FORM B10 (Official Form 10) 4029242

UNITED STATES BANKRUPTCY COURT
NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION

PROOF OF CLAIM
Chapter 11

In Re Kmart Corporation, et al.	**Case Numbers 02-02462 through 02-02499**
Name of Debtor (see attached for complete list of debtors) KMART OF TEXAS L.P.	**Case Number:** 38-3469160

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

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

11 2376153

MCGRATH, VIRGINIA
1800 HEIDELBERG DRIVE
FORT WORTH, TX 76134

- ☐ Check box if you are aware that anyone else has filed a proof of claim relating to your claim. Attach copy of statement giving particulars.
- ☐ Check box if you have never received any notices from the bankruptcy court in this case.
- ☐ Check box if the address differs from the address on the envelope sent to you by the court.

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

Your claim is scheduled as follows:
Class
UNSECURED NON PRIORITY
Amount
CONTINGENT, DISPUTED, UNLIQUIDATED

10083592

This Space is for Court Use Only

Account or other number by which creditor identifies debtor

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

1 Basis for Claim
- ☐ Goods sold
- ☐ Services performed
- ☐ Money loaned
- ☒ Personal injury/wrongful death
- ☐ Taxes
- ☐ Other

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

2. Date debt was incurred: 2-23-01

3. If court judgment, date obtained:

4. Total Amount of Claim at Time Case Filed: $ 65,000 —
If all or part of your claim is secured or entitled to priority, also complete Item 5 or 6 below.
☐ Check this box if claim includes interest or other charges in addition to the principal amount of the claim. Attach itemized statement of all interest or additional charges.

5. Secured Claim.
☐ Check this box if your claim is secured by collateral (including a right of setoff).
Brief Description of Collateral
☐ Real Estate ☐ Motor Vehicle ☐ Other
Value of Collateral $
Amount of arrearage and other charges at time case filed included in secured claim, if any $

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

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

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

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

4761
This Space is for Court Use Only
4-15-02
TRUE
2002 APR 15 PM 2:26
BANKRUPTCY 95

Date	Sign and print the name and title, if any, of the creditor or other person authorized to file this claim (attach copy of power of attorney, if any)
4-9-02	Virginia L McGrath

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

LIST OF DEBTORS, CASE NUMBERS AND TAX IDENTIFICATION NUMBERS:

DEBTOR	CASE NUMBER	TAX ID NUMBER
KMART CORPORATION OF ILLINOIS, INC	02-02462	37-0916029
KMART OF INDIANA	02-02463	38-3413374
KMART OF PENNSYLVANIA LP	02-02464	38-3469157
KMART OF NORTH CAROLINA LLC	02-02465	38-3469154
KMART OF TEXAS L P	02-02466	38-3469160
BLUELIGHT COM LLC	02-02467	77-0529022
BIG BEAVER OF FLORIDA DEVELOPMENT, LLC	02-02468	38-0729500
THE COOLIDGE GROUP, I LC N/K/A TC GROUP I LLC	02-02469	38-2332504
KMART MICHIGAN PROPERTY SERVICES, L L C	02-02470	38-3384536
KMART FINANCING I	02-02471	38-6667809
TROY CMBS PROPERTY, L L C	02-02472	38-3334610
BIG BEAVER DEVELOPMENT CORPORATION	02-02473	38-2834722
KMART CORPORATION	02-02474	38-0729500
BIG BEAVER OF GUAYNABO DEVELOPMENT CORPORATION	02-02475	38-3225644
BIG BEAVER OF CAUGUS DEVELOPMENT CORPORATION	02-02476	38-3053789
BLUE LIGHT COM, INC	02-02477	77-0527034
KMART HOLDINGS, INC	02-02478	38-3293882
KMART OF AMSTERDAM, NY DISTRIBUTION CENTER INC	02-02479	38-3626487
KMART STORES OF INDIANA, INC	02-02480	38-2831604
KMART OF MICHIGAN, INC	02-02481	38-3551696
KMART STORES OF TNCP, INC	02-02482	38-2305127
KMART OVERSEAS CORPORATION	02-02483	31-0972999
JAE, INC	02-02484	38-2970528
VIA, INC	02-02485	51-0331035
BIG BEAVER OF CAGUAS DEVELOPMENT CORP II	02-02486	38-3175257
BIG BEAVER OF CAROLINA DEVELOPMENT CORPORATION	02-02487	38-3175256
K MART PHARMACIES, INC	02-02488	38-1978255
BUILDERS SQUARE, INC	02-02489	74-2259917
K MART INTERNATIONAL SERVICES, INC	02-02490	38-2331210
SOURCING & TECHNICAL SERVICES INC	02-02491	22-3004708
KMART PHARMACIES OF MINNESOTA, INC	02-02492	38-3351987
SII MERCHANDISING, INC	02-02493	38-2760188
KMART CMBS FINANCING, INC	02-02494	38-3334553
KLC, INC	02-02495	75-2490839
PMB, INC	02-02496	75-1371063
II J, INC	02-02497	92-0132179
KBL HOLDING INC	02-02498	26-0031295
SEPR, INC	02-02499	N/A

UNITED STATES BANKRUPTCY COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

In re	Case No 02-02474
	(Jointly Administered)
KMART CORPORATION, et al	Chapter 11
	Chief Judge Susan Pierson Sonderby
Debtors	

NOTICE OF LAST DATE AND PROCEDURES FOR FILING PROOFS OF CLAIM

TO ALL PERSONS ASSERTING A CLAIM AGAINST ANY OF THE ABOVE ENTITIES :

On March 6, 2002, the United States Bankruptcy Court for the Northern District of Illinois, Eastern Division (the "Bankruptcy Court"), entered an Order in the Kmart Chapter 11 cases (the "Bar Date Order") establishing **July 31, 2002**, as the general claims bar date (the "General Bar Date") Except as described below, the Bar Date Order requires that any Claims (as defined herein) against any of the Debtors listed on Exhibit A attached to this Bar Date Notice be filed with the claims agent appointed by the Bankruptcy Court, Trumbull Services, LLC (the "Claims Agent") by submitting a proof of claim to either of the following addresses

If by U S Mail
Kmart Corporation, et al
c/o Trumbull Services, LLC
P O Box 426
Windsor, CT 06095

If by Overnight Courier or Hand Delivery
Kmart Corporation, et al
c/o Trumbull Services, LLC
Griffin Center
4 Griffin Road North
Windsor, CT 06095

Proofs of claim must be actually received on or before 4 00 p m , prevailing Eastern Time, on the General Bar Date, **July 31, 2002** Proofs of claim are deemed filed only when they are actually received by the Claims Agent, and facsimile submissions will not be accepted

For your convenience, a proof of claim form is enclosed with this Bar Date Notice, which sets forth the amount, nature and classification of your Claim(s) as set forth in the Debtors' schedules of assets and liabilities to be filed with the Bankruptcy Court on before April 15, 2002 (the "Schedules")

ENTITIES REQUIRED TO FILE A PROOF OF CLAIM

Pursuant to the Bar Date Order, all persons or entities, including, without limitation, individuals, partnerships, corporations, estates, trusts, unions, indenture trustees, the U S Trustee and governmental units (individually, an "Entity"[1]) holding claims against the Debtors (whether secured,

[1] Entities include, but are not limited to, the following Entities (1) creditors whose Claims against a Debtor arose out of the rejection of executory contracts or unexpired leases by the Debtors prior to the entry of the order establishing the General Bar Date, (2) governmental units holding claims against a Debtor for unpaid taxes, whether arising from prepetition tax years or periods or

not limited to, claims for damages or rescission based on the purchase or sale of any such securities must file a proof of claim on or prior to the General Bar Date unless another exception set forth herein applies

CLAIMS RELATED TO REJECTION OF EXECUTORY CONTRACTS AND UNEXPIRED LEASES

Any Entity whose Claims arose out of the rejection of an executory contract or an unexpired lease must file a proof of claim on or before the later of (1) the date set by the Court in the Order authorizing the rejection of such contract or lease, and (2) the General Bar Date (the "Rejection Bar Date")

CLAIMS RELATED TO AMENDMENTS TO SCHEDULES

If the Debtors amend their Schedules subsequent to the mailing and publication of this Bar Date Notice to reduce the undisputed, noncontingent and liquidated amount or to change the nature or classification of a Claim against a Debtor reflected therein, then the affected claimant shall have until the later of (1) 30 days after such claimant is served with notice that the Debtors have amended their Schedules or (2) the General Bar Date to file a proof of claim or to amend any previously filed proof of claim (the "Amended Schedule Bar Date")

CONSEQUENCES OF FAILURE TO FILE A PROOF OF CLAIM

Any Entity that is required to file a proof of claim, but that fails to do so in a timely manner, will be forever barred, estopped and enjoined from

i asserting any Claim against any of the Debtors that such entity has that (i) is in an amount that exceeds the amount, if any, that is set forth in the Schedules, or (ii) is of a different nature or in a different classification (in either case, an "Unscheduled Claim"), and

j voting upon, or receiving distributions under, any plan or plans of reorganization in these chapter 11 cases in respect of an Unscheduled Claim

If it is unclear from the Schedules whether your Claim is disputed, contingent or unliquidated as to amount or is otherwise properly listed and classified, you must file a proof of claim on or before the General Bar Date Any Entity that relies on the Schedules bears responsibility for determining that its Claim is accurately listed therein

FILING PROOFS OF CLAIM AGAINST OTHER DEBTORS

Any Entity asserting Claims against more than one Debtor must file a separate proof of claim with respect to each such Debtor If more than one Debtor is listed on a form, the Debtors will treat such claim as filed against the first listed Debtor All Entities must identify on their proof of claim the holder or holders of the Claim and the particular Debtor against which their Claim is asserted A list of Debtors, together with their respective case numbers, is attached to this Bar Date Notice as Exhibit A Any Claims filed in the Joint Administration Case Number (Kmart Corporation, Case No 02-02474) shall be deemed filed only against Kmart Corporation

Exhibit A

Kmart Corporation 3100 West Big Beaver Road Troy, MI 48084	Case Number: 02-02474 Taxpayer ID No.: 38-0729500
Kmart Corporation of Illinois, Inc. f/k/a Huck Fixture Company 3100 West Big Beaver Road Troy, MI 48084	Case Number: 02-02462 Taxpayer ID No.: 37-0916029
Kmart of Indiana 3100 West Big Beaver Road Troy, MI 48084	Case Number: 02-02463 Taxpayer ID No.: 38-3413374
Kmart of Pennsylvania LP 3100 West Big Beaver Road Troy, MI 48084	Case Number: 02-02464 Taxpayer ID No.: 38-3469157
Kmart of North Carolina LLC 3100 West Big Beaver Road Troy, MI 48084	Case Number: 02-02465 Taxpayer ID No.: 38-3469154
Kmart of Texas L.P. 3100 West Big Beaver Road Troy, MI 48084	Case Number: 02-02466 Taxpayer ID No.: 38-3469160
Bluelight.com LLC 150 Post Street, Suite 670 San Francisco, CA 94108	Case Number: 02-02467 Taxpayer ID No.: 77-0529022
Big Beaver of Florida Development, LLC 3100 West Big Beaver Road Troy, MI 48084	Case Number: 02-02468 Taxpayer ID No.. 38-0729500
The Coolidge Group, n/k/a, IC Group LLLC 3100 West Big Beaver Road Troy, MI 48084	Case Number: 02-02469 Taxpayer ID No.: 38-2332504
Kmart Michigan Property Services, L.L.C. 3100 West Big Beaver Road Troy, MI 48084	Case Number: 02-02470 Taxpayer ID No.: 38-3384536
Kmart Financing I Bank of New York (Delaware), Trustee 23 White Clay Center Newark, DE 19711	Case Number: 02-02471 Taxpayer ID No.: 38-6667809
Troy CMBS Property, L.L.C. 3100 West Big Beaver Road, Suite 132 (Tax Library) Troy, MI 48084	Case Number. 02-02472 Taxpayer ID No.: 38-3334610
Big Beaver Development Corporation 3100 West Big Beaver Road Troy, MI 48084	Case Number: 02-02473 Taxpayer ID No.: 38-2834722
Big Beaver of Guaynabo Development Corporation 3100 West Big Beaver Road Troy, MI 48084	Case Number: 02-02475 Taxpayer ID No : 38-3225644
Big Beaver of Caguas Development Corporation 3100 West Big Beaver Road Troy, MI 48084	Case Number: 02-02476 Taxpayer ID No.: 38-3053789
Bluelight.com, Inc. f/k/a Shop Us, Inc. 3100 West Big Beaver Road Troy, MI 48084	Case Number. 02-02477 Taxpayer ID No.: 77-0527034
Kmart Holdings, Inc. Kmart #7100 I 95 and Naamans Road Claymont, DE 19703	Case Number: 02-02478 Taxpayer ID No: 38-3293882
Kmart of Amsterdam, NY Distribution Center, Inc. 30600 Telegraph Road Suite 3275 Bingham Farms, MI 48025	Case Number: 02-02479 Taxpayer ID No.: 38-3626487
Kmart Stores of Indiana, Inc. f/k/a Kmart Logistics Services, Inc 3100 West Big Beaver Road Troy, Michigan 48084	Case Number: 02-02480 Taxpayer ID No.: 38-2831604
Kmart of Michigan, Inc. 3250 West Big Beaver Road Suite 329 Troy, MI 48084	Case Number: 02-02481 Taxpayer ID No.: 38-3551696

