Insulin 70/30 25u qAM 32u qHS			

SIGNATURE TRIAGE RN ______ DISPOSITION ☐ WR TO ROOM ______ AT ______

NURSING ASSESSMENT

TIME ______

APPEARANCE/BEHAVIOR ______

SKIN ☐ WARM ☐ HOT ☐ COOL ☐ DRY ☐ MOIST ☐ PALE ☐ FLUSHED ☐ DUSKY

EXTREMITIES ☐ DENIES COMPLAINTS ☐ NO TRAUMA ☐ TRAUMA ______
PULSES INTACT ☑ R ☐ L OTHER ______
SENSATION INTACT ☐ R ☐ L OTHER ______
CAP REFILL < 2 SEC. ☑ R ☐ L OTHER ______
ROM ______
OTHER Rt hip + (L) shoulder pain

NURSING ASSESSMENT

CARDIAC

☑ DENIES COMPLAINTS ☐ NO TRAUMA ☐ TRAUMA ______

☐ CARDIAC MONITOR ON (PATTERN) ______ ☐ NBP MONITOR ON

PULSE ☐ REGULAR ☐ IRREGULAR

PAIN ☐ NO ☐ YES SEVERITY (0-10 ______ ☐ CONSTANT ☐ INTERMITTENT

LOCATION: ______

RADIATION: ______

EDEMA ☐ NO ☐ YES ______

OTHER ______

CHEST/ RESPIRATORY

☑ DENIES COMPLAINTS ☐ NO DISTRESS ☐ NO TRAUMA ☐ TRAUMA ______

☐ PULSE OXIMETER ON - INITIAL READING ______ ☐ O_2 ______

AIRWAY PATENT ☐ YES ☐ NO ______

VENTILATION SPONTANEOUS ☐ YES ☐ NO ______

CHEST MOVEMENT SYMMETRICAL ☐ YES ☐ NO ______

LUNGS CLEAR BILATERALLY ☐ YES ☐ NO ______

RETRACTIONS ☐ NO ☐ YES ______

COUGH ☐ NO ☐ YES ______

OTHER ______

HEAD/ NEURO

☐ DENIES COMPLAINTS ☐ NO TRAUMA ☑ TRAUMA ______

LOC ☐ YES ☑ NO ______

PERL ☑ YES ☐ NO ______

A&O ☑ YES ☐ NO ______

GRASPS EQUAL ☑ YES ☐ NO ______

APHASIA ☐ YES ☑ NO ______

OTHER ______

PUPIL GAUGE	INITIAL GCS CHECK APPROPRIATE #		
8	EYES		Spontaneously
			To verbal command
			To Pain
			No Response
7	BEST MOTOR RESPONSE	To verbal command	Obeys
6		To Painful stimulus	Purposeful movement
			Flexion-withdrawl
			Flexion-abnormal
5			Extension
			No response
4	BEST VERBAL RESPONSE		Oriented / Converses
3			Disoriented / converses
			Inappropriate words
2 (mm.)			Incomprehensible sounds
			No response
	GCS Total		

BACK/ SPINE

☑ DENIES COMPLAINTS ☐ NO TRAUMA ☐ TRAUMA ______

EXTREMITY INVOLVEMENT ☐ NO ☐ YES ______

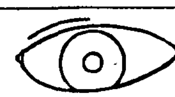
OTHER [illegible]

☐ EYE ☐ EAR ☐ NOSE ☐ THROAT

☑ DENIES COMPLAINTS ☐ NO TRAUMA ☐ TRAUMA ______

☐ VISUAL ACUITY OD 20/______ OS 20/______

PH ☐ N/A BEFORE IRRIGATION______ AFTER______



OTHER ______

ABDOMEN/ GI

☑ DENIES COMPLAINTS ☐ NO TRAUMA ☐ TRAUMA ______

☐ NAUSEA ☐ VOMITING X ______ ☐ HEMOCCULT DONE (RESULTS) ______

☐ CONSTIPATED ☐ DIARRHEA X ______ LBM ______ BOWEL SOUNDS ______

☐ ABD NON-TENDER ☐ TENDER ______ ☐ REBOUND TENDERNESS ☐ GUARDING

OTHER ______

PERINEUM/ GU

☑ DENIES COMPLAINTS ☐ DYSURIA ☐ FREQUENCY ☐ MULTISTIX (RESULTS) ______

LMP ______ G ______ P ______ EDC ______ FHT ______

VAGINAL DISCHARGE ☐ NO ☐ YES ______

OTHER ______

NURSING CARE PLAN

Ultra Comfort

SIGNATURE ASSESSING RN [signature]

TIME	NURSING PROGRESS NOTES
	SEEN BY
1450	To Xray via cart
1504	Back from X-ray Medicated c Demerol & Phenergan c/o pain MD
	to shoulder
1505	Rec'd report.
1525	Ostein repair applied ice pack given to daughter p wheel chair.

[redacted]

0258000 5/28/01 1434
DALEY, MARY R
MR# 10798
MEACHAM, MARK H.
1/24/1953 274548180 048Y
EMERGENCY

PATIENT IDENTIFICATION

ROOM

MEDINA GENERAL HOSPITAL

1000 East Washington Street • Medina, OH 44256
725-1000 • 225-8555 • 336-1000

EMERGENCY DEPARTMENT PHYSICIAN CLINICAL NOTES

☐ Minor Treatment

CHIEF COMPLAINT: (Time: / /) Historian: ☐ Patient More History: ☐ Family ☐ Medics ☐ Other

HPI: Slipped / fell — EMS Arrival

48 yo WF - slipped on cherries in produce dept. @ K-mart
broke fall w/ (L) arm c/o mod pain in (L) upper arm,
proximal pain (L) lower arm and (R) hip - [illegible]
No LOC bumped head but denies pain
No neck pain
No chest / abd pain
No (R) arm or lower ext pain

Baseline MS: [illegible] Baseline PS: [illegible] DNR: ☐ Yes ☐ No

ASSOC SX: ☑ none ☐ myalgias ☐ fatigue ☐ fever ☐ chills ☐ sweating ☐ headache ☐ sore throat ☐ cough ☐ SOB ☐ rash ☐ nausea ☐ vomiting X ☐ constipation ☐ diarrhea X ☐ hematemesis ☐ hematochezia ☐ melena ☐ frequency ☐ urgency ☐ dysuria ☐ hematuria ☐ vag. discharge

WORSENED BY: ☐ nothing ☐ change position ☑ movement ☐ deep breath ☐ supine ☐ upright ☐ walking ☐ cough ☐ food

RELIEVED BY: ☐ nothing ☐ supine ☐ sitting ☑ rest ☐ antacids

MEDICATIONS: ☐ none ☑ see NN ☐ acetaminophen ☐ OCPs

SOCIAL HISTORY: Coronary risks
☐ smoker ____ pack/yrs
☐ alcohol ____ occas ____ heavy
☐ drugs
HTN / DM / Cholest. / Smoker / FH
Lives with:
Occupation:

FAMILY HISTORY: ____ negative
MI ____ HTN ____
☐ DM ____ ☐ gallstones ____
☐ ulcers ____ ☐ cancer ____

PAIN

TIME COURSE: ☑ Sx still present ☐ better ☐ worse ☐ similar Sx previously ☐ continuous ☑ intermittent w/ movement ☐ resolved

SEVERITY: ____ /10 (pain scale) ☐ mild ☐ moderate ☐ severe

QUALITY: ☐ dull ☐ aching ☐ burning ☐ sharp ☐ cramping ☐ squeezing ☐ fullness ☐ stabbing ☐ pressure ☐ tightness ☐ Sx/pain radiates to

FOR INJURY: Occurred: ☑ just PTA ☐ yesterday ☐ today ☐ ____ days PTA
Location: K-Mart ☐ home ☐ school ☐ work ☐ street
Mechanism of Injury: ☑ fall ☐ GSW ☐ MVA ☐ burn ☐ direct blow ☐ stab wound ☐ laceration
LOC: ☐ Yes ☑ No ☐ dazed ☐ amnesia
Dom. Viol.: ☐ Yes ☐ No

PAST HISTORY: ____ negative
☐ HEENT ☐ thyroid ☐ bronchitis ☐ pneumonia ☐ asthma ☐ COPD ☐ pneumothorax ☐ pulmonary embolism ☐ angina ☐ Hospitalization
☐ arrythmia ☐ CHF ☐ MI ☐ hyperlipidemia ☐ HTN ☐ peptic ulcer ☐ gallstones
☐ pancreatitis ☐ diverticulitis ☐ PID ☐ ovarian cysts ☐ UTI ☐ kidney stones ☐ renal dz ☐ cancer ☑ DM/insulin/oral
☐ anemia ☐ sickle cell dz ☐ seizures ☐ migraine ☐ psych ☐ CVA

SURGERY/PROCEDURES: ____ negative
☐ angioplasty ☐ appendectomy ☐ CABG ☐ cardiac cath ☐ cholecystectomy ☐ c-section ☐ ectopic
☐ hernia ☐ hysterectomy ☐ mastectomy ☐ tubal ligation ☐ tumor

