FORM B10 (Official Form 10) 4029364

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

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 2376239

MCNALLY, MYRTLE
3410 NORTH EL PASO #D-10
COLORADO SPRINGS, CO 80907

☐ 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:

Telephone: #

Address:

City/St/Zip:

10083678

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: 5-10-01

3. If court judgment, date obtained:

4. Total Amount of Claim at Time Case Filed: $ 58,000.00
If all or part of your claim is secured or entitled to priority, also complete Item 5 or 6 below.
☐ Check this box if claim includes interest or other charges in addition to the principal amount of the claim. Attach itemized statement of all interest or additional charges.

5. Secured Claim.
☐ Check this box if your claim is secured by collateral (including a right of setoff).
Brief Description of Collateral:
☐ Real Estate ☐ Motor Vehicle
☐ Other _____

Value of Collateral: $_____

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

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

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

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

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

This Space is for Court Use Only

MS #10174

4/22/02

Date
4-15-01

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):

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.

DANIEL G. KAY
ATTORNEY AT LAW
3 SOUTH TEJON STREET, SUITE 200
COLORADO SPRINGS, COLORADO 80903

TELEPHONE 719-635-3611
FAX 719-578-9873

December 12, 2001

Symunde Davis
K-Mart Customer Incident Center
P.O. Box 5058
Troy, MI 48007

RE:	**My Client:**	**Myrtle McNally**
	Your Insured	**Kmart #4332, Colorado Springs**
	Claim Number:	**276542**
	D/L:	**5/10/01**

Dear Ms. Davis:

I recently met with my client to discuss making a demand for settlement of her claim. As you are aware, Ms. McNally was injured when she fell at your insured's store located at 4332 North Nevada Avenue in Colorado Springs, Colorado on May 10, 2001. Ms. McNally's fall was the result of the negligence of your insured's employee or employees who left a pallet in the aisle, which created a dangerous condition on the premises. Ms. McNally was a business invitee of your insured at the time of the incident and she sustained injuries to her neck, shoulder, foot and left breast from her fall. Copies of her incident reports are attached as Exhibit A.

There were two independent eye-witnesses to Ms. McNally's fall, Larry Beldin and Robert Scott. Mr. Beldin advised us that there was a plastic skid in the middle of the aisle and that he had almost fallen over it 2 minutes prior to Ms. McNally's fall. He helped her up after the fall and noted that she was limping and could barely stand. He advised us that the pallet was right in the middle of the aisle as you came around the corner and that he considered it unsafe and dangerous. Mr. Scott indicated that he had almost fallen over this pallet as well and that everyone that came by had a close call. An employee had been unloading items from this pallet and had left, leaving the pallet in the middle of the aisle. After Ms. McNally fell, he stated that another person almost fell and that it was only then that someone picked it up and leaned it against a shelf. Mr. Scott showed the manager of the store what had happened and felt that K-Mart was extremely

negligent in leaving this in the aisle where people coming around the corner could not see it.

At the time of the incident, Ms. McNally was wearing flat shoes with rubber soles. She is 72 years old. She was seen at the Penrose Hospital emergency room for the injuries sustained to her neck, shoulder and foot. X-rays were taken of her cervical spine, left shoulder, chest and left foot, which did not demonstrate any fractures or dislocations. She was advised to take 3 anti-inflammatories three times each day and follow up with her physician if her symptoms did not resolve. Copies of the emergency room records are attached as Exhibit B.

Due to her continuing symptoms, she presented to her family physician, Mary Szymanski, M.D. on May 15, 2001. She reported falling on her left side and having pain and swelling in her neck, shoulder and left breast area. She saw Dr. Szymanski again on June 8, 2001, still complaining of left shoulder and neck pain extending into her upper back. Examination revealed pain in the left lateral neck musculature with increased pain upon range of motion to the right with swelling noted. She was diagnosed with muscle strain of the left trapezius causing cervical neck tenderness and left lateral neck tenderness. She was referred for physical therapy and medications were prescribed. Copies of Dr. Szymanski's records are attached as Exhibit C.

