FORM B10 (Official Form 10) (4/98) USBC, Illinois Northern (4/1/98)

*FILE ORIGINAL FOR CHAPTERS 7 and 11, IN DUPLICATE FOR CHAPTER 13, FOR DATE-STAMPED COPY, SEE #9 BELOW

United States Bankruptcy Court
Northern District of Illinois, Eastern Division

☐ CH 7 ☐ CH 13 ☐ CH 11 PLEASE CHECK CHAPTER

PROOF OF CLAIM

Name of Debtor: K-MART CORP.

Case Number: 02-02474

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

File Claim Form With:

United States Bankruptcy Court
P. O Box A3613
Chicago, Illinois 60690-3612

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

Name and Address Where Notices Should be Sent:
BRIAN J. CONNELLY
979 BEACHLAND BLVD.
VERO BEACH, FL. 32963
Telephone No. 772 231-1100

☐ 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.

Creditor # ________

THIS SPACE IS FOR COURT USE ONLY

Account or other number by which creditor identifies debtor

Check here if this claim ☐ amends ☐ replaces a previously filed claim dated. ________

1. BASIS FOR CLAIM

☐ Goods sold
☐ Money loaned
☐ Taxes
☐ Retiree benefits as defined in 11 U S C § 1114 (a)
☐ Services performed
☒ Personal injury/wrongful death
☐ Other ________
☐ Wages, salaries, and compensation (Fill out below)
Your social security number ________
Unpaid compensation for services performed
from ________ (date) to ________ (date)

2. DATE DEBT WAS INCURRED:

3. IF COURT JUDGMENT, DATE OBTAINED

4. Total Amount of Claim at Time Case Filed: $ 50,000 UNLIQUIDATED.

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 above, 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 $4,300), *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 $1,950* 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 units11 U S.C. § 507(a)(8)
☐ Other—Specify applicable paragraph of 11 U S C § 507(a)________

**Amounts are subject to adjustment on 4/1/98 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 ANY ATTACHMENT MUST BE 8-1/2" BY 11"

9. DATE-STAMPED COPY: To receive an acknowledgment of the filing of your claim, enclose a stamped, self-addressed envelope and an additional copy of this proof of claim.

THIS SPACE IS FOR COURT USE ONLY

FILED
UNITED STATES BANKRUPTCY COURT
NORTHERN DISTRICT OF ILLINOIS
MAR 2 5 2002 3/25/02
KENNETH S. GARDNER, CLERK
MAILROOM - KC KP 931

Date: 3/22/02

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)

Brian J Connelly, Esq.

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 and3571.

INSTRUCTIONS FOR FILING 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 the 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). This form must be filed with the clerk of the bankruptcy court where the bankruptcy case was filed.

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 creditors 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, Eastern District of Virginia), the name of the debtor in the bankruptcy case, and the bankruptcy case number If you received a notice of the case from the court, all of this information is near the top of the notice.

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 avail- able you must attach an explanation of why they are not available.

Proof of Claims should be filed with Trumbull Services at:

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

IN THE CIRCUIT COURT OF THE 19TH
JUDICIAL CIRCUIT IN AND FOR
INDIAN RIVER COUNTY, FLORIDA

CASE NO.: 20 010813 CA11

SANDRA MAINES,

Plaintiff,

ASSIGNED TO JUDGE KENNEY

vs.

K MART CORPORATION,
a Michigan corporation, and
CAREFUL CLEAN, INC.,
a Florida corporation,

Defendants.
_______________________________/

COMPLAINT

Plaintiff, Sandra Maines, by and through her undersigned counsel, sues Defendants, K-Mart Corporation, a Michigan corporation, herein referred to as "K Mart", and Careful Clean, Inc., a Florida Corporation, herein referred to as "Careful Clean", and alleges the following:

1. This is an action for damages which exceeds Fifteen Thousand Dollars ($15,000), exclusive of costs, interest and attorney's fees.

2. On or about August 2, 2000, K-Mart Corporation was the owner and in possession of a building at the Big Kmart located at 1501 US 1, Vero Beach, Florida 32960.

3. On or about August 2, 2000, Careful Clean, Inc. was operating in St. Lucie County, Florida, and was the contracted party responsible for routine floor maintenance at the Big Kmart, located at 1501 US 1, Vero Beach, Florida 32960.

4. Plaintiff, Sandra Maines, at all times material hereto, was a natural person and

resident of Indian River County, Florida.

5. On or about August 2, 2000, Plaintiff, Sandra Maines was browsing in the houseware section of the store. While walking with due care, Ms. Maines slipped and fell in the aisle that was excessively slippery.

COUNT I
NEGLIGENCE CLAIM AGAINST K MART CORPORATION

Plaintiff re-alleges and incorporates by reference the allegations 1 through 5 above and further alleges:

6. Plaintiff Ms. Maines was lawfully on the property of Kmart as a business invitee.

7. The Defendant, as owner and manager of the subject property, owed a non-delegable duty of care to all guests , including Plaintiff, to keep the property and its common areas free from dangerous conditions and hazards.

8. The Defendant Kmart breached its duty of care in that it was careless and negligent including, but not limited to, the following respects:

(a) failing to maintain the premises and area under its control in a reasonable safe condition;

(b) failing to protect or warn Plaintiff of hazardous and dangerous conditions; and

(c) failing to correct the hazardous and dangerous conditions.

(d) failing to properly inspect its premises to ensure the safety of its patrons.

(e) failing to creates and enforce proper safety inspections procedures to ensure the safety of its patrons.

9. As a direct and proximate result of the Defendant Kmart's negligence and failure to

warn, Plaintiff Sandra Maines was injured in and about her body and extremities, suffered pain therefrom, incurred medical expense in the treatment of the injuries, and suffered physical handicap, and her working ability was impaired; the injuries are either permanent or continuing in nature and Plaintiff will suffer the losses and impairment in the future.

WHEREFORE, Plaintiff Sandra Maines demands judgment for damages against Defendant Kmart in excess of $15,000, and further demands trial by jury on all issues so triable as a matter of right.

COUNT II
NEGLIGENCE CLAIM AGAINST CAREFUL CLEAN, INC.

Plaintiff re-alleges and incorporates by reference the allegations 1 through 9 above and further alleges:

10. The Defendant Careful Clean, as a contracted corporation in charge of maintenance of the subject property, owed a duty of care to all guests , including Plaintiff, to keep the property and its common areas free from dangerous conditions and hazards of which it knew or should have known.

11. The Defendant Careful Clean breached its duty in that it was careless and negligent including, but not limited to, the following respects:

(a) failing to maintain the premises and area under its control in a reasonable safe condition;

(b) failing to protect or warn Plaintiff of hazardous and dangerous conditions;

(c) failing to correct the hazardous and dangerous conditions; and

(d) failing to properly train it employees in the inspection and maintenance of the

subject premises to ensure the safety of the patrons of the business.

12. As a direct and proximate result of the negligence of the Defendant, the Plaintiff suffered bodily injury and resulting pain and suffering, disability, disfigurement, mental anguish, loss of capacity for the enjoyment of life, expense of hospitalization, medical and nursing care and treatment, loss of earnings, loss of ability to earn money and aggravation of a previously existing condition. The losses are either permanent or continuing and Plaintiff will suffer the losses in the future.

WHEREFORE, Plaintiff Sandra Maines demands judgment for damages against Defendant Careful Clean in excess of $15,000, and further demands trial by jury on all issues so triable as a matter of right.

Dated this 27th day of November, 2001.

BRIAN J. CONNELLY, Esq.
Gould, Cooksey, Fennell, O'Neill,
Marine, Carter & Hafner, P.A.
979 Beachland Blvd.
Vero Beach, FL 32963
(561) 231-1100
(561) 231-2020 FAX
Florida Bar No. 0058815
Attorney for Plaintiff

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OF COUNSEL
SAMUEL A. BLOCK

*FL BOARD CERTIFIED
CIVIL TRIAL AND
BUSINESS LITIGATION

**FL BOARD CERTIFIED
WILLS, TRUSTS AND ESTATES

September 12, 2001

Richard J. Willis
Claim Service Specialist
The Hartford
Orlando Commercial Claim Center
P. O. Box 947000
Maitland, FL 32794-7000

Re: Our Client : Sandra Maines
Your Insured : Careful Clean, Inc.
Your Claim No. : YAC L 09470
Date of Accident : August 2, 2000

Dear Mr. Willis:

As you are aware, this firm represents Sandra Maines as a result of a slip and fall accident at K-Mart in Vero Beach, Indian River County, Florida. We are writing this letter to present the facts of this claim on behalf of our client in an attempt to settle this claim amicably and without the necessity of litigation. This letter and the enclosed materials are submitted only for the purposes of settlement negotiations and, in the event litigation is entered, we request that all materials be return to our office uncopied. The information we supply herewith is a brief summary of the facts which would be prepared at a trial of this matter. Enclosed for your review and marked as Exhibit "A" is a copy of the Kmart Customer Incident Information form filed with your insured following Ms. Maines's fall. Ms. Maines fell on the premises of Kmart due to an overuse of wax on the floor of the Kmart premises by your insured.

Following her fall, Ms. Maines sought medical treatment in the emergency room of Indian River Memorial Hospital. X-rays were taken and Ms. Maines was later released. Ms. Maines returned again on August 8, 2000 for additional medical treatment of injuries she sustained in this accident. Enclosed and marked as Exhibit "B" is a copy of the records of Indian River Memorial Hospital.

Mrs. Maines received follow-up care of her injury with Dr. Kirk Maes of Barefoot Bay, Florida. Dr. Maes began treating Ms. Maines on August 14, 2000 at which time his impression following an examination was that Ms. Maines had a herniated lumbar disc at the L5-S1 level; completely nondisplaced occult fracture of the radial neck; a cervical muscle strain from her fall; and, trapezius muscle strain. In a narrative report dated June 5, 2001, Dr. Maes stated that Ms. Maines had strain to her cervical muscles and her trapezius muscles and that he felt that she had a herniated lumbar disc. On September 11, 2000, Dr. Maes again evaluated Ms. Maines at which time she still had pain and stiffness in the left wrist and pain over the radial head. The left elbow revealed tenderness in the lateral epicondyle and she still had cervical muscle soreness and trapezius muscle soreness. Dr. Maes further opined that she had impingement of the left shoulder and continued low back pain. Anti-inflammatory medications and physical therapy were prescribed for Ms. Maines. A copy of the records of Dr. Kirk Maes and Spine and Sport is enclosed and marked as Exhibit "C" and "D," respectively.

As a result of the injuries sustained in this accident, Mrs. Maines incurred the following medical expenses:

Indian River Memorial (08/02/00)	$ 681.25
Indian River Memorial (08/02/00)	$ 43.75
Emergency Medicine Associates (08/02/00)	$ 150.00
Emergency Medicine Associates (08/08/00)	$ 150.00
McCorkle Radiology (08/02/00)	$ 109.00
Vero Radiology (MRI)	$ 591.91
Dr. Kirk Maes	$ 600.00
Spine and Sport	$ 1,366.20
Total	$ 3,692.11

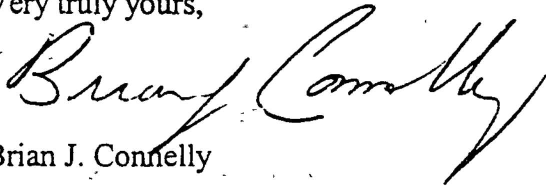
Enclosed and marked as Exhibit "E" is a copy of the above expenses currently contained in our files.

Sandra Maines is a 40 year old hearing impaired woman who, prior to this incident, enjoyed a very active lifestyle with her family. Although unable to hear or speak as a result of a childhood illness, Mrs. Maines received specialized schooling that taught her sign language and she is adept at reading lips. Mrs. Maines suffered from blurred vision and recurrent headaches because of the fall with radiating pain into her lower extremities. As a result of the injury she sustained in this slip and fall accident, Ms. Maines has great difficulty in walking for any distance and finds it difficult to do social activities with her family and friends. In light of Ms. Maines's age, it is likely that she will develop arthritic changes in the site of her injuries in the future.

In summary, there is absolutely no issue of liability in this matter. Your insured overly waxed the floor of the Kmart premises creating a dangerously slippery surface on which customers were forced to walk. The overly waxed floor created by your insured's on the premises presented a dangerous condition that a patron, such as Ms. Maines, could not foresee. Mrs. Maines's family accompanied her to the store and witnessed the accident and observed the excessively waxed flooring. The family members overheard the supervisor advise an employee that the floor was slippery because of the wax and ordered that cones be placed over the area.

In estimating her damages, we have taken into consideration her need for past, present and possible future medical care and treatment and her overall loss of enjoyment of her life. For the purposes of settlement, Ms. Maines will accept $75,000.00 in full and final settlement of her claim. We are giving you the opportunity to settle this matter amicable without the necessity of litigation and respectfully request that you respond to this offer by October 15, 2001. If we do not have a response by that date, this offer will be withdrawn and we will proceed with litigation. In earlier communications, you requested an opportunity to meet and interview Mrs. Maines. In the hope of avoiding unnecessary litigation and additional trauma to Mrs. Maines, I am willing to grant your request. Please call my office to schedule this interview.

Very truly yours,



Brian J. Connelly

BJC/ss
Enclosures
CC: Sandra Maines

Kmart Customer Incident Information

7294 Big Kmart
1501 US 1
VERO BEACH, FL 32960
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,

Your Kmart Store Management

Store Phone Number: ______

TO BE COMPLETED BY CUSTOMER:

Customer name: Sandra Maines
Customer's Street Address: 4765 36th Ave
City: Vero Beach State: FL Zip: 32967 Phone: (561) 770-4264
Customer's sex: ______
Customer's employer: ______
Customer's Social Security Number: 264-59-9881
Customer's Date of Birth: 6-26-61
If injury to a child: Child's name: ______ Child's age: ______ Parent's name: ______

Customer's Description of Incident:

Date of incident 8-2-00 Location of incident: Houseware
Time of incident. 4:20 pm What happened? Slip and fall accident

Do you wish to be contacted? Yes Date reported. 8-2-00 Signature of Customer. Sandra Maines

White copy - for Customer

7

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

TO BE COMPLETED BY STORE PERSONNEL

STORE AUTHORIZA..ION FOR FIRST AID

STORE STAMP
7294 Big Kmart
1501 US 1
VERO BEACH, FL 32960

To: ______________________
Name of Doctor, Clinic or Hospital

Authorized By: ______________________

We will pay the reasonable and ordinary charges for one time emergency first aid treatment of the patient described below, administered within 24 hours of the incident described below, if this form is completed in its entirety, including the Medical Report section below, and this completed form is returned to the store with an itemized bill and a copy of the admitting notes. This authorization is for first aid only, and does not extend to follow-up care and is not an admission of liability.

Patient Name Sandra Maines Incident Date 08-22-00 Incident Time 4:20

Address 4765 30th Ave DOB 6-26-61 Soc. Sec. No. 264-59-8881

VeroBeach 32967 Height 5'7" Weight 180
(City) (State) (Zip Code)

Patient's Employer ______________________

TO BE COMPLETED BY PATIENT

PATIENT AUTHORIZATION TO RELEASE INFORMATION

To: **Any and all providers of medical services:** This authorization or a copy of this authorization will allow you to give to the above-described store or its representative any information you have regarding my medical history, physical, clinical or laboratory findings, diagnosis, treatment, prognosis and related information.

Patient Signature ______________________ Date ______________________
(Parent should sign for patient under age 18 and print child's name next to parent's signature.)

TO BE COMPLETED BY PHYSICIAN

PHYSICIAN'S MEDICAL REPORT

Date of examination / treatment ______________________

History of incident given by patient ______________________

Patient's complaints ______________________

Clinical findings ______________________

Has patient ever had same or similar condition ______________ If yes, when? ______________

Diagnosis ______________________

Treatment rendered ______________________

Prognosis: Is patient disabled? ______________ If yes, how long is disability expected? ______________

Have you treated this patient before? ______________ Approximate date of last treatment ______________

Signature of physician ______________________ Date ______________

Name of physician ______________________ Fed ID ______________

Office address ______________________

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

Indian River Mem. Hospital
Emergency Department

Multiple Minor Injuries

Multiple Minor Injuries Template © 1984 - 1999 RTQA

Date \ Time: 08/02/2000 5.37 22 PM
Patient: MAINES, SANDRA
ED Physician: B.McClure

MAINES, SANDRA
DR TEEL, DUDLEY G. DR# 00001 1931040
ADM 08/02/00 DOB 06/26/61 F
MR# 000355262 -561-770-4264

BP: 161/103 P: 75 R: 18 T: 97.6 %O2

HISTORY

CC(s): Whole Lt side hurts after fall @ KMart

HPI: Slipped landed on Lt buttock + elbow (L) neck pain after merchandise fell on top of pt. ø H/c, LOC, paresthesia, weakness, chest or abd. pain, N/V. Ambulatory.