0258000 5/28/01 1434
DALEY, MARY R
MR# 10798
MEACHAM, MARK M.,
1/24/1953 274548180 048Y
EMERGENCY

PATIENT IDENTIFICATION

MEDINA GENERAL HOSPITAL

1000 East Washington Street • Medina, OH 44256
725-1000 • 225-8555 • 336-1000

EMERGENCY DEPARTMENT PHYSICIAN CLINICAL NOTES

HISTORY ROS:

Constitutional:
weight loss fatigue
weight gain fever Ø

ENT:
☐ hearing loss
☐ ear pain
☐ nose bleeds
☐ sore throat
☐ seasonal allergies
Ø

EYES:
☐ blurred vision Ø

PULM:
☐ cough
☐ wheezing Ø

CVS:
☐ chest pain
☐ palpitations Ø

GI:
☐ diarrhea X
☐ vomiting
☐ abdominal pain
☐ ROS limited to
Ø

GU: Ø
☐ frequency ☐ dysuria ☐ hematuria
☐ urethral discharge ☐ incontinence

FEMALE REPRODUCTIVE:
☐ LNMP ______ G __ P ____
☐ vaginal discharge
☐ abnormal bleeding

INTEGUMENTARY:
☐ rash
☐ edema

LYMPH:
☐ swelling

ENDO:
☐ thyroid

HEMA:
☐ weakness
☐ bruising
Ø

MS: ⓒ Arm pain ⓡ hip pain
☐ back pain
☐ joint pain
Baseline MS:

NEURO:
☐ headache ☐ diplopia
☐ syncope ☐ paresis/paralysis
☐ imbalance ☐ Δ mental status
☐ parasthesias ☐ seizures

PSYCH:
☐ depression ☐ hallucinating
☐ suicidal ☐ audit
☐ visual

ALLERGIES

T	P	R	BP

LAST TETANUS ______
LMP ______ WEIGHT ______

PHYSICAL ASSESSMENT:

Const. General appearance ✓ NAD Distress: Mild ✓ (Ⓐ arm) Mod __ Severe __
Psych Orientation: alert ☑ Yes ☐ No oriented X 3
Mood and affect pained Memory Ok
Head/Face Normocephalic - Not tender
Ⓡ facial marks
Eyes Conjunctivae and lids Ok
Pupils and irises PERRL
Fundi
ENMT Ears clear
Nose Clear
Mouth/Throat clear
Neck Supple
Resp Resp. effort Normal
Perc./Auscultation Cl
CV Palpation
Auscultation Reg s Ø
Pulses
Abdominal aorta
Chest/Breast
GI
Abdomen Soft ⊕ BS
Liver and spleen
Rectum

GU/Pelvic

Lymph Ø

ANT POST

Periph. edema Ø
Back Not tender
Neuro Cranial nerves 2-12 intact
Tendon reflexes
Sensation Ok
Muscle Strength and tone fair
Cerebellum Ok Plantar reflexes
Skin Inspection Multi. Marks Palpation
Musculoskeletal
Gait Ok
ROM limited ↑ pain Ⓛ arm - tender Prox ⓒ humerus
Muscle strength tone fair ⓒ forearm - no deformity
... intact ...

0258000 5/28/01 1434
DALEY, MARY R
MR# 10798
MEACHAM, MARK H.
1/24/1953 274548180 048Y
EMERGENCY
PATIENT IDENTIFICATION

ROOM 6

MEDINA GENERAL HOSPITAL

1000 East Washington Street • Medina, OH 44256
725-1000 • 225-8555 • 336-1000

EMERGENCY DEPARTMENT PHYSICIAN CLINICAL NOTES

☐ Minor Treatment

MEDICAL DECISION MAKING

Slipped / fell
c/o pain (L) humerus

XRay (L) humerus
- forearm
- hip

RESPIRATORY ORDERS

☐ Aerosol RX
Treatment ☐1 ☐2 ☐3
☐ Old Chart

LAB ORDERS

☐ EKG	☐ Troponin	☐ Myoglobin
☐ CBC/Diff	☐ BMP	☐ CPK
☐ U/A	☐ PT-PTT	☐ AMYLASE
☐ Biocept	☐ Liver Profile	☐ CREATININE
☐ Digoxin	☐ Theophylline	☐ ETOH
☐ Pelvic Pkg	☐ Strep Screen	☐ TOX Screen
☐ C & S	☐ ABG's	

XRAY ORDERS

☐ Chest	☐ ABD	☐ Skull
☐ Cervical	☐ Dorsal	☐ Lumbar
☐ Hand R/L	☐ Fingers	☐ Foot R/L
☐ Wrist R/L	☐ Clavicle	☐ Ankle R/L
☐ X Table	☐ CT	☐ Re-xray
☐ Portable		

Lt- Humerus ✓
Lt- forearm ✓
pelvis ✓

PROCEDURE:

Wound Length cm ☐ Layered Closure
CCT Start Stop

	MEDICATION ORDERS	ROUTE	SITE	TIME	By Whom	RESPONSE TO MED
1	Demerol 50 mg	IM	LG	1505	MCA	
2	Phenergan 25 mg					
3						
4						
5						
6						
7						

PROCEDURE ORDERS

LST - glucose 144

(L) velpeau sling

	IV ORDERS	ROUTE	CATHETER	SITE	TIME	By Whom	Time D/C	Amt Absorb
1								
2								
3								
4								

FAMILY DR.	PAGED	ANS.	APR.

COD IMPRESSION Contusion (L) humerus / forearm
[illegible]

☐ ASSIGN TO OBSERVATION
☐ ADMIT TO DR. ROOM
☐ TRANSFER TO
☐ TRANSFER ACCEPTED
DISCHARGE TIME: 1520 DATE: 5/28/01

[signature] 5/28/01
ORDERING PHYSICIAN/PHYSICIAN SIGNATURE DATE

RN SIGNATURE DATE

Medical Records Original

MEDINA GENERAL HOSPITAL
1000 E. Washington Street Medina, Ohio 44256

RADIOLOGY
X-RAY REPORT

NAME:	DALEY, MARY R	ROOM#:	-
DOB:	01/24/1953	AGE:	48Y
ACCT:	0258000	ATTENDING PHYS:	POOL, LOREN, M.D.
DATE:	05/28/2001 14:40	ORDERING PHYS:	POOL, LOREN, M.D.
RAD #:	274-54-8180	FINANCIAL CL:	S
MR#:	10798	PT TYPE:	E
ORDER NO.:	3562094		
EXAM:	FOREARM - LEFT		

LEFT FOREARM:

No fractures or dislocations are seen. There is a possible lytic lesion in the distal radius measuring 2.5 cm in maximal diameter. No cortical breakthrough is seen. The soft tissues are unremarkable.

IMPRESSION:

Possible lytic lesion in the distal radius. CT scan is recommended for further evaluation. Please note that this was not appreciated by the emergency room physician.

James S. Littman, M.D.
RADIOLOGIST

This document has been reviewed and electronically approved by Mark Rosenfeld, M.D. for James S. Littman, M.D. on 05/30/2001 07:42:17.

JSL:kn
DD: 05/29/2001 08:04:55
DT: 05/29/2001 19:40:22
JOB: 124714
VJOB: 227916
COM: FELL AT KMART

cc: Mark H. Meacham, M.D., Referring Physician for Radiology Order

MEDINA GENERAL HOSPITAL
1000 E. Washington Street Medina, Ohio 44256

RADIOLOGY
X-RAY REPORT

NAME:	DALEY, MARY R	ROOM#:	-
DOB:	01/24/1953	AGE:	48Y
ACCT:	0258000	ATTENDING PHYS:	POOL, LOREN, M.D.
DATE:	05/28/2001 14:40	ORDERING PHYS:	POOL, LOREN, M.D.
RAD #:	274-54-8180	FINANCIAL CL:	S
MR#:	10798	PT TYPE:	E
ORDER NO.:	3562092		
EXAM:	PELVIS		

AP PELVIS:

No fractures or dislocations are seen. The hip and sacroiliac joints are relatively well-maintained. Degenerative disc disease is noted in the lower lumbar spine.

James S. Littman, M.D.
RADIOLOGIST

This document has been reviewed and electronically approved by Mark Rosenfeld, M.D. for James S. Littman, M.D. on 05/30/2001 07:42:11.

JSL:kn
DD: 05/29/2001 08:01:01
DT: 05/29/2001 19:39:09
JOB: 124712
VJOB: 227912
COM: FELL AT KMART

cc: Mark H. Meacham, M.D., Referring Physician for Radiology Order

MEDINA GENERAL HOSPITAL
1000 E. Washington Street Medina, Ohio 44256

RADIOLOGY
X-RAY REPORT

NAME:	DALEY, MARY R	ROOM#:	-
DOB:	01/24/1953	AGE:	48Y
ACCT:	0258000	ATTENDING PHYS:	POOL, LOREN, M.D.
DATE:	05/28/2001 14:40	ORDERING PHYS:	POOL, LOREN, M.D.
RAD #:	274-54-8180	FINANCIAL CL:	S
MR#:	10798	PT TYPE:	E
ORDER NO.:	3562093		
EXAM:	HUMERUS - LEFT		

LEFT HUMERUS:

The distal humerus at the elbow joint is not imaged. The imaged humerus is unremarkable without evidence for fracture.