Ms. McNally was seen for physical therapy on June 8, 2001 at Memorial Rehabilitation. Her treatment consisted of heat, manual techniques and massage, cervical traction, electrical stimulation, instruction in self-directed exercises and postural education. She was seen for 6 treatments and, upon her last visit, she was reporting short-term relief of her pain, with her pain remaining constant after 1-2 hours following therapy, although it was decreasing in intensity. Copies of the physical therapy records are attached as Exhibit D.

Because Ms. McNally continued to suffer with pain, she was seen by Eric Ridings, M.D. on June 28, 2001. At that time, she was experiencing neck pain, greater on the left, with a knot at the base of her neck on the left side. Her breast discomfort and shoulder pain had resolved with the exception of pain across the top of her left shoulder. Examination noted tenderness and tightness in the cervical paraspinals and scalene muscles, with cervical range of motion decreased in all planes. She had myofascial tenderness and tightness in the left shoulder and trigger points were elicited in that area. She was diagnosed with cervical and left upper quadrant myofascial pain syndrome and she was referred for further physical therapy involving more substantial myofascial release, manual therapy and a more aggressive program. Dr. Ridings prescribed additional medication for muscle spasms, a cervical pillow and a trial of home electrical stimulation. Copies of Dr. Ridings' office reports are attached as Exhibit E.

Ms. McNally presented to Centura Rehabilitation on July 2, 2001 and was seen 7 sessions. She was having trouble tolerating pushing activities, such as vacuuming, and carrying laundry and groceries. Copies of the physical therapy notes are attached as Exhibit F. She returned to Dr. Ridings on July 26, 2001, at which time she felt 70%

improved, and she was advised to continue with her exercise program and TENS unit usage at home. Although Dr. Ridings felt that Ms. McNally had reached MMI and had not sustained any permanent impairment, he reconsidered this opinion upon her final visit to him on November 8, 2001, due to the gradual recurrence of her symptoms after her physical therapy had been completed. Her pain level had returned to the point it was at the time of her injury and apparently the therapy had provided only temporary relief. She reported constant pain in her neck and shoulder with increased pain upon activities, range of motion of her neck and use of her upper extremity. Examination revealed tightness in the suboccipital region, cervical paraspinals and upper trapezius, with a number of trigger points noted. The exercises she was doing at home did not seem to be helping. Dr. Ridings feels that she has sustained cervical and left shoulder myofascial pain syndrome as a result of the May 10, 2001 fall. Dr. Ridings recommended that Ms. McNally see Dr. Polvi for evaluation for trigger point injections; however, Ms. McNally has decided she does not want to go through this type of treatment.

Ms. McNally has incurred a total of $3,752.15 in medical bills to date; see Exhibit G. A subrogation claim has been asserted by Medicaid in the amount of $395.61 (for medications). Medicare will also assert a subrogation claim; we are awaiting confirmation of this amount and we will forward that to you upon receipt of the same.

At the present time, Ms. McNally experiences occasional neck pain, especially when the weather is cold, and it is necessary for her to take Advil on a frequent basis. She cannot lift heavy objects, as this causes increased pain in her neck, radiating down between her shoulders.

As the result of the debilitating and permanent injuries sustained by my client as the result of the negligence and carelessness of your insured, she has authorized me to make a demand in the amount of $58,000.00 as full and final settlement of her claim.

Your early response will be appreciated.