TIMING: Sxs for <4 min hrs days wks mon yrs
☐ Constant ☐ Intermittent ☐ ↑ing ☒ Present Now ☐ ↓ing ☐ Gone

ALLERGIES: ø none
Last Tetanus: na

HX SOURCES: ☒ Patient\Family ☐ Nursing Notes ☐ Pvt Doc ☐ Old Records ☐ Questionnaire

SEVERITY: Severe 10 9 8 Mod 7 6 5 4 Mild 3 2 1
PAIN? N Y — Location: → Radiation: "Whole left side"
QUALITY: na — Strong
CONTEXT: Occur(ed) While ☐ nl Setting ☐ nl Activity
MODIFYING FACTORS: none

PMH: Meningitis → Deaf — Reviewed? Y N (-) Hx of Systemic Disease? N Y
FH: Reviewed? Y N (-+)
SH: Reviewed? Y N (-+) Deaf-Mute

ROS:

MECHANISM: Fall? (ft) N Y; MVA? (Speed ___ mph) N Y; Seatbelt? na N Y; Airbag? na N Y; Patient Driving? na N Y

CARDIOVASC \ RESP \ GI: Chest Pain? N Y; Pleuritic? na N Y; Trouble Breathing? N Y; Abdominal Pain? N Y

SKIN \ MUSCULOSKELETAL: Lacerations? N Y; Abrasions \ Bruises? N Y; Head \ Face Pain? N Y; Neck Pain? N Y; Upper Back Pain? N Y

Lower Back \ Pelvis Pain? N Y; Upper Extremity Pain? N R L; Lower Extremity Pain? N R L

NEUROLOGICAL: LOC? (sec min) N Y; Headache? N Y

PHYSICAL EXAMINATION

GENERAL APPEARANCE: Vital Signs Noted? Y N; In Distress? N Y

EYES \ ENT \ MOUTH \ FACE: Examined? Y N; Facial Lacerations\Bruises? N Y; Eye Injury \ Pain? N R L

NEURO \ CARDIOVASC \ RESP \ GI: Examined? Y N; Oriented? (x 4) Y N; Motor \ Sensory Deficits? N Y; Chest Wall Tenderness? N Y; Lungs Clear? Y N; Abdominal Tenderness? N Y

MUSCULO-SKELETAL \ SKIN: Examined? Y N; Seatbelt Marks \ Bruises? N Y

(Diagram notes:) (L) diffuse tend. @ Lt buttock, MAEx4, nl ROM. (L) mild cervical paravertebral tend., nl ROM

(T)enderness: (D)eformity:
Head \ Face? N T D; Neck? N T D; Chest \ Ribs? N T D; Back \ Pelvis? N T D; Right Upper Extremity? N T D; Left Upper Extremity? N T D; Right Lower Extremity? N T D; Left Lower Extremity? N T D

MEDICAL DECISION MAKING - CLINICAL COURSE

INITIAL IMPRESSION: Contusions

DIFFERENTIAL: 1. R/O bony abn. 2. R/O

DIAGNOSTIC & TREATMENT PLAN: ☒ Labs \ X-Ray ☐ Repair ☐ Consult ☒ Medications ☐ Ice ☐ ✓ Response

CONSIDERED an EMERGENCY due to: ☒ Severe Pain ☐ Re✓ ☒ DysFunctional BodyPart\Organ\System ☒ Acute Onset of Sxs ☒ Undiagnosed Injury \ Illness ☐ Threat to Life \ Limb ☒ Uncertain Prognosis \ Outcome ☐ Possibility of Adverse Outcome (Complications, Morbidity)

REVIEWED OLD: ☐ X-Rays ☐ Records na

CONFERRED WITH: ☐ Radiologist ☐ Pvt Dr.\Consult na

X-RAY & LAB DATA: none — Lt elbow, C-spine } NAD Teel

CLINICAL COURSE: ☒ Improving ☐ No Change ☐ Worse ☐ See Attached Addenda:

PROCEDURES: ☐ by Physician ☐ by Resident ☐ by PA \ NP ☐ Key Portion Supervised by Physician ☒ None ☐ Dermal Glue ☐ Staples # ___ ☐ Tourniquet ___ min ☐ Sutures: Layer ___ Material ___ # ___ Layer ___ Material ___ # ___ ☐ Debrided ☐ Irrigated w\ Saline Betadyne

DISPOSITION

FINAL DIAGNOSES:
1. multiple contusions c
2. STI 2° fall
3.

DISPOSITION TIME :

STATUS: ☒ Good ☐ Fair ☐ Poor ☐ Critical
DISCUSSED WITH: ☒ Patient ☒ Family

☐ ADMITTED ☐ TRANSFERRED To Dr \ Facility:

☐ DISCHARGED ☐ ReCheck Here On: ___ ☒ FollowUp w/ Dr. Naei By: pr

INSTRUCTIONS GIVEN: ☒ Verbal ☒ Written

PRESCRIPTIONS: none
1. Norflex
2. Naprosyn
3. Ultram

ED PHYSICIAN HAS REVIEWED: na ☒ PA \ NP H&P ☐ Resident H&P } Agrees with Data? Y N; Differs? N Y; Revised Above? N Y

EXCUSES GIVEN: na ☐ Work ___ days ☐ LtDuty ___ days ☐ School ___ days ☐ Gym ___ days

Physician Signature [signature]
PA \ NP \ Resident Signature [signature]

B

Inc ı River Memorial Hospital

Instructions and Information from the Emergency Medical Staff

For: SANDRA MAINES 08/02/2000 8:06:52 PM Doctor: Barbara McClure, ARNP

ABOUT YOUR RESPONSIBILITIES

AFTER YOU LEAVE, YOU MUST PROPERLY CARE FOR YOUR PROBLEM AND OBSERVE ITS PROGRESS. IF YOU DO NOT IMPROVE AS EXPECTED, OR ARE WORSE, DO ONE OF THE FOLLOWING *IMMEDIATELY*: CONTACT YOUR DOCTOR or FOLLOW-UP DOCTOR or CALL HERE 561-567-4311 or RETURN HERE.

The doctor thinks your symptoms may be due to: MULTIPLE CONTUSIONS

Keep this in mind: DIAGNOSIS WITH 100% CERTAINTY IS NOT POSSIBLE in the Emergency Department. Therefore, if you find you are not getting better, another diagnosis is possible, and you must see your doctor or return here.

MULTIPLE CONTUSIONS: are bruises of the skin and muscle. There is no evidence of injury to your internal organs and usually no broken bones. Areas of the skin that are bruised usually have a black and blue discoloration, and muscles that are bruised are usually sore. The most common symptoms are muscle aches, stiffness, swelling, redness, tenderness, and discoloration.

What to Watch For:	Return here immediately if you notice: A) increasing pain or swelling B) increasing or persistent chest pain C) increasing or persistent abdominal pain D) weakness, paralysis, or tingling of your arms or legs E) redness, streaking, or increasing tenderness or your skin bruises F) pain lasting more than 2 weeks
What to Expect:	Your symptoms should improve within 1-2 days, and you should return to normal within 1-2 weeks. It is common for new areas of mild soreness to appear in the first 48 hours after injury; but these should be mild. The appearance of severe or worsening pain means you must be seen again by a doctor.
What to Do:	1. Rest for the first 24-36 hours. If possible, elevate any sore areas above the level of your heart. 2. Apply ice packs (wrap in a towel) to sore areas for 15-20 minutes every hour for the first 24 hours. 3. Stay off your feet for 1-2 days, but you may gradually begin to walk as your pain improves.
What Not to Do:	1. DO NOT do any lifting, bending, or strenuous exercise until your are completely healed. 2. DO NOT remove any splints or braces (if you have been given them) until the doctor says to do so. 3. DO NOT ignore increasing pain - this is a sign you need to be seen again by the doctor.

***** BE SURE TO NOTE THE FOLLOWING *****

1 - REST - QUIET ACTIVITIES FOR 2 DAYS - MEDS 2 - ICE TO ALL SORE AREAS - NO HEAVY LIFTING
3 - FOLLOW UP WITH REFERRAL M.D. AS NEEDED

ABOUT YOUR X-RAYS:

Your X-Rays have been read by the Emergency Doctor. An X-Ray specialist (radiologist) will also read your films. You will be notified if there is any change in your X-Ray diagnosis.

YOU HAVE RECEIVED PRESCRIPTIONS FOR:

Norflex, & Naprosyn (500mg), & Ultram (50mg)
All medications have potential side effects.Ask your pharmacist about any precautions you should take.

SEE A FOLLOW-UP PHYSICIAN IF NECESSARY:

If you do not improve as expected, additional evaluation by another physician will be necessary. Please arrange to be seen by Kirk Maes M.D. on or before _______________. Call the doctor s office soon to make an appointment. IF YOU ARE WORSE AND IF, FOR ANY REASON, YOU CANNOT ARRANGE TO SEE THE DOCTOR, YOU MUST CALL HERE AS SOON AS POSSIBLE.

REMEMBER. YOUR CARE IS NOT YET COMPLETED	**Kirk Maes M.D. 1300 36th St. Vero Beach , FL 32960 664-2233**	**YOU MUST MAKE ARRANGEMENTS FOR FOLLOW-UP OF YOUR PROBLEM**

IT IS IMPORTANT THAT WE HAVE A CORRECT TELEPHONE NUMBER, IN CASE IT IS NECESSARY TO CONTACT YOU.

I have received these instructions, they have been reviewed with me, and I understand my responsibilities to carefully follow them.

Signature of Patient/Guardian: Sandra Maines Discharge Nurse: JS

MEDICAL RECORDS

Tuberculosis Assessment

1. Do you have a cough lasting more than 3 weeks that produces sputum or phlegm? ☐ Yes ☒ No
2. Do you cough up blood? ☐ Yes ☒ No
3. Have you had a fever recently? ☐ Yes ☒ No
4. Do you have night sweats (sheet drenching)? ☐ Yes ☒ No
5. Have you recently had unplanned weight loss of 10 lbs. or more, or 10% of your previous body weight? ☐ Yes ☒ No

If the patient answers "yes" to question 1 and "yes" to one or more of the remaining questions, the admitting nurse will place the patient in respiratory precautions and notify the physician of same. In the event the physician indicates TB has recently been ruled out, the isolation will be discontinued promptly.

Is isolation indicated? (If yes, RN will notify ACC) ☐ Yes ☐ No If yes, physician notified? ☐ Yes ☒ No

Nurse signature ____________ Date ____________

Potential Abuse

1. Are you now or have you recently been physically, psychologically, or sexually abused? ☐ Yes ☒ No ☐ Refused to answer
2. Interviewer observation of patient demeanor: ☒ Open/honest ☐ Reluctant/fearful
3. Interviewer observation of overt physical evidence of abuse: ☐ Yes ☒ No
4. Patient meets hospital criteria for abuse identification: ☐ Yes ☒ No
   If yes, initiate adult or pediatric abuse protocol and appropriate abuse assessment screening tool.
5. Patient desires to talk to Clergy/Social Worker: ☐ Yes ☒ No

Comments: ____________

Identification of Learning Needs, Abilities, Preferences and Readiness to Learn

1. Can patient read/understand English? ☒ Yes ☐ No
2. Are cognitive abilities sufficient to learn? ☒ Yes ☐ No
3. Is there readiness to learn? ☒ Yes ☐ No
4. Is S.O. available for teaching? ☒ Yes ☐ No
5. Are there physical barriers to learning? ☒ Yes ☐ No
6. Are there cultural, religious or emotional barriers to learning? ☐ Yes ☒ No
7. Explanation of barrier(s): Deaf-Mute

Topics	Taught to	Strategies	Response	Evaluation	Comments	Date	Time	Signature

Taught to whom: P Patient, F Family, O Other

Strategies: E Explain, D Demonstrate, RP Role Playing, AV Audiovisual, HD Handout, C Class, P Pt/Education channel

Response: V Voiced Understanding, RD Return Demonstration, VP Voiced Partial Understanding, N Not Ready/Refused to learn, NR Not Responsive

Evaluation: RP Reinforced/Practice, NT No Further Teaching Needed

Nurse signature [signature] Date 8/2/00

Restraints

☐ "Care of the Patient on a Ventilator/Artificial Airway Protocol" initiated.
☐ "Care of the Patient at Risk for Removing Invasive Lines, Tubes, or Catheters Protocol" initiated.
☐ "Care of the Patient at Risk for Fall Injury Protocol" initiated.
☐ Patients with primary behavioral health needs will have a written time limited physician's order. (Note: 4 hours for adults, 2 hours for children and adolescents ages 9-17, 1 hour for children under 9 years of age. When the original order expires, the patient will receive another face to face assessment and if necessary a continuance of the original order.)

Restraint Justification ☐ Confused/Disoriented ☐ Agitated ☐ Combative Other ____________

Alternative Measure Used ☐ Reorient ☐ Family/Sitter ☐ Medications ☐ Full Side Rails Other ____________

Least Restrictive Measures Used ☐ 1 or 2 Wrists ☐ 1 or 2 Legs ☐ Medications Other ____________

al Releases ☐ Done ☐ Not done

se signature ____________ Date ____________

Indian River Memorial Hospital, Inc., Vero Beach, FL
Emergency Department

A

Emergency Department Risk Assessment

MAINES, SANDRA 1931040
DR TEEL, DUDLEY G. DR# 00001
ADM 08/02/00 DOB 06/26/61 F
MR# 000355262 -561-770-4264

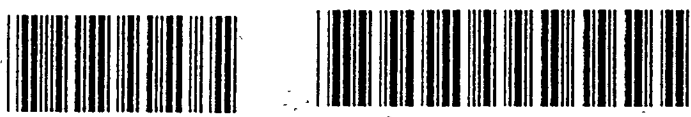
Date 8/02/00 Time 17:02 Last Encounter 6/15/95 Location DO

Drug Allergies

Code	Description
1	NO KNOWN DRUG ALLERGIES

Initials	First, Last Name & Title	Initials	First, Last Name & Title	Initials	First, Last Name & Title

Indian River Memorial Hospital Inc, Vero Beach Fl



N1392

Patient Allergy Listing

MAINES, SANDRA 1931040
DR TEEL, DUDLEY G. DR# 00001
ADM 08/02/00 DOB 06/26/61 F
MR# 000355262 -561-770-4264

ADVANCE DIRECTIVE

Check appropriate box.

	YES	NO
Do you have an advance directive ?	☐	☒
Do you have it now ?	☐	☐
If you do not have an advance directive, would you be interested in receiving educational material ?	☐	☐

Material given. ☒

Patient unable or unwilling to respond. ☐

	YES	NO
Would you like to express your wishes now ?	☐	☐

A. Gay
Employee Signature

8/2/00
Date

Indian River Memorial Hospital Inc, Vero Beach Fl

AD

1931040

Advance Directive

MAINES, SANDRA 1931040
DR TEEL, DUDLEY G. DR# 00001
ADM 08/02/00 DOB 06/26/61 F
MR# 000355262 -561-7

N3063 Rev 04/00

1. **MEDICAL AND SURGICAL TREATMENT**

A. I am under the control of my attending/treating physician who provides physician services to the patient. Indian River Memorial Hospital, Inc. (IRMH). is not legally or vicariously responsible for the conduct or actions of the physicians practicing in the Hospital including, but not limited to emergency physicians, anesthesiologists, pathologists, radiologists, staff or contract physicians Indian River Memorial Hospital, Inc. is not liable for any act or omission in following the instructions of said physicians and I consent to any x-ray examination, laboratory procedure, anesthesia, medical or surgical treatment or hospital services rendered to me under the general and special instructions of my physician. I understand that I should look to the individual physician treating me, rendering care to me or otherwise involved in my treatment for any questions and answers concerning my treatment.

B. I recognize that the physicians operating and practicing in the hospital including, but not limited to: emergency physicians, anesthesiologists pathologists, radiologists, staff or contract physicians and cardiologists, are independent contractors, not agents or employees of the hospital and that the hospital does not control the medical decision, diagnosis or treatments rendered by the physicians treating me in this Hospital. The patient understands that physician services will be delegated by the Hospital to physicians for performance of these services and the patient agrees to same.

2. **AUTHORIZATION FOR RELEASE OF INFORMATION**

I authorize IRMH or its agents or any physicians who have attended me to furnish my insurance company(s), preferred provider organization (PPO), or health maintenance organization (HMO) or their representatives with any and all medical information including any psychiatric, HIV or HIV testing information, alcohol and drug abuse information contained in my medical records. I also understand that this authorization is valid only for the admission date(s) shown above and that I may revoke this consent in writing at any time. I also authorize IRMH, its agents and members of its medical staff to release and/or receive to/from any post acute healthcare providers, any confidential information that would be helpful in my hospital and/or discharge plan of care.

Once I or my healthcare surrogate have agreed to a discharge plan (and with the physician's order), the post acute agencies may have access to my chart for the purpose of continuity of care.

I hereby authorize any involved physician(s), including but not limited to radiologists, cardiologists, pathologists, anesthesiologists, and/or emergency department physicians, to furnish any potentially liable insurance companies or their representatives with any and all information concerning hospitalization, interpretations, examinations, and/or treatments that may be contained in his/her medical records.

3. **ASSIGNMENT OF BENEFITS**

I certify that the insurance information given by me is, to the best of my knowledge, correct. I authorize and assign payment to IRMH all hospital benefits due and payable under the terms of my policies and/or contracts. I assign payment to the physicians (radiologists, pathologists, anesthesiologists, and emergency department physicians) of all medical benefits payable for their professional services. I understand that I am financially responsible for all charges incurred and those charges not paid by my insurer's or third party payors, including any deductible and coinsurance, within a reasonable time not to exceed 60 days from discharge. Should this account be overpaid, I authorize the hospital to transfer any over-payment due me to any outstanding account that I or my dependents may have. I authorize any necessary credit check. Should it become necessary to collect this debt through an attorney or collection agency, I agree to pay the cost of such collection including a reasonable attorney's fee.