James S. Littman, M.D.
RADIOLOGIST

This document has been reviewed and electronically approved by Mark Rosenfeld, M.D. for James S. Littman, M.D. on 05/30/2001 07:42:07.

JSL:kn
DD: 05/29/2001 08:00:35
DT: 05/29/2001 19:38:13
JOB: 124711
VJOB: 227911
COM: FELL AT KMART

cc: Mark H. Meacham, M.D., Referring Physician for Radiology Order

Ordering Physician's Copy

MEDINA GENERAL HOSPITAL
1000 E. Washington Street Medina, Ohio 44256

RADIOLOGY
NUCLEAR MEDICINE

NAME:	DALEY, MARY R	ROOM#:	-
DOB:	01/24/1953	AGE:	48Y
ACCT:	0273633	ATTENDING PHYS:	MUSGRAVE, MARK M.D.
DATE:	06/27/2001 09:22	ORDERING PHYS:	MUSGRAVE, MARK M.D.
RAD #:	274-54-8180	FINANCIAL CL:	S
MR #:	10798	PT TYPE:	O
EXAM:	TOTAL BODY BONE SCAN	ORDER #:	3588860

TOTAL BODY BONE SCAN:

21.5 mCi of Technetium 99 MDP were administered via a right antecubital vein and subsequent static images were performed with demonstration of some very slightly increased activity in the left shoulder, which I believe represents the glenoid and also right distal-most ulna. There are no findings in the left forearm or wrist.

Additional note is made of increased activity in various locations of the left ankle and tarsal regions.

IMPRESSION:

1. No definite abnormalities to correspond with the plain film findings.
2. Abnormal focus of increased activity in the distal ulna on the right of uncertain significance with plain radiography recommended if clinically indicated.

Mark Rosenfeld, M.D.
RADIOLOGIST

This document has been reviewed and electronically approved by Mark Rosenfeld, M.D. on 07/02/2001 11:23:40.

MR:cad
DD: 06/28/2001 13:19:52
DT: 07/02/2001 09:48:51
JOB: 135117
VJOB: 238051
COM: ATTN TO LEFT SHOULDER AND LEFT WRIST

Ordering Physician's Copy

MEDINA GENERAL HOSPITAL
1000 E. Washington Street Medina, Ohio 44256

RADIOLOGY
MRI REPORT

NAME:	DALEY, MARY R	ROOM#:	-
DOB:	01/24/1953	AGE:	48Y
ACCT:	0279590	ATTENDING PHYS:	MUSGRAVE, MARK M.D.
DATE:	07/10/2001 11:02	ORDERING PHYS:	MUSGRAVE, MARK M.D.
RAD #:	274-54-8180	FINANCIAL CL:	S
MR #:	10798	PT TYPE:	O
EXAM:	MRI LEFT SHOULDER	ORDER #:	3598777

MRI LEFT SHOULDER 07/10:

The rotator cuff is intact without evidence for a full thickness tear. There is increased signal in its distal aspect near the attachment to the greater tuberosity consistent with tendinosis. There is mild AC joint hypertrophy without significant impingement. There is increased signal on the T2-weighted images in the region of the rotator interval. I suspect that there is a tear of the rotator interval that may involve the coracohumeral ligament, superior glenohumeral ligament or joint capsule. A small joint effusion is noted. No bursal fluid is identified. Mild degenerative cystic change of the humeral head is seen, otherwise no significant marrow signal abnormality is appreciated. The tendon of the long head of the biceps muscle appears unremarkable.

IMPRESSION:
1. Mild rotator cuff tendinosis without tear.
2. Probable rotator interval tear.

James S. Littman, M.D.
RADIOLOGIST

This document has been reviewed and electronically approved by James S. Littman, M.D. on 07/12/2001 11:50:10.

JSL:te
DD: 07/12/2001 09:00:35
DT: 07/12/2001 10:18:14
JOB: 138476
VJOB: 241956
COM: RCT
PT FELL 5 WKS AGO AT K-MART LANDING ON SHOULDER

MEDINA GENERAL HOSPITAL

1000 EAST WASHINGTON STREET, MEDINA, OHIO 44256
TELEPHONE (330) 725-1000

DISCHARGE INSTRUCTIONS

Emergency Room ☐ MGH ☐ BICC

Patient Name Mary Daley

LACERATIONS & BURNS

- ☐ KEEP DRESSING CLEAN AND DRY
- ☐ HAVE WOUND CHECKED BY YOUR DOCTOR IN _____ DAYS
- ☐ _____ SUTURES SHOULD BE REMOVED IN _____ DAYS
- ☐ YOU MAY _____ MAY NOT _____ CHANGE DRESSING (SEE INSTRUCTIONS FOR DETAIL)
- ☐ WOUND CARE INSTRUCTIONS _____
- ☐ IF SIGNS OF INFECTION OCCUR, CONTACT YOUR DOCTOR AT ONCE:
  INCREASED PAIN — RED STREAKS APPEAR UNDER SKIN
  PUS OR DRAINAGE — SWELLING
- ☐ TETANUS-DIPHTHERIA IMMUNIZATION WAS GIVEN

BACK & NECK INJURIES

- ☐ USE HEAT OR COLD ON THE INJURED AREA, WHICHEVER SEEMS TO HELP.
- ☐ REST AS MUCH AS POSSIBLE UNTIL YOU HAVE IMPROVED.
- ☐ A HARD MATTRESS IS SOMETIMES HELPFUL WITH LOW BACK INJURIES.
- ☐ AVOID POSITIONS AND MOVEMENTS THAT MAKE PAIN WORSE.
- ☐ GENTLE, BUT FIRM MASSAGE WILL INCREASE CIRCULATION IN SOME.

HEAD INJURIES

THE PERSON SHOULD BE WATCHED CLOSELY FOR THE NEXT 24 HOURS. CALL YOUR FAMILY DOCTOR OR RETURN HERE FOR ANY OF THE FOLLOWING:

- LOSS OF CONSCIOUSNESS - BALANCE
- PERSISTENT HEADACHE OR VOMITING
- INCREASING SLEEPINESS OR VARIATION FROM NORMAL PERSONALITY OR BEHAVIOR
- PERSISTENT NOSEBLEED, OR FLUID FORM NOSE OR EARS
- UNEQUAL OR UNRESPONSIVE PUPILS (AS NURSE DEMONSTRATED)

- ☐ WAKEN EVERY _____ HOURS
- ☐ USE NOTHING STRONGER THAN TYLENOL FOR HEADACHE

SPRAINS & STRAINS

- ☐ AVOID USE OF INVOLVED AREA UNTIL PAIN-FREE OR UNTIL TOLD OTHERWISE BY YOUR DOCTOR
- ☐ APPLY ICE BAG FOR 20 MINUTES TO 30 MINUTES EVERY 3-4 HOURS WHILE AWAKE
- ☐ ELEVATE THE AFFECTED AREA TO REDUCE PAIN AND SWELLING
- ☐ REWRAP ACE BANDAGE 2 TO 3 TIMES A DAY, AND REMOVE IT AT NIGHT. LOOSEN IF TOO TIGHT: (IF TOES OR FINGERS GET NUMB, TINGLE, OR COOL TO TOUCH)
- ☐ USE CRUTCHES FOR WALKING
- ☐ NO WEIGHT BEARING ON _____ LEG

DIET

- ☐ CLEAR LIQUID DIET _____

OTHER INSTRUCTIONS

- ☐ IF YOU HAVE PAIN TAKE _____ EVERY _____ HOURS
- ☐ PRESCRIPTION MAY CAUSE DROWSINESS
- ☐ TAKE PRESCRIPTION WITH FOOD
- ☐ HAVE PRESCRIPTION FILLED AND TAKE AS DIRECTED
- ☐ TAKE ANTIBIOTICS UNTIL ALL GONE UNLESS YOUR DOCTOR ADVISES YOU OTHERWISE
- ☐ DRINK PLENTY OF FLUIDS
- ☐ CALL YOUR DOCTOR Musgrave 721-8232
  - ☐ IN 24 HOURS
  - ☐ IN 48 HOURS FOR CULTURE RESULTS
  - ☐ TO MAKE AN APPOINTMENT
  - ☐ IMMEDIATELY IF CONDITION WORSENS, OR RETURN HERE TO EMERGENCY DEPT
- ☐ YOUR X-RAY WILL BE REVIEWED BY A RADIOLOGIST. YOU OR YOUR PHYSICIAN WILL BE NOTIFIED OF ANY CHANGES FROM THE PRELIMINARY READING

ADDITIONAL INSTRUCTIONS

Home

Sleep 2-3 days for Comfort

then increased activity

Darvocet Rx

Flu w/ orthro - Dr Musgrave
330 721-8232

ATTENTION

FOR YOUR EMERGENCY CARE A LICENSED PHYSICIAN IS ALWAYS AVAILABLE. EACH EMERGENCY PATIENT WILL BE ISSUED TWO BILLS, ONE FROM THE HOSPITAL AND ONE FROM THE ATTENDING PHYSICIANS.