Yours truly,

Daniel G. Kay

Enclosures
cc: Myrtle McNally

Kmart Customer Incident Information

4332 Kmart
3020 N. NEVADA ST.
COLORADO SPRINGS, CO 80907
Store Stamp

Dear Kmart Customer,

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

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

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

Sincerely,

Your Kmart Store Management Store Phone Number: 471-3555

TO BE COMPLETED BY CUSTOMER:

Customer name: Myrtle McNally Customer's Street Address: 3410 N. El Paso #D10

City: Co. Sprgs. State: Co Zip: 80909 Phone: 632-2080

Customer's employer: NA Customer's sex: F

Customer's Date of Birth: 1-17-29 Customer's Social Security Number: 509-26-1820

If injury to a child: Child's name: _____ Child's age: _____ Parent's name: _____

Customer's Description of Incident:

Date of incident: 05-10-01 Location of incident: Aisle between Toys +

Time of incident: 11:10 AM. What happened? Cashy. Customer came around corner of ctr. + tripped over pallet. Fell + hurt elbow + foot + shoulder.

Do you wish to be contacted? Yes Date reported: 5-10-01 Signature of Customer: Myrtle McNally

White copy - for Customer

EXHIBIT A

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

file # 276542

Statement of Injured

Name	Married/Single	Telephone #
Myrtle McNally	Widowed	(719) 632-2080
Address (Street, City, State, Zip) 3410 N. El Paso #D-10 Colo Spgs. CO 80909	**Occupation** N/A	**Average Weekly Wage** N/A
Name and ages of dependents N/A	**Date of Birth** 1-17-29	**Social Security No.** 509-26-1820
Employer's name and address N/A		

Height	Weight	Color of Eyes	Color of Hair	Right or left handed

Date, time and place of this accident
5-10-01 KMart, 3020 N. Nevada Ave., Colo Spgs. CO 80907

Describe in detail what you were doing and what happened when you were injured (continue on separate sheet if necessary)
I came around a corner & fell over plastic pallet that was left in the aisle.

Name and addresses of witnesses having knowledge of your accident
Larry Beldin, 3526 N. Cascade #17, CSC 80907
Robert Scott, 1302 S. 25th Street, CSC 80904

Describe your injury
neck, shoulder, (L) breast

Name, address & phone number of treating physician
Mary Szymanski, M.D., 2858 International Clinic, CSC 80910 (719) 632-5700

Date of 1st visit?	# of times seen by physician	Date of last visit?
5-14-01	2 for far	to see Eric Ridings, M.D. on 7-9-01

Are you still receiving treatment?	How often?	Were you compelled to stop work because of this injury?
yes	PT	N/A
If so, when? N/A		**Have you returned to work? If so, on what date?** N/A
If still disabled, state present condition		**When do you expect to return to work?** N/A

Have you ever had a previous injury resulting in permanent or partial disability? If yes, explain.
no - I am disabled due to heart condition + cancer.

Date	Signature of Injured
6-14-01	Myrtle McNally

sent to Eller 6-14-01

This authorization, of photocopy hereof, will authorize you to give Cambridge Integrated Services Group, Inc. 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.

Signature of Injured

Date | Address

STORE AUTHORIZATION FOR FIRST AID

STORE STAMP
4332 Kmart
3020 N. NEVADA ST.
COLORADO SPRINGS, CO 80907

To: _____
Name of Doctor, Clinic or Hospital

Authorized By: _____

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

Patient Name Myrtle McNally Incident Date 5-10-01 Incident Time 11:10 AM

Address 3410 No El Paso PL DOB 1-17-29 Soc. Sec. No. 509-26-8820

Co. Springs, Co. 80907 Height 5'4" Weight 180#
(City) (State) (Zip Code)

Patient's Employer NA

TO BE COMPLETED BY STORE PERSONNEL

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 Myrtle McNally Date 5-10-2001
(Parent should sign for patient under age 18 and print child's name next to parent's signature.)

