FORM B10 (Official Form 10)

4041558

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 CORPORATION et al.

Case Number:
02-02474

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

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

11 2380985

TAYLOR, KENNETH
5021 HYWY 39
SOMERSET, KY 42503

- ☐ 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.

Your claim is scheduled as follows:

Class

UNSECURED NON PRIORITY

Amount

CONTINGENT, DISPUTED, UNLIQUIDATED

If address differs from above, please complete the following:
Creditor Name:

Address:

City/St/Zip:

Telephone: # 606 423-4124
work - 606 678-7307

10088436

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: 11-29-01

3. If court judgment, date obtained:

4. Total Amount of Claim at Time Case Filed: $ Personal injury - Undetermined Pain & Suffering
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.

RECEIVED
TRUSTEE SERVICES
DALLAS
02 APR 19 PM 2:49

This Space is for Court Use Only

MAS FOLDER # 9408
4/19/02

Date	Sign and print the name and title, if any, of the creditor or other person authorized to file this claim (attach copy of power of attorney, if any):
4.10.02	Kenneth L Taylor

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.

STORE AUTHORIZATION FOR FIRST AID

STORE STAMP

TO BE COMPLETED BY STORE PERSONNEL

To: Lake Cumberland Regional
Name of Doctor, Clinic or Hospital

Authorized By: _____

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

Patient Name Kenneth Taylor Incident Date 11-29-01 Incident Time 2015

Address 5021 Hwy 39 DOB 12-11-60 Soc. Sec. No. 404 96 4309

Somerset (City) KY (State) 42503 (Zip Code) Height 5 7" Weight 199

Patient's Employer _____

PATIENT AUTHORIZATION TO RELEASE INFORMATION

TO BE COMPLETED BY PATIENT

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

Patient Signature Kenneth L Taylor Date 11-30-01

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

PHYSICIAN'S MEDICAL REPORT

TO BE COMPLETED BY PHYSICIAN

Date of examination / treatment 11-30-01

History of incident given by patient Pt states was shopping at K-mart last night & daughter says took boxes full from shelf & put in cart & his daughter in RR heard

Patient's complaints neck to be checked because of headache + hurt on back.

Clinical findings Alert, O x 3, NAD, small hematoma at (R) parietal area, scalp

Has patient ever had same or similar condition NO If yes, when? _____

Diagnosis Hematoma, scalp, parietal area (R); Closed Head Injury

Treatment rendered Ord CT head & cervical spine; Head Injury sheet to pt to read; Tramadol 50 mg po q 4-6° prn #20

Prognosis: Is patient disabled? NO If yes, how long is disability expected? _____

Have you treated this patient before? No Approximate date of last treatment _____

Signature of physician _____ Date 11-30-01

Name of physician _____ Fed ID _____

Office address Lake Cumberland Reg. Hospital - ER
Langdon St Somerset Ky

TO BE COMPLETED BY STORE PERSONNEL

TO BE COMPLETED BY PATIENT

TO BE COMPLETED BY PHYSICIAN

STORE AUTHORIZATION FOR FIRST AID

STORE STAMP
7255 Kmart
420 EAST HIGHWAY 30
SOMERSET, KY 42501

To: Lake Cumberland Regional
Name of Doctor, Clinic or Hospital

Authorized By: _____

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

Patient Name Amber D. Taylor Incident Date 11-29-01 Incident Time 9:15 pm

Address 5021 Hwy 39 DOB 11-04-84 Soc. Sec. No. 405 25 0420

Somerset (City) KY (State) 42503 (Zip Code) Height 5'4" Weight 115

Patient's Employer _____

PATIENT AUTHORIZATION TO RELEASE INFORMATION

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

Patient Signature Kenneth L Taylor (Amber D Taylor) Date 11-30-01
(Parent should sign for patient under age 18 and print child's name next to parent's signature.)

PHYSICIAN'S MEDICAL REPORT

Date of examination / treatment 11/30/01

History of incident given by patient [illegible]

Patient's complaints HA neck pain

Clinical findings strain neck — neuro exam WNL

Has patient ever had same or similar condition No If yes, when? _____

Diagnosis [illegible]

Treatment rendered [illegible]

Prognosis: Is patient disabled? No If yes, how long is disability expected? _____

Have you treated this patient before? No Approximate date of last treatment _____

Signature of physician _____ Date 11/30/01

Name of physician [illegible] Fed ID _____

Office address [illegible]

TAYLOR KENNE 00100036223005412000000000003

957

LAKE CUMBERLAND REG HOSP
PO BOX 620
SOMERSET, KY 42502
BUSINESS OFFICE

STATEMENT DATE 12/03/01

PAGE 1 OF 1

ACCOUNT NUMBER	PATIENT NAME	STATEMENT PERIOD
1000362230	TAYLOR KENNETH L	EMERGENCY 11/30/01 TO 11/30/01

AMOUNT DUE
$0.00

TAYLOR KENNETH L
5021 HWY 39
SOMERSET KY 42503

MAIL PAYMENT TO
LAKE CUMBERLAND REG HOSP
PO BOX 620
SOMERSET, KY 42502
BUSINESS OFFICE

TO RECEIVE PROPER CREDIT, PLEASE RETURN THIS PORTION WITH YOUR PAYMENT
NOTE: SHOULD YOU WISH TO PAY BY CREDIT CARD, SEE AUTHORIZATION NOTICE ON THE BACK.