I understand I have the right to receive an itemized statement upon request.

4. **MEDICARE AND/OR MEDICAID**

I certify that the information given by me in applying for payment under Title XVIII, and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical information to release such information to the Social Security Administration or its intermediaries.

I request that any payment of authorized benefits be made on my behalf. I understand that I am responsible for any insurance deductibles and coinsurance.

If Medicaid is applicable, I authorize IRMH and the hospital insurance carrier to make available to the Florida Division of Family Services any requested information concerning medical, insurance, and financial records relating to my hospitalization. I hereby assign to IRMH all benefits.

5. **ACKNOWLEDGEMENT OF RECEIPT - AN IMPORTANT MESSAGE FROM MEDICARE.**

If I am Medicare eligible, my signature only acknowledges my receipt of this message from INDIAN RIVER MEMORIAL HOSPITAL on the above admission and does not waive any of my rights to request a review or make me liable for any payment.

6. **RELEASE OF RESPONSIBILITY FOR PERSONAL ARTICLES**

It is understood and agreed that IRMH maintains a safe for the safekeeping of money and valuables and IRMH shall not be liable for the loss or damage to any money, jewelry, contact lenses, general prosthesis, eyeglasses, dentures, documents, wearing apparel, radios, purse, wallet, or other articles of unusual value and small size, unless placed therein, and shall not be liable for loss or damage to any personal property, unless deposited in the IRMH safe for safekeeping and shall not in any event be liable in any loss or damage to any personal property. If I choose to keep such items with me, I understand that I will assume all responsibility for them.

7. **RELEASE FROM RESPONSIBILITY OF DISCHARGE**

I hereby, release both the physician and the hospital from any and all responsibility for any resulting ill effect in the event that I leave the hospital against the advice of my attending physician. I acknowledge that I have been informed of the risks involved.

I have read and agree with all the above information.

X Sandra Maines — SIGNATURE — DATE 8-2-00

1931040 — PATIENT ACCOUNT NUMBER

C. Gay — WITNESS — DATE 8-2-00

SIGNATURE OF AUTHORIZED PERSON — DATE

Indian River Memorial Hospital, Inc. Vero Beach, Florida

PATIENT AUTHORIZATION AND CONSENT

1931040
MAINES, SANDRA
DR TEEL, DUDLEY G. DR# 00001
ADM 08/02/00 DOB 06/26/61 F
MR# 000355262 561-770-4264

P4C4

50 REV 3/00K

Date 08/02/00 Time 17:02

Patient Demographic Record

A G

Patient Name	MAINES, SANDRA	
Address	4765 30TH AVE	
City-State-Zip	VERO BEACH	FL 32967
Telephone Number	561 770-4264	
SS Number	264599881	
Date of Birth	06/26/61	
Age	039Y	
Sex	F	
Marital Status	S	
Race	2	

Patient Employer		
Address		
City-State-Zip		00000
Telephone	000 000-0000	

Guarantor Name	MAINES, SANDRA	
Address	4765 30TH AVE	
City-State-Zip	VERO BEACH	FL 32967
Telephone Number	561 770-4264	
Relationship	01	
Employer		

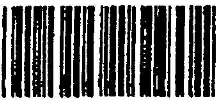
Nearest Relative	BETTY BROWN/MOTHERNLAW	
Address		
City-State-Zip		00000
Telephone Number	561 567-2678	

Primary Payor	SELF PAY	
Group Name	OUTPATIENT	
Group Number		
Subscriber	MAINES, SANDRA	
Policy Number	264599881	
Address		00000-0000

Secondary Payor	
Group Name	
Group Number	
Subscriber	
Policy Number	
Address	

Patient Account Number	1931040
Medical Record Number	000355262
Financial Class	A - SELF PAY
Patient Type	Q - CONV CARE
Complaint	FALL
Comments	

Indian River Memorial Hospital Inc, Vero Beach Fl



QC1000 Rev. 04/92

1931040

Patient Demographic Record

MAINES, SANDRA 1931040
DR TEEL, DUDLEY G. DR# 00001
ADM 08/02/00 DOB 06/26/61 F
MR# 000355262 561-770-4264

RPT: RM

INDIAN RIVER MEMORIAL HOSPITAL
1000-36th Street
Vero Beach, Florida 32960
(561) 567-4311

MR#: 355262
ACCT#: 1931040
ROOM: -0000-
DATE DISCH:
ORDER#: 2615998

PATIENT : MAINES, SANDRA
DOB : 06/26/1961
DATE : 08/02/2000
AGE :
ADDORD# :
PT TYPE : Q

REQUESTING PHYSICIAN: DUDLEY G. TEEL, M.D.
ATTENDING PHYSICIAN: Dominick J. Buro, D.O.
REFERRED TO: DOMINICK J. BURO, D.O.

DIAGNOSIS & COMMENTS:
PROCEDURE DATE:

LEFT ELBOW 3 VIEWS:

HISTORY: Trauma

No effusion. No fracture. Joint space is normal. Normal soft tissues.

IMPRESSION: NORMAL EXAMINATION.

\: MEDQ:054
/: 424
D: 08/03/2000 DT: 08:40
T: 08/03/2000 TT: 11:24
J: 237748
2615998
ID: 10276594

This Document Has Been Reviewed and Electronically Approved
By PETER H. JOYCE, M.D. on 08/03/2000.

Dictated by GEORGE T. PUSKAR, M.D.

CC: George T. Puskar, M.D., FAX # 000424 P
Dominick J. Buro, D.O., FAX # 000627 P

RPT: RM

INDIAN RIVER MEMORIAL HOSPITAL
1000-36th Street
Vero Beach, Florida 32960
(561) 567-4311

PATIENT : MAINES, SANDRA MR#: 355262
DOB : 06/26/1961 ACCT#: 1931040
DATE : 08/02/2000 ROOM: -0000-
AGE : DATE DISCH:
ADDORD# : ORDER#: 2616000
PT TYPE : Q

REQUESTING PHYSICIAN: DUDLEY G. TEEL, M.D.
ATTENDING PHYSICIAN: Dominick J. Buro, D.O.
REFERRED TO: DOMINICK J. BURO, D.O.

DIAGNOSIS & COMMENTS:
PROCEDURE DATE:

CERVICAL SPINE 5 VIEWS:

HISTORY: Trauma

FINDINGS:

Normal prevertebral soft tissues. On the lateral view, there is gradual smooth reversal of the cervical lordosis which may reflect patient position or muscle spasm. There is no acute angulation. There is no abnormal widening of the intraspinous or intralaminar space. No fracture or subluxation is present.

IMPRESSION: NO FRACTURE OR SUBLUXATION.

\: MEDQ:054
/: 424
D: 08/03/2000 DT: 08:54
T: 08/03/2000 TT: 11:35
J: 237752
2616000
ID: 10276600

This Document Has Been Reviewed and Electronically Approved By PETER H. JOYCE, M.D. on 08/03/2000.

Dictated by GEORGE T. PUSKAR, M.D.

CC: George T. Puskar, M.D., FAX # 000424 P
Dominick J. Buro, D.O., FAX # 000627 P

IMAGING SCIENCES / RADIOLOGY

INDIAN RIVER MEMORIAL HOSPITAL — VERO BEACH, FLORIDA — EMERGENCY RECORD

PATIENT NAME	ACCOUNT NO	AGE	DATE OF BIRTH	TIME	DATE
Maines, Sandra		39	6/26/61	1035	8/18/00

PRIVATE MD: NZA | PT ORIGINATED FROM: | METHOD OF ARRIVAL: [ ] BLS [ ] ALS [ ] Carried [x] Walk [ ] Wheel Chair [ ] Ambulance [ ] Stretcher | [x] CC [ ] ACUTE | TRIAGE CLASS: N

INITIAL NURSING ASSESSMENT

INITIAL ASSESSMENT TIME 1035 [x] Awake & Alert [x] Oriented [x] Skin Warm [x] Color Good

CHIEF: [illegible] 2° meningitis

WT | LMP | EDOC | HEAD CIRCUMFERENCE

TIME 1037 Tx'd here 8/2/00 ŝ mult contusions STI 2° fall. Returns today due to continuing chest-upper back pain, leg pain radiating to calfs. Headache and nausea (per interpreter) — [illegible]

1125 [illegible]
[illegible] [illegible] + NST in stable cond. [illegible] daughter's sign language. SB

ALLERGIES: NKDA

LATEX ALLERGY [ ] Yes [ ] No

TIME	T.	BP	P	R	PAIN A (0-10) P (0-5)	O2 SAT	GCS A/P
1037	97	146/100	76	20	9/10		4 5 6 (15)

CURRENT MEDICATIONS:
Norflex
Naprosyn
Ultram

VISUAL ACUITY: OD ²⁰/ OS ²⁰/ OU ²⁰/ | CORRECTED [ ] Yes [ ] No | LAST TETANUS | LOT NO | MFGR | [ ] DT 0.5cc | [ ] R [ ] L Deltoid

RN SIGNATURE: [signature] | TIME TO TREATMENT ROOM: 1125

MED / IV / Tx ORDERS

TIME ORDERED	ORDERS	COMPLETED	PAIN	ORDERS	COMPLETED
	[ ] O2 Sat				
	[ ] Monitor				
	[ ] O2				
	[ ] IV				

TEST	TIME	RESULT
CBC		
PT/PTT		
T & X		
T & S		
Bl Cul		
BHCG		
Amylase		
Cardiac Marker Series		
Comp Metabolic Panel		
CHEM 7		
ETOH		
Hepatic Function Panel		
ABG		
UA		
C & S		
RESP TREATMENT		
EKG		
Abd -> ↑		
CXR		
C-Spine		
L-Spine		
CT Scan		
Gm St		
GC		
Chlam		
Wet Pr		
KOH		

HISTORY & PHYSICAL

ER MD Contact 1225

HPI

SHW 8/9/00

PMH/R O S

Social Hx — Family Hx

PE

X^C

Procedure Note

DICTATION [ ] Yes [x] No | PMD | CALLED | RETND CALL | ARRIVED

Initial Impressions

CARDIAC RISK [ ] Low [ ] Moderate [ ] High

DISCHARGE DIAGNOSIS: multiple contusion, STI 2° fall

MD SIGNATURE: [signature]

NURSE SIGNATURE — INITIAL — NURSE SIGNATURE: A. [signature] — INITIAL

NURSE SIGNATURE — INITIAL — ADDENDUM [ ] 1 [ ] 2 [ ] 3 [ ] 4 — CHART PROCESSED: [signature] — REGISTERED BY: LAG

FEE — [ ] Old record

DISPOSITION

ADMIT TO ROOM | OTHER: Home | TIME: 1240 | INPUT | OUTPUT | NOTIFIED | REFERRAL MD

DISPOSITION ASSESSMENT: [x] Awake & Alert [x] Oriented [x] Skin Warm & Dry [x] Color Good | LEFT VIA [ ] Carried [x] Ambulated [ ] Wheel Chair [ ] Stretcher

DISPOSITION VALUABLES: [ ] See List [ ] With Patient [ ] Safe [ ] With Family (Name)

DISPOSITION NURSE: [signature] RN

MAINES, SANDRA 1932216
MCCLURE, BARBARA (ARNP) 739
ADM 08/08/00 DOB 06/26/61 F
MR# 000355262 -561-770-4264

CHART

MAINES, SANDRA 1932216
MCCLURE, BARBARA (ARNP) 739
ADM 08/08/00 DOB 06/26/61 F
MR# 000355262 -561-770-4264

Indian River Mem. Hospital
Emergency Department

Multiple Minor Injuries
Multiple Minor Injuries Template © 1994 - 1999 ETSA

Date \ Time: 08/08/2000 11:34:29 AM
Patient: MAINES, SANDRA
ED Physician: B.McClure
BP: 146/100 P: 76 R: 20 T: 97.2 %O2:

HISTORY

CC(s): [illegible] persistent muscle ache [illegible] fall

HPI: on 8/2/00. Lt arm/elbow + neck improved. Mid back persists. Ø [illegible] weakness, [illegible], abd. pain, N/V. Daughter acts as sign interpreter

TIMING: Sxs for: 6 min hrs days wks mon yrs
Constant / Intermittent / ↑ ing / ☒ Present Now / ☒ ↓ ing / Gone

ALLERGIES: Ø none
Last Tetanus: na

HX SOURCES: ☒ Patient\Family ☐ Nursing Notes ☐ Pvt Doc ☐ Old Records ☐ Questionnaire

SEVERITY: Severe 10 9 8 Mod 7 6 5 4 Mild 3 2 1
PAIN? N Y — Back
Location: → Radiation:
QUALITY: Sharp Spasms
CONTEXT: Occur(ed) While ☐ nl Setting ☐ nl Activity
MODIFYING FACTORS: none

PMH: Deaf-mute 2° meningitis. Reviewed? Y N (-). Hx of Systemic Disease? N
FH: Reviewed? Y N (-)
SH: Reviewed? Y N (-)

ROS:
MECHANISM: MVA? (Speed ___ mph) N; Seatbelt? na; Airbag? na; Patient Driving? na; Fall? (___ ft) Y
CARDIOVASC \ RESP \ GI: Chest Pain? N; Pleuritic? na; Trouble Breathing? N; Abdominal Pain? N
SKIN \ MUSCULOSKELETAL: Lacerations? N; Abrasions \ Bruises? N; Head \ Face Pain? N; Neck Pain? N; Upper Back Pain? Y
Lower Back \ Pelvis Pain? N; Upper Extremity Pain? N R L; Lower Extremity Pain? N R L
NEUROLOGICAL: LOC? (___ sec min) N; Headache? N

PHYSICAL EXAMINATION

GENERAL APPEARANCE: Vital Signs Noted? Y; In Distress? N
EYES \ ENT \ MOUTH \ FACE: Examined? Y; Facial Lacerations\Bruises? N; Eye Injury \ Pain? N R L
NEURO \ CARDIOVASC \ RESP \ GI: Examined? Y; Oriented? (x 3) Y; Motor \ Sensory Deficits? N; Chest Wall Tenderness? N; Lungs Clear? Y; Abdominal Tenderness? N

MUSCULO-SKELETAL \ SKIN: Examined? Y; Seatbelt Marks \ Bruises? N
Diagram notes: Diffuse paraspinal [illegible] [illegible] — MAE x 4 — al [illegible] — al CMS

(T)enderness (D)eformity
Head \ Face? N; Neck? N; Chest \ Ribs? N; Back \ Pelvis? T; Right Upper Extremity? N; Left Upper Extremity? N; Right Lower Extremity? N; Left Lower Extremity? N

MEDICAL DECISION MAKING - CLINICAL COURSE

INITIAL IMPRESSION: muscle spasm
DIFFERENTIAL: 1. R/O 2. R/O
DIAGNOSTIC & TREATMENT PLAN: ☐ Labs \ X-Ray ☐ Repair ☐ Consult ☒ Medications ☐ Ice ☐ ✓ Response

CONSIDERED an EMERGENCY due to: ☐ Severe Pain ☒ Re✓ ☐ DysFunctional BodyPart\Organ\System ☐ Acute Onset of Sxs ☐ Undiagnosed Injury \ Illness ☐ Threat to Life \ Limb ☐ Uncertain Prognosis \ Outcome ☐ Possibility of Adverse Outcome (Complications, Morbidity)
REVIEWED OLD: ☐ X-Rays ☐ Records — na
CONFERRED WITH: ☐ Radiologist ☐ Pvt Dr.\Consult — na
X-RAY & LAB DATA: none

CLINICAL COURSE: ☐ Improving ☒ No Change ☐ Worse ☐ See Attached Addenda:
PROCEDURES: ☐ by Physician ☐ by Resident ☐ by PA \ NP ☐ Key Portion Supervised by Physician ☒ None ☐ Dermal Glue ☐ Staples # ___ ☐ Tourniquet ___ min ☐ Sutures: Layer: ___ Material: ___ #: ___ Layer: ___ Material: ___ #: ___ ☐ Debrided ☐ Irrigated w\: Saline Betadyne

FINAL DIAGNOSES:
1. multiple contusion + STI 2° fall
2.
3.

DISPOSITION TIME: :
STATUS: ☒ Good ☐ Fair ☐ Poor ☐ Critical
DISCUSSED WITH: ☒ Patient ☒ Family

DISPOSITION

☐ ADMITTED ☐ TRANSFERRED To Dr \ Facility:
☒ DISCHARGED ☐ ReCheck Here On: ☒ FollowUp w/: Dr. Maes By: 8/14/00

INSTRUCTIONS GIVEN: ☒ Verbal ☒ Written

PRESCRIPTIONS: none
1. Vioxx
2. Valium
3.