EXPLANATIONS

Filing of Chapter 11 Bankruptcy Case	A bankruptcy case under chapter 11 of the Bankruptcy Code (title 11, United States Code) has been filed in this court by or against the Debtors listed in this notice, and an order for relief has been entered. Chapter 11 allows a debtor to reorganize or liquidate pursuant to a plan. A plan is not effective unless confirmed by the court. You may be sent a copy of the plan and a disclosure statement telling you about the plan, and you might have the opportunity to vote on the plan. You will be sent notice of the date of the confirmation hearing, and you may object to confirmation of the plan and attend the confirmation hearing. Unless a trustee is serving, the Debtors will remain in possession of the Debtors' property and may continue to operate any business.
Creditors May Not Take Certain Actions	Prohibited collection actions are listed in Bankruptcy Code § 362. Common examples of prohibited actions include contacting the Debtors by telephone, mail or otherwise to demand repayment; taking actions to collect money or obtain property from the Debtors; repossessing the Debtors' property; starting or continuing lawsuits or foreclosures.
Meeting of Creditors	A meeting of creditors is scheduled for the date, time and location listed on the front side. *The Debtors' representative must be present at the meeting to be questioned under oath by the trustee and by creditors* Creditors are welcome to attend, but are not required to do so. The meeting may be continued and concluded at a later date without further notice.
Claims	A Proof of Claim is a signed statement describing a creditor's claim. A Proof of Claim form is included with this notice You can obtain additional Proof of Claim forms at any bankruptcy clerk's office, or from the Claims Agent, Trumbull Services, LLC, who can be contacted at the address and phone number listed in the attached Notice. You may look at the schedules filed at the bankruptcy clerk's office. If your claim is scheduled and is *not* listed as disputed, contingent, or unliquidated, it will be allowed in the amount scheduled unless you file a Proof of Claim or you are sent further notice about the claim. Whether or not your claim is scheduled, you are permitted to file a Proof of Claim. If your claim is not listed at all *or* if your claim is listed as disputed, continent or unliquidated, then you must file a Proof of Claim or you might not be paid any money on your claim against the Debtors in the bankruptcy case. The deadline for filing a proof of claim is July 31, 2002
Discharge of Debts	Confirmation of a chapter 11 plan may result in a discharge of debts, which may include all or part of your debt. See Bankruptcy Code § 1141(d). A discharge means that you may never try to collect the debt from the Debtors, except as provided in the plan.
Bankruptcy Clerk's Office	Any paper that you file in this bankruptcy case should be filed at the bankruptcy clerk's office at the address listed on the front side. You may inspect all papers filed, including the list of the Debtors' property and debts at the bankruptcy clerk's office.
Legal Advice	The staff of the bankruptcy clerk's office cannot give legal advice. You may want to consult an attorney to protect your rights.

Other Sources of Information

This case has been assigned to Chief Judge Susan Pierson Sonderby. You can obtain copies of pleadings and other papers filed in the case, including the case docket, by contacting the Bankruptcy Court's website at www.ilnb.uscourts.gov. You can also obtain copies of such papers by contacting the official copy service, Landmark Document Services, at (312) 845-1000.

Information about the case can be obtained from the claims agent, Trumbull Services, LLC, by contacting its website at www.trumbullbankruptcy.com, by calling Trumbull at (877) 876-2705 (domestic calls) or (860) 687-7580 (international calls).

BIG K mart

Big Kmart Store # 7270 * 3640 Alta Mesa Blvd * Fort Worth, Texas 76133

DATE: 3-20-01

FAX

Number of Pages including cover sheet: 8

TO:	FROM:
Cambridge	Ken Thomas
	Loss Prevention
Phone :	Phone:
Fax Phone: (248) 816-7835	Fax Phone:
CC:	CC:

REMARKS: Urgent __ For Your Review __ Reply ASAP ←

Regarding Customer Accident #269700
Ms. Virginia McGrath.
Accident date: 2-23-01
Cambridge Integrated Services Group Inc
P.O. Box 970
Birmingham Mi ~~48~~ Mi 48012

Cambridge Integrated Sys.
(248) 816-7835
Claim #269700

Statement of Injured

Name	Name of Spouse	Telephone #
Virginia L McGrath	.	817-293-6130

Address	Occupation	Average Weekly Wage
1800 Heidelberg Dr.	Self employed, care giver	$225.00-part time

Former Address	Date of Birth	Social Security #
	2-2-33	372-32-4263

Employer's Name, Address, and Phone Number
Self Employed

Height	Weight	Eye Color	Glasses/Contacts	Hair Color	Right or Left Handed
5' 3"	147	blue	Glasses	Brown	Right

Any Previous injuries resulting in permanent or partial disability? Explain and provide date(s)
No, None

Date, time, and place of this incident
02-23-2001 Time Between 6:30 and 7 P M Kmart 7270 Ft.worth, Tx.

Describe in detail what you were doing and what happened when you were injured at Kmart

(continue on a separate sheet if necessary) I came in too the store, I did some shoping, and after checking out I went too the cafeteria to have something to eat

AS I was walking out I step in some wet solution on the floor and fell → other side

down, I hurt my back and hit my head braking my glasses and a cut just above

Name, address, & phone number of witness having knowledge of this incident
K Mart employees, Vickie the asst. manger and also the Manger

Describe your injury in detail, My back was hurt and I hit my head bricking my glasses and got a deep cut above my eye. Because of the injuey pain in my back and head. →

Name, address, & phone number of treating physician | Date of 1st visit | Number of visits

Are you still treating? Yes | How often? 3 times a wk. Dr. Walker Chiro | Have you missed time from work? | Date returned to work

If not, when are you expected to return to work? Part time ? | If still disabled, state your present condition

Over

This authorization, or a photo copy hereof, will authorize you to give **Cambridge Integrated Services Group, Inc.** or its representative, all information you may have regarding my condition while under your observation or treatment, including the history obtained, x-ray and physical findings, diagnosis and prognosis.

Signed Virginia L McGrath
Signature of Injured

Address 1800 Heidelberg Dr.
Ftworth Tx 76134

Date _____

my eye, I was bleeding a lot from the cut, It was more then ten minute before any one came to help me. The women at the cafeteria came over with some ice. And two women from the service desk came over I told them to call 911 for a ambulance, then a nother women came told me her name was Vickie and she was the Asst. manager, She took a report She ask me how and why I fell, I told her that the floor was wet with some oilie solution and showed it to her, she had a wet sign put in place Then the Manager came. And then the ambulance came and took me to the hospital. They treated me, I didnt get any names, When I get the bills all that information will be on it. KMart is responible for all my injuries and my broken glasses, And my billfold was several ft. from me and when I got it back there was 120.00 gone out of it, And I know it was in the billfold. Sence the accident I have a lot of pain in my back and I have headaches every day. I'm going to have treatments two to three times a week some time more, The problem is I have to pay for the treatments my self, If I dont get what is coming too me and I can't wait no five or six week, I will get a Attorney.

1st eye care. glasses Broken 337.50
For. myself. eye— Stolen money 120
Lost wages 440
Prescription 17.28
gas 25.00 1 month. bk + forth to my care.
$ 939.78

1st Report

MedStar
Harris. Methodist S.W. ER 730.00
Dr. Don Walker 405.00
Dr. Bohnsack 3-19-01 92.00
60.00
1,287.00

939.78
2,226.90
12,123.86
60.000

Please mail me BK
The payments. & I will
pay them R Off.

There will be 1 more Dr. Bill from ER
of my MRI I'm heading on mon 26. 3/01

Virginia McGrath

♦♒♋♦

1800 Heidelberg Drive ♦ Fort Worth, Texas 76134
Fax (817) 551-5627 ♦ Home Phone (817) 293-6130

September 23, 2001

Dear Ms Peters,

Regarding Case # 269700 Under the assumption that I had a sinus infection, I have been on 3 different medications as prescribed by Dr Bohnsack since 7/27/01 Upon taking my third prescription I had a bad dizzy spell and admitted myself into Harris Hospital. Dr Bohnsack conducted a test to check on my sinus cavity and concluded that I had a bad reaction to my prescription, not a sinus infection Dr Bohnsack prescribed a nose spray only and sent me to Dr. Kostohryr who took an x-ray and determined that everything was clear He later sent me to Quest Diagnostics for blood work and that was also found to be clear of infection Then Dr Kostohryr sent me to Dr Tanna MD who determined that I needed a CS The results of that were also clear, causing Dr Kostohryr to be at a loss to explain why I was in so much pain Since I had been experiencing fuzzy/unclear thinking and memory and bad head aches all the time, he sent me back for additional blood work which also yielded clear results Therefore, as my next step in this effort to get relief from so much daily pain, I am going to see a pain Dr on 10-09-01 this is Dr S.K. Nair MD, who will be my last hope for help I am very tired of taking pain medication 3-4 times daily in addition to having to take medication for muscle spasms I can not go on like this much longer It is even more frustrating to think that I am in this condition due to someone else's neglect since the accident I suffered at the K-Mart store on 2-23-01 I will get all my paper work together to send to you as soon as I get the report from Dr Nair For now I will need to continue to lay down after only a few hours of activity and do only as much as I am able to do I will also need to continue relying on the help of my husband and daughter In order to contact me, my husband's FAX # is (817) 551-5627

Yours truly,

Virginia McGrath

9/6/01

ATTENDING PHYSICIAN STATEMENT

RAJENDRA K. TANNA, M.D., P.A.
700 HEMPHILL, SUITE A
FORT WORTH TX 76104
(817) 336-8855

Account Number
16073.0

Page No. 1

Date
09/06/01

VIRGINIA L MCGRATH
1800 HEIDELBERG DR
FORT WORTH TX 76134

Date of Service	CPT/ ICD9	Procedure/ Diagnosis/es	POS/ TOS		Charge/ Payment
09/06/01	99243	OV/CONSULT/INTERMEDIATE	3	*	115.93
	477.0		3		

* Pending Insurance

Previous Balance	.00
Today's Total	115.93
Total Due	115.93
Patient Due Balance	.00

Doctor : RAJENDRA K. TANNA, M.D.
Tax I.D. : 751826221

Next Appointment :

1/22/02

From: METROPLEX PAIN MGMT, PA
221 BEDFORD ROAD
SUITE 200
BEDFORD TX 76022

Phone # (817) 268-0104
Tax Id. 75-2552646

02*05*02

Regarding: VIRGINIA MCGRATH
SSN: 372-32-4263
1800 HEIDELBERG
FT. WORTH TX 76134

VIRGINIA MCGRATH
1800 HEIDELBERG
FT. WORTH TX 76134

Account # : 15091
Home Phone : (817) 293-6130
Work Phone : (817) 364-6809
Employer :
Referred by: JOSEPH DANIELS, D.O.

Sex : F
Chart :
Age : 69 yr. 00 mo.
Date of Birth: 02-02-33
Accident Date: 02-23-01

Doc	Physician	Tax I.D. #	Provider #
1	J. MICHAEL STANTON, D.O.	75-2552646	86W010
8	LEROY GILLAN, CRNA	75-2552646	80490H

Loc	Location Name
6	SURGICAL & DIAGNOSTIC CT

Insurance Company	Policy Number	Group Number	Auth. Number	Provider Id.
MEDICARE	372324263A			80490H
BANKERS LIFE & CASUALTY	201051315	G		752552646

Date of Service	CPT Code	Transaction Description	Charge Amount	Insurance Portion	Patient Paid	Balance Due
01*22*02	00630	BLOCK - L-ESI	0.00	0.00	0.00	0.00
01*22*02	TOTAL	Total Anesthesia	0.00	0.00	0.00	0.00
01*22*02	62311	BLOCK - L-ESI	600.00*	0.00	0.00	600.00
01*22*02	64405	BLOCK - OCCIPITAL NERVE	375.00*	0.00	0.00	375.00
01*22*02	64405	BLOCK - OCCIPITAL NERVE	375.00*	0.00	0.00	375.00
Totals			1350.00	0.00	0.00	1350.00

* Insurance Pending

254

SURGICAL AND DIAGNOSTIC CENTER, L.P.
729 Bedford Euless Road West, Suite 100
Hurst, Texas 76053

PATIENT DISCHARGE SUMMARY
MPM

Patient. McGrath, Virginia
Patient ID: 6289 Svc. Date: JAN 2 2 2002
Age: 68 Sex: F
Doctor. Joseph Daniels,DO

Discharged by:	Accompanied by:	Date	Time
Dr. B Stanton	Husband	1-22-02	

Mode: With
[x]Ambulatory [ ]Walker [ ]Wheelchair

If you have any complaints during your stay at SDC, you can direct them to either the Director of Surgical Services or you may contact the Texas Department of Health at 1-888-973-0022

DISCHARGE INSTRUCTIONS: PATIENT / SIGNIFICANT OTHER DEMONSTRATES KNOWLEDGE OR SKILL IN THE FOLLOWING:

MEDICATIONS	DRUG/DOSE	FREQUENCY	PRECAUTIONS	x Check if prescription given to patient	x
[x]NONE	Resume previous medications				

DO NOT DRINK ALCOHOL, DRIVE, OPERATE MACHINERY, OR MAKE LEGAL DECISIONS FOR 24 HOURS

DIET: Drink lots of fluids the first 24 hours and return to your normal diet.

ACTIVITY LEVEL: Reintroduce activity slowly as tolerated. Have a quiet day--No heavy lifting.

INSTRUCTIONS: Warm moist heat to the back for 30 minutes, four times a day as needed for discomfort

I UNDERSTAND THAT I MUST NOT DRIVE HOME AND THAT SDC WILL NOTIFY THE DEPARTMENT OF PUBLIC SAFETY IF THERE IS ANY INDICATION THAT I WILL ATTEMPT TO DRIVE. I ALSO UNDERSTAND THAT I NEED A COMPETENT ADULT TO BE RESPONSIBLE AND TO HELP ME AT HOME.

FOLLOW-UP CARE:
Call Dr. M. Sparta on as well for follow-up. The phone number is 268-0104.

YOUR FOLLOW-UP CALL IS IMPORTANT TO US AND TO YOUR CARE.