SUMMARY OF ACCOUNT

LAKE CUMBERLAND REG HOSP
PO BOX 620
SOMERSET, KY 42502
BUSINESS OFFICE

STATEMENT DATE 12/03/01

STATEMENT PERIOD	PATIENT NAME	ACCOUNT NUMBER
11/30/01 TO 11/30/01	TAYLOR KENNETH L	1000362230

THE INSURANCE CLAIMS OUTSTANDING REPRESENTS OUR ESTIMATE OF INSURANCE LIABILITY BASED ON OUR BEST INFORMATION

ACCOUNT BALANCE LAST STATEMENT	NEW CHARGES OR ADJUSTMENTS	NEW PAYMENTS OR CREDITS	NEW ACCOUNT ADJUSTMENTS	INSURANCE CLAIMS OUTSTANDING
0.00	1103.91	0.00	0.00	1,103.91

AMOUNT DUE
$0.00

DATE	DESCRIPTION	UNITS	AMOUNT
*11/30/01	EMERGENCY SERVICES		
*11/30/01	CT HEAD W O CONTRAST	1	954.16
12/03/01	K MART #7255 BILLED		

DATE	DESCRIPTION	UNITS	AMOUNT
*11/30/01	URGENT CARE VISIT	1	149.75
	TOTAL CHARGES		1,103.91
	ACCOUNT BALANCE		1,103.91
	ESTIMATED INSURANCE		1,103.91

* INDICATES NEW ITEMS SINCE LAST STATEMENT

IF YOU HAVE QUESTIONS REGARDING YOUR ACCOUNT, PLEASE CALL: 606-676-2240

THANK YOU FOR CHOOSING LAKE CUMBERLAND REGIONAL HOSPITAL.
ITEMIZED STATEMENT UPON REQUEST

THIS BILL IS FOR HOSPITAL SERVICES ONLY
PLEASE RETAIN THIS PORTION FOR YOUR RECORDS

TAYLOR KENNE 00100036216205412000000000008

956

LAKE CUMBERLAND REG HOSP
PO BOX 620
SOMERSET, KY 42502
BUSINESS OFFICE

STATEMENT DATE 12/03/01

PAGE 1 OF 1

ACCOUNT NUMBER	PATIENT NAME	STATEMENT PERIOD
1000362162	TAYLOR AMBER	EMERGENCY 11/30/01 TO 11/30/01

AMOUNT DUE
$0.00

TAYLOR KENNETH
5021 HWY 39
SOMERSET KY 42503

MAIL PAYMENT TO
LAKE CUMBERLAND REG HOSP
PO BOX 620
SOMERSET, KY 42502
BUSINESS OFFICE

TO RECEIVE PROPER CREDIT, PLEASE RETURN THIS PORTION WITH YOUR PAYMENT
NOTE: SHOULD YOU WISH TO PAY BY CREDIT CARD, SEE AUTHORIZATION NOTICE ON THE BACK.

SUMMARY OF ACCOUNT

LAKE CUMBERLAND REG HOSP
PO BOX 620
SOMERSET, KY 42502
BUSINESS OFFICE

STATEMENT DATE 12/03/01

STATEMENT PERIOD	PATIENT NAME	ACCOUNT NUMBER
11/30/01 TO 11/30/01	TAYLOR AMBER	1000362162

THE INSURANCE CLAIMS OUTSTANDING REPRESENTS OUR ESTIMATE OF INSURANCE LIABILITY BASED ON OUR BEST INFORMATION

ACCOUNT BALANCE LAST STATEMENT	NEW CHARGES OR ADJUSTMENTS	NEW PAYMENTS OR CREDITS	NEW ACCOUNT ADJUSTMENTS	INSURANCE CLAIMS OUTSTANDING
0.00	731.00	0.00	0.00	731.00

AMOUNT DUE
$0.00

DATE	DESCRIPTION	UNITS	AMOUNT
*11/30/01	EMERGENCY SERVICES		
*11/30/01	MOTRIN 600 MG TAB (GENER	1	4.75
*11/30/01	ER LEVEL II	1	149.75
12/03/01	K MART #7255 BILLED		

DATE	DESCRIPTION	UNITS	AMOUNT
*11/30/01	SPINE CERVICAL (ROUTINE)	1	309.25
*11/30/01	SKULL PA 2LATS TOWNS	1	267.25
	TOTAL CHARGES		731.00
	ACCOUNT BALANCE		731.00
	ESTIMATED INSURANCE		731.00

* INDICATES NEW ITEMS SINCE LAST STATEMENT

IF YOU HAVE QUESTIONS REGARDING YOUR ACCOUNT, PLEASE CALL: 606-676-2240

THANK YOU FOR CHOOSING LAKE CUMBERLAND REGIONAL HOSPITAL.
ITEMIZED STATEMENT UPON REQUEST

THIS BILL IS FOR HOSPITAL SERVICES ONLY
PLEASE RETAIN THIS PORTION FOR YOUR RECORDS

STATEMENT

Bluegrass Radiology Assoc
PO Box 3176
Somerset KY 42564

Address Service Requested

Statement Date: 01/21/2002
Account Number: 362230
Amount Due: $171.00

Office Hours: 8:00 a.m. to 4:30 p.m. Monday - Friday
Phone: 888/273-2009 IRS# 61-1121623

Patient: KENNETH L TAYLOR

AMOUNT PAID

611121623000000000000003622300017100 8

*21 *********3-DIGIT 425

KENNETH L TAYLOR 362230
5021 HIGHWAY 39
SOMERSET KY 42503-5099

MAKE CHECK PAYABLE & REMIT TO:

Bluegrass Radiology Assoc
PO Box 3176
Somerset KY 42564

PLEASE CHECK BOX IF ABOVE ADDRESS IS INCORRECT AND ENTER CHANGES ON REVERSE.