ED PHYSICIAN HAS REVIEWED: na
☒ PA \ NP H&P ☐ Resident H&P — Agrees with Data? Y N; Differs? N Y; Revised Above? N Y

EXCUSES GIVEN: na ☐ Work ___ days ☐ LtDuty ___ days ☐ School ___ days ☐ Gym ___ days

Physician Signature [signature]
PA \ NP \ Resident Signature [signature]

Date 08/08/00 Time 10:50 **Patient Demographic Record** HF

Patient Name	MAINES, SANDRA
Address	4765 30TH AVE
City-State-Zip	VERO BEACH FL 32967
Telephone Number	561 770-4264
SS Number	264599881
Date of Birth	06/26/61
Age	039Y
Sex	F
Marital Status	S
Race	2

Patient Employer	
Address	
City-State-Zip	00000
Telephone	000 000-0000

Guarantor Name	MAINES, SANDRA
Address	4765 30TH AVE
City-State-Zip	VERO BEACH FL 32967
Telephone Number	561 770-4264
Relationship	01
Employer	

Nearest Relative	BETTY BROWN/MOTHERNLAW
Address	
City-State-Zip	00000
Telephone Number	561 567-2678

Primary Payor	MEDICARE
Group Name	OP PRIMARY
Group Number	
Subscriber	MAINES, SANDRA
Policy Number	264599881A
Address	JACKSONVILLE, FL 32231-0000

Secondary Payor	
Group Name	
Group Number	
Subscriber	
Policy Number	
Address	

Patient Account Number	1932216
Medical Record Number	000355262
Financial Class	K - MEDICARE/OP
Patient Type	Q - CONV CARE
Complaint	RE CHECK/BACK/CHEST PAIN
Comments	

Indian River Memorial Hospital Inc, Vero Beach Fl

DEMO

QC1000 Rev. 04/92

1932216

Patient Demograpic Record

MAINES, SANDRA 1932216
DR MCCLURE, BARBAR DR# 00739
ADM 08/08/00 DOB 06/26/61 F
MR# 000355262 561-770-4264

1. MEDICAL AND SURGICAL TREATMENT

A. I am under the control of my attending/treating physician who provides physician services to the patient. Indian River Memorial Hospital, Inc. (IRMH), is not legally or vicariously responsible for the conduct or actions of the physicians practicing in the Hospital including, but not limited to emergency physicians, anesthesiologists, pathologists, radiologists, staff or contract physicians Indian River Memorial Hospital, Inc. is not liable for any act or omission in following the instructions of said physicians and I consent to any x-ray examination, laboratory procedure, anesthesia, medical or surgical treatment or hospital services rendered to me under the general and special instructions of my physician. I understand that I should look to the individual physician treating me, rendering care to me or otherwise involved in my treatment for any questions and answers concerning my treatment.

B. I recognize that the physicians operating and practicing in the hospital including, but not limited to: emergency physicians, anesthesiologists, pathologists, radiologists, staff or contract physicians and cardiologists, are independent contractors, not agents or employees of the hospital and that the hospital does not control the medical decision, diagnosis or treatments rendered by the physicians treating me in this Hospital. The patient understands that physician services will be delegated by the Hospital to physicians for performance of these services and the patient agrees to same.

2. AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize IRMH or its agents or any physicians who have attended me to furnish my insurance company(s), preferred provider organization (PPO), or health maintenance organization (HMO) or their representatives with any and all medical information including any psychiatric, HIV or HIV testing information, alcohol and drug abuse information contained in my medical records. I also understand that this authorization is valid only for the admission date(s) shown above and that I may revoke this consent in writing at any time. I also authorize IRMH, its agents and members of its medical staff to release and/or receive to/from any post acute healthcare providers, any confidential information that would be helpful in my hospital and/or discharge plan of care.

Once I or my healthcare surrogate have agreed to a discharge plan (and with the physician's order), the post acute agencies may have access to my chart for the purpose of continuity of care.

I hereby authorize any involved physician(s), including but not limited to radiologists, cardiologists, pathologists, anesthesiologists, and/or emergency department physicians, to furnish any potentially liable insurance companies or their representatives with any and all information concerning hospitalization, interpretations, examinations, and/or treatments that may be contained in his/her medical records.

3. ASSIGNMENT OF BENEFITS

I certify that the insurance information given by me is, to the best of my knowledge, correct. I authorize and assign payment to IRMH all hospital benefits due and payable under the terms of my policies and/or contracts. I assign payment to the physicians (radiologists, pathologists, anesthesiologists, and emergency department physicians) of all medical benefits payable for their professional services. I understand that I am financially responsible for all charges incurred and those charges not paid by my insurer's or third party payors, including any deductible and coinsurance, within a reasonable time not to exceed 60 days from discharge. Should this account be overpaid, I authorize the hospital to transfer any over-payment due me to any outstanding account that I or my dependents may have. I authorize any necessary credit check. Should it become necessary to collect this debt through an attorney or collection agency, I agree to pay the cost of such collection including a reasonable attorney's fee.

I understand I have the right to receive an itemized statement upon request.

4. MEDICARE AND/OR MEDICAID

I certify that the information given by me in applying for payment under Title XVIII, and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical information to release such information to the Social Security Administration or its intermediaries.

I request that any payment of authorized benefits be made on my behalf. I understand that I am responsible for any insurance deductibles and coinsurance.

If Medicaid is applicable, I authorize IRMH and the hospital insurance carrier to make available to the Florida Division of Family Services any requested information concerning medical, insurance, and financial records relating to my hospitalization. I hereby assign to IRMH all benefits.

5. ACKNOWLEDGEMENT OF RECEIPT - AN IMPORTANT MESSAGE FROM MEDICARE.

If I am Medicare eligible, my signature only acknowledges my receipt of this message from INDIAN RIVER MEMORIAL HOSPITAL on the above admission and does not waive any of my rights to request a review or make me liable for any payment.

6. RELEASE OF RESPONSIBILITY FOR PERSONAL ARTICLES

It is understood and agreed that IRMH maintains a safe for the safekeeping of money and valuables and IRMH shall not be liable for the loss or damage to any money, jewelry, contact lenses, general prosthesis, eyeglasses, dentures, documents, wearing apparel, radios, purse, wallet, or other articles of unusual value and small size, unless placed therein, and shall not be liable for loss or damage to any personal property, unless deposited in the IRMH safe for safekeeping and shall not in any event be liable in any loss or damage to any personal property. If I choose to keep such items with me, I understand that I will assume all responsibility for them.

8. RELEASE FROM RESPONSIBILITY OF DISCHARGE

I hereby, release both the physician and the hospital from any and all responsibility for any resulting ill effect in the event that I leave the hospital against the advice of my attending physician. I acknowledge that I have been informed of the risks involved.

I have read and agree with all the above information.

X Sandra Maines — SIGNATURE — DATE 8/8/00

PATIENT ACCOUNT NUMBER — WITNESS — DATE

SIGNATURE OF AUTHORIZED PERSON — DATE

Indian River Memorial Hospital, Inc. Vero Beach, Florida

PATIENT AUTHORIZATION AND CONSENT

PAC4

MAINES, SANDRA 1932216
MCCLURE, BARBARA (ARNP) 739
ADM 08/08/00 DOB 06/26/61 F
MR# 000355262 -561-770-4264

7750 REV 3/00K

Tuberculosis Assessment

1. Do you have a cough lasting more than 3 weeks that produces sputum or phlegm? ☐ Yes ☒ No
2. Do you cough up blood? ☐ Yes ☒ No
3. Have you had a fever recently? ☐ Yes ☒ No
4. Do you have night sweats (sheet drenching)? ☐ Yes ☒ No
5. Have you recently had unplanned weight loss of 10 lbs. or more, or 10% of your previous body weight? ☐ Yes ☒ No

If the patient answers "yes" to question 1 and "yes" to one or more of the remaining questions, the admitting nurse will place the patient in respiratory precautions and notify the physician of same. In the event the physician indicates TB has recently been ruled out, the isolation will be discontinued promptly.

Is isolation indicated? (If yes, RN will notify ACC) ☐ Yes ☒ No If yes, physician notified? ☐ Yes ☐ No

Nurse signature [signature] Date 8/8/00

Potential Abuse

1. Are you now or have you recently been physically, psychologically, or sexually abused? ☐ Yes ☒ No ☐ Refused to answer
2. Interviewer observation of patient demeanor: ☒ Open/honest ☐ Reluctant/fearful
3. Interviewer observation of overt physical evidence of abuse: ☐ Yes ☒ No
4. Patient meets hospital criteria for abuse identification: ☐ Yes ☒ No
   If yes, initiate adult or pediatric abuse protocol and appropriate abuse assessment screening tool.
5. Patient desires to talk to Clergy/Social Worker: ☐ Yes ☒ No

Comments:

Identification of Learning Needs, Abilities, Preferences and Readiness to Learn

1. Can patient read/understand English? ☒ Yes ☐ No
2. Are cognitive abilities sufficient to learn? ☒ Yes ☐ No
3. Is there readiness to learn? ☒ Yes ☐ No
4. Is S.O. available for teaching? ☒ Yes ☐ No
5. Are there physical barriers to learning? ☒ Yes ☐ No
6. Are there cultural, religious or emotional barriers to learning? ☐ Yes ☒ No
7. Explanation of barrier(s):

Topics	Taught to	Strategies	Response	Evaluation	Comments	Date	Time	Signature

Taught to whom:
P Patient
F Family
O Other

Strategies:
E Explain
D Demonstrate
RP Role Playing
AV Audiovisual
HD Handout
C Class
P Pt. Education channel

Response:
V Voiced Understanding
RD Return Demonstration
VP Voiced Partial Understanding
N Not Ready/ Refused to learn
NR Not Responsive

Evaluation:
RP Reinforced/Practice
NT No Further Teaching Needed

Nurse signature Date

Restraints

☐ "Care of the Patient on a Ventilator/Artificial Airway Protocol" initiated.
☐ "Care of the Patient at Risk for Removing Invasive Lines, Tubes, or Catheters Protocol" initiated.
☐ "Care of the Patient at Risk for Fall Injury Protocol" initiated.
☐ Patients with primary behavioral health needs will have a written time limited physician's order. (Note: 4 hours for adults, 2 hours for children and adolescents ages 9-17, 1 hour for children under 9 years of age. When the original order expires, the patient will receive another face to face assessment and if necessary a continuance of the original order.)

Restraint Justification ☐ Confused/Disoriented ☐ Agitated ☐ Combative Other

Alternative Measure Used ☐ Reorient ☐ Family/Sitter ☐ Medications ☐ Full Side Rails Other

Least Restrictive Measures Used ☐ 1 or 2 Wrists ☐ 1 or 2 Legs ☐ Medications Other

Trial Releases ☐ Done ☐ Not done

Nurse signature Date

Indian River Memorial Hospital, Inc., Vero Beach, FL
Emergency Department

Emergency Department Risk Assessment

EDRA

31-1580-5 Rev. 5/99

1932216
MAINES, SANDRA 739
MCCLURE, BARBARA (ARNP) F
ADM 08/08/00 DOB 06/26/61
MR# 000355262 -561-770-4264

Indian River Memorial Hospital

Instructions and Information from the Emergency Medical Staff

08/08/2000 12:43:11 PM

Doctor: Barbara McClure, ARNP

For: SANDRA MAINES

ABOUT YOUR RESPONSIBILITIES

AFTER YOU LEAVE, YOU MUST PROPERLY CARE FOR YOUR PROBLEM AND OBSERVE ITS PROGRESS. IF YOU DO NOT IMPROVE AS EXPECTED, OR ARE WORSE, DO ONE OF THE FOLLOWING *IMMEDIATELY*: CONTACT YOUR DOCTOR or FOLLOW-UP DOCTOR or CALL HERE 561-567-4311 or RETURN HERE

The doctor thinks your symptoms may be due to: MULTIPLE CONTUSIONS

Keep this in mind: DIAGNOSIS WITH 100% CERTAINTY IS NOT POSSIBLE in the Emergency Department. Therefore, if you find you are not getting better, another diagnosis is possible, and you must see your doctor or return here.

MULTIPLE CONTUSIONS: are bruises of the skin and muscle. There is no evidence of injury to your internal organs and usually no broken bones. Areas of the skin that are bruised usually have a black and blue discoloration, and muscles that are bruised are usually sore. The most common symptoms are muscle aches, stiffness, swelling, redness, tenderness, and discoloration.

What to Watch For:	Return here immediately if you notice: A) increasing pain or swelling B) increasing or persistent chest pain C) increasing or persistent abdominal pain D) weakness, paralysis, or tingling of your arms or legs E) redness, streaking, or increasing tenderness or your skin bruises F) pain lasting more than 2 weeks
What to Expect:	Your symptoms should improve within 1-2 days, and you should return to normal within 1-2 weeks. It is common for new areas of mild soreness to appear in the first 48 hours after injury; but these should be mild. The appearance of severe or worsening pain means you must be seen again by a doctor.
What to Do:	1. Rest for the first 24-36 hours. If possible, elevate any sore areas above the level of your heart. 2. Apply ice packs (wrap in a towel) to sore areas for 15-20 minutes every hour for the first 24 hours. 3. Stay off your feet for 1-2 days, but you may gradually begin to walk as your pain improves.
What Not to Do:	1. DO NOT do any lifting, bending, or strenuous exercise until your are completely healed. 2. DO NOT remove any splints or braces (if you have been given them) until the doctor says to do so. 3. DO NOT ignore increasing pain - this is a sign you need to be seen again by the doctor.

***** BE SURE TO NOTE THE FOLLOWING *****

1 - MOIST HEAT TO ALL SORE AREAS
2 - STOP NORFLEX & NAPROSYN - NEW MEDS
3 - NO VIGOROUS OR STRENUOUS ACTIVITIES
4 - MUST FOLLOW UP AS SCHEDULED

YOU HAVE RECEIVED PRESCRIPTIONS FOR:

Valium 5 mg (1 p.o. tid prn spasms), & Vioxx (25 mg)
All medications have potential side effects.Ask your pharmacist about any precautions you should take.

YOU MUST SEE A FOLLOW-UP PHYSICIAN:

The care of your problem is not complete. Additional evaluation by another doctor is necessary. Please arrange to be seen by Kirk Maes M.D. on or before 08/14/2000. Call right away for an appointment. Obtain authorization from your HMO.If for any reason you cannot arrange to see the doctor by this time, you must call here as soon as possible.

Kirk Maes M.D.
1300 36th St.
Vero Beach , FL 32960
664-2233

YOU MUST MAKE ARRANGEMENTS FOR FOLLOW-UP OF YOUR PROBLEM

REMEMBER. YOUR CARE IS NOT YET COMPLETED

IT IS IMPORTANT THAT WE HAVE A CORRECT TELEPHONE NUMBER, IN CASE IT IS NECESSARY TO CONTACT YOU.

I have received these instructions, they have been reviewed with me, and I understand my responsibilities to carefully follow them.

Signature of Patient/Guardian: Sandra Maines   Discharge Nurse:

MEDICAL RECORDS

Kirk E. Maes, M.D.

Orthopedic Surgery and Sports Medicine

8000 Ron Beatty Blvd. Ste B-3
Barefoot Bay, FL 32976
Ph 664-2233 Fax 664-3060

NAME: **SANDRA MAINES** **DATE:** **August 14, 2000**

Sandra is a 39 year old black female. She is referred from the Indian River emergency room. She was seen there twice in August, first on August 2nd and next on August 8th. She has had a fall and injured her left elbow, her neck and her lower back. She is deaf and dumb and there are serious communication problems interacting with her although frankly she is an extremely pleasant woman with her interpreter.

P.E.Elbow: There is pain over the radial head. There is no pain on the olecranon. There is full range of motion with only pain with the extremes of full extension. There is no pain with resisted dorsi flexion or palmar flexion to suggest tendinitis.

P.E.Neck: She has full range of motion. There is some pain over the left trapezius muscle more so than the right. She has good shoulder motion with only mild evidence of impingement and she has slightly limited range of motion of the neck secondary to the neck muscle pain. There is no significant pain over the mid line compared to the paraspinous muscles.

P.E.: Her extremities show decreased strength of the anterior tib on the right compared to the left, decreased strength on the peroneals on the right compared to the left which recreates a fair amount of her pain in the posterior aspect of her thigh. The pain is there constantly. She describes this as the worst pain that she has ever experienced. She has good hip range of motion, good knee range of motion. She has symmetric reflexes at the knee, slightly decreased reflex at the right ankle compared to the left and a positive straight leg raise on the right side with sitting recreating and aggravating the back and leg pain.

X-RAYS: She has x-rays from Indian River Hospital that are essentially normal although one of the views show a possibility of a very slight impacted fracture on one aspect of the radial neck which in fact I think is what is really go on. She also has AP and lateral neck films that show no evidence of damage to her cervical spine and no degenerative changes.

IMPRESSION:

1. She has a herniated lumbar disc at the L5S1 level by clinical exam.
2. She has a completely nondisplaced _______ occult fracture of the radial neck. I think that this represents what is brewing with the pain in the left radial head.
3. She has cervical muscle strain from her fall and landed on the left upper extremity in addition to trapezius muscle strain.

PLAN: She was given Naprosyn and Ultram and Noraflex on her first visit to the emergency room, they switched her to Vioxx and Valium on her second visit. We have reviewed all of her medicines with her and I want her to continue the Vioxx 25 mgs q day. She can use the Ultram for pain. We also talked about mixing in Tylenol for the pain. I want her to use lots of ice and heat and I want to see her back in a month to check her progress. Symptomatic treatment of her occult fracture. She should do well with continued ice and heat treatments as well as anti-inflammatories for her muscle strains. We are going to check her back in a month. If she is still having trouble I will get an MRI, possibly refer her to one of our other physicians locally who can give her epidural Corticosteroid injections and consider physical therapy to help get her through her back injury in a conservative nature.

9-11-00 Scheduled MRI 9-13-00

AYA

C

Kirk E. Maes, M.D.