Call between 8:00am and 12:00 Noon on the date written above.
After 4:30pm, during the week andon weekends, voice mail will forward any questions or problems you might have to the doctor.
Call (817)268-0104 and follow the directions to send a voice mail message.

I have read, understand, and promise to comply fully with the instructions given above I understand that failure to do so is Against Medical Advice.

Virginia McGrath

Return for next Epidural Injection _____

Patient/Significant Other

Return to Dr. _____ **office on** _____ **at** _____ **am/pm**

NA

Interpreter

V. Ibsen

Nurse

c:\dischmpm.revised 062900

Walker Chiropractic Clinic
105 Boland Street
Fort Worth, TX 76107-1221
Office Phone (817) 332-1234

MCGRATH0 1

01-14-02

Patient:

Virginia McGrath
1800 Heidelberg Dr
Fort Worth, TX 76134

Diagnosis:

1. 739.2
2. 722.51
3. 729.1
4. 739.3

Date	Description	Code #	Charge	Payments
03-21-01	INSURANCE PAYMENT Feb 19	010219		-4.35
03-31-01	INSURANCE PAYMENT Feb 19	010219		-1.09
03-16-01	Chiro Manip Treat 3-4 regions	010316	32.00	
04-10-01	INSURANCE PAYMENT Mar	010316		-51.20
05-09-01	INSURANCE PAYMENT [illegible]	010316		-12.80
03-21-01	Chiro Manip Treat 3-4 regions	010321	32.00	
03-27-01	Chiro Manip Treat 3-4 regions	010327	32.00	
03-27-01	Ultrasound-Not covered Medicar	010327	15.00	
03-30-01	Chiro Manip Treat 3-4 regions	010330	32.00	
03-30-01	Lumbar-Ap/Lat X-Ray	010330	75.00	
04-03-01	Chiropractic MT 1-2 regions	010403	32.00	
04-03-01	Ultrasound	010403	15.00	
04-10-01	Chiro Manip Treat 3-4 regions	010410	32.00	
04-10-01	Ultrasound-Not covered Medicar	010410	15.00	
04-13-01	Chiro Manip Treat 3-4 regions	010413	32.00	
04-16-01	Chiro Manip Treat 3-4 regions	010416	32.00	
05-07-01	INSURANCE PAYMENT	010416		-98.74
04-18-01	Chiro Manip Treat 3-4 regions	010418	32.00	
08-08-01	INSURANCE PAYMENT	010418		-25.60
10-02-01	INSURANCE PAYMENT	010418		0.00
04-20-01	Chiro Manip Treat 3-4 regions	010420	32.00	
04-23-01	Chiro Manip Treat 3-4 regions	010423	32.00	
04-25-01	Chiro Manip Treat 3-4 regions	010425	32.00	
04-27-01	Chiro Manip Treat 3-4 regions	010427	32.00	
04-30-01	Chiro Manip Treat 3-4 regions	010430	32.00	
05-02-01	Chiro Manip Treat 3-4 regions	010502	32.00	
05-04-01	Chiro Manip Treat 3-4 regions	010504	32.00	
05-08-01	Chiro Manip Treat 3-4 regions	010508	32.00	
05-11-01	Chiro Manip Treat 3-4 regions	010511	32.00	
05-14-01	Chiro Manip Treat 3-4 regions	010514	32.00	

Current 30 Days 60 Days 90 Days

CONTINUED

*** CONTINUED ***

SREEKUMARAN K. NAIR, M.D.
DIPLOMATE, AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY
Neurology, Neuro-Rehabilitation, Electrodiagnostics
1111 Fifth Avenue, Suite A
Fort Worth, TX 76104
Phone (817) 336-2026 Fax (817) 336-5996

October 22, 2001

R. K. Tanna, MD
700 Hemphill, #A
Fort Worth, TX 76104

RE: VIRGINIA MCGRATH

Dear Dr. Tanna:

Thank you for referring this patient to me for evaluation.

HISTORY OF PRESENT ILLNESS: The patient is a 68-year-old female who was involved in an accident in February 2001. She fell down at a K-Mart store and had a laceration on the left side of the forehead above the eyebrow. There was no loss of consciousness. She thinks she had some memory loss afterwards. Now she is getting dizzy. She had a CT scan and MRI scan of the head, and they were negative. She complains of a lot of pain over the left eye. She recently had bleeding from the left nostril. She has neck and back pain. She has a history of scoliosis.

PAST MEDICAL HISTORY: Allergies and gastroesophageal reflux disease.

SOCIAL HISTORY: The patient does not smoke, drink or abuse drugs.

FAMILY HISTORY: Unremarkable.

REVIEW OF SYSTEMS: Negative except as mentioned above.

PHYSICAL EXAMINATION: Height is 5'3" and weight is 150 pounds. Pulse rate is 80 beats per minute and regular. Blood pressure is 130/80. The neck is supple. There is a questionable right cervical bruit. Chest is clear to auscultation. Cardiovascular examination is unremarkable. S1 and S2 are present and normal.

RE: VIRGINIA MCGRATH
October 22, 2001
Page 2

NEUROLOGICAL EVALUATION: The patient is awake, alert and oriented. Language function is intact. Memory function and thought processes are intact. Overall, patient's mental status is normal. On cranial nerve examination, visual fields are intact. Fundi are benign. Pupils are equal and normal bilaterally. Reaction to light and accomodation is present and normal. Extraocular muscles are intact. There is no nystagmus. There is no facial asymmetry. Tongue and uvula are in the midline. Gag response is normal. Speech and swallowing functions are intact. Sternomastoid, trapezius and masticatory muscles are normal. Sensory examination of the face is normal. Hearing is intact. On motor system examination, muscle strength is 5/5, bilaterally symmetrical and normal. Muscle stretch reflexes are 2/4, bilaterally symmetrical and normal. Muscle tone and bulk are normal. Plantar response is bilaterally downgoing. On sensory examination, all primary and cortical modalities are normal. Gait is intact. Coordination is normal.

IMPRESSION:
1. Headaches, probably post traumatic. This may be secondary to the forehead laceration causing some degree of neuropathic pain in that area.
2. Cervicalgia
3. Low back pain.
4. Possible right carotid stenosis.

RECOMMENDATIONS: At this time, I am not prescribing any medications. I would like to review the MRI and CT scan films. I also recommend that she have a carotid doppler study. After reviewing these studies, we may schedule her for EMG testing. I will see the patient again in a few weeks.

Thank you for this kind referral.

Sincerely,

S. K. Nair, M.D.

SKN/mm

CC: Dr. Bohnsack

☐ 5701 Bryant Irvin Rd. #201
Fort Worth, Tx 76132
(817) 346-4000

SOUTHWEST MEDICAL ASSOCIATES, P.A.

after accident

4-17-01

5701 Bryant Irvin Rd #201
Fort Worth, TX 76132
(817) 263-2500

TAX ID# 752811022

Bonnsack

PHYSICIAN SIGNATURE

NEW PATIENT	DX	CPT	FEE
LEVEL II		99202	
LEVEL III		99203	
LEVEL IV		99204	
LEVEL V		99205	
ESTABLISHED PATIENT	**DX**	**CPT**	**FEE**
LEVEL I		99211	
LEVEL II		99212	
LEVEL III		99213	140
LEVEL IV		99214	
LEVEL V		99215	

PHYSICALS	NEW	DX	EST	FEE
Under Age 1	99381		99391	
Age 1-4	99382		99392	
Age 5-11	99383		99393	
Age 12-17	99384		99394	
Age 18-39	99385		99395	
Age 40-64	99386		99396	
Age 65 & Over	99387		99397	

LABORATORY	DX	CPT	FEE
ARTHRITIS PROFILE		80072	
CBC		85022	
CHOLESTEROL		82465	
CULTURE ANY OTH SOUR.		87070	
CULTURE CHLAMYDIA		87110	
CULTURE: GC		87072	
CULTURE HERPES		87250	
CULTURE URINE		87086	
DRUG SCREEN		82660	
EKG		93000	
GENE PROBE		87797	
GENERAL HEALTH SCRN		80050	
GLUCOSE		82947	
GLYCO HB		83036	
HDL LIPID PROFILE		83718	
HEMOCCULT SCREENING		82270	

LABORATORY (CONT'D)	DX	CPT	FEE
HEMOGLOBIN A,C		83036	
HEP b ANTIBODY		86803	
HEPATITIS PANEL		80059	
HIV TEST		86701	
HOLTER		93224	
LIPID PANEL		80061	
MONO TEST		86308	
NASAL SMEAR		89190	
PAP SMEAR (HMO 99000)		88150	
PATH COLLECTION		99000	
PREGNANCY SERUM		84702	
PREGNANCY URINE		81025	
PRO TIME		85610	
PSA		84153	
SED RATE		85651	
SGOT/ALT		84460	
STREP SCREEN		86403	
STOOL CULTURE		87045	
STOOL FOR O & P		87117	
THEOPHYLLINE LEVEL		80198	
THYROID PANEL W/TSH		80092	
URIC ACID		84550	
URINALYSIS		81000	
WET MOUNT/KOH		87210	
VENIPUNCTURE		36415	

IMMUNIZATION/INJECTIONS		CPT	FEE
ALLERGY SERUM		95180/55	
ALLERGY SHOT		95115	
B-12	J3420	90782	
BICILLIN, 2	J0530	90788	
CELESTONE		J0702	
CHICKEN POX		90716	
DECADRON LA		71141	
DECADRON Rg		J1100	
DEPO PROVERA		J1050	

IMMUN/INJEC (CONT'D)	DX	CPT	FEE
DEPOTESTOSTERONE 100MG		J1070	
DT		90702	
DPT		90701	
ESTRADIOL J0970		90782	
GAMMA GLOBULIN		90741	
HEPATITIS B 44 45 46		907	
HIB TITER		90737	
IMITREX		J3030	
INFLUENZA		90724	
KENALOG 40		J3301	
MEASLES VACCINE		90705	
MMR VACCINE		90707	
ORAL POLIO		90712	
PHENERGAN 50 MG		J2550	
PNEUMONIA		90732	
ROCEPHIN 250 x 1 J0696		90788	
ROCEPHIN 500 x 2 J0696		90788	
STADOL 4 mg J3490		90782	
TB TINE		86585	
TETANUS		90703	
TETRAMUNE		90720	
THERAPEUTIC MED NAME			
TORADOL J3490		90782	

SURGERY	DX	CPT	FEE
ANOSCOPY		46600	
CRYOSURGERY		17110	
ENDOMETRIAL BIOPSY		58100	
FLEXIBLE SIG		45330	
FOREIGN BODY REMUL			
HEMORRHOID EX		46320	
I/D ABSCESS		10060	
NAIL REMOVAL		11750	
VASECTOMY		55250	

X-RAYS	DX	CPT	FEE
ABDOMEN 1 VIEW		74000	
ANKLE 3 VIEWS		73610	
CERVICAL SPINE 5 VIEW		72050	
CERVICAL SPINE 2 VIEW		72040	
CHEST 1 VIEW PA		71010	
CHEST 2 VIEWS		71020	
ELBOW 2 VIEWS		73070	
EXTRA VIEW		76499	
FINGER(S) 3 VIEWS		73140	
FOOT 3 VIEWS		73630	
HAND 3 VIEWS		73130	
HIP 2 VIEWS		73510	
KNEE 2 VIEWS		73560	
LUMBOSACRAL SPINE 5V		72110	
LUMBOSACRAL SPINE 2V		72100	
SHOULDER 2-3 VIEWS		73030	
SINUS IV (WATER'S)		70210	
SINUS SERIES 3-4 VIEWS		70220	
TOE(S) 3 VIEWS		73660	
WRIST 3-4 VIEWS		73110	

MISCELLANEOUS	DX	CPT	FEE
AUDIOMETRY		92552	
EAR IRRIGATION		69210	
DIAPHRAGM FITTING		57170	
NEUBULIZER Tx		94650	
PSYCHOTHERAPY 1HR		90844	
SPECIAL REPORT		99080	
SPECIAL SUPPLIES		99070	
SPIROMETRY		94010	
TYMPANOMETRY		32567	

ICD-9 DIAGNOSIS

Code	Diagnosis
* 789.0	ABDOMINAL PAIN
790.93	ABNORMAL PSA
706.01	ACNE
314.01	ADD
702.0	ACTINIC KERATOSIS
477.9	ALLERGIC RHINITIS
300.00	ANXIETY
* 716.9	ARTHRITIS
* 414.0	ASHD
* 493	ASTHMA
* 427.3	ATRIAL FIBRILLATION
611.72	BREAST LUMP
611.71	BREAST PAIN
466.0	BRONCHITIS / BRCHIOLITIS
727.3	BURSITIS
427.9	CARDIAC ARRYTHMIA
682.9	CELLULITIS / ABSCESS
786.50	CHEST PAIN
786.52	CHEST WALL PAIN
091.3	CONDYLOMA
428.0	CONGESTIVE HEART FAIL
* 372.0	CONJUNCTIVITIS
564.0	CONSTIPATION
924.9	CONTUSION
492.8	COPD / EMPHYSEMA
311	DEPRESSION
692.9	DERMATITIS
562.11	DIVERTICULITIS
562.10	DIVERTICULOSIS
* 250.0	DIABETES MELLITUS
625.3	DYSMENORRHEA
536.8	DYSPEPSIA
380.4	EAR WAX
381.81	EUSTACHIAN TUBE DYS
780.7	FATIGUE
729.1	FIBROMYALGIA
V04.8	FLU VACCINE
829.0	FRACTURE
* 535.0	GASTRITIS / DUODENITIS
558.9	GASTROENTERITIS
599.7	HEMATURIA
307.81	HEADACHE-MUSCLE/CONT
346.9	HEADACHE-MIGRAINE/VASC.
286.5	HEMORRHAGIC DIS
455.0	HEMORRHOIDS
573.3	HEPATITIS
053.9	HERPES-ZOSTER (SHINGLES)
272.0	HYPERLIPIDEMIA
401.9	HYPERTENSION ESSENT
244.9	HYPOTHYROIDISM
684	IMPETIGO/PYODERMIA
487.1	INFLUENZA
703.0	INGROWN NAIL
564.1	IRRITABLE BOWL SYN
879.8	LACERATION
847.2	LUMBAR STRN/PAIN
606.9	MALE INFERTILITY
627.2	MENOPAUSAL SYMPTOMS
626.4	MENSTRUAL IRREGULARITY
075	MONONUCLEOSIS
728.85	MUSCLE SPASM PAIN
729.1	MYALGIA/MYOSITIS
278.00	OBESITY
* 715.0	OSTEOARTHRITIS/DJD
* 380.1	OTITIS EXTERNA
381.00	OTITIS MEDIA
620.2	OVARIAN CYST
281.0	PERNICIOUS ANEMIA
462	PHARYNGITIS/TONSILLITIS
V70.0	PHYSICAL EXAM
728.71	PLANTAR FACILTIS
481	PNEUMONIA
725	POLYMYALGIA RHEUMATIC
V22	PREGNANCY
601.9	PROSTATITIS
569.3	RECTAL BLEEDING
* 461	SINUSITIS
709.9	SKIN/SUBCUTANEOUS LESIO
848.9	SPRAIN
034.0	STREP/ACUTE
729.1	TENDONITIS/MYOSITIS
110.5	TINEA CORPORIS
305.1	TOBACCO ABUSE
099.40	URETHRITIS
465.9	URI
599.0	URINARY TRACT INF
616.0	VAGINITIS/VULVITIS
780.4	VERTIGO
079.99	VIRAL SYNDROME
078.10	WARTS
V20.0	WELL CHILD
V72.3	WELL WOMAN