CUMBERL1-0048280-0003497-0154821-001-000138-#004060

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

DATE	DOCTOR	CPT	DESCRIPTION OF SERVICE	AMOUNT
11/30/01	10	70450	CT HEAD W/O CONTR	$171.00

BALANCE DUE: $171.00

Patient: KENNETH L TAYLOR Account Number: 362230 Statement Date: 01/21/2002

Location: LAKE CUMBERLAND REGIONAL HOSPT Refering Physician: SEMBILLO AVELINA

YOUR INSURANCE COMPANY HAS NOT RESPONDED TO OUR CLAIM. THE ACCOUNT BALANCE IS YOUR RESPONSIBILITY. PLEASE REMIT UPON RECEIPT. IF YOU HAVE QUESTIONS, PLEASE CALL YOUR INSURANCE

CUMBERL1-0048280-0003497-0154821-001-000138-#004060

Bluegrass Radiology Assoc
PO Box 3176
Somerset KY 42564

Phone: 888/273-2009 IRS# 61-1121623

STATEMENT

Bluegrass Radiology Assoc
PO Box 3176
Somerset KY 42564

Address Service Requested

Statement Date: 01/21/2002
Account Number: 362162
Amount Due: $105.00

Office Hours: 8:00 a.m. to 4:30 p.m. Monday - Friday
Phone: 888/273-2009 IRS# 61-1121623

Patient: AMBER TAYLOR

AMOUNT PAID

611121623000000000000003621620010500 9

*21 *********3-DIGIT 425

KENNETH TAYLOR 362162
5021 HIGHWAY 39
SOMERSET KY 42503-5099

MAKE CHECK PAYABLE & REMIT TO:

Bluegrass Radiology Assoc
PO Box 3176
Somerset KY 42564

PLEASE CHECK BOX IF ABOVE ADDRESS IS INCORRECT AND INDICATE CHANGES ON BACK

CUMBERL1-0048280-0003501-0154821-001-000137-#004064

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

DATE	DOCTOR	CPT	DESCRIPTION OF SERVICE	AMOUNT
11/30/01	10	70260	SKULL SERIES COMPLETE	$50.00
11/30/01	10	72052	SPINE CERVICAL COMPLETE	$55.00

BALANCE DUE: $105.00

Patient: AMBER TAYLOR Account Number: 362162 Statement Date: 01/21/2002

Location: LAKE CUMBERLAND REGIONAL HOSPT Refering Physician: JACKSON RAYMOND C

YOUR INSURANCE COMPANY HAS NOT RESPONDED TO OUR CLAIM. THE ACCOUNT BALANCE IS YOUR RESPONSIBILITY. PLEASE REMIT UPON RECEIPT. IF YOU HAVE QUESTIONS, PLEASE CALL YOUR INSURANCE

Bluegrass Radiology Assoc
PO Box 3176
Somerset KY 42564

Phone: 888/273-2009 IRS# 61-1121623

CUMBERL1-0048280-0003501-0154821-001-000137-#004064

SOMERSET EMERGENCY PHYSICIANS 888 596 3339
P O BOX 890
WHITLEY CITY KY 42653
DETAIL PRINTED 1/25/02 8.16 BY ajk001

0- 30 days	0.00
31- 60 days	320.00
61- 90 days	0.00
91-120 days	0.00
121-150 days	0.00
150+ days	0.00
Posted	320.00
Unposted	0.00
Total bal	320.00
- Pending	320.00
= Pat bal	0.00

Last aging 01/10/02

KENNETH L TAYLOR
5021 HWY 39
SOMERSET KY 42503

Home 606 423 4124
Work 000 0000
PT-0007 BC-0001
CS-0000 DR-0011

KENNETH L TAYLOR M-12/11/60- 41-362230
Next app't

Last chg 113001 320.00 Last ins pay
SSN: 404 96 4309 Last per pay
Diag:959.01 INJURY NOS, HEAD
Reg date 113001

Insurance	Subscriber	Policy id		
KMART-LIABILITY	TAYLOR KENNETH	404964309	-	TB PR IY-01

ACTIVE COVERAGES

-PRIMARY-
1145-KMART-LIABILITY CLAIM
420 E HWY 80
SOMERSET KY 42501
Phone 1: 000 0000
First id 404964309
Employer: TRU CHECK
OHIO ST SOMERSET KY 42501

Subscr: TAYLOR KENNETH L
Sex: M DOB:121160 SSN:404964309 PR: 1
Effective: - SCT:I BA:Y
Phone 2: 000 0000
Second id