Orthopedic Surgery and Sports Medicine

8000 Ron Beatty Blvd., Ste B-3
Barefoot Bay, FL 32976
Ph 664-2233 Fax 664-2060

NAME: SANDRA MAINES **DATE:** September 11, 2000

Sandra has multiple problems. First, her left wrist is still painful. Next, her left elbow is tender. She is still having cervical muscle pain, trapezius strain and shoulder pain. She is also having back pain with no improvement on Vioxx.

P.E.WRIST: Her left wrist is painful over the radial head over the distal radius especially with dorsiflexion. She is somewhat improved since her last visit. There are no problems at the right wrist. This seems to be extensor tendinitis.

P.E.ELBOW: Her left elbow is tender over the lateral epicondyle consistent with tennis elbow. She has no pain at the olecranon. There is no pain at the medial epicondyle. There is no pain over the medial head.

P.E.: Third, she is still having cervical muscle strain. She has left trapezius strain. She has a positive Neer and a positive Hawkins sign. She has pain with resisted abduction. She has rotation to 90 degrees. She has internal rotation to the small of her back compared with her bra strap on the opposite side. There is no pain over the AC joint. She is still having pain down the back of her right leg. There is sciatic stretch pain over the back and down the leg with straight leg raising. The reflexes remain symmetric on exam today. The motor strength remains symmetric.

X-RAYS: She had no imaging studies today.

IMPRESSION:

1. She has multiple problems with her wrist, elbow, cervical muscle, trapezius, shoulder and back.

PLAN: We gave her a subacromial injection that relieved at least 50% of her pain in her left shoulder. I want her to get an MRI. I will see her back in a week. She may need to see one of the spine guys, we will play that by ear.

VERO RADIOLOGY ASSOCIATES
777 37th Street Vero Beach, FL 32960

Vero X-Ray
Suite A-105
(561)562-0163
Fax (561)562-1505

Advanced MRI
Suite A-105
(561)562-0163
Fax (561)562-1505

Women's Imaging Center
Suite A-107
(561)562-0163
Fax (561)562-8707

Peter H. Joyce, M.D.
Jay P. Colella, M.D
George T. Puskar, M.D.

Robert R. Bisset, M.D.
Heather S. Nagel, M.D.
Margaret W. Weeks, M.D.

September 13, 2000

Kirk E Maes MD
8000 Ron Beatty Blvd
Micco, Fl 32976

Re: **MAINES, SANDRA**
No: 80633 DOB: 06/26/61

MRI SCAN OF LUMBAR SPINE

Clinical history: A 39-year-old female with right leg pain being evaluated for disc herniation.

Technique: T1 and turbo T2 sagittal, T1 axial and MR myelography images were obtained.

Findings: Lumbar spine is normal in appearance. There is no disc herniation, canal or foraminal stenosis, or any significant degenerative change. The conus and cauda equina appear unremarkable. There are no paraspinal abnormalities. No evidence of spondylolysis or spondylolisthesis.

IMPRESSION
NORMAL EXAMINATION.

Thank you for the referral of this patient.

George Puskar, M.D.

GTP/ras
T: 09/14/00

This Document Has Been Reviewed and Electronically Approved By Vero Radiology Associates.

Kirk E. Maes, M.D.

Orthopedic Surgery and Sports Medicine

8000 Ron Beatty Blvd. Ste B-3
Barefoot Bay, FL 32976
Ph 664-2233 Fax 664-3060

NAME: **SANDRA MAINES** **DATE:** **September 18, 2000**

Sandra comes back to day with an MRI of her lumbosacral spine.

P.E.: She has significant improvement of her impingement from her injection last week. She is very happy with that. She is still having predominant amount of pain related to the right scapulothoracic muscular girdle. She has pain over the trapezius. She has pain over the right sided paraspinous muscles. She has pain in her lower back that is consistent with before. Her reflexes in the lower extremities are normal. Her range of motion in her hips and knees is normal. She has normal strength in the lower extremities and normal sensation. She still has a fair amount of pain in her upper extremities, in particular the right posterior shoulder. She has decreased pain on Neer and Hawkins testing. She has good strength with rotator cuff testing but a lot of pain with the posterior aspect of his shoulder.

X-RAYS: The MRI of her lumbosacral spine was normal. There is no evidence of disc pathology.

IMPRESSION:

1. She has scapulothoracic motor dysfunction and paraspinous muscle pain.
2. She has low back pain non discogenic.

PLAN: We sent her to physical therapy. They are going to work on some modalities and some strengthening and stretching for the shoulder girdle. They will evaluate the situation with her back. We will see her back in about two months prn.

NAME Maines Scendia

AGE 39 DATE 12/14/00

CC f/u fall.

DOI 8/2/00

PSHx

HPI Not able to do PT because of insurance problems.
(Medicare wouldn't cover 2° accident)

Shoulder Still having pain & stiffness over the trapezius muscles
R > L. Worse c̄ stretch. ⊖ Neer ⊖ Hawkins

elbow Pain @ elbow @ biceps tendon inserti[on] of Rt arm over biceps muscle - pain c̄ extension

PMHx

[illegible] Mild pain over radial neck - Ø pain c̄ supination /pronation - extends to shoulder,

Back Back is s̄ pain unless bending over for performing tasks.
Nontender over lumbar region ⊖ st leg raise 2+ DTR @ patella.
pain c̄ extension / flexion

MEDS

STUDIES

IMPRESSION ① s/p fall now c̄ residual muscle weakness + pain 2° incomplete rehab.

ALLERGIES

Needs PT to improve ROM + decrease spasms.
Will dictate letter to pt's lawyer to attempt to get
RTC 2 mos.

SOC Hx PT.

Letter to: Gould, Cooksey, Fennell, O'Neil, Marine, Carter + Hafner
[illegible]: Brian J. Connelly
979 Beachland Blvd

COPY NOTE TO Vero Bch, 32963

DX CODE

DICTATED

Kirk E. Maes, M.D.

Orthopedic Surgery and Sports Medicine

8000 Ron Beatty Blvd., Ste B-3
Barefoot Bay, FL 32976
Ph 664-2233 Fax 664-2060

December 14, 2000

Brian J. Connelly, Atty.
979 Beachland Blvd.
Vero Beach, FL 32963

RE: SANDRA MAINES

Dear Mr. Connelly,

I take care of Sandra Maines. She had a fall on 8-02-00 and had ongoing trouble with her upper back musculature following the injury.

She clearly has made an incomplete recovery. We have got her on anti-inflammatory medicines and have done the best that we could without a formal physical therapy program. She clearly is in a stagnant situation at this juncture and is in serious need of physical therapy.

Please do everything possible to arrange this through the accident insurance. We have written a prescription for the physical therapy which she has in her possession and we have a copy of it.

If you need any further information, please do not hesitate to contact me.

Sincerely,

Kirk Maes, MD.

/sjo

Kirk E. Maes, M.D.

Orthopedic Surgery and Sports Medicine

8000 Ron Beatty Blvd., Ste B-3
Barefoot Bay, FL 32976
Ph 664-2233 Fax 664-2060

NAME: **SANDRA MAINES**

SUMMARY OF CARE: **DATE:** **JUNE 6, 2001**

Sandra is a very pleasant 39 year old black female who was injured in what I believe was an automobile accident on August 2, 2000. She was seen in the emergency room on a couple of different occasions, both on August 2nd and again on August 8th. Her complicating problems are that she is deaf but she is a remarkably pleasant women and is capable of communicating through her interpreter. She had no fractures but she did have pain over her left elbow, her left wrist, her neck and her low back. She was seen on August 14th by me in Orthopedic consultation. I felt at that time that she had a totally non displaced radial neck fracture. It was very subtle on the x-rays and was not anything that needed significant intervention. However I believe that that was what represented the problem. She had strain to her cervical muscles and her trapezius muscles and I felt that she had a herniated lumbar disc on her initial examination. We saw her back on September 11th. She still had pain and stiffness in the left wrist and pain over the radial head. This was however improving. Her left elbow showed tenderness in the lateral epicondyle. She still had some cervical muscle soreness and trapezius muscle soreness. She had impingement of the left shoulder and she continued with low back pain. We kept her on anti-inflammatory medicines. We ordered an MRI and we gave her a subacromial injection at that visit. She was seen again on September 18th. Review of her MRI was totally normal. There was no evidence of disc pathology despite her ongoing back pain. We sent her to physical therapy and they started working with her on a regular basis to help resolve the problems. We saw her back a few months later on the 14th of December 2000. She continued to have low back pain which we felt was due to incomplete rehab and secondary muscle weakness from her injury. She needed to continue her physical therapy to decrease her spasms and increase her flexibility and her strength. Her shoulder was still having some pain and stiffness over the trapezius muscles but her impingement had improved following the shot. Her elbow had pain at the elbow and the biceps insertion and there was some pain with extension of the arm and extension of the shoulder. The radial head and neck pain was mostly gone. There was no pain with supination and pronation. We kept her on the anti-inflammatory regimen and continued her therapy. We had made arrangements for her to have an appointment on February 19th but she did not show up for that appointment. We ultimately saw her back on April 11, 2001. She was feeling totally normal at this juncture. Her neck pain had totally resolved after her physical therapy. Her low back pain had totally resolved after the physical therapy. Her left elbow contusion was not painful any longer. She had full motion, strength and function. She was extremely happy with her treatment and as far as I could tell was 100% resolved and as such I presume that she will have no further problems. With a normal MRI of her back it is not reasonable to presume that she will have future problems related to this injury. Her very insignificant radial head fracture healed and should cause no long term problems. The contusion and shoulder impingement resolved with her injection and a therapy program and should not cause problems for her in the future. Her neck and trapezius muscle strain have resolved after therapy and should be stable from this point forward. I do not anticipate that she will have sequela in the long run. Her prognosis to remain normal from this point forward is excellent. She has not sustained any permanent injury and I do not anticipate any future medical needs or expenditures related to this situation. If you have any questions, please do not hesitate to contact me.

Sincerely,

Kirk E. Maes, M.D.

Kirk E. Maes, M.D.

/sjo

Dictated but not Proof Read

KIRK E. MAES, M.D.
DEA # ______________ LIC. # ME0078507
KRISTINA M. LOSAPIO, ARNP, M.S.
DEA # ______________ LIC # RN2858932
ORTHOPEDIC SURGERY AND SPORTS MEDICINE
8000 RON BEATTY BOULEVARD, SUITE B-3
BAREFOOT BAY, FL 32976
(561) 664-2233

NAME Meiner, Sandra AGE ______

ADDRESS ______________ DATE 12/14/00

℞

PT eval + treat

(1) Rt elbow - improve ROM / flexibility
↓ inflammation

(2) (R) Trapezius / paraspinous muscles
↓ inflammation + improve ROM.

(3) Lowback - improve strength + flexibility
↓ pain

Label

Refill ______ times

Klosapio ARNP
(Signature)

In order for the brand name product to be dispensed, the prescriber must write 'Medically Necessary' below the signature.

0IO80194352

D

Fall Aug 2nd 2000 K-mart
Fell sideward + landed on left + back

Onset: LB - w/ 24 neck + SH (L) > (R)
neck - SH

AM w D W
Bending
sleep ↓
Cough c̄ H.

Δ SX:
constant
[illegible]

Ron - fall - ER [illegible]

KIRK E. MAES, M.D.
DEA # ________________ LIC. # ME0078507
KRISTINA M. LOSAPIO, ARNP, M.S.
DEA # ________________ LIC # RN2858932
ORTHOPEDIC SURGERY AND SPORTS MEDICINE
8000 RON BEATTY BOULEVARD, SUITE B-3
BAREFOOT BAY, FL 32976
(561) 664-2233

NAME Meines, Sandra AGE ______
ADDRESS ________________ DATE 12/14/00

℞
PT eval + treat

(1) Rt elbow - improve ROM / flexibility
↓ inflammation

(2) (B) Trapezius / paraspinous muscles
↓ inflammation + improve ROM.

(3) Low back - improve strength + flexibility
↓ pain

Label

Refill ______ times

K Losapio ARNP
(Signature)

In order for the brand name product to be dispensed, the prescriber must write 'Medically Necessary' below the signature.

0IOB0194352

[illegible]

If you have ever had a listed symptom in the *past*, please check that symptom in the "Past" column. If you are *presently* troubled by a particular symptom, check that symptom in the "Present" column. (Numerical codes listings are provided for the therapist's reference.)

Past	Present	
☐	☐	Neck Pain (723.1)
☐	☐	Shoulder Pain (719.41)
☐	☐	Pain in Upper Arm or Elbow (719.42)
☐	☐	Hand Pain (719.44)
☐	☐	Upper Back Pain (724.1)
☐	☐	Low Back Pain (724.2)
☐	☐	Pain in Upper Leg or Hip (719.45)
☐	☐	Pain in Lower Leg or Knee (729.5)
☐	☐	Pain in Ankle or Foot (719.47)
☐	☐	Jaw Pain (526.9)
☐	☐	Swelling/Stiffness of Joint(s)
☐	☐	Fainting, Visual Disturbances, Nausea (780.2)
☐	☐	Convulsions (780.3)
☐	☐	Dizziness (780.4)
☐	☐	Headache (784.0)
☐	☐	Muscular In-coordination (781.3)
☐	☐	Tinnitus (Ear Noises) (388.3)
☐	☐	Rapid Heart Beat (785.0)
☐	☐	Chest Pains (786.5)
☐	☐	Loss of Appetite (783.0)
☐	☐	Anorexia (783.0)
☐	☐	Abnormal Weight ☐ Gain (783.1) ☐ Loss (783.2)
☐	☐	Excessive Thirst (783.5)
☐	☐	Chronic Cough (786.2)
☐	☐	Chronic Sinusitis (473.9)
☐	☐	General Fatigue (780.7)

Present Weight:_______Pounds Height:_____Feet____Inches

If family member has had any of the following, please mark the appropriate box:

☐ Cancer ☐ Lung Problems ☐ Headaches
☐ Rheumatoid Arthritis ☐ High Blood Pressure ☐ Lupus
☐ Diabetes ☐ Epilepsy ☐ Other
☐ Heart Problems ☐ Back Problems ____________

Past	Present	
☐	☐	Irregular Menstrual Flow (626.4)
☐	☐	Profuse Menstrual Flow 626.7)
☐	☐	Breast Soreness/Lumps (611.72)
☐	☐	Vaginal Discharge (623.5)
☐	☐	PMS (625.4)
☐	☐	Loss of Bladder Control (788.30)
☐	☐	Painful Urination (788.1)
☐	☐	Frequent Urination (788.41)
☐	☐	Abdominal Pain (789.0)
☐	☐	Constipation/Irregular bowel habits (564.0)
☐	☐	Difficulty in Swallowing (787.2)
☐	☐	Heartburn/Indigestion (787.1)
☐	☐	Dermatitis/Eczema/Rash (692.9)

Please check any of the following that apply to you:

☐	☐	Tobacco use (305.1)
☐	☐	Alcohol use (305.0)
☐	☐	Birth Control Pills used
☐	☐	Medications (please list them)____________
☐	☐	Drug or Alcohol Dependence (303.9)
☐	☐	Pregnancy
☐	☐	Surgical Procedures (please list them)_____
☐	☐	Coffee/Tea/Caffeinated Soft Drinks, cups per day____________

Yes	No	
☐	☐	Do you have a permanent disability rating Location____________ Date rating received___/___/___ Rating Percentage__________%
☐	☐	Do you have a pacemaker?

Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or are presently troubled by a listed disorder.

Past	Present	
☐	☐	Depression (311.0)
☐	☐	Aortic Aneurysm (441.5)
☐	☐	High Blood Pressure (401.9)
☐	☐	Angina (413.9)
☐	☐	Heart Attack (410.9)
☐	☐	Stroke (436.0)
☐	☐	Asthma (493.9)
☐	☐	Cancer (199.1)
☐	☐	Prostate Problems (601.9)
☐	☐	Anorexia (783.0)
☐	☐	Blood Disorder (790.6)
☐	☐	Emphysema (chronic lung disorders) (492
☐	☐	Arthritis (716.9)
☐	☐	Diabetes (250.0)
☐	☐	Ulcer (556.9)
☐	☐	Kidney Stones (592.0)
☐	☐	Bladder Infection (595.9)
☐	☐	Kidney Disorders (by condition)
☐	☐	Colitis (558.9)
☐	☐	Irritable Colon (564.1)
☐	☐	HIV/AIDS (042.0)
☐	☐	Other____________

PATIENT'S SIGNATURE *Sandra Maines* DATE *2/27/01*

Fall Aug 2nd 2000 K-mart
Feell [illegible] + [illegible] a [illegible] + [illegible]
Onset: LB - w/ 24 neck + SH (L) > (R)
neck - SH

AM [illegible] Δ W
Bending
Sleep ↓
Cough [illegible]
Δ SX:
constant
[illegible]

Rem - fall - ER [illegible]

If you have ever had a listed sy[illegible]tom in the *past*, please check that [illegible]ptom in the "Past" column. If you are *presently* troubled by a particular symptom, check that symptom in the "Present" column. (Numerical codes listings are provided for the therapist's reference.)

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Present Weight:_______Pounds Height:_____Feet____Inches

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☐	☐	Coffee/Tea/Caffeinated Soft Drinks, cups per day__________

Yes	No	
☐	☐	Do you have a permanent disability rating Location__________ Date rating received____/____/____ Rating Percentage__________%
☐	☐	Do you have a pacemaker?