Osteoporosis

DATE/TIME	PATIENT/CHART#	DOB	PRIOR BALANCE	REASON FOR APPOINTMENT:
04/17/01 09:00A	MCGRATH, VIRGINIA	02/02/1933 68	0.00	YEARLY PHYSICAL

(A) DR # 41 — (A) DOCTOR NAME: JAMES R. BOHNSACK, M.D. — LOCATION — 372-37-1068

TODAY'S CHARGE: 140

(R) DR # 41 — (R) DOCTOR NAME: JAMES R. BOHNSACK, M.D. — LOCATION

PHONE (H) 817 294-6130 (W)

PAY CHOICE ☐ CARD ☐ CASH ☐ CK#

PATIENT NO — RESPONSIBLE PARTY: MCGRATH VIRGINIA

ADJUSTMENTS

TICKET NO

ADDRESS: [illegible]

NEXT APPT ______ DAYS ______ WEEKS ______ MONTHS

CITY: FORT WORTH — STATE: TX — ZIP: 76132 — TYPE

TODAY'S PAYMENT —

INSURANCE COMPANY: MEDICARE PART B [illegible] — POLICY I D: 372[illegible] — RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD / OTHER

BALANCE DUE

I hereby authorize my insurance benefits to be paid directly to the above signed physician, realizing I am responsible to pay noncovered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Patient Signature

5701 Bryant Irvin Rd #201
Fort Worth, Tx 76132
(817) 346-4000

SOUTHWEST MEDICAL ASSOCIATES, P.A.

5701 Bryant Irvin Rd. #201
Fort Worth, TX 76132
(817) 263-2500

1/0 charge 8-21-01
Sinusitis
Beasley
TAX ID# 752811022

PHYSICIAN SIGNATURE

NEW PATIENT	DX	CPT	FEE
LEVEL II		99202	
LEVEL III		99203	
LEVEL IV		99204	
LEVEL V		99205	
ESTABLISHED PATIENT	**DX**	**CPT**	**FEE**
LEVEL I		99211	
LEVEL II		99212	
LEVEL III		99213	
LEVEL IV		99214	
LEVEL V		99215	

PHYSICALS	NEW	DX	EST	FEE
Under Age 1	99381		99391	
Age 1-4	99382		99392	
Age 5-11	99383		99393	
Age 12-17	99384		99394	
Age 18-39	99385		99395	
Age 40-64	99386		99396	
Age 65 & Over	99387		99397	

LABORATORY	DX	CPT	FEE
ARTHRITIS PROFILE		80072	
CBC		85022	
CHOLESTEROL		82465	
CULTURE ANY OTH SOUR.		87070	
CULTURE CHLAMYDIA		87110	
CULTURE GC		87072	
CULTURE HERPES		87250	
CULTURE URINE		87086	
DRUG SCREEN		82660	
EKG		93000	
GENE PROBE		87797	
GENERAL HEALTH SCRN		80050	
GLUCOSE		82947	
GLYCO HB		83036	
HDL LIPID PROFILE		83718	
HEMOCCULT SCREENING		82270	

LABORATORY (CONT'D)	DX	CPT	FEE
HEMOGLOBIN A,C		83036	
HEP c ANTIBODY		86803	
HEPATITIS PANEL		80059	
HIV TEST		86701	
HOLTER		93224	
LIPID PANEL		80061	
MONO TEST		86308	
NASAL SMEAR		89190	
PAP SMEAR (HMO 89000)		88150	
PATH COLLECTION		99000	
PREGNANCY SERUM		84702	
PREGNANCY URINE		81025	
PRO TIME		85610	
PSA		84153	
SED RATE		85651	
SGOT/ALT		84460	
STREP SCREEN		86403	
STOOL CULTURE		87045	
STOOL FOR O & P		87117	
THEOPHYLLINE LEVEL		80198	
THYROID PANEL W/TSH		80092	
URIC ACID		84550	
URINALYSIS		81000	
WET MOUNT/KOH		87210	
VENIPUNCTURE		36415	

IMMUNIZATION/INJECTIONS		CPT	FEE
ALLERGY SERUM		95150/55	
ALLERGY SHOT		95115	
B-12	J3420	90782	
BICILLIN, 2	J0530	90788	
CELESTONE		J0702	
CHICKEN POX		90716	
DECADRON LA		71141	
DECADRON Rg		J1100	
DEPO PROVERA		J1050	

IMMUN/INJEC (CONT'D)	DX	CPT	FEE
DEPOTESTOSTERONE 100MG		J1070	
DT		90702	
DPT		90701	
ESTRADIOL J0970		90782	
GAMMA GLOBULIN		90741	
HEPATITIS B 44 45 46		907	
HIB TITER		90737	
IMITREX		J3030	
INFLUENZA		90724	
KENALOG 40		J3301	
MEASLES VACCINE		90705	
MMR VACCINE		90707	
ORAL POLIO		90712	
PHENERGAN 50 MG		J2550	
PNEUMONIA		90732	
ROCEPHIN 250 x 1 J0696		90788	
ROCEPHIN 500 x 2 J0696		90788	
STADOL 4 mg J3490		90782	
TB TINE		86585	
TETANUS		90703	
TETRAMUNE		90720	
THERAPEUTIC MED NAME			
TORADOL J3480		90782	

SURGERY	DX	CPT	FEE
ANOSCOPY		46600	
CRYOSURGERY		17110	
ENDOMETRIAL BIOPSY		58100	
FLEXIBLE SIG		45330	
FOREIGN BODY REMUL			
HEMORRHOID EX		46320	
I/D ABSCESS		10060	
NAIL REMOVAL		11750	
VASECTOMY		55250	

X-RAYS	DX	CPT	FEE
ABDOMEN I VIEW		74000	
ANKLE 3 VIEWS		73610	
CERVICAL SPINE 5 VIEW		72050	
CERVICAL SPINE 2 VIEW		72040	
CHEST 1 VIEW PA		71010	
CHEST 2 VIEWS		71020	
ELBOW 2 VIEWS		73070	
EXTRA VIEW		76499	
FINGER(S) 3 VIEWS		73140	
FOOT 3 VIEWS		73630	
HAND 3 VIEWS		73130	
HIP 2 VIEWS		73510	
KNEE 2 VIEWS		73560	
LUMBOSACRAL SPINE 5V		72110	
LUMBOSACRAL SPINE 2V		72100	
SHOULDER 2-3 VIEWS		73030	
SINUS IV (WATER'S)		70210	
SINUS SERIES 3-4 VIEWS		70220	
TOE(S) 3 VIEWS		73660	
WRIST 3-4 VIEWS		73110	

MISCELLANEOUS	DX	CPT	FEE
AUDIOMETRY		92552	
EAR IRRIGATION		69210	
DIAPHRAGM FITTING		57170	
NEUBULIZER Tx		94650	
PSYCHOTHERAPY 1HR		90844	
SPECIAL REPORT		99080	
SPECIAL SUPPLIES		99070	
SPIROMETRY		94010	
TYMPANOMETRY		92567	

ICD-9 DIAGNOSIS

*	789.0	ABDOMINAL PAIN
	790.93	ABNORMAL PSA
	706.01	ACNE
	314.01	ADD
	702.0	ACTINIC KERATOSIS
	477.9	ALLERGIC RHINITIS
	300.00	ANXIETY
*	716.9	ARTHRITIS
*	414.0	ASHD
*	493	ASTHMA
*	427.3	ATRIAL FIBRILLATION
	611.72	BREAST LUMP
	611.71	BREAST PAIN
	466.0	BRONCHITIS / BRCHIOLITIS
	727.3	BURSITIS
	427.9	CARDIAC ARRYTHMIA
	682.9	CELLULITIS / ABSCESS
	786.50	CHEST PAIN
	786.52	CHEST WALL PAIN
	091.3	CONDYLOMA
	428.0	CONGESTIVE HEART FAIL
*	372.0	CONJUNCTIVITIS
	564.0	CONSTIPATION
	924.9	CONTUSION
	492.8	COPD / EMPHYSEMA
	311	DEPRESSION
	692.9	DERMATITIS
	562.11	DIVERTICULITIS
	562.10	DIVERTICULOSIS
*	250.0	DIABETES MELLITUS
	625.3	DYSMENORRHEA
	536.8	DYSPEPSIA
	380.4	EAR WAX
	381.81	EUSTACHIAN TUBE DYS
	780.7	FATIGUE
	729.1	FIBROMYALGIA
	V04.8	FLU VACCINE
	829.0	FRACTURE
*	535.0	GASTRITIS / DUODENITIS
	558.9	GASTROENTERITIS
	599.7	HEMATURIA
	307.81	HEADACHE-MUSCLE/CONT
	346.9	HEADACHE-MIGRAINE/VASC.
	286.5	HEMORRHAGIC DIS
	455.0	HEMORRHOIDS
	573.3	HEPATITIS
	053.9	HERPES-ZOSTER (SHINGLES)
	272.0	HYPERLIPIDEMIA
	401.9	HYPERTENSION ESSENT
	244.9	HYPOTHYROIDISM
	684	IMPETIGO/PYODERMIA
	487.1	INFLUENZA
	703.0	INGROWN NAIL
	564.1	IRRITABLE BOWL SYN
	879.8	LACERATION
	847.2	LUMBAR STRN/PAIN
	606.9	MALE INFERTILITY
	627.2	MENOPAUSAL SYMPTOMS
	626.4	MENSTRUAL IRREGULARITY
	075	MONONUCLEOSIS
	728.85	MUSCLE SPASM PAIN
	729.1	MYALGIA/MYOSITIS
	278.00	OBESITY
*	715.0	OSTEOARTHRITIS/DJD
*	380.1	OTITIS EXTERNA
	381.00	OTITIS MEDIA
	620.2	OVARIAN CYST
	281.0	PERNICIOUS ANEMIA
	462	PHARYNGITIS/TONSILLITIS
	V70.0	PHYSICAL EXAM
	728.71	PLANTAR FACILTIS
	481	PNEUMONIA
	725	POLYMYALGIA RHEUMATIC
	V22	PREGNANCY
	601.9	PROSTATITIS
	569.3	RECTAL BLEEDING
	461	SINUSITIS
	709.9	SKIN/SUBCUTANEOUS LESIO
	848.9	SPRAIN
	034.0	STREP/ACUTE
	729.1	TENDONITIS/MYOSITIS
	110.5	TINEA CORPORIS
	305.1	TOBACCO ABUSE
	099.40	URETHRITIS
	465.9	URI
	599.0	URINARY TRACT INF
	616.0	VAGINITIS/VULVITIS
	780.4	VERTIGO
	079.99	VIRAL SYNDROME
	078.10	WARTS
	V20.0	WELL CHILD
	V72.3	WELL WOMAN

NAUSEA
SEVERE HA/BODY PAIN

DATE/TIME	PATIENT/CHART#	DOB	PRIOR BALANCE	REASON FOR APPOINTMENT
08/10/01 11:00A	MCGRATH, VIRGINIA	07/02/1933 68	$ 0.00	REGULAR VISIT

SINUS HA
ELEVATED BP

(A) DR # 86 (A) DOCTOR NAME BRUCE BEASLEY, P.A. LOCATION 343 33 72 63

TODAY'S CHARGE

PHONE (H) 817-292-6130 (W)

PAY CHOICE ☐ CARD ☐ CASH ☐ CK# ____

(R) DR. # 41 (R) DOCTOR NAME BRUCE BEASLEY, P.A. LOCATION

PATIENT NO — RESPONSIBLE PARTY MCGRATH VIRGINIA

ADJUSTMENTS

TICKET NO 56539

NEXT APPT ________ DAYS ________ WEEKS ________ MONTHS

SEX F — ADDRESS 1920 HEIDELBERG DR

CITY FORT WORTH — STATE TX — ZIP 76134 — TYPE

TODAY'S PAYMENT

I hereby authorize my insurance benefits to be paid directly to the above signed physician, realizing I am responsible to pay noncovered services and I hereby authorize the release of pertinent medical information to insurance carriers.