DISCHARGE ☐ AMB ☒ W/C

PT TEACHING ☐ SEE DISCHARGE SHEET ☐ EXCUSE

☐ PT EDUCATION SHEET GIVEN (specify)

DR. SIGNATURE Loren R Rook

I HEREBY ACKNOWLEDGE RECEIPT OF THE INSTRUCTIONS ABOVE. I UNDERSTAND THAT I HAVE RECEIVED EMERGENCY TREATMENT, AND WILL ARRANGE FOR FOLLOW-UP WITH MY OWN DOCTOR.

X _____ DISCHARGE RN SIGNATURE DATE 5/28/04 X Mary Daley PATIENT SIGNATURE

DALEY MARY R
ACCT# - 0258000
MEDRC# - 000010798
274-54-8180 1/24/1953
5/28/01 POOL, LOREN, M.D.
PATIENT IDENTIFICATION

MEDINA GENERAL HOSPITAL
1000 East Washington Street Medina, OH 44256
725-1000 • 225-8555 • 336-1000

REGISTRATION CONSENT

PATIENT: _____ **ACCT.NO.:** _____

1. **Authorization for Medical Treatment**
I, the undersigned, do hereby voluntarily consent to and authorize such medical care for the patient whose name appears above, encompassing diagnostic procedures including, but not limited to, radiological diagnostic and therapeutic measures, physical/medical diagnostic and therapeutic measures, the administration of drugs or materials for diagnosis and treatment, and obtaining of specimens for diagnosis by any designated route or device and medical treatment by all members of the Medical Staff at Medina General Hospital, their assistants, or designees as may be necessary in their judgment, including but not limited to care and treatment by nursing and paramedical personnel. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatment or examination in the hospital.

2. **Assignment of Benefits and Guarantee of Payment**
I, the undersigned, hereby ASSIGN to Medina General Hospital, Medina, Ohio, all my rights, title and interest in any and all insurance benefits and/or sums of money which may be payable to me by reason of this hospitalization and/or treatment in Medina General Hospital. I understand that I am financially responsible to Medina General Hospital for any and all charges resulting from said hospitalization and/or treatment.

3. **Authorization for Release of Information**
I authorize Medina General Hospital to release any medical information necessary to bill my account and to receive preadmission or continued length of stay certifications to my insurance company or their authorized representative, a Welfare Agency, the fiscal intermediaries and representative under Medicare and Medicaid, Workers' Compensation, and other federal, state or local insurance or reimbursement programs. This authorization is also granted to release all information concerning my illness or injury and hospital treatment, including but not limited to my patient chart, to another health facility in the event of my transfer to that health facility. I furthermore authorize Medina General Hospital to release information relating to my social and medical history and information to my family physician and/or referring physician. This consent may be revoked by me at any time, except to the extent that action has been taken in reliance thereon.

4. **Ohio Revised Code Section 3727.12 Dated Disclosure**
Pursuant to Section 3727.12 of the Ohio Revised Code, you are entitled upon request to a list of the usual and customary charges for Room and Board, and the usual and customary rates for a selected number of x-ray, laboratory, emergency room, operating room, delivery room, physical therapy and pulmonary therapy services.

5. **PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST - Medicare Patients Only.**
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I request that payment of authorized benefits be made on my behalf to Medina General Hospital.

6. **Personal Valuables** - Medina General Hospital is not responsible for patient's valuables and personal items.

7. **Physicians who render professional services to me at Medina General Hospital are independent practitioners and are not employees or agents of the hospital. Medina General Hospital is not responsible for the acts or omissions of physicians that are not directed or controlled by Medina General Hospital.**

If patient is unable to consent, or is a minor, complete the following: Patient is unable to consent because _____ _____. Patient is a minor _____ years of age.

I Have Read This Form (Or Had It Read To Me), It Has Been Explained To Me And I Understand Its Contents.

M Powell 5-28-01 / Mary Daley 5-28-01
Witness Date / Signature of Patient Date

Signature of Patient's Legal Representative Date

Signature of Insured Certificate Holder Date

Date of Original/Revision: 1/97, 2/97
Distribution: Medical Records
JetForm-CONSENT
Form Number: 1001

MAY 3 1 2001

Left wrist LT shoulder

X-RAY

TIB DS A++ (L) shoulder (L) wrist (2) views 6-11-01
Cancelled test b/c didn't went A/R 10:00 1500

5-31-01...OC...NEW...PVT...MARY R. DALEY... This is the first time I have evaluated this patient. HISTORY OF PRESENT ILLNESS: She is a 48-year-old female who was in K-Mart and slipped on a cherry and fell twisting her arm funny. She subsequently presented in the Medina General emergency department with left arm pain. According to her, she was unable to get up and she had to have the squad take her from K-Mart to the hospital. Upon evaluation at the hospital, x-rays were taken and no fractures were seen. She was called back however by Dr. Pool because of the fact that she had a lesion on her left wrist that needed to be evaluated. She was therefore referred to me for further evaluation.
PAST MEDICAL HISTORY: Diabetes, chronic migraines.
PAST SURGICAL HISTORY: Hysterectomy, Laparoscopy, T & A, appendectomy.
MEDICATIONS: Insulin.
ALLERGIES: **ZANTAC, PENICILLIN, NAPRONEX, SULFA, BIAXIN, CODIENE, DILANTIN, IMITREX, PROZAC, TORADOL.**
PHYSICAL EXAM: Shows a woman who has multiple skin lesions which she says are from her diabetes. However, she is not an insulin dependent diabetic. They almost look like injection wounds or burns. There are multiple skin lesions all the way up and down her arms. She was cooperative for the exam but not in a very good mood. She was neurologically and vascularly intact in her left upper extremity. She had exquisite pain and tenderness with any attempts at motion. She said she couldn't lift her arm up or raise it at all. She had no neck tenderness with range of motion. Her left shoulder was tender and painful with motion. Her elbow was less tender with motion. She did have left wrist pain with no swelling compared to the contralateral side. She was completely neurologically and vascularly intact in that upper extremity.

X-RAY INTERPRETATION: I did repeat her x-rays in the office today. AP and lateral of her wrist as well as AP, lateral and axillary view of her shoulder. On the axillary view you can see that her shoulder is definitely located. Her shoulder shows a type II acromion. She has no obvious fractures in the left shoulder. She does however have a bone looks a little bit mottled and funny looking. In the distal radius region I do not see a fracture however I do see a circumscribed lesion in the apophyseal region. There does seem to be a reactive rim of bone however it is not truly very good. There is no identifiable matrix components to it. It does seem a little bit destructive in nature. Differential would include metastases, giant cell tumor, infection although highly unlikely.

ASSESSEMENT AND PLAN: She does have left sided wrist pain. I think the best thing I can do since she was very touch and hard to examine, would be to put her back in the sling and swath that she came in immobilizing her total left upper extremity. I did however show her pendulum exercises to keep her arm moving. I want to get a bone scan. I think this would help me evaluate this lesion in the distal radius area and would also help me pick up any subacute fractures and help evaluate her entire bony skeleton for any other type of abnormalities, metastases or subacute fractures that I am not seeing on x-ray evaluation today. I will see her back after I get the results of this bone scan. She agrees to and understands this treatment plan. She is happy with her care. I did give her a prescription for oral pain medication to help with the pain. I will see her back after the results of the bone scan.
Mark M. Musgrave, MD/lmt

6-15-01 Total Body BS Attn (L) Sh. /wrist @ MGH
6-27-01 @ 9:30-12:30

JUN 19 2001 No show, card sent

JUL 06 2001 X-RAY LT shoulder

MRI (L) Shld ~~Q ESSI RCT~~ CANCELLED 7-9-01 @ 4:00

MRI (L) shld @ MGH Dx RCT 7-10-01 @ 10:30
FAX Script to Hospice

7-6-01...OC...EST...PVT...MARY DALEY...Mary returns today and she stated she is not having any relief. She did not go have her bone scan done when we told her to do because she felt it was not necessary and finally she did decide to go. Now, she returns and the bone scan results are listed in the chart and basically nothing is lighting up down in the distal radius region. She is lighting up a bit in her shoulder and I think the best thing I can do would be to get an MRI to evaluate this shoulder. We are going to do that and we will see her back after we get the results of her MRI. Her physical examination is unchanged. She still have pain with motion in the forward elevation and abduction planes. Therefore we will get an MRI and see her back after the results are known. Mark M. Musgrave, MD/lmt

PROGRESS REPORT: Patient: Mary Daley **Age**: 43
DATE OF TREATMENT: July 24, 2001
PHYSICIAN: Y. P. Mok, M.D.
PRE-OPERATIVE DIAGNOSIS: 1. Left shoulder strain/sprain
2. Diabetic neuropathy, both feet
POST-OPERATIVE DIAGNOSIS: Same
B/P: 144/88 **PULSE**: 90

This patient was last seen two years ago. Her chronic recurring migraines no longer existed following two sessions of acupuncture treatments. Plantar fasciitis symptoms also subsided completely since that time. Her neuropathic condition was improved until the past four months. The burning pain and skin breakdown on the left lower leg occurred again.