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☐	☐	Colitis (558.9)
☐	☐	Irritable Colon (564.1)
☐	☐	HIV/AIDS (042.0)
☐	☐	Other__________

PATIENT'S SIGNATURE Sandra Maines DATE 2/27/01

Patient Name: MAINES, Sandra — Int. Eval.

Subjective: Verbal cons to eval + Rx — Date: 2/27/01
through dgt written by pt. ⊖

Objective:
012......Traction
033......Iontophoresis
535......Functional Activities
530...Therapeutic Activities
140/265. Tx Stm Jt. Mobs
250......MFR
124......Massage — Upp. Traps (L>R) x 10' [illegible]
035.....Ultrasound
032/014.....E-stim — IFC c HP Upp. Traps (40-150) [illegible] x 15'
112...Neuro-re-ed
116....Gt. Training

110...Ther. Ex. Repex Medx Biodex — NO Δ c Repeat motion testing at C-Spine, L-Spine unclear.

Assessment: – cervical / thoracic strain / sprain
– LBP – unknown at – need to R/O HNP
– (L) elbow lateral epicondylitis

Plan: (1) E-stim + MH Both Traps middle + lower, massage to upper traps (2) Add U.S. to (L) elbow next visit (3) Try (R) sidelying to

Tx Time: 1 1/4 hr. — Therapist: M Rodd [signature]

Subjective: Neck + SH a little better. NO Δ in LB pain — Date: 3-8-01

Objective:
012......Traction
033......Iontophoresis
535......Functional Activities
530...Therapeutic Activities
140/265. Tx Stm Jt. Mobs
250......MFR
(124)......Massage
035.....Ultrasound
032/(014).....E-stim
112...Neuro-re-ed
116....Gt. Training

110...(Ther. Ex.) Repex Medx Biodex — (R) SL centralized + [illegible] pain – [illegible] c EIL – (R) SL → [illegible] → (R) SL

Assessment: Above SX consistent c derangement # 5 that appears to be amenable to mechanical Rx

Plan: HEP of (R) SL – NO ✓

Tx Time: 45' — Therapist: M Rodd [signature]

PROGRESS NOTES

Marjorie R. Rodd, P.T., Cert. MDT
License no. -0007940

Marjorie R. Rodd, P.T., Cert. M.D.T.

copy sent 3/7/01

INITIAL EVALUATION (97001)

PATIENT : Sandra Maines

DATE : March 1, 2001

PHYSICIAN : Kirk Maes, M.D.

CHIEF COMPLAINT: Cervical pain, lumbar pain, and left elbow pain.

HISTORY OF PRESENT ILLNESS: The patient reports that she had a fall in K-Mart on August 2, 2000. She apparently slipped and fell backwards landing on her head, shoulders, and back. The onset of symptoms began immediately with low back pain and, within 24-hours the patient experienced neck and shoulder pain, left greater than the right. She has not had intervention other than medication to date and feels that her symptoms are either unchanged or worsening. As you know, the patient is deaf and unable to communicate and we did use her daughter to perform this verbal exchange with the patient.

GENERAL HEALTH: The patient is in excellent health.

OBJECTIVE FINDINGS: Standing posture is fair. Sitting posture is fair. Cervical range of motion is within normal limits. Lumbar range of motion is severely limited in both flexion and extension. Cervical repeat motion testing was not productive of change in symptoms. There is +4 tenderness to palpation in both upper trapezius, rhomboids, and levator scapula musculature. Repeat motion testing of the lumbar spine also did not seem to change the patient's symptoms, however I do not feel that this test was done as effectively as I would have liked to have seen and I will re-test this again in the future. There was some difficulty in communicating exactly what I wanted the patient to do and to be able to assess the response. We will try the side lying position to see if this will be effective.

The patient did complain of pain in the lateral aspect of the left elbow and she, most likely, put this behind her during the fall and sustained an injury from hitting the floor.

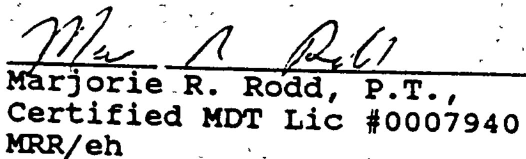
2021 Indian River Blvd. • Vero Beach, Florida 32960 • (561) 567-8040 • Fax (561) 567-8420

Kirk Maes, M.D.
Patient : Sandra Maines
Initial Evaluation
Page Two

PHYSICAL THERAPY CONCLUSION:
1. Cervical sprain/strain.
2. Lumbar pain, inconclusive. Will need further evaluation to determine if mechanical in nature or not.
3. Left lateral epicondylitis.

TREATMENT PLAN: Treat with modalities including massage, electrical stimulation, therapeutic exercise of cervical and lumbar musculature, and ultrasound to the left elbow. We will treat three times a week for 3-4 weeks and encourage the patient on a home exercise program to begin range of motion and therapeutic exercise to restore normal flexibility and strength and decrease pain.

REHABILITATION POTENTIAL: Fair.



Marjorie R. Rodd, P.T.,
Certified MDT Lic #0007940
MRR/eh

I certify the above is medically necessary and will be reviewed by me in 30 days.

Kirk Maes, M.D.

Marjorie R. Rodd, P.T., Cert. M.D.T.

PROGRESS REPORT

PATIENT : MAINES, Sandra

DATE : March 20, 2001

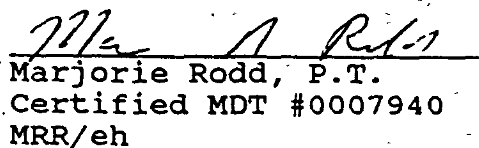
PHYSICIAN : Kirk Maes, M.D.

DIAGNOSIS : Cervical pain, lumbar pain, left elbow pain

This is only our third visit to Mrs. Maines since her first visit on 02/27/01. She did miss one appointment and there was a misunderstanding as to how often I wanted to see her after her first visit and that is why we have only had three visits. She has been very compliant and cooperative and has been a pleasure to work with in the clinic. We have not had a difficult time in communicating as her daughter is always present and very adept at the sign language, so I therefore feel we are getting a very accurate picture as to her progress.

She reports that her neck and arm are slowly improving, and, indeed, they seem to be much less sensitive to touch and to general motion. I am most encouraged as the symptoms in the right lower extremity have responded very well to our mechanical intervention and it now does seem very consistent with a lumbar derangement that is amenable to mechanical treatment. Indeed, when she is on her right side, there is no pain and on this visit she was able to progress onto her stomach and even into extension in the prone position where one week ago she had immediately reproduction of pain in attaining the prone position. This would indicate an excellent progress as well as excellent potential.

She is to continue this over the next 48 hrs. and we are to see her again to progress into the standing extensions and hopefully reach stability over the next five to ten days. I am very encouraged as to her overall progress and will keep you well informed.



Marjorie Rodd, P.T.
Certified MDT #0007940
MRR/eh

2021 Indian River Blvd. • Vero Beach, Florida 32960 • (561) 567-8040 • Fax (561) 567-8420

Patient Name: [illegible]

Subjective: CANCELLED APPT. MISSED APPT. Date:

For ill

Date/time 3/14/01

Patient called by

☐ Rescheduled On

☐ Refused to reschedule

Objective:

012......Traction

033......Iontophoresis

535......Functional Activities

530...Therapeutic Activities

140/265. Tx Stm Jt. Mobs

0......MFR

4......Massage

5......Ultrasound

2/014......E-stim

2...Neuro-re-ed

6....Gt. Training

110...Ther. Ex. Repex Medx B

Assessment:

Plan:

Tx Time:

Therapist:

Subjective: - neck + SH improving. pain in (R) leg less, [illegible] Date: 3-20-01

Objective:

012......Traction

033......Iontophoresis

535......Functional Activities

530...Therapeutic Activities

140/265. Tx Stm Jt. Mobs

250......MFR

124......Massage cerv + UT + lev scap X10' [illegible]

035 X4 Ultrasound (L) elbow 1.0 w/cm² X4' [illegible]

032 (014)......E-stim FC c HP UT/lev scap 80-150 X15' bipolar [illegible]

112...Neuro-re-ed

116....Gt. Training

30" (110...Ther. Ex.) Repex Medx Biodex pt [illegible] to progress to prone + engage in extension [illegible] LB [illegible] (R) LE Sx limited [illegible] (L) elbow pain

Assessment: - Soft tissue trauma. Responding well to Rx c [illegible] in pain + [illegible]

- (R) LE Sx consistent c HNP amenable to Rx - pt cooperative + very compliant

Plan: (R) SL → prone [illegible] elbow (caution (L) elbow) [illegible] REIS (avoid [illegible] 2° + (L) elbow

Tx Time: 1 1/4"

Therapist: M Rodd [signature]

PROGRESS NOTES

Marjorie R. Rodd, P.T., Cert. MDT

License no. -0007940

Patient Name: Maines, Sandra

Subjective: AS pt did extension procedures they became easier to do + ↓ pain. minimal pain (R) buttock, no pain **Date:** 3/21/01

Objective: ... neck, SH (L) elbow ... day to day

012.....................Traction

033..............Iontophoresis

535......Functional Activities

530...Therapeutic Activities

140/265. Tx Stm Jt. Mobs

250..........MFR

(124).......Massage: cerv + UT + lev scap X10' ...

(035)......Ultrasound: (L) elbow 1.0w/cm2 X4' ...

032/(014)....E-stim: IFC c HP UT lev scap 80-150 X15' ...

112...Neuro-re-ed

116....Gt. Training

110..(Ther. Ex.) Repex Medx Biodex: pt in (R) SL c 0/10 pain ... + ... on elbows c 0/10 pain. Able to perform EIL c minimal tightness in mid-lumbar + less strain on (L) elbow - able to do 4 Reps

Assessment: Excellent Response - Resolving lumbar derangement #5. Despite being ... ~ 6 mos pt has been very diligent + able to Reduce + centralize in < 3 weeks time + only 3 visits.

Plan: (1) progress to stabilization phase of annular healing process (2) RX neck, SH, (L) elbow 2X wk for 2-3 weeks

Tx Time: 1 hr

Therapist: M Rodd PT, Cert MDT

Subjective: Very much better in all areas - very appreciative of treatment **Date:** 3/26/01

Objective:

012.....................Traction

033..............Iontophoresis

535......Functional Activities

530...Therapeutic Activities

140/265. Tx Stm Jt. Mobs

250..........MFR

(124).......Massage: cerv + UT X10' ...

(035)......Ultrasound: 1.0w/cm2 (L) elbow x5' ...

032/(014)....E-stim: IFC c HP lev scap/UT 80-150 bipolar X15' ...

112...Neuro-re-ed

116....Gt. Training

110..(Ther. Ex.) Repex Medx Biodex: TTP + 1 in traps, +2 (L) elbow Full end Range SX free lumbar ext

Assessment: (1) musculoskeletal strain in neck + SH Resolving + close to complete resolution (2) (L) elbow sprain progress + expect full recovery in next 2-4 weeks c time + no complications (3) Derangement Reduced

Plan: test annular stability next visit + anticipate DC next wk

Tx Time:

Therapist: M Rodd PT, Cert ...

PROGRESS NOTES

Marjorie R. Rodd, P.T., Cert. MDT
License no. -0007940

Patient Name: Maines, Sandra

Subjective: Cont. to do well - very excited - how much progress she has made Date: 3-27-01

Objective:
012......................Traction
033..............Iontophoresis
535......Functional Activities
530...Therapeutic Activities
140/265. Tx Stm Jt. Mobs
250............MFR
(124)......Massage (L) UT [illegible] 10-OC
(035)......Ultrasound 1.0 w/cm2 (L) elbow x 5'
032/(014)....E-stim IFC/MHP [illegible] 80/150 x
112...Neuro-re-ed 15 - OC
116....Gt. Training

110...(Ther.) Ex. Repex Medx Biodex FIL test - 10-10-10 No ↑ in sx or ext ROM. pt init in Recovery ex

Assessment: Annulus stable for 10 visits - pt ready to begin remodeling process to assure complete Rehab + future prevention

Plan: Begin Recovery program

Tx Time: 50"

Therapist: M Rodd

Subjective: No ↑ in sx from last visit to date - beginning to feel good again Date: 4/2/01

Objective:
012......................Traction
033..............Iontophoresis
535......Functional Activities
530...Therapeutic Activities
140/265. Tx Stm Jt. Mobs
250............MFR
124......Massage UT/cerv/lev scap x 12' [illegible]
035.NC...Ultrasound (L) elbow 1.0 w/cm2 x 4' [illegible]
032/014.....E-stim IFC c HP UT/lev scap.
112...Neuro-re-ed 80-150 bipolar x 15' [illegible]
116....Gt. Training

110...Ther. Ex. Repex Medx Biodex Reviewed mechanical process + healing protocol

Assessment: Stable -

Plan: If cont stable D.C. next visit

Tx Time: 50"

Therapist: M Rodd

PROGRESS NOTES

Marjorie R. Rodd, P.T., Cert. MDT
License no. -000794

Spine & Sport Institute
561-567-8040
Fax 561-567-8420

Marjorie R. Rodd, P.T.

2021 Indian River Blvd.
Vero Beach, FL
32960

Patient Maines, Sandra DX cer. ē lumbar pain. Ⓛ elbow pain

Precautions/Contraindications

Goals:

( ) decrease/abolish pain
( ) increase ROM
( ) increase strength
( ) return to previous functional level

(✓) P.T. EVALUATE and TREAT
( ) COMPREHENSIVE SPINE MGMT.
( ) BACK SCHOOL
( ) SPINAL MOBILIZATION
( ) JOINT MOBILIZATION
( ) MEDX EVAL/RX
( ) BIODEX EVAL/RX
( ) BIOFEEDBACK/NEUROMUSCULAR RE-ED
( ) REPEX
( ) THERAPEUTIC EXERCISE
( ) resistive
( ) assistive
( ) active
( ) passive

( ) MYOFASCIAL RELEASE
( ) SOFT TISSUE MOBILIZATION
( ) ELECTRICAL STIMULATION
( ) THERAPEUTIC MASSAGE
( ) TRACTION
( ) cervical
( ) lumbar
( ) ULTRASOUND
( ) MOIST HEAT
( ) COLD PACK
( ) GAIT TRAINING
( ) HOME PROGRAM
( ) PELVIC FLOOR RE-ED

RECEIVED APR 0 AM BY:

FREQUENCY: PRN ___ TIW ✓ BIW ___ WEEKLY ___ DURATION 4WKS

I certify that the above physical therapy is medically necessary and will be reviewed by me within 30 days.

[signature] M.D. Date 3/27/01

Dr. Maes

Patient Name: MAINES SANDRA

Subjective: Feel I am nearly fully healed - expect time will slowly return me to my former level

Date: 4/3/01

Objective:

012........................Traction
033................Iontophoresis
535......Functional Activities
530...Therapeutic Activities
140/265. Tx Stm Jt. Mobs

250.............MFR
(124).......Massage Con (L) UT 10 min DC
(035).....Ultrasound 1.0w/cm2 6 min (L) elbow
(032)/014.......E-stim IFC mH (L) UT 8 aw 80/150 10 min DC
112...Neuro-re-ed
116....Gt. Training

110...Ther. Ex. Repex Medx Biodex

Assessment: Full Relief at all involved areas

Plan: D.C. on Recovery

Tx Time: 45

Therapist: M Rodd [illegible]

Subjective:

Date:

Objective:

012........................Traction
033................Iontophoresis
535......Functional Activities
530...Therapeutic Activities
'0/265. Tx Stm Jt. Mobs

250.............MFR
124.......Massage
035.....Ultrasound
032/014.....E-stim
112...Neuro-re-ed
116....Gt. Training

110...Ther. Ex. Repex Medx Biodex

Assessment:

Plan:

Tx Time:

Therapist:

PROGRESS NOTES

Marjorie R. Rodd, P.T., Cert. MDT
License no. -0007940

Marjorie R. Rodd, P.T., Cert. M.D.T.

DISCHARGE SUMMARY

PATIENT: SANDRA MAINES

PHYSICIAN: Kirk Maes, m.d.

DATE: April 3, 2001

We have seen Mrs. Maines for a total of eight visits for treatment of a cervical thoracic strain/sprain, greater on the left than right, low back pain secondary to lumbar derangement with referred pain into the right lower extremity and left elbow lateral epicondylitis secondary to a fall she sustained on August 2, 2000.

Mrs. Maines has done extremely well in all three areas of injury. She is stable now in the low back condition. I performed a flexion test to assure the integrity of the annulus and the healing process on 04/02/01 and found her to be stable. She has done recovery exercises over the last 24 hours and presents today still symptom free with normal range of motion in all planes of the lumbar spine. She reports that her left elbow is doing okay and that the tenderness is still present in the left upper trapezius and cervical area. However, it is much better and we both anticipate that over time with continued use of moist heat and gentle exercises at home it should fully resolve. Therefore, we will discharge Mrs. Maines today on a home program of postural correction, correct body mechanics and recovery exercises for the lumbar derangement. She has been extremely pleasant to work with, very cooperative in our program and has followed through with every exercise and instruction to the letter. It is unfortunate that she was forced to wait over this exceedingly long period of time from the date of her injury to when she was able to receive care as she has gone on with pain and suffering much longer than obviously would have been needed as we were able to fully resolve her injuries in eight visits. However, I am still pleased that we were able to help her and appreciate the opportunity that you gave us in doing so. It was a pleasure to meet her and her family. She was a delight to have in my clinic.