ARCHIVED COVERAGES

5-SEND TO PATIENT
Phone 1: 000 0000
First id 404964309
Employer: TRU CHECK
OHIO ST SOMERSET KY 42501

Subscr: TAYLOR KENNETH L
Sex: M DOB:121160 SSN:404964309 PR: 1
Effective: - SCT:G BA:Y
Phone 2: 000 0000
Second id

OFF BILL COMMENTS

** No Off Bill Comments Found **

** No Collection Notes Found **

FastNotes

** No FastNotes Found **

BILLING NOTES

** No Billing Notes Found **

INSURANCE NOTES

** No Insurance Notes Found **

PATIENT NOTES

** No Patient Notes Found **

Tick# 55067 U 251 30 KENNETH TAYLOR Total: 320.00
11/30/01 11-SEMBILLO MD LCRH OC
-LINE DETAIL-
113001-113001 99284 - -E/M HIGH/URG 959.01 -INJURY NOS, YYY 1 320.00
-CLAIM INFO- Claim #
120101- -KMART-LIABILITY CLA-00550671-Y-N-F pending
-SUMMARY-

	KMART-LIAB						
				Status	FILED	*Balance*	320.00
Paid	.00	.00	.00	Expected	320.00	Ins	320.00
W/O	.00	.00	.00	Personal	.00	Pat	.00
Pat paid to print on form			.00	Other pd	.00		

** End of Detail **

SOMERSET EMERGENCY PHYSICIANS 888 596 3339
P O BOX 690
WHITLEY CITY KY 42653
DETAIL PRINTED 1/25/02 8.17 BY ajk001

0- 30 days	0.00	KENNETH TAYLOR	Home 606 423 4124
31- 60 days	320.00	5021 HWY 39	Work 000 0000
61- 90 days	0.00		PT-0007 BC-0001
91-120 days	0.00	SOMERSET KY 42503	CS-0000 DR-0019
121-150 days	0.00		
150+ days	0.00	AMBER TAYLOR	F-11/09/84- 17-362162
Posted	320.00	Next app't	
Unposted	0.00		
Total bal	320.00		
- Pending	320.00		
= Pat bal	0.00		
		Last chg 113001 320.00	Last ins pay
		SSN: 405 25 0420	Last per pay
		Diag:959.01 INJURY NOS, HEAD	
Last aging 01/10/02		Reg date 113001	

Insurance	Subscriber	Policy id	TB PR
KMART-LIABILITY	TAYLOR AMBER	405250420	IY-02

ACTIVE COVERAGES

-PRIMARY-
1145-KMART-LIABILITY CLAIM
420 E HWY 80
SOMERSET KY 42501
Phone 1: 000 0000
First id 405250420
Employer: CHILD

Subscr: TAYLOR AMBER
Sex: F DOB:110984 SSN:405250420 PR: 2
Effective: - SCT:I BA:Y
Phone 2: 000 0000
Second id

ARCHIVED COVERAGES

** No Archived Coverages Found **

OFF BILL COMMENTS

** No Off Bill Comments Found **

COLLECTION NOTES

** No Collection Notes Found **

FastNotes

** No FastNotes Found **

BILLING NOTES

INSURANCE NOTES

** No Insurance Notes Found **

PATIENT NOTES

** No Patient Notes Found **

Tick# 55127 U 300 11 AMBER TAYLOR Total: 320.00
11/30/01 19-JACKSON MD LCRH ER
-LINE DETAIL-

113001-113001 99284	-	-E/M HIGH/URG	959.01	-INJURY NOS,	YYY	1 320.00
113001-113001	-	-ADX	847.0	-SPRAIN/STRAI	YYY	1 0.00

-CLAIM INFO-
120101- -KMART-LIABILITY Claim # CLA-00551271-Y-N-F pending
-SUMMARY-

KMART-LIAB					
Paid	.00	.00	.00	Status FILED	*Balance* 320.00
W/O	.00	.00	.00	Expected 320.00	Ins 320.00
Pat paid to print on form			.00	Personal .00	Pat .00
				Other pd .00	

** End of Detail **

Prescription #: 6882262
Prescription For: TAYLOR, KENNETH
Pharmacist's Name: STITH JIM
Pharmacy Phone: (606)679-1121
This drug expires: 11/30/2002

Pharmacy Dept# 7255
420 EAST HIGHWAY 80
SOMERSET, KY 42501
(606)679-1121

RECEIPT

Rx: 6882262 Pharmacist: JIM

TAYLOR, KENNETH (606) 423-4124
5021 HWY 39
SOMERSET, KY 42501

ULTRAM 50MG **TAB MCNE** NDC:00045-0659-60

Dr. SEMBILLO, AVELINA Subtotal: $24.10

11/30/01 Qty: 20 **CASH:** **$24.10**

DRUG NAME: **ULTRAM 50MG** **TAB MCNE**

GENERIC NAME: TRAMADOL (TRA-ma-doll)

COMMON USES: This medicine is an analgesic used to treat or prevent pain.