She suffered from an accidental fall about two months ago. This occurred at the K-Mart store. She slipped on a cherry, fell and twisted the left shoulder. The pain was so intense, she was unable to get up by herself. Eventually, the emergency squad brought her to the ER, and she was referred to an orthopaedic surgeon, Dr. Musgrave. No definitive finding was identified after a bone scan and MRI studies. Dr. Musgrave concluded that she may have some injury to the rotator cuff because of the persistent pain. Possible surgical intervention was discussed.

Today, the patient returns to our Pain Clinic for pain management. She is extremely reluctant to have surgery because of her diabetic condition. The left lower leg ulcer is located primarily at the distal half of the medial aspect of the tibia. There are two areas of ulceration with the size of approximately 1 inch in diameter with a constant stinging pain. Wound care was not able to heal this type of ulcer. She also describes some arthritic pain of the left hip, but she is mostly focused on the left shoulder strain/sprain symptoms.

I explained to the patient that my treatment might be able to relieve her pain, but does not replace the orthopaedic surgeon's follow-up. The patient agreed.

Procedure: Basic acupuncture

The patient was prepared in the usual fashion.

1. LI 11, ST 38 and 41, K 7
2. YNSA shoulder zone
3. Sooji 2G x 2
4. Sujok 1S x 4
5. H 7 and SP 4 in the opposite meridian

The treatment was very affective. The patient became 95% asymptomatic in her shoulder area. She was able to raise her arm to a near normal range which is an improvement from 40% up to 85% range of motion. The right hip and lower leg pain was also relieved. No complication. Possible follow-up in three weeks.

Y. P. Mok, M.D.

YPM/mkd

ent Name: Daley, Mary Attending: Ross

e: 11/9/01

Fell 8/01 c/o shoulder/arm injury. Also c/o pain/feet
bilat 2° IDDM. Scores shoulder pain #6 (rotator
cuff per Dr Musgrave) Scores foot pain #7-8/10
Unable to wear shoes/feet constant numb/tingling
bilat feet. Amb severely impaired. Also c/o migraine
w/ N/A sx's. Uses Darvocet B.I.D. per PCP. Acupuncture
helps shoulder pain only. Blood sugars out of
control - 1x per PCP
Multiple areas of excoriation, arms & legs - pt c/o
"scratches"

tals: HR 96 (reg) irreg BP 172/100 Resp 20

ientation A+Ox3 Affect: good

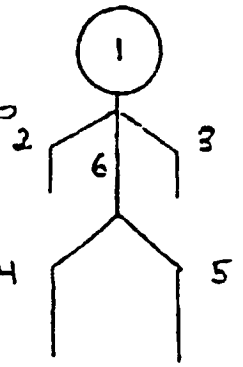
rdiovascular:

Skin: Warm, dry, lesions

Pulses:	Right	Left
Radial	+2/4	+2/4
Pedal		
Post tib	+2/4	+2/4

Color

Temp



Edema: None noted

usculoskeletal

Gait wnl. deficit noted

Strength/Tone P-V muscle tightness noted

ROM + flexion + rotation (L) + (R)

Symmetry

Follow-up

CN II – XII

DTR's	Right	Left
Patellar	+2/4	+2/4
Biceps	+2/4	+2/4
Triceps		
Post Tibial		

Sensation intact ; Burning , tingling no feet

Assessment / Plan

Dmp: Diabetic Radiculopathy

Plan: 1) Avinza 300 mg q.d. Celebrex 200 mg q.d.
2) F/U 1 mo
3) D/C Vioxx - Consider Celebrex next visit
4) Referral to Dr. Meacham for B.P.
5) Neurometer test

V.K.

12/3

Neurology referral - Ramchandran

: V.K.

Ohio Pain Services

Patient Name: Mary Daley Attending: Dr. Ross

Date: 12/12/01

F/U from OV. 11/9/01 Lt shoulder, arm pain today #6 - stinging Lt hand, fingers, numbness Lt shoulder - @ feet burning, stinging, Lt worst Rt, Lt calf heavy, Sleeps poorly - foot pain, burning, stinging. Bladder good / Bowels good - Rt hip constant dull ache & occ. shooting pain Lat aspect Rt hip - (Father @ Southwest & CHF right now) - takes tylenol + Lidoderm for pain - tylenol does not help) R. Hochstetler 4 PA

Vitals: HR 80 reg irreg BP 140 / 90 Resp 16

Orientation A+O x 3

Affect: Good

Cardiovascular:

Pulses:	Right	Left
Radial	2/4	2/4
Pedal		
Post tib	2/4	2/4

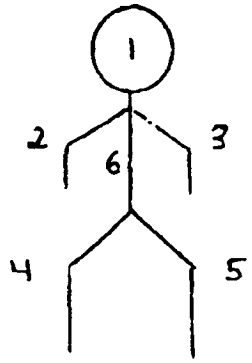
Edema: None noted

Skin:

Warm/dry

Color

Temp



Musculoskeletal

Gait Walks slowly - limp

Strength/Tone P-V muscle tightness L 3-5, knee

ROM ↓ flexion + rot (L) + (R)

Symmetry

Follow-up

Neurologic

CN II - XII intact PERRLA nl EOMI nl

DTR's	Right	Left
Patellar	1/4	1/4
Biceps		
Triceps		
Post Tibial	1/4	1/4

Sensation intact

Assessment / Plan

Impr: Diabetic Radiculopathy

Plan: 1) Ultracet TID q.i.d.
2) E-Stim today - set up for home unit
3) Neurology Referral ASAP

V. Rivera

APPROVED OMB NO 0938-0279

1 PROVIDER NAME, ADDRESS, AND TELEPHONE NUMBER	2	3 PATIENT CONTROL NO	4 TYPE OF BILL
MEDINA GENERAL HOSPITAL P O BOX 75600 CLEVELAND OH 44101 3307251000		0258000	131

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
340733166	052801	052801	1				

12 PATIENT NAME	13 PATIENT ADDRESS
DALEY, MARY R	905 A WADSWORTH RD MEDINA OH 44256

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 CONDITION CODES 25 26 27 28 29 30	31
01241953	F	D	052801	14	2	7	14	1	10798		

32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
05	052801										A B C

DALEY MARY R
905 A WADSWORTH RD
MEDINA OH 44256

	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
271	M/S/C NON-STERILE		052801	2	24 75		
320	R/D GEN	72170	052801	1	122 00		
320	R/D GEN	73060	052801	1	108 00		
320	R/D GEN	73090	052801	1	92 00		
450	ER GEN	99283	052801	1	144 00		
636	DRUGS/DETAIL CODE	J2175	052801	1	13 00		
636	DRUGS/DETAIL CODE	J2550	052801	1	13 00		
001	TOTAL			8	516 75		

50 PAYER	51 PROVIDER NO	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56
					516 75	

57	DUE FROM PATIENT	516 75

58 INSURED'S NAME	59 P REL	60 CERT - SSN - HIC - ID NO	61 GROUP NAME	62 INSURANCE GROUP NO

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

67 PRIN. DIAG CD	68 CODE	69 CODE	OTHER DIAG CODES 70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM DIAG CD	77 E-CODE	78
92303	92310	92401	25000	71690					71941	E8859	

79 P C	80 PRINCIPAL PROCEDURE CODE	DATE	81 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
OH35042283 POOL, LOREN		

84 REMARKS S

85 PROVIDER REPRESENTATIVE X

86 DATE EXT.5672 06/06/01

IB-92 HCFA 1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

(DB)

JOHN BROOKS CAMERON AND AS
ATTN: JOHN
247 EAST SMITH ST
MEDINA, OH 44256

CARRIER

PICA

06 HEALTH INSURANCE CLAIM FORM [EQ]

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER	1a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
☐ (Medicare #)	☐ (Medicaid #)	☐ (Sponsor's SSN)	☐ (VA File #)	☐ (SSN or ID)	☐ (SSN)	☒ (ID)	274548180

2 PATIENT'S NAME (Last Name, First Name, Middle Initial)	3 PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
DALEY MARY	01 24 53 M ☐ F ☒	SAME

5. PATIENT'S ADDRESS (No., Street)	6 PATIENT RELATIONSHIP TO INSURED	7 INSURED'S ADDRESS (No , Street)
905 A WADSORTH ROAD	Self ☒ Spouse ☐ Child ☐ Other ☐	