Marjorie Rodd, P.T. Certified MDT #0007940
CAW:MRR/902

2021 Indian River Blvd. • Vero Beach, Florida 32960 • (561) 567-8040 • Fax (561) 567-8420

E

INDIAN RIVER MEMORIAL INC
D 8604447
ORLANDO FL 32886-0447
561 567 4311

APPROVED OMB NO.

3 PATIENT CONTROL NO: 1931040001 181

5 FED. TAX NO.: 592496294
6 STATEMENT COVERS PERIOD FROM: 080200 THROUGH: 080200
7 COV D | 8 N-C D | 9 C-I D | 10 L-R D | 11

12 PATIENT NAME: MAINES, SANDRA
13 PATIENT ADDRESS: 4765 30TH AVE VERO BEACH FL 32967-1758

14 BIRTHDATE	15 SEX	16 MS	17 DATE (ADMISSION)	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.
06261961	F	S	080200	17	1	7	17	01	355262

CONDITION CODES

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH
05	080200	11	080200							

37 A B C

38
MAINES, SANDRA
4765 30TH AVE

VERO BEACH FL 32967-1758

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

42 REV CD	43 DESCRIPTION	44 HCPCS / RATES	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0250	PHARMACY			1	750		
0252	DRUGS/NON GENERIC			1	6650		
0320	DX-X RAY			2	33725		
0450	EMERGENCY ROOM			2	27000		
0001	PAGE 1 OF 1 TOTAL				68125		

50 PAYER	51 PROVIDER NO	52	53	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56
SELF PAY		Y	Y			

57 DUE FROM PATIENT ▶ 68125

58 INSURED'S NAME	59 P.REL	60 CERT - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
MAINES, SANDRA	01	264599881	OUTPATIENT	

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

67 PRIN. DIAG. CD	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD	77 E-CODE	78
924.01	923.11	920	E849.6						92401	E885	

79 P.C: 9
80 PRINCIPAL PROCEDURE CODE DATE | 81 OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE

82 ATTENDING PHYS. ID E22067
BURO, DOMINICK J. D.O.

83 OTHER PHYS. ID

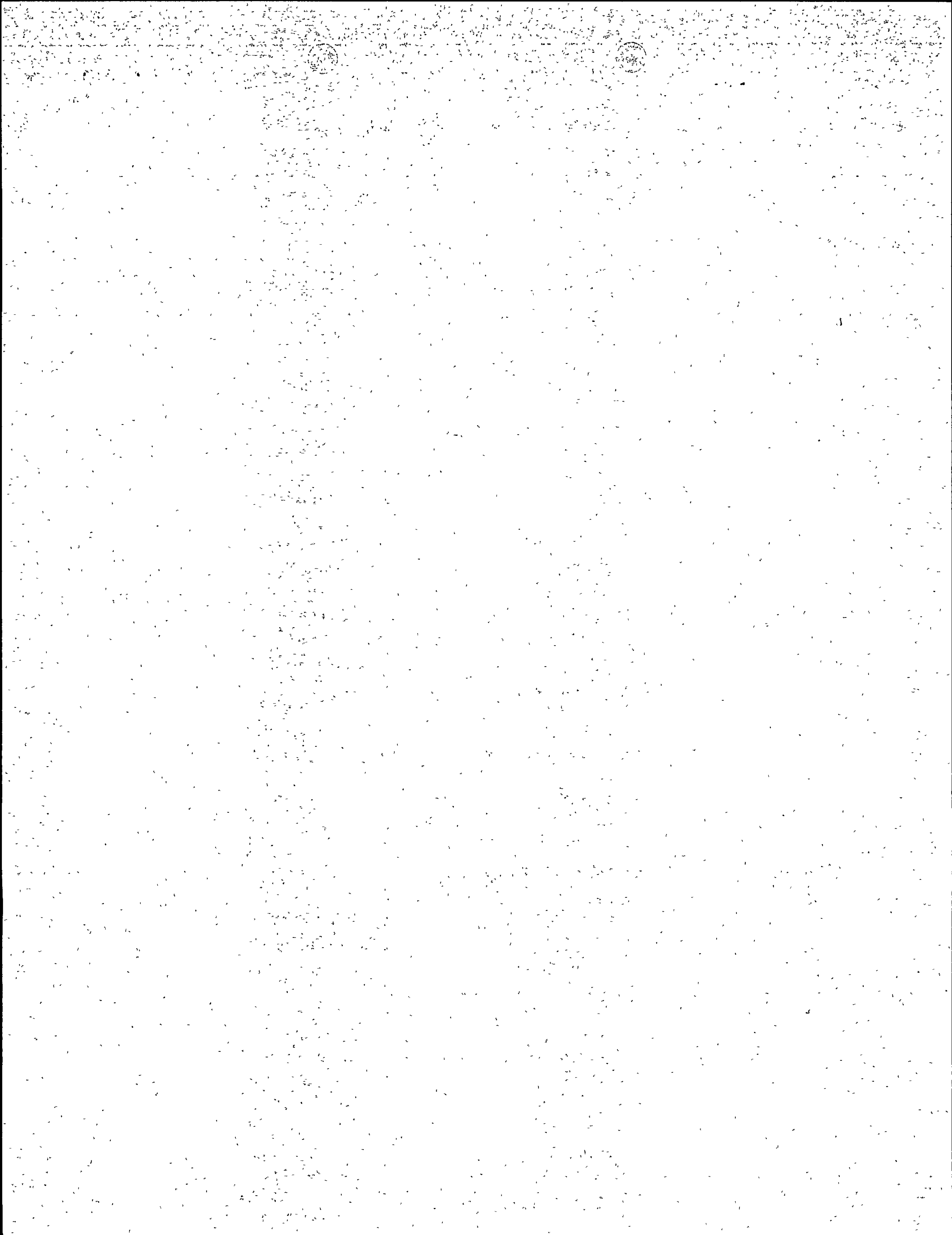
OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE X | 86 DATE

UB-92 HCFA-1450 **OCR/ORIGINAL**

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



Sandra Maines
4765 30th Ave
Vero Beach FL 32967-1758

August 16, 2000

Re: Account No. 1932216 Sandra Maines

You have received health care services at Indian River Memorial Hospital. Because our goal is to provide the highest quality service, we are supplying you with the following summarized information for the services rendered during the period of August 08, 2000.

Since you are covered under a health insurance policy: A claim has been filed with the insurance carrier given at the time of registration. If you gave secondary insurance at the time of registration, we will file after your primary insurance has paid. However, if you did not provide your secondary insurance, please contact us immediately with this essential information. Our records indicate that your insurance is as follows: MEDICARE.

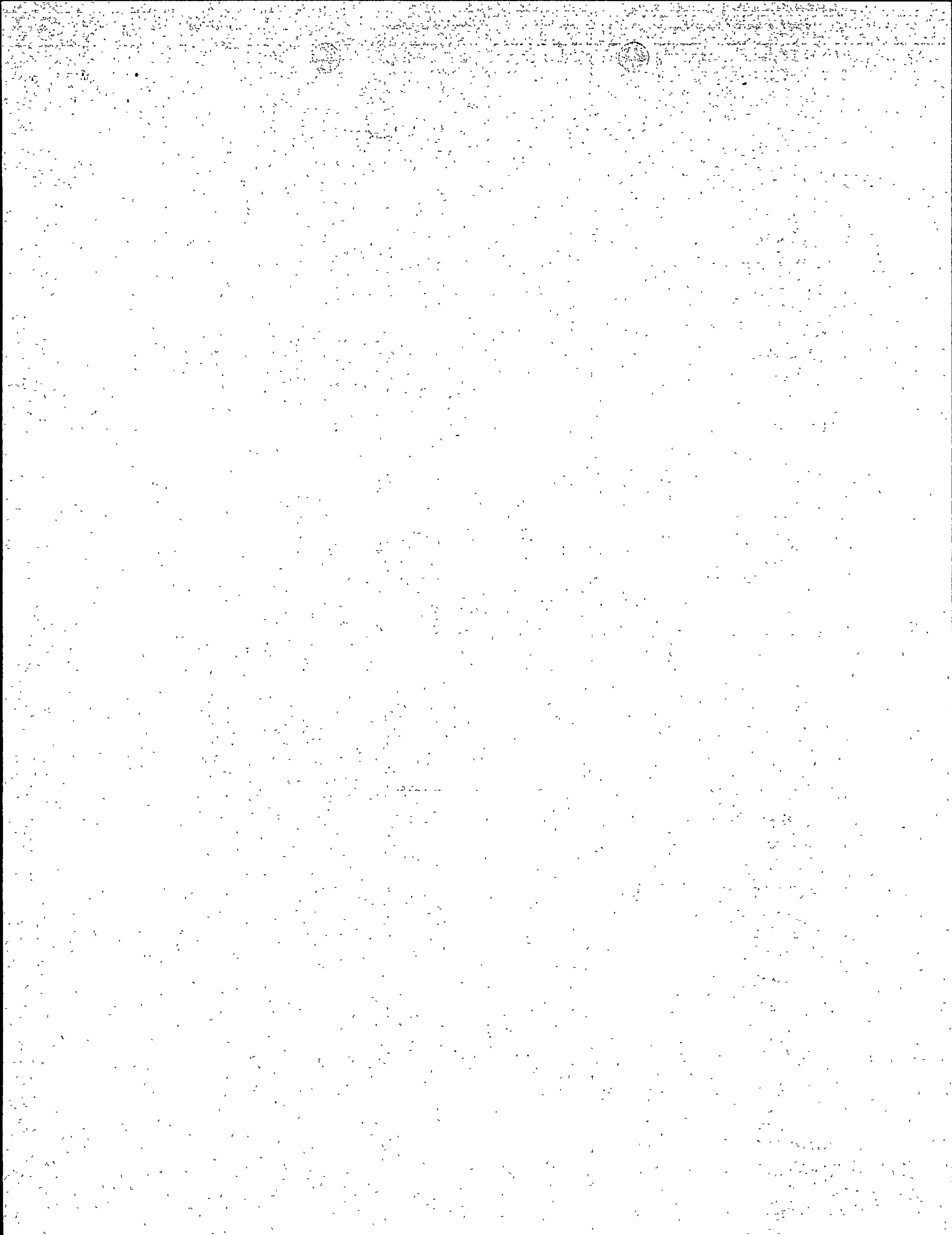
The summary of charges below does not include most physician charges. Radiologists, pathologists, surgeons, anesthesiologists, consulting physicians, and others will bill you separately. If you have any questions regarding the bill from your physicians, please contact them directly.

Emergency Room and Outpatient	43.75
Total Charges	$ 43.75

Indian River Memorial Hospital
Patient Accounts Department
(561) 567-4311 ext 3-1000

1000 36th Street, Vero Beach, Florida 32960 (561) 567-4311 Fax No (561) 562-5628

PLTOM



EMERGENCY MEDICINE ASS[illegible]IATES
P.O. BOX 860231
ORLANDO, FL 32886

PATIENT: SANDRA MAINES

LOCATION: INDIAN RIVER MEMORIAL HOSP

SANDRA MAINES 10280
4765 30TH AVE
VERO BEACH FL 32967

ACCOUNT NUMBER
B504-0053614-02

BILLING INQUIRIES: MONDAY THRU FRIDAY
8:00 AM TO 5:00 PM EST
TOLL FREE PHONE: 1-800-679-5234

DATE	BALANCE DUE	STATUS
11-10-00	56.32	J1 ER

PLEASE DETACH TOP PORTION AND RETURN WITH YOUR REMITTANCE TO INSURE CREDIT TO YOUR ACCOUNT

0385 DUN

KEEP THIS PORTION FOR YOUR RECORDS

IMPORTANT

Your insurance company has applied a portion of this bill to your deductible. The outstanding balance is your responsibility. Please remit prompt payment of the balance due.

PRIMARY INSURANCE
MEDICARE FLORIDA PHONE: 800 333 7586
PO BOX 44117 JACKSONVILLE FL 32231
POL: 264599881A PLAN: GRP:

SECONDARY INSURANCE
PRIVATE PAY PHONE:
POL: PLAN: GRP:

DATE	CODE	DESCRIPTION	CHARGES	CREDITS	BALANCE
CALL: MONDAY THRU FRIDAY HOURS: 8:00 AM TO 5:00 PM EST TOLL FREE PHONE: 1-800-679-5234					
08-08-00	99283	EMERGENCY DEPT. VISIT, LEVEL THREE	150.00		150.00
09-11-00	PAYMENT	PMT-MEDICARE		.29	149.71
09-11-00	ADJUST	CONT LOSS-MEDICARE		93.39	56.32
09-11-00	ADJUST	CONT LOSS-MEDICARE		99.39-	155.71
09-11-00	ADJUST	CONT LOSS-MEDICARE		99.39	56.32

MAKE CHECK PAYABLE AND MAIL TO:
EMERGENCY MEDICINE ASSOCIATES
P.O. BOX 860231
ORLANDO, FL 32886

IRS#: 65-0128777

PLEASE PAY THIS AMOUNT 56.32

ACCT NO: B504-0053614-02

EMERGENCY MEDICINE AS[illegible]CIATES
P.O. BOX 860231
ORLANDO, FL 32886

PATIENT: SANDRA MAINES

LOCATION: INDIAN RIVER MEMORIAL HOSP

SANDRA MAINES 10814
4765 30TH AVE
VERO BEACH FL 32967

ACCOUNT NUMBER
B504-0053614-01

BILLING INQUIRIES: MONDAY THRU FRIDAY
8:00 AM TO 5:00 PM EST
TOLL FREE PHONE: 1-800-679-5234

DATE	BALANCE DUE	STATUS
10-2[illegible]	150.00	L P3 ER

PLEASE DETACH TOP PORTION AND RETURN WITH YOUR REMITTANCE TO INSURE CREDIT TO YOUR ACCOUNT

KEEP THIS PORTION FOR YOUR RECORDS

0077 FIN

IMPORTANT

YOUR ACCOUNT IS SEVERELY PA[illegible]
THIS IS YOUR FINAL NOT[illegible]

We have repeatedly attempted to correspond wi[illegible] an effort to resolve this outstanding balance. We have bee[illegible] [illegible]s to assist you in settling your account without further actio[illegible] [illegible]his cannot be done in a reasonable time, we have no alternative bu[illegible] [illegible]fer your account to a commercial collection agency.

If you wish to prevent such action, please remi[illegible] payment promptly or contact our office at the above number to dis[illegible] [illegible]lternative arrangements.

DATE	CODE	DESCRIPTION	CHARGES	CREDITS	BALANCE
CALL: MONDAY THRU FRIDAY HOURS: 8:00 AM TO 5:00 PM EST T[illegible] [illegible]E PHONE: 1-800-679-5234					
08-02-00	99283	EMERGENCY DEPT. VISIT, LEVEL THREE	[illegible]		150.00

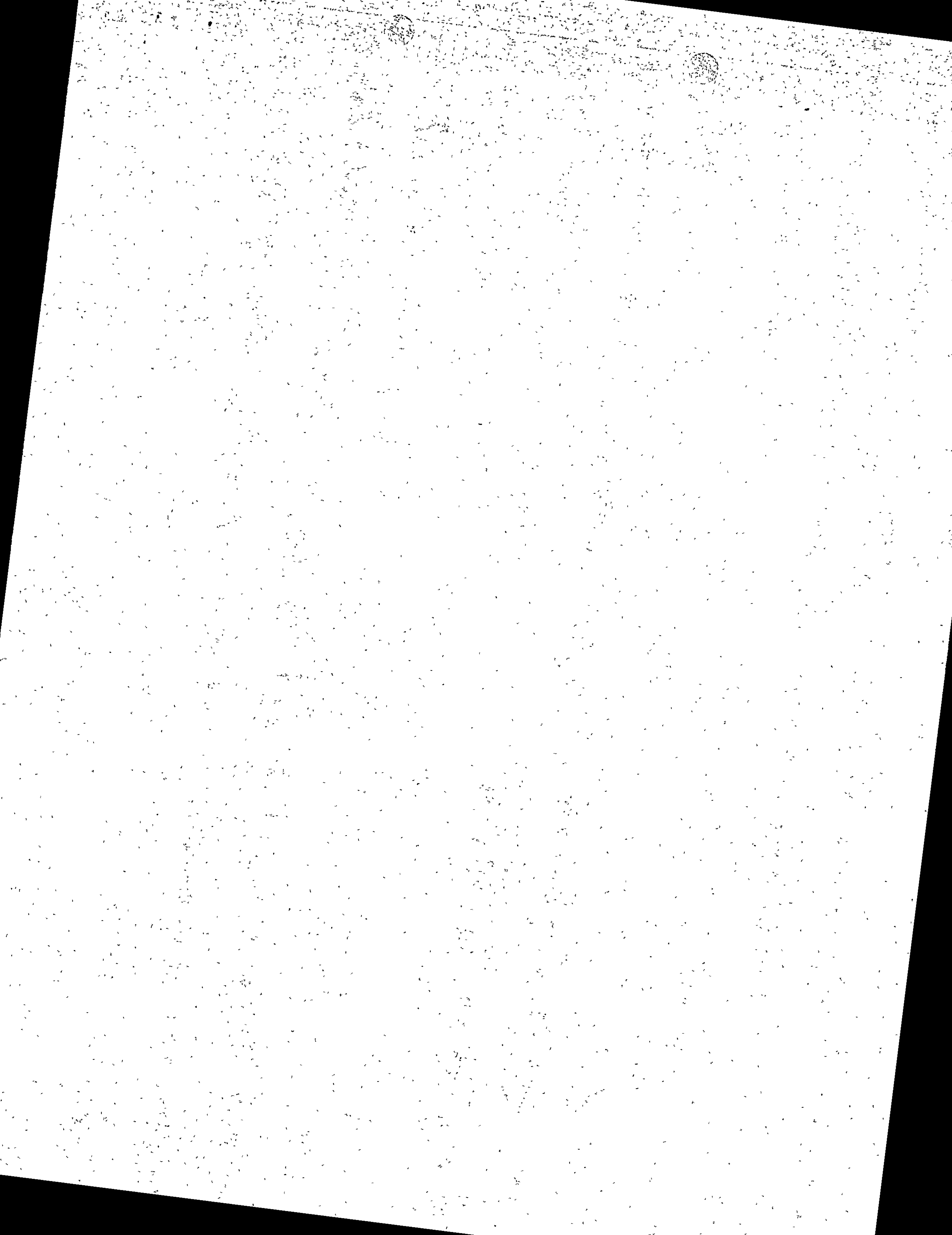
MAKE CHECK PAYABLE AND MAIL TO:

EMERGENCY ME[illegible] [illegible]NE ASSOCIATES
P.O. BOX 8[illegible]
ORLANDO, F[illegible]

PLEASE PAY THIS AMOUNT 150.00

MAINES
[illegible]: B504-0053614-01

IRS#: 65-0128777



STATEMENT

McCorkle Radiology Associates
777 37th St Suite D 106
Vero Beach FL 32960

IRS# 59-1406248 Phone: 561/567-1942

ACCOUNT NUMBER	DATE OF STATEMENT
01-04-01[illegible]	11/30/2000
PATIENT'S PHONE NUMBER	**PATIENT'S DATE OF BIRTH**
561/770-4264	06/26/1961
EMPLOYER	**PRIMARY INSURANCE**
ADMISSION DATE	**SECONDARY INSURANCE**

PATIENT:
MAINES, SANDRA

We accept MasterCard and Visa. $10 Min. See Credit Card information on back.
We will file insurance for you. See information on back.