INSURANCE COMPANY — POLICY I D — RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD / OTHER

MEDICARE ... PARTICIPATING — 37032... — BALANCE DUE

Patient Signature

5701 Bryant Irvin Rd #201
Fort Worth, Tx 76132
(817) 346-4000

SOUTHWEST MEDICAL ASSOCIATES, P.A.

5701 Bryant Irvin Rd. #201
Fort Worth, TX 76132
(817) 263-2500

TAX ID# 752811022

7-27-01 2:00 pm

PHYSICIAN SIGNATURE

NEW PATIENT	DX	CPT	FEE
LEVEL II		99202	
LEVEL III		99203	
LEVEL IV		99204	
LEVEL V		99205	
ESTABLISHED PATIENT	**DX**	**CPT**	**FEE**
LEVEL I		99211	
LEVEL II		99212	
LEVEL III		99213	70
LEVEL IV		99214	
LEVEL V		99215	

PHYSICALS	NEW	DX	EST	FEE
Under Age 1	99381		99391	
Age 1-4	99382		99392	
Age 5-11	99383		99393	
Age 12-17	99384		99394	
Age 18-39	99385		99395	
Age 40-64	99386		99396	
Age 65 & Over	99387		99397	

LABORATORY	DX	CPT	FEE
ARTHRITIS PROFILE		80072	
CBC		85022	
CHOLESTEROL		82465	
CULTURE: ANY OTH SOUR		87070	
CULTURE CHLAMYDIA		87110	
CULTURE GC		87072	
CULTURE HERPES		87250	
CULTURE URINE		87086	
DRUG SCREEN		82660	
EKG		93000	
GENE PROBE		87797	
GENERAL HEALTH SCRN		80050	
GLUCOSE		82947	
GLYCO HB		83036	
HDL LIPID PROFILE		83718	
HEMOCCULT SCREENING		82270	

LABORATORY(CONT'D)	DX	CPT	FEE
HEMOGLOBIN A,C		83036	
HEP b ANTIBODY		86803	
HEPATITIS PANEL		80059	
HIV TEST		86701	
HOLTER		93224	
LIPID PANEL		80061	
MONO TEST		86308	
NASAL SMEAR		89190	
PAP SMEAR (HMO 99000)		88150	
PATH COLLECTION		99000	
PREGNANCY SERUM		84702	
PREGNANCY URINE		81025	
PRO TIME		85610	
PSA		84153	
SED RATE		85651	
SGOT/ALT		84460	
STREP SCREEN		86403	
STOOL CULTURE		87045	
STOOL FOR O & P		87117	
THEOPHYLLINE LEVEL		80196	
THYROID PANEL W/TSH		80092	
URIC ACID		84550	
URINALYSIS		81000	
WET MOUNT/KOH		87210	
VENIPUNCTURE		36415	

IMMUNIZATION/INJECTIONS		CPT	FEE
ALLERGY SERUM		95150/55	
ALLERGY SHOT		95115	
B-12	J3420	90782	
BICILLIN, 2	J0530	90788	
CELESTONE		J0702	
CHICKEN POX		90716	
DECADRON LA		Z1141	
DECADRON Rg		J1100	
DEPO PROVERA		J1050	

IMMUN/INJEC (CONT'D)	DX	CPT	FEE
DEPOTESTOSTERONE 100MG		J1070	
DT		90702	
DPT		90701	
ESTRADIOL J0970		90782	
GAMMA GLOBULIN		90741	
HEPATITIS B 44 45 46		907	
HIB TITER		90737	
IMITREX		J3030	
INFLUENZA		90724	
KENALOG 40		J3301	
MEASLES VACCINE		90705	
MMR VACCINE		90707	
ORAL POLIO		90712	
PHENERGAN 50 MG		J2550	
PNEUMONIA		90732	
ROCEPHIN 250 x 1 J0696		90788	
ROCEPHIN 500 x 2 J0696		90788	
STADOL 4 mg J3490		90782	
TB TINE		86585	
TETANUS		90703	
TETRAMUNE		90720	
THERAPEUTIC MED NAME			
TORADOL J3450		90782	

SURGERY	DX	CPT	FEE
ANOSCOPY		46600	
CRYOSURGERY		17110	
ENDOMETRIAL BIOPSY		58100	
FLEXIBLE SIG		45330	
FOREIGN BODY REMOL			
HEMORRHOID EX		46320	
I/D ABSCESS		10060	
NAIL REMOVAL		11750	
VASECTOMY		55250	

X-RAYS	DX	CPT	FI
ABDOMEN 1 VIEW		74000	
ANKLE 3 VIEWS		73610	
CERVICAL SPINE 5 VIEW		72050	
CERVICAL SPINE 2 VIEW		72040	
CHEST 1 VIEW PA		71010	
CHEST 2 VIEWS		71020	
ELBOW 2 VIEWS		73070	
EXTRA VIEW		76499	
FINGER(S) 3 VIEWS		73140	
FOOT 3 VIEWS		73630	
HAND 3 VIEWS		73130	
HIP 2 VIEWS		73510	
KNEE 2 VIEWS		73560	
LUMBOSACRAL SPINE 5V		72110	
LUMBOSACRAL SPINE 2V		72100	
SHOULDER 2-3 VIEWS		73030	
SINUS IV (WATER'S)		70210	
SINUS SERIES 3-4 VIEWS		70220	
TOE(S) 3 VIEWS		73660	
WRIST 3-4 VIEWS		73110	

MISCELLANEOUS	DX	CPT	FE
AUDIOMETRY		92552	
EAR IRRIGATION		69210	
DIAPHRAGM FITTING		57170	
NEUBULIZER Tx		94640	
PSYCHOTHERAPY 1HR		90844	
SPECIAL REPORT		99080	
SPECIAL SUPPLIES		99070	
SPIROMETRY		94010	
TYMPANOMETRY		92567	

ICD-9 DIAGNOSIS

	* 789.0	ABDOMINAL PAIN		564 0	CONSTIPATION		053 9	HERPES-ZOSTER (SHINGLES)		728 71	PLANTAR FACILTIS
	790 99	ABNORMAL PSA		924 9	CONTUSION		272 0	HYPERLIPIDEMIA		481	PNEUMONIA
	706 01	ACNE		492 8	COPD / EMPHYSEMA		401 9	HYPERTENSION ESSENT		725	POLYMYALGIA RHEUMATIC
	314 01	ADD		311	DEPRESSION		244 9	HYPOTHYROIDISM		V22	PREGNANCY
	702 0	ACTINIC KERATOSIS		692 9	DERMATITIS		684	IMPETIGO/PYODERMIA		601 9	PROSTATITIS
	477.9	ALLERGIC RHINITIS		562 11	DIVERTICULITIS		487.1	INFLUENZA		569.3	RECTAL BLEEDING
	300 00	ANXIETY		562 10	DIVERTICULOSIS		703 0	INGROWN NAIL		461	SINUSITIS
	* 716.9	ARTHRITIS		* 250.0	DIABETES MELLITUS		564 1	IRRITABLE BOWL SYN		709 9	SKIN/SUBCUTANEOUS LESION
	* 414.0	ASHD		625 3	DYSMENORRHEA		878.8	LACERATION		848 9	SPRAIN
	* 493	ASTHMA		536 8	DYSPEPSIA		847 2	LUMBAR STRN/PAIN		034 0	STREP/ACUTE
	* 427.3	ATRIAL FIBRILLATION		380 4	EAR WAX		606 9	MALE INFERTILITY		729 1	TENDONITIS/MYOSITIS
	611 72	BREAST LUMP		381 81	EUSTACHIAN TUBE DYS		627 2	MENOPAUSAL SYMPTOMS		110 5	TINEA CORPORIS
	611 71	BREAST PAIN		780 7	FATIGUE		626 4	MENSTRUAL IRREGULARITY		305 1	TOBACCO ABUSE
	466 0	BRONCHITIS / BRCHIOLITIS		729.1	FIBROMYALGIA		075	MONONUCLEOSIS		099 40	URETHRITIS
	727 3	BURSITIS		V04 8	FLU VACCINE		728.85	MUSCLE SPASM PAIN		465 9	URI
	427 9	CARDIAC ARRYTHMIA		820.0	FRACTURE		729 1	MYALGIA/MYOSIT'S		599 0	URINARY TRACT INF
	682.9	CELLULITIS / ABSCESS		* 535.0	GASTRITIS / DUODENITIS		278 00	OBESITY		616 0	VAGINITIS/VULVITIS
	786 50	CHEST PAIN		558.9	GASTROENTERITIS		* 715.0	OSTEOARTHRITIS/DJD		780.4	VERTIGO
	786 52	CHEST WALL PAIN		599 7	HEMATURIA		* 386.1	OTITIS EXTERNA		079 99	VIRAL SYNDROME
	091 3	CONDYLOMA		307 81	HEADACHE-MUSCLE/CONT		381 00	OTITIS MEDIA		078.10	WARTS
	428 0	CONGESTIVE HEART FAIL		346.9	HEADACHE-MIGRAINE/VASC		620 2	OVARIAN CYST		V20.0	WELL CHILD
	* 372.0	CONJUNCTIVITIS		286 5	HEMORRHAGIC DIS		281 0	PERNICIOUS ANEMIA		V72 3	WELL WOMAN
				455 0	HEMORRHOIDS		462	PHARYNGIT.S/TONSILLITIS			
				573 3	HEPATITIS		V70 0	PHYSICAL EXAM			

DATE/TIME	PATIENT/CHART#	DOB	PRIOR BALANCE	REASON FOR APPOINTMENT
R07/27/01 02:00P	MCGRATH, VIRGINIA	02/02/1933 70	$ 0.00	REGULAR VISIT

(A) DR #	(A) DOCTOR NAME	LOCATION	TODAY'S CHARGE
41	JAMES R. BOHNSACK, M.D.	332-22-4263	

(R) DR #	(R) DOCTOR NAME	LOCATION	ADJUSTMENTS
-1	JAMES R BOHNSACK, M.D.		

PATIENT NO	RESPONSIBLE PARTY	PHONE	PAY CHOICE
	MCGRATH VIRGINIA	(H) 817-293-0130 (W)	☐ CARD ☐ CASH ☐ CK#

ADDRESS	CITY	STATE	ZIP	TYPE	TODAY'S PAYMENT	NEXT ____ DAYS APPT ____ WEEKS ____ MONTHS	TICKET NO
1000 HELEN BERG DR	FORT WORTH	TX	76134		0		SE282

INSURANCE COMPANY	POLICY I.D	RELATIONSHIP TO INSURED	BALANCE DUE
MEDICARE PART B PARTICIPATING	373324263A	SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	

I hereby authorize my insurance benefits to be paid directly to the above signed physician, realizing I am responsible to pay noncovered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Patient Signature

STATEMENT

Radiology Associates of Tarrant County
P O. Box 2927
Ft. Worth TX 76113

Address Service Requested

CHECK CREDIT CARD USING FOR PAYMENT AND FILL OUT BELOW

☐ ☐ VISA ☐ ☐

CARD NUMBER	AMOUNT
NAME ON CARD (PLEASE PRINT)	EXP DATE
SIGNATURE	

STATEMENT DATE	ACCOUNT #	PAY THIS AMOUNT
11/16/2001	10316580	$9.17

Office Hours: 8:00 a.m. - 5:00 p.m. Mon - Fri
Phone: 817/321-0320 IRS# 75-1286819

Patient: MCGRATH VIRGINIA L

AMOUNT PAID

*26 *********3-DIGIT 761

VIRGINIA L MCGRATH 10316580
1800 HEIDELBERG DR
FORT WORTH TX 76134-3331

MAKE CHECK PAYABLE & REMIT TO

Radiology Associates of Tarrant County
P O Box 99337
Ft. Worth TX 76199

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

TARRANT4-0046525-0004921-0143513-001-000983-#005257

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

DATE	DESCRIPTION OF SERVICES	CODE	DXCODE	AMOUNT
08/18/01	CAT HEAD W/O CONTRAST	70450	784.0	$194.00
09/30/01	PMT-MEDICARE 09202001	700		$36.67–
09/30/01	CR-MEDICARE ADJUSTMENT	780		$148.16–

GIVE US YOUR BILLING INFORMATION AT WWW.RATC.COM

158.83

BALANCE DUE: $9.17

Patient: MCGRATH VIRGINIA L	Account Number: 10316580	Statement Date: 11/16/2001
Location of Service	Referring Physician	Performing Physician
HARRIS SW HOSPITAL	FRED W ROHM	JOHN EVANS MD

OUR OFFICE HAS FILED OR REFILED A CLAIM WITH YOUR INSURANCE CARRIER. IF PAYMENT IS NOT RECEIVED WITHIN 30 DAYS WE WILL LOOK TO YOU FOR PAYMENT. THANK YOU.