CITY	STATE	8. PATIENT STATUS	CITY	STATE
MEDINA	OH	Single ☐ Married ☐ Other ☐		

ZIP CODE	TELEPHONE (Include Area Code)		ZIP CODE	TELEPHONE (INCLUDE AREA CODE)
44256	(330)725-7015	Employed ☐ Full-Time Student ☐ Part-Time Student ☐		( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10 IS PATIENT'S CONDITION RELATED TO	11. INSURED'S POLICY GROUP OR FECA NUMBER
a OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO	a INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐
b OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐	b AUTO ACCIDENT? PLACE (State) ☐ YES ☒ NO	b EMPLOYER'S NAME OR SCHOOL NAME
c EMPLOYER'S NAME OR SCHOOL NAME	c OTHER ACCIDENT? ☒ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: JOHN BROOKS CAMERON AND AS
d INSURANCE PLAN NAME OR PROGRAM NAME	10d RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO *If yes*, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNATURE ON FILE — SIGNED _____ DATE 06/26/01

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

SIGNATURE ON FILE — SIGNED _____

14 DATE OF CURRENT MM DD YY	ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
05 08 01	INJ		

17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I D NUMBER OF REFERRING PHYSICIAN	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
LOREN POOL MD		

19 RESERVED FOR LOCAL USE	20 OUTSIDE LAB? ☐ YES ☒ NO	$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)	22 MEDICAID RESUBMISSION CODE	ORIGINAL REF NO
1 923 11 — 3 E88 53 — 2. 923 10 — 4		

23 PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 05 28 01	23	1	99283		92311	162 00	1				
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D NUMBER SSN EIN	26 PATIENT'S ACCOUNT NO	27 ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE	29 AMOUNT PAID	30. BALANCE DUE
341295788 ☐ ☒	EQ312674		$ 162 00	$ 0 00	$ 162 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)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33 PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
LOREN POOL, MD	MEDINA GENERAL HOSPITAL 1000 EAST WASHINGTON DR MEDINA, OH 44258	(440)788-2214 NORTHEAST OHIO EMERGENCY AFF 21755 BROOKPARK RD CLEVELAND, OH 44126
SIGNED 06/26/01 DATE		PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

1743798 258000H
MEDINA GENERAL HOSPITAL
1000 EAST WASHINGTON ST
MEDINA, OHIO 44256
ADDRESS SERVICE REQUESTED

(330) 725-4514 OR 1-800-521-7747

STATEMENT DATE		BALANCE DUE
06-16-01		$ 516.75

IF PAYING BY CREDIT CARD FILL OUT BELOW

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS

CARD NUMBER	AMOUNT $
SIGNATURE	EXP DATE

MAIL TO:

MEDINA GENERAL HOSPITAL
P. O. BOX 75616
CLEVELAND, OHIO 44101-4755

1743798 258000H 1743798
DALEY, MARY R
905 A WADSWORTH RD
MEDINA OH 44256

PLEASE RETURN TOP PORTION WITH YOUR PAYMENT

☐ PLEASE INDICATE ADDRESS CHANGE ON REVERSE SIDE

COPY

Account Number: 258000H

Guarantor/Patient: DALEY, MARY R

Date of Service: 05-26-01

Type of Service: EMERGENCY

Current Balance $ 516.75

We appreciate the opportunity to serve you. This above amount is now due on this account. If you are unable to pay in full or if you have any other questions, call us at 330-725-4514 or 800-521-7747, Monday - Friday 8:00 a.m. - 4:30 p.m.

Otherwise, please make your check payable to MEDINA GENERAL HOSPITAL and mail with the top portion of this statement in the envelope provided.

To save time and money, you may PAY BY CHECK OVER THE PHONE with QUICKCHECK. We also accept VISA, MASTERCARD, DISCOVER & AMERICAN EXPRESS. Call us for details.

You may qualify for free care if your gross annual income is at or below federal poverty guidelines at the time of service. PLEASE SEE REVERSE SIDE OF THIS STATEMENT FOR IMPORTANT INFORMATION. Call us for details.

Sincerely,

Medina General Hospital

Medinal

INSURANCE INFORMATION

15666 SNOW RD STE 204
BROOKPARK, OH 44142-2351

IF YOU HAVE MEDICAL INSURANCE, PLEASE COMPLETE THE REVERSE SIDE AND MAIL IT TO US. YOU ARE RESPONSIBLE TO PAY THE AMOUNT SHOWN DUE FROM PATIENT.

The radiologist is a private physician specializing in the use of x-rays for medical diagnosis and therapy. The bill from the radiologist is for his personal professional consultative services. Films were presented to the radiologist for his interpretation, as well as his written and oral consultation with your physician. The hospital bill may include a charge for x-rays to cover the use of its equipment, the films, supplies, and technical personnel, but, that charge does not include the fee for interpretation of the x-rays by the radiologist.

FN 279590
MARY DALEY
905 A WADSWORTH RD
MEDINA, OH 44256

FN
RADIOLOGY PROFESSIONALS INC
15666 SNOW RD STE 204
BROOKPARK, OH 44142-2351

ACCOUNT NUMBER	DUE FROM PATIENT	AMOUNT ENCLOSED
FN 279590	359.00	$

909 SELF 130129 ◇ DETACH HERE AND RETURN TOP PORTION WITH YOUR PAYMENT TO INSURE PROPER CREDIT ◇278 07/30/01

ACCOUNT NAME	ACCOUNT PHONE	ACCOUNT NUMBER	STATEMENT DATE
MARY DALEY	330-725-7015	FN 279590	07/30/01

DATE	PROCEDURE	DESCRIPTION	CHARGES	PAYMENTS & ADJUSTMENTS	BILLED TO INSURANCE	DUE FROM PATIENT
07/10/01 T# 130129	73221	MRI LEFT SHOULDER	359.00			359.00

FOR QUESTIONS CALL ▶ 1-330-722-3640 MON-FRI 8AM-4PM 1-800-481-3622

WRITE ACCOUNT NO. ON YOUR CHECK AND MAKE PAYABLE TO ▶ RADIOLOGY PROFESSIONALS INC

DUE FROM PATIENT
359.00
♦ PAY THIS AMOUNT ♦

PAYMENTS AND INSURANCE INFORMATION MAILED SEVEN DAYS PRIOR TO THE ABOVE STATEMENT DATE MAY NOT YET APPEAR.

15666 SNOW RD STE 204
BROOKPARK, OH 44142-2351

INSURANCE INFORMATION

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FN 258000
MARY DALEY
905 A WADSWORTH RD
MEDINA, OH 44256

FN
RADIOLOGY PROFESSIONALS INC
15666 SNOW RD STE 204
BROOKPARK, OH 44142-2351

ACCOUNT NUMBER	DUE FROM PATIENT	AMOUNT ENCLOSED
FN 258000	108.00	$

909 SELF 122660 DETACH HERE AND RETURN TOP PORTION WITH YOUR PAYMENT TO INSURE PROPER CREDIT - 306 06/18/01

ACCOUNT NAME	ACCOUNT PHONE	ACCOUNT NUMBER	STATEMENT DATE
MARY DALEY	330-725-7015	FN 258000	06/18/01

DATE	PROCEDURE	DESCRIPTION	CHARGES	PAYMENTS & ADJUSTMENTS	BILLED TO INSURANCE	DUE FROM PATIENT
05/28/01	73090	FOREARM 2 VIEWS LEFT	36.00			
05/28/01	73060	HUMERUS LEFT	36.00			
05/28/01	72170	PELVIS	36.00			
T# 122660						108.00

FOR QUESTIONS CALL ▶ 1-330-722-3640 MON-FRI 8AM-4PM 1-800-481-3622

WRITE ACCOUNT NO. ON YOUR CHECK AND MAKE PAYABLE TO ▶ RADIOLOGY PROFESSIONALS INC

DUE FROM PATIENT
108.00
♦ PAY THIS AMOUNT ♦

PAYMENTS AND INSURANCE INFORMATION MAILED SEVEN DAYS PRIOR TO THE ABOVE STATEMENT DATE MAY NOT YET APPEAR

Statement

Page Number	1

OHIO PAIN SERVICES INC
970 EAST WASHINGTON ST
SUITE 203
MEDINA, OH 44256
(330) 723-7246

Phone Number	(000) 000-0000
Guarantor Code	370630326
Closing Date	2/13/2002
Last Billed Date	2/1/2002