BEFORE USING THIS MEDICINE: Some medicines or medical conditions may interact with this medicine. INFORM YOUR DOCTOR OR PHARMACIST of all prescription and over-the-counter medicine that you are taking. USE OF THIS MEDICINE is notrecommended if you are also taking cyclobenzaprine or medicine for depression or other emotional or mood disorders. If you are taking any of these medicines, be sure your doctor knows. ADDITIONAL MONITORING OF YOUR DOSE OR CONDITION may be needed if you are taking bupropion, narcotic analgesics, or have a history of seizures. Inform your doctor of any other medical conditions, allergies, pregnancy, or breast-feeding. Contact your doctor or pharmacist if you have any questions or concerns about using this medicine.

HOW TO USE THIS MEDICINE: Follow the directions for using this medicine provided by your doctor. STORE THIS MEDICINE at room temperature, away from heat and light. IF YOU MISS A DOSE OF THIS MEDICINE, take it as soon as possible. If it is almost time for your next dose, skip the missed dose and go back to your regular dosing schedule. Do NOT take 2 doses at once.

CAUTIONS: DO NOT EXCEED THE RECOMMENDED DOSE OR TAKE THIS MEDICINE for longer than prescribed. IF YOU EXPERIENCE difficulty breathing or tightness of chest; swelling of eyelids, face, or lips; or develop a rash or hives, tell your doctor immediately. Do not take any more of this medicine unless your doctor tells you to do so. AVOID ALCOHOL while you are using this medicine. This medicine will add to the effects of alcohol and other depressants. DO NOT DRIVE, OPERATE MACHINERY, OR DO ANYTHING ELSE THAT COULD BE DANGEROUS until you know how you react to this medicine. Using this medicine alone, with other medicines, or with alcohol may lessen your ability to drive or to perform other potentially dangerous tasks. BEFORE YOU BEGIN TAKING ANY NEW MEDICINE, either prescription or over-the-counter, check with your doctor or pharmacist. FOR WOMEN: IF YOU PLAN ON BECOMING PREGNANT, discuss with your doctor the benefits and risks of using this medicine during pregnancy. THIS MEDICINE IS EXCRETED IN BREAST MILK. DO NOT BREAST-FEED while taking this medicine.

POSSIBLE SIDE EFFECTS: SIDE EFFECTS, that may go away during treatment, include dizziness, nausea, drowsiness, dry mouth, constipation, headache, or sweating. If they continue or are bothersome, check with your doctor. CHECK WITH YOUR DOCTOR AS SOON AS POSSIBLE if you experience skin rash, itching, seizures, or hallucinations. If you notice other effects not listed above, contact your doctor, nurse, or pharmacist.

OVERDOSE: If overdose is suspected, contact your local poison control center or emergency room immediately. Symptoms of overdose may include cold and clammy skin, low body temperature, slowed breathing, slowed heartbeat, drowsiness, dizziness, lightheadedness, seizures, deep sleep, and loss of consciousness.

ADDITIONAL INFORMATION: DO NOT SHARE THIS MEDICINE with others for whom it was not prescribed. DO NOT USE THIS MEDICINE for other health conditions. KEEP THIS MEDICINE out of the reach of children. IF USING THIS MEDICINE FOR AN EXTENDED PERIOD OF TIME, obtain refills before your supply runs out.

The information in this monograph is not intended to cover all possible uses, directions, precautions, drug interactions, or adverse effects. This information is generalized and is not intended as specific medical advice. If you have questions about the medicines you are taking or would like more information, check with your doctor, pharmacist, or nurse. Copyright 2001 First DataBank, Inc. All rights reserved. Database Edition 01.4 Information Expires December 28, 2001

Kmart Pharmacy Save Money...Feel Better

Do not exceed recommended dosage
Follow dosing directions very carefully.
Use cautiously with other depressant-type drugs
May cause drowsiness/dizziness.Drive with caution
May cause dry mouth.
Check with Dr. before taking any other medicine
Report hives/itching/prob -lems in breathing to Dr
Promptly report unusual symptoms/effects to Dr

Prescription #: 6882238
Prescription For: **TAYLOR, AMBER**
Pharmacist's Name: STITH JIM
Pharmacy Phone: (606)679-1121
This drug expires: 11/30/2002

RECEIPT

Pharmacy Dept# 7255
420 EAST HIGHWAY 80
SOMERSET, KY 42501
(606)679-1121

Rx: 6882238 Pharmacist: JIM

TAYLOR, AMBER (606) 423-4124
5021 HWY 39
SOMERSET, KY 42501

IBUPROFEN 600MG TAB SCHN NDC:00364-0766-05
Generic For: MOTRIN 600MG TAB

Dr. JACKSON, RAYMOND Subtotal: $4.39

11/30/01 Qty: 12 **CASH: $4.39**

DRUG NAME: **IBUPROFEN 600MG TAB SCHN**

GENERIC NAME: IBUPROFEN (eye-byoo-PROE-fen)

COMMON USES: This medicine is a nonsteroidal anti-inflammatory drug (NSAID) used to relieve the symptoms of arthritis. It is also used to relieve pain and to treat other conditions as determined by your doctor.

BEFORE USING THIS MEDICINE: Some medicines or medical conditions may interact with this medicine. INFORM YOUR DOCTOR OR PHARMACIST of all prescription and over-the-counter medicine that you are taking. DO NOT TAKE THIS MEDICINE if you are also taking heparins or tacrolimus. ADDITIONAL MONITORING OF YOUR DOSE OR CONDITION may be needed if you are taking aminoglycoside antibiotics, anticoagulants, cyclosporine, lithium, or methotrexate. Inform your doctor of any other medical conditions, allergies, pregnancy, or breast-feeding. Contact your doctor or pharmacist if you have any questions or concerns about taking this medicine.