Radiology Associates of Tarrant County
P.O. Box 99337
Ft. Worth TX 76199

Phone: 817/321-0320 IRS# 75-1286819

TARRANT4-0046525-0004921-0143513-001-000983-#005257

STATEMENT

Radiology Associates of Tarrant County
P O Box 2927
Ft. Worth TX 76113

Address Service Requested

CHECK CREDIT CARD USING FOR PAYMENT AND FILL OUT BELOW

☐ ☐ VISA ☐ ☐

CARD NUMBER	AMOUNT
NAME ON CARD (PLEASE PRINT)	EXP DATE
SIGNATURE	

STATEMENT DATE	ACCOUNT #	PAY THIS AMOUNT
11/26/2001	10330393	$10.52

2

Office Hours: 8:00 a.m. - 5:00 p.m. Mon - Fri
Phone: 817/321-0320 IRS# 75-1286819

Patient: MCGRATH VIRGINIA L

AMOUNT PAID

*28 *********3-DIGIT 761

VIRGINIA L MCGRATH 10330393
1800 HEIDELBERG DR
FORT WORTH TX 76134-3331

MAKE CHECK PAYABLE & REMIT TO:

Radiology Associates of Tarrant County
P.O. Box 99337
Ft. Worth TX 76199

TARRANT4-0046700-0005914-0144689-001-002835-#006782

☐ 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	CODE	DXCODE	AMOUNT
08/29/01	CAT LIMITED/FOLLOW UP	76380	473.0	$125.00
10/19/01	PMT-MEDICARE 10092001	700		$42.10–
10/19/01	CR-MEDICARE ADJUSTMENT	780		$72.38–

925.a

GIVE US YOUR BILLING INFORMATION AT WWW.RATC.COM

BALANCE DUE: $10.52

Patient: MCGRATH VIRGINIA L	Account Number: 10330393	Statement Date: 11/26/2001
Location of Service	Referring Physician	Performing Physician
HARRIS SW HOSPITAL	GEORGE JR KOSTOHRYZ	DAVID J ROBINSON M

THIS ACCOUNT IS PAST DUE! PLEASE REMIT PAYMENT IN FULL OR CALL OUR OFFICE IF PAYMENT ARRANGEMENTS ARE NECESSARY. THANK YOU

Radiology Associates of Tarrant County
P.O. Box 99337
Ft. Worth TX 76199

Phone: 817/321-0320 IRS# 75-1286819

TARRANT4-0046700-0005914-0144689-001-002835-#006782

UNIVERSAL CONSENT FOR TREATMENT

MRL 1-3-26-01

I understand that my health condition requires inpatient or outpatient admission. I consent to and authorize testing, treatment and/or hospital care as ordered by my doctor and his/her consultants, associates and assistants. I authorize Hospital nurses, employees and others as necessary to carry out the instructions of my doctor(s) with respect to the procedures and treatment they have ordered. I understand that it may be necessary for representatives of outside health care companies to assist in my care. I also understand student nurses and others in professional training programs may be among the individuals who provide care to me. If I am to receive obstetrical care, this consent is given for any child(ren) born to me during this hospitalization. I understand that in connection with my treatment, photos or videos may be taken. Any tissue or body parts removed from my body may be retained or disposed of by the Hospital at its sole discretion.

I also understand and acknowledge that Texas Law provides that if any health care worker is exposed to my blood or other bodily fluid, the Hospital may perform tests, with or without my consent, on my blood or other bodily fluid to determine the presence of Hepatitis B, Hepatitis C or Human Immunodeficiency Virus (the causative agent of AIDS). I understand that this testing is necessary to protect those caring for me while I am a patient of the Hospital. I understand that the results of tests taken under these circumstances are confidential and do not become part of my medical record.

I acknowledge and agree that the doctors participating in my care in the Hospital do not work for the Hospital. They are not employees, servants or agents of the Hospital. They are either engaged in the private practice of medicine or are licensed practitioners participating in the care of patients as part of a post-graduate medical education program. In addition to my attending doctor, other doctors who may participate in my care may include radiologists, pathologists, anesthesiologists, neonatologists, cardiologists, emergency physicians and other specialists. I acknowledge and agree that the Hospital is not responsible for the judgment or conduct of any doctor who treats or provides a professional service to me, but rather is an independent contractor who is engaged in private practice and is not an agent, servant or employee of the Hospital.

NO GUARANTEE: I acknowledge that no guarantees or warranties have been made to me with respect to treatment to be provided at this Hospital. I understand that all supplies, medical devices and other goods sold or furnished to me by the Hospital are sold or furnished on an "AS IS" basis, and Texas Health Resources disclaims any expressed or implied warranties with respect to them.

If the person signing this form is not the patient, please give full name, phone number and address.

_____

_____

I HAVE READ AND UNDERSTAND THIS INFORMATION

Signature of Patient or Legally Authorized Representative	Relationship to Patient	Reason Patient Unable to Sign
Witness	Title	Date of Signature

HOSPITAL BOX MUST BE CHECKED

Texas Health Resources

UNIVERSAL CONSENT FOR TREATMENT

FORM NO (998541055 8/00)

☐ AMH ☐ HMHEB ☐ MRMC ☐ PHW ☐ PHA
☐ HCCH ☐ HMNW ☐ PHD ☐ SPMC
☐ HMEC ☐ HMSPG ☐ PHK ☐ WRH
☐ HMFW ☐ HMSW ☐ PHP ☐ Other _____

PATIENT IDENTIFICATION

9080
THR 60 (Rev 8/00)

ADMISSION ACKNOWLEDGMENTS

RELEASE OF INFORMATION: I consent and authorize the Hospital to release all information contained in my financial and medical records, including diagnoses and test results, to (a) any of my treating practitioners, (b) my insurance company or health plan, (c) any other person or entity that is responsible for paying or processing for payment of any portion of my Hospital bill, (d) governmental or accrediting agencies, (e) any other health care provider to which I am transferred for care, (f) to entities utilizing this information for quality management, peer review and/or outcome analysis such as tumor registry follow-up, or (g) any other person or entity as required or allowed by state and federal law. This consent applies to all records created in the course of and relating to this hospitalization, including those related to alcohol and/or substance abuse diagnosis or treatment, mental health treatment, and/or any communicable disease, including HIV/AIDS. To provide the practitioners who will treat me during this hospitalization with access to my prior medical history, I also consent and authorize any health care provider to release to any of the practitioners who treat me during this hospitalization all information contained in my medical records from prior treatment that is relevant to my current care and treatment. If I am the patient or the patient's legal guardian, I also consent to release of billing and medical records to my primary care physician and his/her medical group. I authorize the Hospital to release my home address, telephone number and social security number to the manufacturers of the medical devices I receive, in accordance with the medical device tracking provisions of the federal Safe Medical Devices Act.

This release shall remain valid until I notify the Hospital, in writing, of my desire to revoke it. I understand there are times when the law allows the Hospital to release information regardless of whether or not I give my consent. For example, the Hospital may release information to doctors, nurses, [illegible] or to a court of law that requires subpoenaed records. I understand that this information may be released either orally or in document form whether or not I withdraw my consent.

ADVANCE DIRECTIVES:

a. To be completed for Hospital outpatients and emergency room patients only:

Are you (the patient) presenting an Out-of-Hospital DNR order or bracelet?	☐ Yes	☐ No	Copy provided?	☐ Yes	☐ No

b. To be completed for Hospital inpatients and outpatients undergoing invasive procedures only:

1 Who is answering the following questions?	Patient?	☐ Yes	☐ No*	Person with Patient?	☐ Yes*	☐ No
2 Was printed information about Advance Directives offered to you?		☐ Yes	☐ No	Information received?	☐ Yes	☐ No
3 Do you (the patient) have a Directive to Physicians (Living Will)?		☐ Yes	☐ No	Copy provided?	☐ Yes	☐ No
4 Do you (the patient) have a Medical Power of Attorney?		☐ Yes	☐ No	Copy provided?	☐ Yes	☐ No
5 Do you (the patient) have a Mental Health Directive?		☐ Yes	☐ No	Copy provided?	☐ Yes	☐ No
6 Are you (the patient) presenting an Out-of-Hospital DNR order or bracelet?		☐ Yes	☐ No	Copy provided?	☐ Yes	☐ No
7 Would you like to discuss Advance Directives with a Hospital staff member?		☐ Yes*	☐ No	Referral to _____		

I understand it is my responsibility to provide a copy of my Advance Directives to the Hospital.
(*Hospital Staff Note: Shaded area indicates that Advance Directive follow-up documentation is required.)

PATIENT RIGHTS AND RESPONSIBILITIES: I have received written information regarding my rights and responsibilities as a patient. This information tells me how to register a complaint I might have.

MY VALUABLES: I understand that the Hospital does not assume responsibility for personal property I may keep with me during my treatment/hospitalization. I understand that unnecessary items should be sent home, and that a safe is available for my valuables.

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS: I hereby assign to the Hospital, and any practitioner providing care and treatment to me, any and all benefits and all interest and rights (including causes of action and the right to enforce payment) for services rendered under any insurance policies or any reimbursement or prepaid health care plan. If my treatment was caused by events which result in legal action, I assign to the Hospital an interest in any claims I may have. I hereby promise to pay for all services rendered to me to the extent I am legally responsible for such payment. I understand I am responsible for all health insurance copayments and deductibles. Charity care may be available if Hospital eligibility criteria are met.

If I am a MEDICAID PATIENT, I understand that the services or items that I request to be provided to me may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the Texas Department of Human Services or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care. If I am a Medicaid Star patient, these provisions may not apply.

FOR MEDICARE/TRICARE PATIENTS ONLY: I acknowledge receipt of the written material entitled, "Important Message from Medicare/Tricare," which is located on the back of this form.

If the person signing this form is not the patient, please give full name, phone number and address.

I HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND ON THE BACK OF THIS FORM.

Signature of Patient or Legally Authorized Representative	Relationship to Patient	Reason Patient Unable to Sign
Witness	Title	Date of Signature

HOSPITAL BOX MUST BE CHECKED

PATIENT IDENTIFICATION

Texas Health Resources

ADMISSION ACKNOWLEDGMENTS

FORM NO. HM-998540682 (Rev. 7/00) PAGE 1 OF 2

☐ AMH ☐ HMHEB ☐ MRMC ☐ PHW ☐ PHA
☐ HCCH ☐ HMNW ☐ PHD ☐ SPMC
☐ HMEC ☐ HMSPG ☐ PHK ☐ WRH
☐ HMFW ☐ HMSW ☐ PHP ☐ Other _____

9051
THR 61 (Rev. 7/00)

PATIENT COPY

OUTPATIENT RADIOLOGY IMAGING SERVICES

C-091

MRI

Patient Name VIRGINIA MCGRATH 817-293-6130

Age: 68 DOB: 2/2/33 SSN: 372-32-4263 MEDICARE PART B

Date of Exam: MON 3/26 Time: 8:30 Pre-Cert # INSURANCE 372324263A

PRIORITY ☐ Fax handwritten preliminary report at time of exam. Fax# _____ ☐ Routine report via mail

☒ Fax transcribed results, prior to mailing. Fax# 817-346-4006

ALL PATIENTS MUST GO DIRECTLY TO ADMISSION IN THE ATRIUM TO CHECK IN.
ADMISSIONS IS OPEN FROM 7AM-5PM M-F, OTHER TIMES GO TO THE ER ADMISSIONS AREA.
YOU MUST CHECK IN AT ADMISSIONS EACH TIME YOU HAVE AN X-RAY!!!!

CHEST	UPPER EXTREMITY	Lt	Rt	GASTRO-INTESTINAL	SONOGRAM
	Shoulder	☐	☐	Ba Swallow	Gallbladder
Chest (1 view)	A/C Joint	☐	☐	Barium Enema/Double	Abdomen
Chest (2 view)	Scapula	☐	☐	Barium Enema/Single	Pelvis
Ribs (1 side) Lt. Rt	Clavicle	☐	☐	Dysphagia/with Speech	Renal
Ribs Bilateral	Humerus	☐	☐	Oral Gallbladder	Thyroid
ABDOMEN	Elbow	☐	☐	Sm. Bowel	OB
	Forearm	☐	☐	Upper GI	Testicular
KUB	Wrist	☐	☐		Aorta
Abdomen (2 view)	Hand	☐	☐	**C.T.**	Carotid Doppler
Cystogram (Post Surgery)	Finger (s)	☐	☐	Contrast (Y/N)	Venous Doppler
Cystogram - Voiding				Abdomen	Arterial Doppler
IVP	**LOWER EXTREMITY**	Lt.	Rt	Chest	Other
				Head	
	Femur, 1 view	☐	☐	Neck (Soft Tissue)	
PELVIS	Femur, 2 views	☐	☐	Pelvis	
	Knee, 2 views	☐	☐	Sinus (complete)	
Pelvis, 1 view	Lower Leg, 2 views	☐	☐	Sinus (limited)	**NUCLEAR MEDICINE**
Pelvis, 2 views	Ankle	☐	☐	Spine (C-Spine)	
Pelvis - with lateral hip	Foot	☐	☐	Spine (Lumbar Spine)	Bone Scan (complete)
Hip Joint, 2 views	Toe (s)	☐	☐	Other	Bone Scan (limited)
					Thyroid
	SPINE				HIDA
HEAD				**MRI**	HIDA/CCK
	Cervical Spine, 2 views			Contrast (Y/N)	Muga (Heart)
Skull 2V	Cervical Spine, Complete			Head	Lung
Skull Series	Dorsal Spine, 3 views			C-Spine	Renal
Sinus Series	Lumbar Spine, 2 views			Dorsal Spine	Liver
Sinus "Waters"	Lumbar Spine, Complete (5 views)			Lumbar Spine	Myocardial Infarction
Nose	Sacrum			Upper Extremity	IN III (WBC Scan)
Orbits	Coccyx			Lower Extremity	
Mandible	Sacro-ILLIAC			MRA	DXA Bone Density
				Abdomen	
Other				Other	

Diagnosis: S/P CLOSED HEAD INJURY; LIGHT _____ ICD9 Code Physician's Signature: Dr James Bohannon

PATIENT IDENTIFICATION

41317

Harris Methodist Southwest

OUTPATIENT RADIOLOGY IMAGING SERVICES

IF PAYING BY MASTERCARD DISCOVER VISA OR AMERICAN EXPRESS, FILL OUT BELOW

CHECK CARD USING FOR PAYMENT

[ ] MASTERCARD [ ] DISCOVER [ ] VISA [ ] AMERICAN EXPRESS

CARD NUMBER AMOUNT

SIGNATURE EXP DATE

HARRIS METHODIST SOUTHWEST
ATTENTION BUSINESS OFFICE
6000 WESTERN PLACE SUITE 540
FORT WORTH, TX 76107-4660

8089

FORWARDING SERVICE REQUESTED

STATEMENT DATE	PAY THIS AMOUNT	ACCT #
03-12-01	405.17	372324263 004

PAYMENT DUE DATE 03/27/01

SHOW AMOUNT PAID HERE $

ADDRESSEE

VIRGINIA LOUISE GILLEY MCGRATH
1800 HEIDELBERG DR
FORT WORTH, TX 76134-3331

REMIT TO:

HARRIS METHODIST SOUTHWEST
P O BOX 916047
FT WORTH, TX 76191-6047

PAGE: 1

ITEMIZED STATEMENT

[ ] Please check box if address is incorrect or insurance information has changed and indicate change(s) on reverse side

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

PATIENT NAME	PATIENT ACCOUNT NO.	ADMISSION DATE	DISCHARGE DATE	PAGE
MCGRATH VIRGINIA LOUISE G	372324263 004	02-23-01	02-23-01	1
SERVICE PROVIDED	**HARRIS METHODIST SOUTHWEST**			

	DESCRIPTION OF TRANSACTION			AMOUNT
	PHARMACY			
02-23-01	BETADINE SOLUTION 120ML	CHG0223	001	10.45
	SUB TOTAL			10.45
	STERILE SUPPLY			
02-23-01	DERMABOND TOPICAL DB12	PH05461	001	94.00
02-23-01	DRSNG GZE 4X4 16 PLY 10/PK	CEN0223	001	2.00
	SUB TOTAL			96.00
	EMERGENCY ROOM			
02-23-01	EMERGENCY ROOM LEVEL-2	CHG0223	001	123.00
02-23-01	12011 LAC-SMP-EENT/MM (<1")	CHG0228	001	153.17
	SUB TOTAL			276.17
	DRUG/CHEMO THERAPY			
02-23-01	TETANUS DIPH TOX. ADULT 0.5ML	PH05493	001	22.55
	SUB TOTAL			22.55
	TOTAL CHARGES			405.17
	PHARMACY			10.45
	STERILE SUPPLY			96.00
	EMERGENCY ROOM			276.17
	DRUG/CHEMO THERAPY			22.55
	TOTAL CHARGES			405.17
	ESTIMATED INSURANCE PAYMENT			0.00
	ESTIMATED PATIENT PAYMENT			405.17
	INSURANCE : PAYMENT(S)			0.00
	: ADJUSTMENT(S)			0.00
	PATIENT : PAYMENT(S)			0.00
	: ADJUSTMENT(S)			0.00
	ACCOUNT BALANCE:			405.17

DIRECT ANY INQUIRIES TO CUSTOMER SERVICE
(817) 570-8500 OR (800) 215-2160
YOU CAN ALSO EMAIL US AT
THSBUSINESSOFFICEQUESTIONS@TEXASHEALTH.ORG

TEXAS HEALTH RESOURCES
Presbyterian Healthcare System ★ Harris Methodist Hospitals
Arlington Memorial Hospital

8089*0C60P6BOV000110

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW

HARRIS METHODIST SOUTHWEST
ATTENTION BUSINESS OFFICE
6000 WESTERN PLACE SUITE 540
FORT WORTH, TX 76107-4660

8089

FORWARDING SERVICE REQUESTED

STATEMENT DATE	PAY THIS AMOUNT	ACCT #
10/30/01	1,191.75	372324263 005

PAYMENT DUE DATE 11/14/01

SHOW AMOUNT PAID HERE $

ADDRESSEE

MCGRATH,VIRGINIA,LOUISE
1800 HEIDELBERG DR
FORT WORTH, TX 76134-3331

REMIT TO

HARRIS METHODIST SOUTHWEST
P O BOX 916047
FT WORTH, TX 76191-6047

☐ Please check box if address is incorrect or insurance information has changed and indicate change(s) on reverse side

PAGE: 1
STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

PATIENT NAME	PATIENT ACCOUNT NO.	ADMISSION DATE	DISCHARGE DATE	PAGE
MCGRATH,VIRGINIA,LOUISE	372324263 005	03/26/01	03/26/01	1
SERVICES PROVIDED	**HARRIS METHODIST SOUTHWEST**			

This letter is to inform you that your insurance. carrier has failed to pay their contracted amount.

We have been unsuccessful in all of our attempts to secure the correct amount due from your carrier.

At this time we have no alternative but to bill you, the member, for the balance of the account. Any discrepancy, at this time, is between you and your carrier.

Please remit payment for the above amount.

DIRECT ANY INQUIRIES TO CUSTOMER SERVICE
(817) 570-8500 OR (800) 215-2160
YOU CAN ALSO EMAIL US AT
THSBUSINESSOFFICEQUESTIONS@TEXASHEALTH.ORG

TEXAS HEALTH RESOURCES
Presbyterian Healthcare System ★ Harris Methodist Hospitals
Arlington Memorial Hospital

8089*0IM02VSWJ000476

2-23-01

FACIAL & SCALP CONTUSIONS:

Your exam shows you have a contusion (deep bruise) around the face or scalp. Injuries around the face and head cause a lot of swelling, especially around the eyes. This is because the blood supply to this area is so good. Usually the swelling from a contusion will be better in 2-3 days, but it takes 7-10 days for a "black eye" to clear up.

You should apply ice packs to the injured area for about 20-30 minutes every 2-3 hours until the swelling improves. Use mild pain medicine as needed. Please call or return here right away if you have:

* Severe pain or headache, unrelieved by mild pain medicine.
* Unusual sleepiness, confusion, personality changes, vomiting.
* Persistent nosebleed, double or blurred vision, or drainage from the nose or ear.

You may have a mild headache, slight dizziness, nausea, and weakness for a few days. This usually clears up with bed rest and mild pain medicine. Contact your doctor if you are concerned about facial deformity or have any difficulty with your bite, pain with chewing, or double vision.

HEAD INJURY:

You have suffered a minor head injury. You do not need to stay in the hospital any longer, but you should have someone with you to check your condition every few hours for the next 24 hours. You may go to sleep, but someone should wake you up several times during the night to make sure you know who and where you are, and that you are able to talk and move around normally. You should see your doctor or go to the emergency room at once if any of the following symptoms develop over the next few days:

* Severe headaches not helped by pain medicine.
* Vomiting more than 2-3 times.
* Mental confusion, restlessness, or personality changes.
* Increasing weakness, sleepiness, blackouts, or seizures.
* Loss of balance or trouble with movement or coordination.
* A clear or bloody drainage from the nose or ear.

You should get plenty of rest over the next 2-3 days. Avoid using aspirin or alcohol; take acetaminophen (Tylenol) as needed for headache or other pain.

Head injuries may cause a moderate headache, weakness, dizziness, nausea, and depression for up to a week or more after the injury. This post-injury state usually gets better with bed rest and mild pain medicine. If any of these symptoms last for more than a week, you will need further medical attention. Please call the emergency room or your doctor if you have any questions or concerns about your head injury.

COLD THERAPY:

Your doctor advises cold therapy for your injury. This is the best initial treatment for sprains, muscle strains, and bruises (contusions). Cold therapy helps reduce pain, swelling, bleeding into the tissues, and muscle spasm from injuries. Pain relief from cold applications is due to a "counter-irritant" effect; at first the pain increases with the cold pack, then it becomes numb.

The best way to apply cold treatments is with a plastic bag full of crushed ice, or a frozen gel pack. (Chemical cold packs are not recommended because they keep their cool for just a few minutes). Place the cold pack over the injury for 30 minutes; repeat the treatment every 2-3 hours for 2-3 days. Use a dry towel or washcloth between the cold pack and your skin to avoid injury to the skin. An elastic bandage can be applied over the ice pack to create compression; this is very effective in cooling injured tissues.

2-2[illegible]-01 [illegible]

HARRIS METHODIST SOUTHWEST

6100 HARRIS PARKWAY -- FT. WORTH, TEXAS 76132 -- PHONE: 817-346-5055

DISCHARGE INSTRUCTIONS FOR << MCGRATH,VIRGINA >>

Our doctors and staff appreciate your choosing us for your emergency medical care needs. Read these aftercare instructions carefully. Please call us if you have any questions about your medical problem. We are here to serve you.

DERMABOND TOPICAL SKIN ADHESIVE

DERMABOND is a sterile, liquid topical skin adhesive. The film will usually remain in place for 5 to 10 days, then, naturally sloughs (falls) off your skin.

CHECK WOUND APPEARANCE

Some swelling, redness and pain is common with all wounds and normally will go away as the wound heals. If swelling, redness or pain increase or if the wound feels warm to touch, contact a doctor. If the edges reopen or separate, contact a doctor. A wound treated with DERMABOND should be monitored for signs of infection such as: erythema (redness around a wound); edema (swelling); warmth; pain; and pus. If any of these signs appear, then the wound should be evaluated and treated by a physician.

BANDAGING

- If bandaged, keep the bandage dry.
- Do not apply liquid or ointment medications or other substances to the wound after closure with DERMABOND adhesive, as these substances can weaken the film closure.
- Replace the dressing daily until the adhesive film has fallen off or if it should become wet unless otherwise instructed by your physician.
- Do not scratch, rub, or pick at the DERMABOND adhesive film. This may loosen the film before your wound is healed.
- Do not place tape directly over the DERMABOND adhesive film because removing the tape may also remove the film.
- Protect the wound from prolonged exposure to sunlight or tanning lamps while the film is in place.

TOPICAL MEDICATIONS

- Protect your wound from repeat injury until the skin has had sufficient time to heal.
- You may occasionally and briefly wet your wound in the shower or bath. Do not soak or scrub your wound, swim, and avoid periods of heavy perspiration until the DERMABOND adhesive has naturally fallen off. After showering or bathing, gently blot your wound dry with a soft towel. If a protective dressing is being used, apply a fresh, dry bandage, keeping tape off the DERMABOND adhesive film.
- Apply a clean, dry bandage over the wound if necessary to protect the wound.

PRECAUTIONS

- NO SWIMMING while DERMABOND is in place. Do not swim or get wet until after DERMABOND sloughs off naturally.
- Do not rub with a rough towel or other material.

If you have any questions or concerns about this product, please consult your doctor.

See Back side

[illegible] on floor hard, my glasses [illegible] [illegible] [illegible] [illegible] ask for something [illegible]

FACIAL & SCALP CONTUSIONS:
Your exam shows you have a contusion (deep bruise) around the face or scalp. Injuries around the face and head cause a lot of swelling, especially around the eyes. This is because the blood supply to this area is so good. Usually the swelling from a contusion will [illegible] better in [illegible] days, but it takes [illegible] days for a "black eye" to [illegible].

You should apply ice packs to the injured area for about 20-30 minutes every [illegible] hours until the swelling improves. [illegible] mild pain medicine [illegible].
Please [illegible] return here [illegible] if you have:

- * Severe pain or headache, [illegible] relieved by mild pain medicine.
- * Unusual sleepiness, confusion, [illegible] changes [illegible] vomiting.
- * [illegible] nosebleed, [illegible], or drainage from the nose or ear.

You may have a mild headache, [illegible] dizziness, nausea, and weakness for a few [illegible]. This usually clears [illegible] with bed rest and mild pain medicine. Contact your doctor if you are concerned about facial deformity, [illegible], difficulty with [illegible], pain with chewing, or double vision.

HEAD INJURY
You have suffered a minor head injury. [illegible] not need to stay in the hospital any longer, but [illegible] should have someone with you to check your condition every few hours for the next [illegible] hours. [illegible] you may go to sleep, but someone should wake you up [illegible] times during the night to make sure you know who and where you are, and that you are able to [illegible] and [illegible] normally. You should see your doctor or go to the emergency [illegible] at once if any of the following symptoms develop over the next few days:

- * Severe headaches not helped by pain medicine.
- * Vomiting more than [illegible] times.
- * Mental confusion, [illegible], or personality changes.
- * Increasing weakness, [illegible], or seizures.
- * Loss of balance or [illegible] with movement or coordination.
- * A clear or bloody drainage from the nose or ear.

You should get plenty of rest over the next [illegible] days. Avoid using aspirin or [illegible]; take acetaminophen (Tylenol) as needed for headache or other pain.

Head injuries may cause a moderate headache, weakness, dizziness, nausea, and depression for up to a week or more after the injury. This post injury state usually gets better with bed rest and mild pain medicine. If any of these symptoms last for more than a week, you will need further medical attention. Please call the emergency room or your doctor if you have any questions or concerns about your head injury.

COLD THERAPY
Your doctor advises cold therapy for your injury. This is the best initial treatment for sprains, muscle strains, and bruises (contusions). Cold therapy helps reduce pain, swelling, bleeding into the tissues, and muscle spasm from [illegible]. [illegible] relief from cold application is due to a "counter irritant" effect; at first the pain increases with the cold pack, then it becomes numb.

The best way to apply cold treatments is with a plastic bag full of crushed ice, or a frozen gel pack. [illegible] cold packs are not recommended because they keep them cool for only a few minutes. Place the cold pack over the injury [illegible] 20 minutes, repeat the treatment every [illegible] hours for 2-3 days. Use a towel or washcloth between the cold pack and your skin to avoid injury to the skin. An elastic bandage can be applied over the ice pack to [illegible] compression, this [illegible] to [illegible] in cooling injured tissues.

<< MCGRATH,VIRGINA >> HARRIS METHODIST SOUTHWEST Page

FOLLOW-UP CARE:
Your physician today has been DR. FRED ROHM,D.O.
For follow-up care you have been referred to the following doctor or clinic:
JAMES R. BOHNSACK Phone: 817-346-4000
5701 BRYANT IRVIN DR. #201
Please make an appointment for further treatment in _____ days. Be sure to tell your referral doctor or clinic that we have sent you, and bring your medicines and instructions to the office. If you had x-rays, an EKG, or lab tests today, they have been reviewed by your doctor. We will contact you at once if other important findings are noted after further review by our staff. If you do not continue to improve or if your condition worsens, please call your doctor or the emergency department right away so you can be examined

I acknowledge receipt of these instructions. I understand that my condition may require more care and will arrange for further treatment as recommended.