AMOUNT PAID
AMOUNT DUE
$109.00

MAKE CHECK PAYABLE & REMIT TO:

*7 *********3-DIGIT 329

SANDRA MAINES 01-04-01931040
4765 30TH AVE
VERO BEACH FL 32967-1217

McCorkle Radiology Associates
777 37th St Suite D 106
Vero Beach FL 32960

MCCORKL4-0036509-0001088-0083376-001-000126-#001135

☐ PLEASE CHECK BOX IF ABOVE ADDRESS IS INCORRECT AND INDICATE CHANGES ABOVE.

DETACH HERE — AND RETURN THIS TOP PORTION WITH YOUR PAYMENT USING THE RETURN ENVELOPE ENCLOSED

DATE	*		DESCRIPTION OF SERVICES	DIAGNOSIS	AMOUNT
08/02/00	4	72050-26	SPINE CERVICAL MINIMUM 4 VIEWS		$70.00
08/02/00	4	73080-26	ELBOW 3 VIEWS		$39.00
			THIS ACCOUNT IS PAST DUE-PLEASE REMIT A PAYMENT /MB		

PATIENT	ACCOUNT NUMBER	BALANCE DUE	$109.00
MAINES, SANDRA	01-04-01931040		

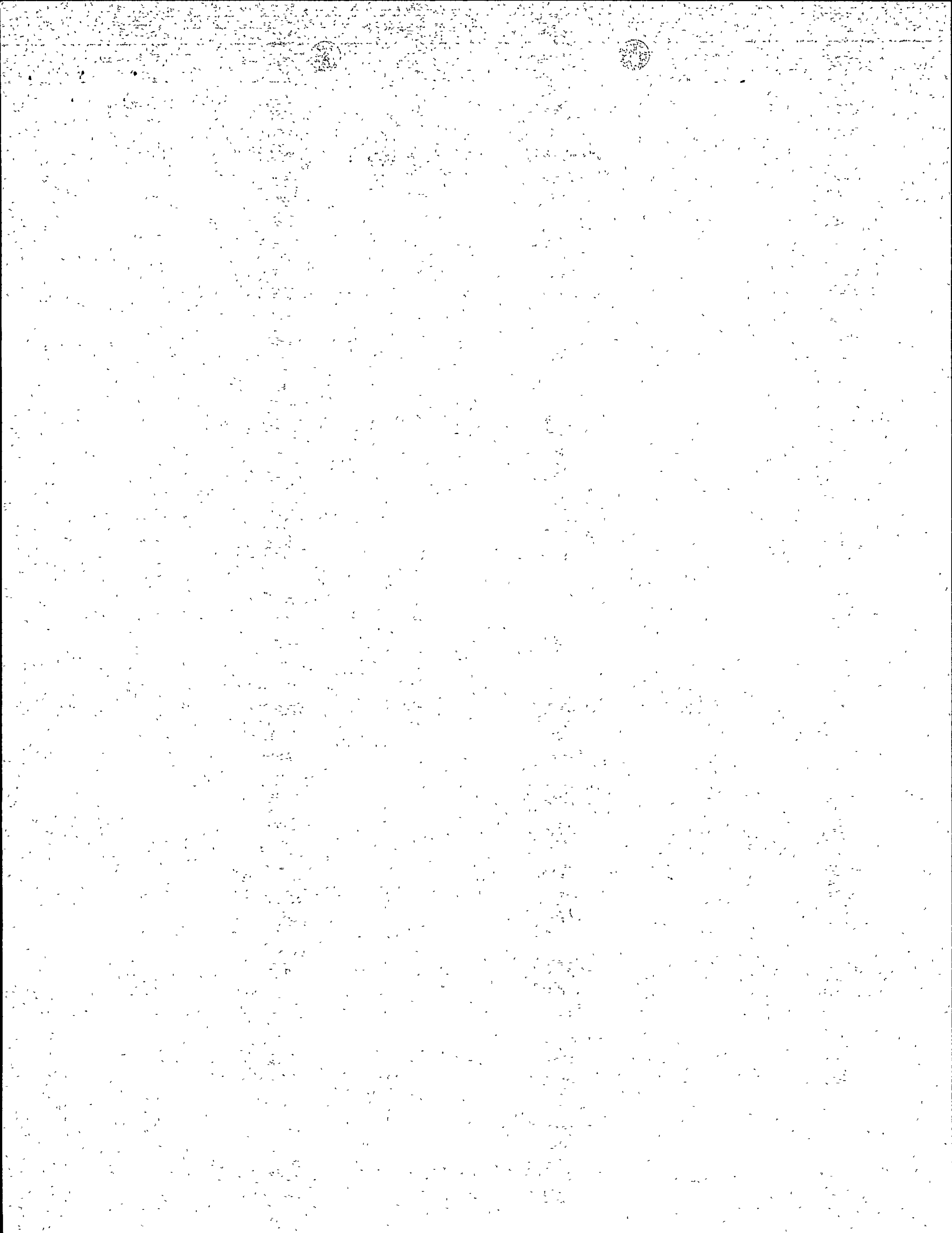
LOCATION OF SERVICE	PHYSICIAN PERFORMING SERVICE	DATE OF STATEMENT
IND RIV MEM HOSP EMERGENCY 1000 36TH STREET VERO BEACH FL 32960	PUSKAR, GEORGE T M.D.	11/30/2000

INJURY DATE	ADMISSION DATE	DISCHARGE DATE	REFERRING PHYSICIAN	*PLACE OF SERVICE
			BURO, DOMINICK D.O.	1 INPATIENT HOSPITAL 2 OUTPATIENT HOSPITAL 3 DOCTOR'S OFFICE IND LAB 4 EMERGENCY ROOM 5 OFFICE 6 NURSING HOME 7 OTHER 8 CLINIC

McCorkle Radiology Associates
777 37th St Suite D 106
Vero Beach FL 32960

IRS# 59-1406248 Phone: 561/567-1942

MCCORKL4-0036509-0001088-0083376-001-000126-#001135



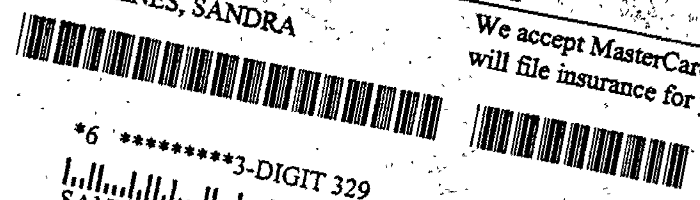
Vero Radiology Associates
777 37th St, Suite D 106
Vero Beach FL 32960

STATEMENT

IRS# 59-2755370 Phone: 561/567-1942

ACCOUNT NUMBER	DATE OF STATEMENT
02-04-00022060	11/17/2000
PATIENT'S PHONE NUMBER	PATIENT'S DATE OF BIRTH
561/770-4264	06/26/1961
EMPLOYER	PRIMARY INSURANCE
	264599881A
ADMISSION DATE	SECONDARY INSURANCE

PATIENT:
MAINES, SANDRA



We accept MasterCard and Visa. $10 Min. See Credit Card information on back. We will file insurance for you. See information on back.

AMOUNT

AMOUNT

$118.3

*6 **********3-DIGIT 329
SANDRA MAINES 02-04-00022060
4765 30TH AVE
VERO BEACH FL 32967-1217

MAKE CHECK PAYABLE & REMIT TO:

Vero Radiology Associates
777 37th St. Suite D 106
Vero Beach FL 32960

PLEASE CHECK BOX IF ABOVE ADDRESS IS INCORRECT AND INDICATE CHANGES ABOVE.

MCCORKL1-0036074-0000975-0081660-001-000990-#001308

DETACH HERE AND RETURN THIS TOP PORTION WITH YOUR PAYMENT USING THE RETURN ENVELOPE ENCLOSED

DATE	*	DESCRIPTION OF SERVICES		DIAGNOSIS	AMOUNT
09/13/00	5	72148-GA	MRI L-SPINE	7242	$591.91
11/08/00		999920	MEDICARE PAYMENT		$473.53-

PATIENT
MAINES, SANDRA

PLACE OF SERVICE
VERO RADIOLOGY ASSOCIATES
ADVANCED MRI VERO BEACH FL 32960

ACCOUNT NUMBER	BALANCE DUE
02-04-00022060	$118.38

DATE	ADMISSION DATE	DISCHARGE DATE

PHYSICIAN PERFORMING SERVICE
PUSKAR, GEORGE T M.D.

REFERRING PHYSICIAN
MAES, KIRK E M.D.

DATE OF STATEMENT
11/17/2000

WE HAVE HEARD FROM MEDICARE OR YOUR PRIVATE INSURANCE CARRIER. YOU ARE NOW RESPONSIBLE FOR ANY BALANCE ON THIS ACCOUNT.

*PLACE OF SERVICE
1 INPATIENT HOSPITAL 5 OFFICE
2 OUTPATIENT HOSPITAL 6 NURSING HOME
3 DOCTOR'S OFFICE/IND LAB 7 OTHER
4 EMERGENCY ROOM 8 CLINIC

Vero Radiology Associates
777 37th St. Suite D 106
Vero Beach FL 32960

IRS# 59-2755370 Phone: 561/567-1942

MCCORKL1-0036074-0000975-0081660-001-000990-#001308

STATEMENT PAGE 1

Account Number	Statement Date	Account Balance	Outstanding Ins.	Amount Due	Payment Due Date	Amount Enclosed
001021	10/30/00	78.54	0.00	78.54	10/30/00	

KIRK E MAES MD
8000 RON BEATTY BLVD
STE B3
BAREFOOT BAY, FL 32976

- Guarantor -	- Patient -
SANDRA MAINES 4765 30TH AVE. VERO BEACH, FL 32967	SANDRA MAINES 4765 30TH AVE. VERO BEACH, FL 32967

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE

Date	Claim #	Patient	Pro	Code	Description	Charges	Credits
08/14/00	002320	SANDRA	IR	99205	NEW PATIENT LEVEL 5	195.00	
					Pri DX: 722.10		
08/31/00	002320	SANDRA	IR		MEDICARE billed 195.00		
09/11/00	002512	SANDRA	IR	99214	OV LEVEL 4	85.00	
					Pri. DX: 726.10		
09/11/00	002512	SANDRA	IR	20610	INJ/ASPIRATION SHLD, HIP, KNEE	90.00	
					Pri. DX: 726.10		
09/11/00	002512	SANDRA	IR	J2930	CELESTONE UP TO 125MG	5.00	
					Pri DX: 726.10		
09/18/00	002549	SANDRA	IR	99214	OV LEVEL 4	85.00	
					Pri DX. 722 10		
09/19/00	002320	SANDRA	IR		MEDICARE		131.12
09/19/00	002320	SANDRA	IR		MEDICARE WRITEOFF		31.10
09/19/00	002549	SANDRA	IR		MEDICARE billed 85.00		
10/09/00	002549	SANDRA	IR		MEDICARE		59.73

0 - 30 Days:	0.00	91 - 120 Days:	0.00	Amount Due.......	78.54
31 - 60 Days:	45.76	Over 120 Days:	0.00	Outstanding Ins.:	0.00
61 - 90 Days.	32.78			Account Balance.:	78.54

From	Office Phone	Statement Date	Account Balance
KIRK E MAES MD Tax ID: 593589462	(561) 664-2233	10/30/00	78.54

Patient	Account Number	Payment Due Date	Amount Due
SANDRA MAINES	001021	10/30/00	78.54

STATEMENT

Account Number	Statement Date	Account Balance	Outstanding Ins.	Amount Due	Payment Due Date	Amount Enclosed
001021	01/12/01	87.68	0.00	9.14	02/12/01	

KIRK E MAES MD
8000 RON BEATTY BLVD
STE B3
BAREFOOT BAY, FL 32976

- Guarantor -	- Patient -
SANDRA MAINES 4765 30TH AVE. VERO BEACH, FL 32967	SANDRA MAINES 4765 30TH AVE. VERO BEACH, FL 32967

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE

Date	Claim #	Patient	Pro	Code	Description	Charges	Credits
					- Previous Balance -	78.54	
12/14/00	003637	SANDRA	IR	99213	EST LEVEL 3	55.00	
					Pri DX 724 2		
12/20/00	003637	SANDRA	IR		MEDICARE billed 55 00		
01/10/01	003637	SANDRA	IR		MEDICARE		36.58
01/10/01	003637	SANDRA	IR		MEDICARE WRITEOFF		9.28

0 - 30 Days:	9.14	91 - 120 Days:	45.76	Amount Due......:	9.14
31 - 60 Days:	0.00	Over 120 Days:	32.78	Outstanding Ins.:	0.00
61 - 90 Days:	0.00			Account Balance.:	87.68

From	Office Phone	Statement Date	Account Balance
KIRK E MAES MD Tax ID: 593589462	(561) 664-2233	01/12/01	87.68

Patient	Account Number	Payment Due Date	Amount Due
SANDRA MAINES	001021	02/12/01	9.14

SPINE & SPORT INSTITUTE
2021 INDIAN RIVER BLVD.
VERO BEACH, FL 32960
(561) 567-8040
FED TAX ID# 65-0704415

STATEMENT DATE: 05/07/2001
PATIENT: SANDRA MAINES
INJURED: 08/02/2000
PHYSICIAN: MAES, KIRK E, MD
ID NO:
EMPLOYER: NONE

BRIAN J CONNELLY
979 BEACHLAND BLVD
VERO BEACH FL 32963

ACCT 103173 SP MR DIAGNOSIS:

DATE	DESCRIPTION	CHARGES	INSURANCE PAID	ADJUSTS	PATIENT PAID
	BALANCE FORWARD 0.00				
02/27/01	EVALUATION	193.20			
02/27/01	E-STEM	34.50			
02/27/01	MASSAGE	34.50			
03/08/01	E-STEM	34.50			
03/08/01	THER. EXERCISE	103.50			
03/08/01	MASSAGE	34.50			
03/20/01	E-STEM	34.50			
03/20/01	THER. EXERCISE	103.50			
03/20/01	ULTRASOUND	34.50			
03/20/01	MASSAGE	34.50			
03/21/01	BRIAN J CONNEL Billed 434.70 for 02/27-03/08/1				
03/21/01	E-STEM	34.50			
03/21/01	THER. EXERCISE	51.75			
03/21/01	ULTRASOUND	34.50			
03/21/01	MASSAGE	34.50			
03/23/01	BRIAN J CONNEL Billed 641.70 for 02/27-03/21/1				
03/26/01	E-STEM	34.50			
03/26/01	THER. EXERCISE	51.75			
03/26/01	ULTRASOUND	34.50			
03/26/01	MASSAGE	34.50			
03/27/01	E-STEM	34.50			
03/27/01	THER. EXERCISE	51.75			
03/27/01	ULTRASOUND	34.50			
03/27/01	MASSAGE	34.50			
04/02/01	E-STEM	34.50			
04/02/01	THER. EXERCISE	51.75			
04/02/01	ULTRASOUND	34.50			
04/02/01	MASSAGE	34.50			
04/03/01	E-STEM	34.50			
04/03/01	ULTRASOUND	34.50			
04/03/01	MASSAGE	34.50			

CONTINUED ON NEXT PAGE