HOW TO USE THIS MEDICINE: Follow the directions for using this medicine provided by your doctor. TAKE THIS MEDICINE with food and a glass of water or with milk. STORE THIS MEDICINE at room temperature, away from heat and light. IF YOU MISS A DOSE OF THIS MEDICINE, take it as soon as possible. If it is almost time for your next dose, skip the missed dose and go back to your regular dosing schedule. Do not take 2 doses at once.

CAUTIONS: DO NOT TAKE THIS MEDICINE if you ever had any unusual or allergic reaction to aspirin, ibuprofen, naproxen, or any other medicine used to treat pain, fever, swelling, or arthritis. DO NOT DRIVE, OPERATE MACHINERY, OR DO ANYTHING ELSE THAT COULD BE DANGEROUS until you know how you react to this medicine. Using this medicine alone, with other medicines, or with alcohol may lessen your ability to drive or to perform other potentially dangerous tasks. ALCOHOL WARNING: If you consume 3 or more alcoholic drinks every day, ask your doctor whether you should take this medicine or other pain relievers/fever reducers. This medicine may cause stomach bleeding. BEFORE YOU BEGIN TAKING ANY NEW MEDICINE, either prescription or over-the-counter, check with your doctor or pharmacist. This includes any medicine which contains aspirin or other non-prescription pain relievers. FOR WOMEN: USE OF THIS MEDICINE DURING PREGNANCY has resulted in fetal and newborn death. If you think you may be pregnant, contact your doctor immediately. THIS MEDICINE IS EXCRETED IN BREAST MILK. IF YOU ARE OR WILL BE BREAST-FEEDING while you are using this medicine, check with your doctor or pharmacist to discuss the risks to your baby.

POSSIBLE SIDE EFFECTS: SIDE EFFECTS, that may go away during treatment, include nausea, vomiting, diarrhea, gas, constipation, indigestion, dizziness, lightheadedness, drowsiness, or headache. If they continue or are bothersome, check with your doctor. CHECK WITH YOUR DOCTOR AS SOON AS POSSIBLE if you experience swelling of hands or ankles, ringing in ears, rash, itching. CONTACT YOUR DOCTOR IMMEDIATELY if you experience swelling of hands, face, lips, eyes, throat, or tongue; difficulty swallowing or breathing; or hoarseness. CONTACT YOUR DOCTOR IMMEDIATELY AND STOP TAKING THIS MEDICINE if you notice any of the following unlikely but very serious side effects: black stools, persistent stomach/abdominal pain, vomit that looks like coffee grounds. If you notice other effects not listed above, contact your doctor, nurse, or pharmacist.

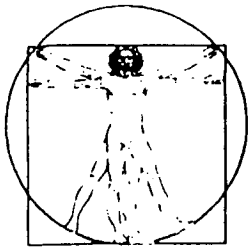
OVERDOSE: If overdose is suspected, contact your local poison control center or emergency room immediately.

ADDITIONAL INFORMATION: DO NOT SHARE THIS MEDICINE with others for whom it was not prescribed. DO NOT USE THIS MEDICINE for other health conditions. KEEP THIS MEDICINE out of the reach of children. IF USING THIS MEDICINE FOR AN EXTENDED PERIOD OF TIME, obtain refills before your supply runs out.

The information in this monograph is not intended to cover all possible uses, directions, precautions, drug interactions, or adverse effects. This information is generalized and is not intended as specific medical advice. If you have questions about the medicines you are taking or would like more information, check with your doctor, pharmacist, or nurse. Copyright 2001 First DataBank, Inc. All rights reserved. Database Edition 01.4 Information Expires December 26, 2001

Kmart Pharmacy Save Money...Feel Better

Take with food or milk (or immediately after)
Take medication with a full glass of water
Consult Dr before taking aspirin or pain relievers
Check w/Dr before drinking alcoholic beverages
May cause drowsiness/dizziness.Drive with caution
Check with Dr. before taking any other medicine
Report hives/itching/prob -lems in breathing to Dr
Promptly report unusual symptoms/effects to Dr



Blue Grass Physiotherapy PLLC
347 Bogle Street
Somerset, Ky 42503
Ph: (606) 678-5708

Discharge Summary

Patients Name: Amber Taylor	Patient No.	Physician:
Admitting Diagnosis: Cervical Strain Sprain		
Eval Date: 12/10/01	Discharge Date: 01/09/02	Discharge Prognosis: Good

Ms. Amber Taylor started PT 12/10/01 2° cervical Strain + H/A from a tool box that fell on the back of her head/neck while shopping @ KMART. She attended PT regularly 3x/wk for ~ 1 month.