Staff Signature Patient or Representative Signature
Friday, February 23, 2001 - 07:36 PM

MEDSTAR

Area Metropolitan Ambulance Authority
551 E Berry Street
Fort Worth Texas 76110
Tel (817) 923 3700 Fax (817) 921-3540

STATEMENT DATE	ACCOUNT BALANCE	ACCT #
03/05/01	730.00	570362

MCGRATH VIRGINIA L
02/23/01
M10223150

Page 1

SHOW AMOUNT PAID HERE $

ADDRESSEE:

MCGRATH VIRGINIA L
1800 Heidelberg Dr
Fort Worth, TX 76134-3331

MAKE CHECKS PAYABLE AND REMIT TO:

MEDSTAR
Drawer #99059
Fort Worth, Texas 76199-0059

STATEMENT

DATE	SERVICE	DESCRIPTION	QTY	CHARGE	PAY / ADJ	AMOUNT
02/23	A0427	ALS1 EMERGENCY BASERATE				695.00
02/23	A0390	MILEAGE $5.00 PER MILE				35.00

CURRENT	31-60	61-90	91-120	121 & OVER	BALANCE
					730.00

IF WE WILL FILE A CLAIM WITH YOUR INSURANCE COMPANY PLEASE VERIFY THE INFORMATION BELOW WHICH PERTAINS TO YOUR INSURANCE COVERAGE. EVEN IF YOU HAVE PROVIDED INSURANCE INFORMATION TO THE HOSPITAL OR DOCTOR YOU MUST ALSO PROVIDE THIS INFORMATION TO MEDSTAR. BE ADVISED THAT ALTHOUGH WE ARE FILING YOUR INSURANCE, YOU ARE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. YOU ALSO ARE REQUIRED TO PROVIDE ADDITIONAL INFORMATION TO YOUR INSURANCE COMPANY.

****IF ANY OF THE FOLLOWING INFORMATION IS INCORRECT OR HAS CHANGED, PLEASE INDICATE THE CHANGE(S) ON THE REVERSE SIDE AND FORWARD TO MEDSTAR AT THE ADDRESS ABOVE.****

X _____ DATE _____
PATIENT OR AUTHORIZED SIGNATURE

TEXAS IMAGING & DIAGNOSTIC CENTER
3840 W. NW HWY #400
DALLAS, TEXAS 75220
214-357-5229
FAX#214-357-5488

PROMISSORY NOTE

I, Virginia Mcgraith hereby agree to pay $995.00 for services that I received on 5-21-01 at Texas Imaging & Diagnostic Center. This amount will be paid at SEE BELOW per month by the tenth of every month till the balance is paid off. I agree to reimburse Texas Imaging & Diagnostic Center for any collection fees, if my account is referred to an outside collection agency for lack of payment.

Date 5-21-01 Patient Signature Virginia L McGrath

Patient has been informed we will set up a payment arrangement she will bring $200.00 dollars on the day of visit and we will bill 4 monthly installments of $198.75. This is a payment agreement and the patient understands this.

INITIALS VLM

995.00

FORM NO 854

RECEIPT Date May 21, 2001 No. 475047

Received From Virginia McGrath

Address 1800 Nolaeiberg Dr

Fort Worth, TX 76134 Dollars ($200.00)

For MRI

*MUST PAY 4 INSTALMENT PAY. of 198.75 PER MONTH

How Paid	Balance Due	By
Cash	795.00	Saldaña

26531

PATIENT NAME	:	**McGRATH, Virginia**
PATIENT NUMBER	:	**10071**
REFERRING PHYSICIAN	:	**J. Don Walker, D.C.**
DATE OF EXAMINATION	:	**5/25/01**

MRI LUMBAR SPINE

CLINICAL INFORMATION:

Back pain

TECHNIQUE:

T1, proton density, and T2 weighted sagittal, and T1 and T2 weighted axial images of the lumbar spine were performed using the spin echo technique.

FINDINGS:

Review of the images demonstrates a marked rotoscoliosis of the lumbar spine with advanced degenerative spondylosis.

The conus medullaris appears normal.

There does appear to be clumping of the nerve roots within the thecal sac below the tip of the conus medullaris suggesting arachnoiditis.

At L1-2, there is a broad based disc bulge with associated vertebral ridging which effaces the ventral aspect of the thecal sac. There is also facet hypertrophy, particularly on the right. The spinal canal dimensions remain adequate. The right neuroforamen is only very mildly compromised.

At L2-3, there is also a broad based disc protrusion with associated vertebral ridging and also facet hypertrophy, particularly on the right. The right neuroforamen is somewhat compromised. The left neuroforamen and spinal canal dimensions remain adequate.

3840 W NORTHWEST HWY., SUITE 400 DALLAS TEXAS 75220
TEL 214 357 5229 TOLL-FREE 1 888 357 5229
FAX 214 357 5488 TOLL-FREE 1 888 357 5488
www.texasimaging.com

At L3-4, there is prominent vertebral ridging with a broad based disc protrusion as well as facet hypertrophy, and there is lateral subluxation. The thecal sac is considerably distorted. The spinal canal dimensions remain adequate. The foramina appear to be compromised bilaterally, particularly on the right.

At L4-5, there is also broad based disc bulge with associated vertebral ridging and facet hypertrophy. There is also distortion of the thecal sac and compromised to the left lateral recess and left neuroforamen. The right neuroforamen is adequate.

At L5-S1, there is prominent facet arthropathy, particularly on the left as well as a disc bulge with associated vertebral ridging. The left neuroforamen is compromised. The right neuroforamen and spinal canal remain adequate.

Note is made of prominent atrophy of the erector spinae muscles.

IMPRESSION:

1. Marked degenerative spondylosis with associated disc protrusions, as described above
2. There is an associated scoliosis.
3. Clumping of the nerve root sleeves in the caudal aspect of the thecal sac suggests arachnoiditis
4. There is compromise of the left neuroforamen and lateral recess at L4-5, compromise of the L5-S1 neuroforamen on the left, and of the L2-3 and L3-4 neuroforamina on the right

---

MARK S. GIBSON, M.D.

MSG/ks

DICTATED – MN – 5/28/01 – 8:34 p.m.
TRANSCRIBED – MON – 5/28/01 – 11:53 p.m.

JB3702

3840 W. NORTHWEST HWY., SUITE 400 DALLAS TEXAS 75220
TEL 214 357 5220 TOLL-FREE 1 888 357 5229
FAX 214 357 5488 TOLL FREE 1 888 357 5488
www.texasimaging.com

Please do not leave the pack on for too long; it can cause frostbite. If you have circulation problems or a skin disease, you should not use ice packs because of the increased risk of causing frostbite injury.

TETANUS AND DIPHTHERIA PREVENTION:

You were given a shot today to prevent tetanus infection. Your booster shot included both tetanus and diphtheria toxoid. You will be protected from both of these infections for at least 5 years. Remember this date so you will not be given unnecessary tetanus shots in the future. Your booster may cause some swelling, pain, and tenderness in your arm. This is normal. It does not mean that you are allergic to tetanus shots. To relieve the pain from your booster rest your arm, apply ice packs, and take mild pain medicine.

ADDITIONAL INSTRUCTIONS:

TAKE MEDICAIOTNS AS DIRECTED

PRESCRIPTIONS:

Fill all the prescriptions ordered by your doctor and take them as directed.

* If you have been given an antibiotic, be sure to take all of it.
* Keep your drugs out of the reach of children, in a cool, dry, dark place.
* Don't give your medicine to other people or use it for other illnesses.
* Call us right away if you have problems with drug side-effects or allergy.

Bring your medicines with you any time you go to emergency for treatment.

CEPHALOSPORIN ANTIBIOTICS:

You have been prescribed a cephalosporin drug. Examples of these antibiotics are: Ceclor, Ceftin, Duricef, Keflex, Suprax, Zinacef. These are given for infections of the skin, ear, respiratory tract, and urinary system. They are usually well-tolerated, but if they upset your stomach, take them with food. If you are allergic to penicillin, there is a small risk you will have a similar reaction to cephalosporin antibiotics. Be sure to take antibiotics until all the medicine is gone unless you develop severe side effects.

Please note that birth control pills may not work as well as normal when you are taking an antibiotic. The most common side effects of these drugs are: diarrhea, indigestion, stomach cramps, and vomiting; women can get yeast infections with antibiotic treatment. Please stop taking your medicine and call your doctor right away if you have severe side effects, or any symptoms of drug allergy: hives, itching, rash, fever, or breathing problems. Cephalosporins have not been shown to be completely safe in pregnancy.

HARRIS SW O PATIENT RADIOLOGY IM ING FORM

Wed 14th 3:30

WITH CPT4 CODES

Patient Name Virginia McGath D.O.B 2/2/33 S.S.# 372 32 #263

Date/Time of Exam 11/14/01 3:30 P PreCert # Medicare

Priority X Fax handwritten preliminary report at time of exam.
___ Fax transcribed report.

Fax # (817)294-7425

ALL PATIENTS MUST GO DIRECTLY TO ADMISSIONS IN THE ATRIUM TO CHECK IN. ADMISSIONS IS OPEN FROM 7 AM - 5 PM, M-F. AFTER HOURS, GO TO ER ADMISSIONS. YOU MUST CHECK IN AT ADMISSIONS EACH TIME YOU HAVE AN X-RAY !!!

* Asterisk indicates LMRP available for Medicare

CHEST	CPT4	UPPER EXTREMITY	CPT4	GASTRO-INTESTI		CPT4	SONOGRAM	CPT4
*Chest (1 view)	71010	Shoulder (2 view) R / L	73030	BaSw		74220	*Gallbladder	76705
*Chest (2 view)	71020	A/C joint	73050	Dysphagia w/speech		74230	*Abdomen	76700
Ribs (1 side) R / L	71101	Scapula R / L	73010	Ba Enema - dbl		74280	Pelvis	76856
Ribs - bilateral	71111	Clavicle R / L	73000	Ba Enema - single		74270	*Renal	76775 / 76770
		Humerus R / L	73060	Hypaque Enema		74270	Thyroid	76536
ABDOMEN	CPT4	Elbow R / L	73070	Small Bowel		74250	OB	76805
		Forearm R / L	73090	UGI		74240	Testicular	76870
Kub	74000	Wrist R / L	73110				*Aorta	76770
Abdomen (2 view)	74020	Hand R / L	73130	C.T.		CPT4	*Carotid Doppler	93880
Cystogram - postop	74430	Finger(s) R / L	73140	Contrast	With	W/O	*Venous Uni R / L	93971
Cystogram - voiding	74455			*Abdomen	74160	74150	*Venous Bilat	93970
IVP w/ tomo	74415	LOW EXTREMITY	CPT4	*Chest	71260	71250	*Arterial Doppler	93922
IVP w/o tomo	74400			*Head	70460	70450		
		Femur (1 view) R / L	73550	*Neck S.T.	70491	70490	NUCLEAR MED	CPT4
PELVIS	CPT4	Femur (2 view) R / L	73550	*Pelvis	72193	72192		
		Knee (2 view) R / L	73560	Sinus		76375	Bone Scan-Comp	78306
Pelvis (1view)	72170	Low Leg (2 view) R / L	73590	*C-Spine		72125	Bone Scan-Limit	78300
Pelvis (2 view)	72170	Ankle (3 view) R / L	73610	*L-Spine	72132	72131	Thyroid	78000
Pelvis w/ lat. Hip	73520	Foot (3 view) R / L	73630				HIDA	78223
Hip joint (2 view)	73510	Toe(s) R / L	73660	MRI		CPT4	HIDA w/CCK	74290
				Contrast	With	W/O	MUGA (heart)	78472
HEAD	CPT4	SPINE	CPT4	*Head	70552	70551	Lung	78585
				*C-Spine	72142	72141	Lymphoscintigra	
Skull (2 view)	70250	C-Spine (2 view)	72040	*T-Spine	72147	72146	Injection	38790
Skull series	70260	C-Spine complete	72050	*L-Spine	72149	72148	*Procedure	78195
Sinus series	70220	T-Spine (3 view)	72072	Up Ext		73220	Renal-flow/funct	78707
Sinus (waters view)	70210	L-Spine (2 view)	72100	Low Ext		73725	Liver	78215
Nose	70160	L-Spine (5 view)	72110	MRA		70545		
Orbits	70200	Sacrum	72220	*Abdomen		74185	BONE DENSITY	CPT4
Mandible	70110	Coccyx	72220					
		Sacroiliac	72202				*DEXA (wrist)	76076
		Scoliosis (1 view)	72069					

Wt 150 — DIAGNOSIS (MUST BE INCLUDED)

780.4 — ICD9 CODE (MUST BE INCLUDED)

L. Vargas M.D / R

ORDERING PHYSICIAN'S SIGNATURE (MUST BE SIGNED)

FAX ORDER TO HSW RADIOLOGY DEPT. AT 817-346-5005

FOLLOW-UP CARE:
Your physician today has been DR. FRED ROHM,D.O.
For follow-up care you have been referred to the following doctor or clinic:
JAMES R. BOHNSACK Phone: 817-346-4000
5701 BRYANT IRVIN DR. #201
Please make an appointment for further treatment in _____ days. Be sure to tell your referral doctor or clinic that we have sent you, and bring your medicines and instructions to the office. If you had x-rays, an EKG, or lab tests today, they have been reviewed by your doctor. We will contact you at once if other important findings are noted after further review by our staff. If you do not continue to improve or if your condition worsens, please call your doctor or the emergency department right away so you can be examined.

I acknowledge receipt of these instructions. I understand that my condition may require more care and will arrange for further treatment as recommended.

Staff Signature Patient or Representative Signature
Friday, February 23, 2001 - 07:36 PM