JOHN BROOKS CAMERON ATTY
247 E SMITH RD
MEDINA, OH 44256

Fax 722-5877

New Balance	$50.00
Amount Enclosed	

PENDING WITH INSURANCE $0.00 **AMOUNT DUE $50.00**

Please return top portion with your payment

Date	Provider Tax ID	Description of Services	Proc Code	Diag Code	Charges	Credits
		Previous Balance $0.00				
/24/2001	341729213	000000868 MARY R DALEY				
/24/2001		ACUPUNCTURE	97780	719.4	$95.00	
/6/2001		Guarantor Payment MARY R DAL				$25.00
		Check#				$10.00
/6/2001		Guarantor Payment MARY R DAL Check# 6456				$10.00
0/2/2001		Guarantor Payment MARY R DAL Check# 6484				
		Encounter Bal. $50.00				
11/9/2001	341729213	000000868 MARY R DALEY				
11/9/2001		OFFICE/OUTPATIENT VISIT, EST	99213	719.40	$69.00	
12/10/2001		Plan Payment OHIO JOB AND FA				$34.35
12/10/2001		Writeoff OHIO JOB AND FAMI				$34.65
		Check#				
		Encounter Bal. $0.00				
11/16/2001	341729213	000000868 MARY R DALEY				
11/16/2001		NERVE CONDUCTION	95904	719.40	$225.00	
12/10/2001		Plan Payment OHIO JOB AND FA				$62.82
12/10/2001		Writeoff OHIO JOB AND FAMI				$162.18
		Check#				

Continued on next page

Statement

Page Number	2

OHIO PAIN SERVICES INC
970 EAST WASHINGTON ST
SUITE 203
MEDINA, OH 44256
(330) 723-7246

Phone Number	(000) 000-0000
Guarantor Code	370630326
Closing Date	2/13/2002
Last Billed Date	2/1/2002

JOHN BROOKS CAMERON ATTY
247 E SMITH RD
MEDINA, OH 44256

New Balance	$50.00
Amount Enclosed	

PENDING WITH INSURANCE $0.00 **AMOUNT DUE $50.00**

Please return top portion with your payment

Date	Provider Tax ID	Description of Services	Proc Code	Diag Code	Charges	Credits
		Encounter Bal. $0.00				
2/12/2001	341729213	000000868 MARY R DALEY				
2/12/2001		OFFICE/OUTPATIENT VISIT, EST	99213	719.40	$69.00	
2/31/2001		Plan Payment OHIO JOB AND FA				$34.35
2/31/2001		Writeoff OHIO JOB AND FAMI				$34.65
		Check#				
12/12/2001		INTERFERENTIAL STIM	97014	719.40	$47.00	
12/31/2001		Plan Payment OHIO JOB AND FA				$10.70
12/31/2001		Writeoff OHIO JOB AND FAMI				$36.30
		Check#				
		Encounter Bal. $0.00				
2/28/2001	341729213	000000868 MARY R DALEY				
2/28/2001		INTERFERENTIAL STIM	97014	719.40	$94.00	
/28/2002		Plan Payment OHIO JOB AND FA				$21 40
/28/2002		Writeoff OHIO JOB AND FAMI				$72.60
		Check#				
		Encounter Bal. $0.00				
		Total Balance $50.00				
		Ins. Portion $0.00				
		PATIENT OWES $50.00				

VISA, MASTER CARD AND DISCOVER ACCEPTED. THANK YOU.

Closing Date	Last Pmt Date	Last Pmt Amt	Over 30 Days	Over 60 Days	Over 90 Days	New Charges	Credits
2/13/2002	0/0/0000	$0.00	$0.00	$0.00	$50.00	$599.00	$549.00

Please Pay This Amount	$50.00

PHONE NUMBER	(330) 725-7015
Guarantor Code	000001191

OHIO PAIN SERVICES INC
970 EAST WASHINGTON ST
SUITE 203
MEDINA, OH 44256
(330) 723-7246

STATEMENT

PLEASE RETURN TOP PORTION
WITH YOUR PAYMENT

MARY R DALEY
905 WADSWORTH RD
MEDINA, OH 44256

PATIENT

CLOSING DATE	PAGE	NEW BALANCE
08/01/2001	1	$95.00

Last Billed Date 01/03/2000

PENDING WITH INSURANCE $0.00 **AMOUNT DUE** **$95.00** **AMOUNT ENCLOSED** $

CHARGES OR PAYMENTS AFTER CLOSING DATE WILL APPEAR ON YOUR NEXT STATEMENT

DATE	Provider Tax ID	DESCRIPTION OF SERVICES	PROC. CODE	DIAG. CODE	CHARGES	CREDITS
		Previous Balance $0.00				
07/24/2001	341729213	000000868 MARY R DALEY				
07/24/2001		ACUPUNCTURE	97780	719.4	$95.00	
		Encounter Bal. $95.00				
		Total Balance $95.00				
		Ins. Portion $0.00				
		PATIENT OWES $95.00				

VISA , MASTER CARD AND DISCOVER ACCEPTED. THANK YOU.

CLOSING DATE	LAST PAYMENT DATE	LAST PAYMENT AMOUNT	OVER 30 DAYS	OVER 60 DAYS	OVER 90 DAYS		NEW CHARGES	CREDITS
08/01/2001	01/10/2000	$20.00	$0.00	$0.00	$0.00		$95.00	$0.00

PLEASE PAY THIS AMOUNT $95.00

APPROVED OMB NO 0938-027S

ST11842 LASER UB-92

1	2	3 PATIENT CONTROL NO	4 TYPE OF BILL
MEDINA GENERAL HOSPITAL PO BOX 75600 CLEVELAND OH 44101 4755 330 725 1000		R1 0279590-001	131

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
340733166	071001	071001					

12 PATIENT NAME	13 PATIENT ADDRESS
DALEY MARY R	905 A WADSWORTH RD MEDINA OH 44256

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
01241953	F	D	071001	10	3	1	10	01	10798		

	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE SPAN CODE	35 OCCURRENCE SPAN FROM	35 OCCURRENCE SPAN THROUGH	36 OCCURRENCE SPAN CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37
a	05	052801											A
b													B
c													C

38	39 VALUE CODES CODE	39 VALUE CODES AMOUNT	40 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	41 VALUE CODES AMOUNT
DALEY MARY R 905 A WADSWORTH RD MEDINA OH 44256	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
1	0610	MAGNETIC RES IMG	73221LT	071001	1	156400		
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
1	0001	TOTAL				156400		

50 PAYER	51 PROVIDER NO	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56
					156400	

57 DUE FROM PATIENT ▶

58 INSURED'S NAME	59 P REL	60 CERT - SSN - HIC - ID NO	61 GROUP NAME	62 INSURANCE GROUP NO

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

67 PRIN DIAG CD	68 CODE	69 CODE	70 CODE	OTHER DIAG. CODES 71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM DIAG CD	77 E-CODE	78
840.4	726.10										000

79 P C	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
9						

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

84 REMARKS S

82 ATTENDING PHYS ID	83 OTHER PHYS ID	OTHER PHYS ID
OH35069174 MUSGRAVE MARK M D		

85 PROVIDER REPRESENTATIVE	86 DATE
X	EXT.5672 072001

APPROVED OMB NO 0938-0279

ST11842 LASER UB-92

MEDINA GENERAL HOSPITAL PO BOX 75600 CLEVELAND OH 44101 4175 330 725 1000	2	3 PATIENT CONTROL NO R1 0273633-001	TYPE OF BILL 131

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
340733166	062701	062701					

12 PATIENT NAME	13 PATIENT ADDRESS
DALEY MARY R	905 A WADSWORTH RD MEDINA OH 44256

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
01241953	F	D	062701	09		1	09	01	10798		

	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a	11	062701										A
b												B
												C

38 DALEY MARY R
905 A WADSWORTH RD
MEDINA OH 44256

	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
1	0340	RADIOLOGY NUCLEAR	78306	062701	1	73000		
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
	0001	TOTAL				73000		

50 PAYER	51 PROVIDER NO	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56

57 DUE FROM PATIENT 73000

58 INSURED'S NAME	59 P REL	60 CERT - SSN - HIC - ID NO	61 GROUP NAME	62 INSURANCE GROUP NO

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

67 PRIN DIAG CD	68 CODE	69 CODE	OTHER DIAG. CODES 70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM DIAG CD	77 E-CODE	78
719.43	842.00										000

79 P C	80 PRINCIPAL PROCEDURE CODE	DATE	81 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
OH35069174 MUSGRAVE MARK M D

83 OTHER PHYS ID

OTHER PHYS. ID

84 REMARKS S

85 PROVIDER REPRESENTATIVE X

86 DATE EXT.5672 072001

CRYSTAL CLINIC, INC.
P.O. BOX 75575
CLEVELAND, OH 44101-4755

1168

Division Phone Numbers for Billing Inquires:

Crystal Arthritis Center or Orthopaedic Surgeons
(330) 668-4048
(800) 662-4043

Summit Hand Center
(330) 668-4055
(800) 522-4263

Falls Orthopaedic Surgeons
(330) 929-9136

Check Card Using for Payment

VISA MasterCard

Card Number	Exp Date
Signature	Amount

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
8/04/01	612.00	265677

Page: 1

SHOW AMOUNT PAID HERE $

ADDRESSEE:

MARY R DALEY
905A WADSWORTH RD
MEDINA, OH 44256-3250

REMIT TO:

CRYSTAL CLINIC, INC.
P.O. BOX 75575
CLEVELAND, OH 44101-4755

100063

Date	Procedure	ICD	POS	Description	Amount
				Balance forward as of 07/07/01	384.00
				Physician services for MARY R DALEY	
				Rendered by MARK M MUSGRAVE MD	
07/06/01	99214		O	OFFICE/OUTPATIENT VISIT, EST, COSI MEDI MOD	113.00
07/06/01	73030 LT		O	X-RAY EXAM OF SHOULDER, COMPLE COSI MEDI TE	115.00

YOUR ACCOUNT IS NOW OVER 30 DAYS PAST DUE. IF YOU HAVE NOT ALREADY SENT US YOUR PAYMENT, PLEASE DO SO TODAY. WE ACCEPT MOST MAJOR CREDIT CARDS.