Upon D/C she reports not having a headache + no c/o cervicalgia

ROM: completely WFL's

Strength of Cervical + UE WFL's 5/5

Pt demonstrates good posture

Pt has met all PT goals

David Escobar MSPT

BLUE GRASS PHYSIOTHERAPY PLLC
Physical Therapy Summary

PATIENT NAME: Amber TAylor FREQUENCY ____ / WK

MONTH: Jan 2002 PATIENT #: ____

		4:15-5:15		4:00-5:00					1/2 hr Sep																						
Date ?	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Eval																															
Therapeutic Ex																															
Home Ex Inst																															
Gait Train																															
Ultra Sound		BT		BT					BT																						
U.S. /c hydrocort																															
Pre-Mod E-stim																															
IFC E-stim																															
TENS Instruction																															
Paraffin Bath																															
Whirlpool																															
Fluidotherapy																															
MHP / ICE		BT		BT					BT																						
Manual Traction																															
Mechanical Trac																															
Massage																															
Other Man Th Tech		BT		BT					BT																						
Orthotic/Brace ✓																															
Joint Mob																															
Work Hardening																															
Therapist Initial																															
Therapist Initial		BT-Betty Duckes, PTA																													

Soap Notes: 01/04/02 S: Pt reports her neck is doing better ē Falling New Years Eve

O: MHP c-spine x 15 min. Performed soft tissue ē trigger point release c-spine. Receives US, cont@ 1.5 w/cm² to same.

A: Responding well to therapy, minimal c/o's of H/A's ē pt becoming IJ ē self postural assessment.

P: Cont ē completion of goals.

Betty Duckes, PTA

BLUE GRASS PHYSIOTHERAPY PLLC
Physical Therapy Summary

PATIENT NAME: Amber Taylor FREQUENCY ____ / WK
MONTH: Dec. 2001 PATIENT #: ____

										3:15-4:15	3:30-4:30	4:00-5:00	4:00-4:45	4:00-5:00					4:15-5:00											3:30-4:30
Date ?	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Eval										DE																					
Therapeutic Ex																															
Home Ex Inst																															
Gait Train																															
Ultra Sound										GB	GB	GB	GB	DE					BT											DE
U.S. /c hydrocort																															
Pre-Mod E-stim																															
IFC E-stim																															
TENS Instruction																															
Paraffin Bath																															
Whirlpool																															
Fluidotherapy																															
MHP / ICE										DE	GB	GB	GB	BT					BT											DE
Manual Traction																															
Mechanical Trac																															
Massage																															
Other Man Th Tech										DE	GB	DE	BT	DE					BT											DE
Orthotic/Brace ✓																															
Joint Mob																															
Work Hardening																															
Therapist Initial	DE Daniel Escobar, MSPT																														
Therapist Initial	BT - Betty Jucker, PTA													GB Gerri Ball SPTA																	

Soap Notes: 12/10/01 See Eval

12/19/01 S: C/o's of H/A today
O: MHP x 20 min c-spine. Performed soft tissue mobs & trigger point release. Terminated c US, cont@ 1.5 w/cm². Cont review of postural self-awareness.
A: Receives temporary relief @ present
P: Cont c POC. Betty Jucker, PTA-

12/31/01 S: "I feel I've got all the ROM back but still stiff in"
O: MHP x 15-20min followed by soft tissue mobs to trigger points. US as per protocol
A: Pt tolerated Rx well having less H/A's
P: Cont progressing as tolerated Daniel Escobar PT

Physical Therapy Evaluation

Patient: Amber Taylor
Patient #:
Address:

Phone:
Age: 17 DOB 11/9/84

Blue Grass Physiotherapy, PLLC
347 Bogle Street
Somerset, Ky 42503
(606) 678-5708

Treatment Freq: 3 x/wk
Treatment Duration: 4 /wks

Diagnosis: Cervical Strain 847
Physician: Ø
Insurance: BC/BS

X/D Female states that while shopping @ Kmart in somerset Ky some tool boxes fell off the shelf behind she and her dad striking them on the back of the head + neck. X-Rays were taken + came out Θ for any fx's. Her mother brings her to the clinic + she is still complaining of stiff neck + residual H/A's. She denies any PMHx of prev. serious musculoskeletal trauma to head or neck: no hx of DM, HBP, HTN,

OBjective: C-ROM WNL's in all directions + no report of pain

STRENGTH: B) Upper Extremities = 5/5
Reflexes: B) WNL's
Sensation: Sharp/Dull discrimination intact
Palpation: Extreme tender B) Sub Occipitals, facet pillars scalene, + levates scapulae.
SPECIAL TEST: Compression (AXIAL) Θ, DISTRACTION Θ but relieves rpt of neck + head pain

GOAL ↓ Pain + H/A to Ø
Pt to become Indep in self postural assessment + correction

PLAN: MHP
Manual therapy
gentle man cervical mob/traction
US to sub occipitals facets Bilat

Patient Certification:

1. The therapy services are/ were furnished while the patient was under the care of a physician.
2. A plan for such services is or was established and periodically reviewed by the physician.
3. The therapy services are or were required by the patient.
4. The patient understands the therapy plan and goals as outlined.
5. The above modalities will be used in combination and may vary as the patients condition warrants.