Account No.	Billing Date	Responsible Party	Please Pay This Amount
265677	8/04/01	MARY R DALEY	612.00

Asterisked (*) items indicate that an insurance claim has been sent to your insurance company.

CRYSTAL CLINIC, INC.
P.O. BOX 75575
CLEVELAND, OH 44101-4755

Division Phone Numbers

Crystal Arthritis Center or Orthopaedic Surgeons
(330) 668-4048
(800) 662-4043

Summit Hand Center
(330) 668-4055
(800) 522-4263

Falls Orthopaedic Surgeons
(330) 929-9136

Current	31-60 Days	61-90 Days	91-120 Days	Over 121 Days	Balance Due

JOHN BROOKS CAMERON AND ASSOCIATES
ATTORNEYS AT LAW
247 EAST SMITH ROAD
MEDINA, OHIO 44256
330-722-8989

EXPLANATION	AMOUNT	

S-1244 10
BR 79

8049

PAY Twenty dollars 00/100 DOLLARS

DATE	TO THE ORDER OF	CHECK NO.	AMOUNT	EXPLANATION	CHECK AMT
7/23/01	Crystal Clinic, Inc	8049	20 —	Mary Daley - MR	20
				FICA FED W.TH STATE	

NATIONAL CITY BANK
CLEVELAND, OHIO

⑈008049⑈ ⑆041000124⑆ 37456578⑈

Dr. Mark M Musgrave
4015 Medina Road #90
Medina, OH 44256

COPY

Fax

To: John Brooks Cameron & Assoc. From: Lynn

Fax: 330-722-5871 Pages: 1

Phone: Date: 7/23/01

Re: Records Request CC:

We have received a request for medical records for Mary Daley, we will be happy to process that request upon receipt of the copying fee. Those charges are as follows:

Records search fee $15.00	$15
$1 per page for the first 10 pages	$1
$.50 per page for pages 11-50	
$.20 per page for pages 51 and higher	
$6.00 per x-ray film copy	
Postage	$1
Total charge	$ 20.00

Please make checks payable to Crystal Clinic, Inc (Tax ID 34-1097127)

These fees are in compliance with H.B. 508

Lynn Tuck
Secretary

CCI-215

CRYSTAL CLINIC, INC
P O. BOX 75575
CLEVELAND, OH 44101-4755

1168

Division Phone Numbers for Billing Inquires:

Crystal Arthritis Center or Orthopaedic Surgeons
(330) 668-4048
(800) 662-4043

Summit Hand Center
(330) 668-4055
(800) 522-4263

Falls Orthopaedic Surgeons
(330) 929-9136

Check Card Using for Payment

Card Number	Exp Date
Signature	Amount

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
6/09/01	384.00	265677

Page 1

SHOW AMOUNT PAID HERE $

ADDRESSEE:

MARY R DALEY
905A WADSWORTH RD
MEDINA, OH 44256-3250

REMIT TO:

CRYSTAL CLINIC, INC.
P.O. BOX 75575
CLEVELAND, OH 44101-4755

Date	Procedure	ICD	POS	Description		Amount
				Physician services for MARY R DALEY		
				Rendered by MARK M MUSGRAVE MD		
05/31/01	99204		0	OFFICE/OUTPATIENT VISIT, NEW, MOD	COSI MEDI	192 00
05/31/01	73030 LT		0	X-RAY EXAM OF SHOULDER, COMPLETE	COSI MEDI	115.00
05/31/01	73100 LT		0	X-RAY EXAM OF WRIST	COSI MEDI	77.00

YOUR INSURANCE HAS PAID THEIR PORTION ON YOUR BILL, THE BALANCE DUE IS YOUR COPAY/DEDUCTIBLE. PLEASE REMIT PAYMENT IMMEDIATELY. WE ACCEPT MOST MAJOR CREDIT CARDS.

COPY

Account No.	Billing Date	Responsible Party	Please Pay This Amount
265677	6/09/01	MARY R DALEY	384.00

Asterisked (*) items indicate that an insurance claim has been sent to your insurance company.

CRYSTAL CLINIC, INC.
P.O. BOX 75575
CLEVELAND, OH 44101-4755

Division Phone Numbers

Crystal Arthritis Center or Orthopaedic Surgeons
(330) 668-4048
(800) 662-4043

Summit Hand Center
(330) 668-4055
(800) 522-4263

Falls Orthopaedic Surgeons
(330) 929-9136

Current	31-60 Days	61-90 Days	91-120 Days	Over 121 Days	Balance Due

1168*0EW0U17FY002689

MEDINA GENERAL HOSPITAL
P O BOX 75600
CLEVELAND OH 44101
3307251000

3 PATIENT CONTROL NO								
0273633								131
5 FED TAX NO	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D	8 N-C D	9 C I D	10 L P D	11	
340733166	062701	062701	1					

12 PATIENT NAME	13 PATIENT ADDRESS
DALEY, MARY R	905 A WADSWORTH RD MEDINA OH 44256

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
01241953	F	D	062701	09		1	09	1	10798								

CONDITION CODES

32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	THROUGH	37
11	062701								A
									B
									C

DALEY MARY R
905 A WADSWORTH RD
MEDINA OH 44256

	39 CODE	39 VALUE CODES AMOUNT	41 CODE	41 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
340	NUCLEAR MED GEN	78306	062701	1	730 00		
001	TOTAL			1	730 00		

COPY

THIS IS NOT A BILL
This statement is for
your information. A BILL
will be sent to you.

50 PAYER	51 PROVIDER NO		54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56
				730 00	
57	DUE FROM PATIENT			730 00	

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID - SSN - HIC - ID NO	61 GROUP NAME	62 INSURANCE GROUP NO

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

67 PRIN DIAG CD	68 CODE	OTHER DIAG CODES 70 CODE	72 CODE	74 CODE	76 ADM DIAG CD	77 E-CODE	78
71943	84200						

79 P C	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
9						
	OTHER PROCEDURE CODE	DATE			OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID
OH35069174 MUSGRAVE, MARK

83 OTHER PHYS ID

OTHER PHYS ID

64 REMARKS S

85 PROVIDER REPRESENTATIVE X

86 DATE EXT.5672 07/03/01

UB-92 HCFA-1450 PRINTED 07/05/01 PAGE 107 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

1759801 01-1569H
MEDINA LIFE SUPPORT TEAM
P. O. BOX 16211
ROCKY RIVER, OH 44116
ADDRESS SERVICE REQUESTED

(330) 725-4544 OR 1-800-521-7747

STATEMENT DATE		BALANCE DUE
06-30-01		$ 340.00

IF PAYING BY CREDIT CARD, FILL OUT BELOW

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS

CARD NUMBER	AMOUNT $
SIGNATURE	EXP DATE

MAIL TO:

MEDINA LIFE SUPPORT TEAM
1000 EAST WASHINGTON ST
MEDINA, OHIO 44256

1759801 01-1569H
DALEY, MARY R 1759801
905 WADSWORTH RD APT A
MEDINA OH 44256

PLEASE RETURN TOP PORTION WITH YOUR PAYMENT

☐ PLEASE INDICATE ADDRESS CHANGE ON REVERSE SIDE

Account Number: 01-1569H

Guarantor/Patient: DALEY, MARY R

Date of Service: 05-28-01

Current Balance: $ 340.00

COPY

We appreciate the opportunity to serve you. The above amount is now due on this account. If you are unable to pay in full or if you have any other questions, call us at 330-725-4544 or 800-521-7747, Monday - Friday 8:00 a.m. - 4:30 p.m.

Otherwise, please make your check payable to MEDINA LIFE SUPPORT TEAM and mail with the top portion of this statement in the envelope provided.

To save time and money, you may **PAY BY CHECK OVER THE PHONE** with QUICKCHECK. We also accept VISA, MASTERCARD, DISCOVER & AMERICAN EXPRESS. Call us for details.

You may qualify for free care if your gross annual income is at or below federal poverty guidelines at the time of service. PLEASE SEE REVERSE SIDE OF THIS STATEMENT FOR IMPORTANT INFORMATION. Call us for details.

Sincerely,

Medina Life Support Team

Medinazabl

STATEMENT