Physicians Signature Date:

David Escobar MSPT 12/10/01
Physical Therapist Signature Date:

FAMILY TOTALS

		Claims $$ Unpaid
Last Statement Balance	870.00	870.00
Unbilled Fees/Adjustments	345.00	345.00
Payments Received/Adjustments	0.00	0.00
Current A/R Balance	1215.00	1,215.00

Option Billing Totals

		Total Amt. Billed to Date
Billing Code #1: Total Open Budget left to bill	0.00	.....0.00
Billing Code #2: Total Fixed Budget left to bill	0.00	.....0.00
Billing Code #3: Total on Escrow or Suspense	0.00	**Estimated**
Billing Code #4: Total Unpaid Assigned Insurance	0.00	
		----------Co/Self-Pay Due
Current Option Billing Balance	0.00	Awaiting SecIns
*** Total Family Balance ***	1215.00	<<Unpaid Ins>>

Office Address: BLUE GRASS PHYSIOTHERAPY PLLC

347 BOGLE STREET
SOMERSET, KY. 42502-2502
(606)-678-5708

Federal Tax ID Number: 611371336

BALANCE ON ACCOUNT #00698 - KENNETH TAYLOR

PATIENTS	BILL CODE	DOB	DLS	YTD	ITD
AMBER TAYLOR	KMART CUSTOME	11/09/1984	01/09/02 009	345.00 031	1215.00

KENNETH TAYLOR

5021 HWY. 39
SOMERSET KY 42503

STATEMENT BALANCE 870.00 ACCT # 00698
DATE LAST PAID / / AMT> 0.00
RESIDENCE PHONE 606-423-4124
OFFICE PHONE 606-678-7307

CURRENT	>30 DAYS	>60 DAYS	>90 DAYS	UPDATED PRESENT BALANCE
0.00	870.00	0.00	0.00	1215.00

UNBILLED TREATMENTS AND PAYMENTS

DATE	DR	QTY	TREATMENT	INS-PD/ADJ	PATIENT	AMOUNT
01/02/02	01	01	MOIST HEAT/CRYOTHERAPY	97010*INS*	AMBER	42.00
01/02/02	01	01	ULTRASOUND THERAPY	97035*INS*	AMBER	43.00
01/02/02	01	01	MANUAL THERAPY TECHNIQUES	97140*INS*	AMBER	30.00
01/04/02	01	01	MOIST HEAT/CRYOTHERAPY	97010*INS*	AMBER	42.00
01/04/02	01	01	ULTRASOUND THERAPY	97035*INS*	AMBER	43.00
01/04/02	01	01	MANUAL THERAPY TECHNIQUES	97140*INS*	AMBER	30.00
01/09/02	01	01	MOIST HEAT/CRYOTHERAPY	97010*INS*	AMBER	42.00
01/09/02	01	01	ULTRASOUND THERAPY	97035*INS*	AMBER	43.00
01/09/02	01	01	MANUAL THERAPY TECHNIQUES	97140*INS*	AMBER	30.00

----------YTD BILLED TREATMENTS AND PAYMENTS ----------

DATE	DR	QTY	TREATMENT	INS-PD/ADJ	PATIENT	AMOUNT
12/10/01	01	01	PT EVALUATION	97001*INS*	AMBER	70.00
12/10/01	01	01	MOIST HEAT/CRYOTHERAPY	97010*INS*	AMBER	42.00
12/10/01	01	01	ULTRASOUND THERAPY	97035*INS*	AMBER	43.00
12/10/01	01	01	MANUAL THERAPY TECHNIQUES	97140*INS*	AMBER	30.00
12/11/01	01	01	MOIST HEAT/CRYOTHERAPY	97010*INS*	AMBER	42.00
12/11/01	01	01	ELECTRIC STIMULATION THERAPY	97014*INS*	AMBER	38.00
12/11/01	01	01	MANUAL THERAPY TECHNIQUES	97140*INS*	AMBER	30.00
12/12/01	01	01	MOIST HEAT/CRYOTHERAPY	97010*INS*	AMBER	42.00
12/12/01	01	01	ULTRASOUND THERAPY	97035*INS*	AMBER	43.00
12/12/01	01	01	MANUAL THERAPY TECHNIQUES	97140*INS*	AMBER	30.00
12/13/01	01	01	MOIST HEAT/CRYOTHERAPY	97010*INS*	AMBER	42.00
12/13/01	01	01	ULTRASOUND THERAPY	97035*INS*	AMBER	43.00
12/13/01	01	01	MANUAL THERAPY TECHNIQUES	97140*INS*	AMBER	30.00
12/14/01	01	01	MOIST HEAT/CRYOTHERAPY	97010*INS*	AMBER	42.00
12/14/01	01	01	ULTRASOUND THERAPY	97035*INS*	AMBER	43.00
12/14/01	01	01	MANUAL THERAPY TECHNIQUES	97140*INS*	AMBER	30.00
12/19/01	01	01	MOIST HEAT/CRYOTHERAPY	97010*INS*	AMBER	42.00
12/19/01	01	01	ULTRASOUND THERAPY	97035*INS*	AMBER	43.00
12/19/01	01	01	MANUAL THERAPY TECHNIQUES	97140*INS*	AMBER	30.00
12/31/01	01	01	MOIST HEAT/CRYOTHERAPY	97010*INS*	AMBER	42.00
12/31/01	01	01	ULTRASOUND THERAPY	97035*INS*	AMBER	43.00
12/31/01	01	01	MANUAL THERAPY TECHNIQUES	97140*INS*	AMBER	30.00