TO BE COMPLETED BY PATIENT

PHYSICIAN'S MEDICAL REPORT

Date of examination / treatment 5/10/01

History of incident given by patient tripped on pallett 1110 AM

Patient's complaints (L) lat Neck, (L) shoulder, (L) upper chest, (R) toes Ache

Clinical findings _____

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

Diagnosis _____

Treatment rendered X Rays

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

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

Signature of physician _____ Date 5-10-01

Name of physician Pionkowski Fed ID _____

Office address 2131 N Tejon CS, C 80907

TO BE COMPLETED BY PHYSICIAN

Centura Health

Emergency Department

ERFST-3006 PENROSE ST. FRANCIS HEALTH SERVICES
5/10/01 12:15 (QBN P)
NAME: MONALLY, MYRTLE SEX:F MS:W EC:C ID:N CLERK: YA
R#: 429490-6-1016 DOB: 01/17/29 AGE:72 SS#: 509-26-1820
T. ADD: 3410 N EL PASO D10, COLORADO SPRINGS, CO 80907
EMRCON: HURLEY, PENNY REL:O EMRCON PH#: 719-594-4375
GUARANTOR: PATIENT REL:P PAT PHONE#: 719-632-2080
GUAR ADD: SAME AS PATIENT
PAT EMPL: HOMEMAKER GUARAN PH#: SAME AS PAT
JOB TITLE: P/EMPL PH#:
INS CO: PRIVATE PAY SP/CON PH#: 719-632-2080
ACC DATE/TIME:05/10/01 11:10 TEMP ADDR:

Personal Physician	Time Called	Time Call Returned
WELCH MICHAEL DO (719)632-5700		

Physician Referral	Police	Allergies NKA ☐ MS, Codieme, Panvil
		SOKA

Complaint: NECK, FOOT, SHOULDER PAIN

Time Ordered	☐ Old Chart Lab And X-Ray	Time Ordered	Medications / Treatment Ordered
	C spine ✓ ✓ 9:30		
	(L) shoulder ✓		
	CXR 2 ✓ ✓		
	(R) toes ✓		

Examination Time	Vital Signs Wt.	Temp.	O. R.	Pulse	Resp.	BP	Pulse OX	Nurses Initials
			983	→ 80 ↑	20	→ 165/85 ↑	96	MW

Physicians Report:

1) Adv TID w/meals
2) Rev PMD if no better in 2-3d.
3) Rev if ↑ HA

Clinical Impressions:

Patient Instructions

Physicians Signature

Discharge Condition Good ☐ Fair ☐ Serious ☐ Critical ☐

Days Off

Admitted To Room

EXHIBIT B

REG1-7086-03 PENROSE - ST. FRANCIS HEALTH SERVICES
05/10/01 12:24 (15093) (QBX$$P)

PATIENT NAME: MCNALLY, MYRTLE
SEX: F EC: C AGE: 72
ADMIT: 05/10/01 12:15
IP BED: ACCOM: UNIT: EMR1
ADM DIAG: NECK, FOOT, SHOULDER PAIN
ATD: WELCH MICHAEL DO 8045

MR#: 429490 6-1016
DOB: 01/17/1929 ID: N
DISCHARGE:
SVC: TRAUMA

ER PHYSICIAN: FRES
PRIMARY: WELCH MICHAEL DO

PATIENT INFO

STREET: 3410 N EL PASO D10
CITY: COLORADO SPRINGS
STATE: CO ZIP: 80907
PHONE: 719-632-2080
MS: W RELIG: NONE
PREVIOUS NAME:
COUGH: POB: ENID OK
SSN#: 509-26-1820

☒ EMPLOYER: HOMEMAKER
TITLE:
STREET:
CITY:
STATE: ZIP:
PHONE:
RETIRE DATE: 01/01/90

GUARANTOR INFO

RELATIONSHIP: PATIENT
NAME: MCNALLY, MYRTLE
STREET: 3410 N EL PASO D10
CITY: COLORADO SPRINGS
STATE: CO ZIP: 80907
PHONE: 719-632-2080
SSN#: 509-26-1820

☒ EMPLOYER: HOMEMAKER
TITLE:
STREET:
CITY:
STATE: ZIP:
PHONE:
RETIRE DATE: 01/01/90

EMERGENCY CONTACT

RELATIONSHIP: SON
NAME: DAWLEY, JAMES
EMPLOYER:
WK PHONE:
HOME PHONE: 719-632-2080
TEMP ADDRESS:
ER CONTACT: HURLEY, PENNY
REL: O PHONE: 719-594-4375
WK PHONE:

MISC INFO

ONSET DATE: 05/10/01
ADMIT TYPE: E SOURCE: W
ACCIDENT: 05/10/01 11:10
PLACE: KMART/N NEVADA
RPTD: Y MOA: W TYPE: 5
LAST HERE:
HOSPITAL:
ADMIT: ADM CLERK: YA
DISCH:

FINANCIAL CLASS: PRIVATE PAY (P)

INSUR 1:
REL: CODE:
INSURED:
INS ID:
SS#:
GRP NAME:
GRP NO.:
AUTH #.:

STREET:
CITY:
STATE: ZIP:

INSUR 2:
REL: CODE:
INSURED:
INS ID:
SS#:
GRP NAME:
GRP NO.:
AUTH #.:

STREET:
CITY:
STATE: ZIP:

COMMENTS: PT WILL BILLING KMART

-*-

1. **CONSENT FOR HEALTH CARE SERVICES:** I voluntarily consent to and authorize the rendering of health care services, includin routine hospital services, diagnostic procedures, intravenous therapy, medications, injections, laboratory services, and other service or procedures, including the use or potential use of restraint, which my attending physician or others holding clinical privilege consider necessary. I understand that health care services may be rendered by students, interns or residents under physicia supervision. I further understand that the practice of medicine is not an exact science and I acknowledge that no promises c guarantees have been made to me regarding treatment or services rendered in this health care facility.

2. **AUTHORIZATION FOR RELEASE OF INFORMATION.** I authorize the hospital and my physicians to release information from m medical records to any health care provider involved in any way in my care and treatment, to any party assisting the hospital in th collection of hospital charges and to any person or entity which is or may be liable for all or part of the hospital charges, includin but not limited to, my insurance carrier, any third-party payor, the Medicare/Medicaid programs, and my employer's workers compensation carrier, and any third party utilization and quality review agent, if any, used by the payor. I also authorize the release of information needed for discharge planning, transfer, and follow-up purposes.

3. **MEDICARE and/or MEDICAID CERTIFICATION.** I certify that the information given by me in applying for payment under the Medicare and/or Medicaid programs is correct, and I authorize the release of all information needed to act on this request. I reques that payment of authorized benefits be made to the Hospital on my behalf for the Hospital's and physicians' charges for which the Hospital is authorized to bill in connection with these health care services.

4. **RETENTION OF SPECIMENS.** I authorize the Hospital to take, retain, preserve and use for scientific or teaching purposes, o dispose of at its convenience, all specimens, tissues, parts, or organs taken from my body during my hospitalization.

5. **INDEPENDENT PRACTITIONERS.** I understand that I may be billed separately by professionals, including but not limited tc emergency department physicians, radiologists, pathologists, and anesthesiologists, who are independent contractors and are no agents or employees of the Hospital for health care services rendered to me. I further understand that it is my responsibility to verify my insurance benefits and coverage, if any.

6. **FINANCIAL AGREEMENT.** I understand that there is no guarantee of reimbursement or payment from any insurance company o other payor. I acknowledge full financial responsibility for, and agree to pay, all charges of the Hospital and of physicians rendering services not otherwise paid by my health insurance or other payor. All charges are due and payable upon receipt of the bill. I payment is not made within 90 days after receipt of the bill, a delinquent charge or interest at the maximum legal rate may be added I agree to pay all reasonable legal expenses necessary for the collection of any debt. I acknowledge and understand that any refunc that I may be owed will be forwarded to the address on file with the Hospital.

7 **REAUTHORIZATION REQUIREMENTS.** I understand that it is my sole responsibility to obtain all preauthorizations and to comply with all requirements of any insurance or medical/hospital coverage plan upon which I am relying for coverage of the Hospital's anc physician's charges.

8. **ASSIGNMENT FOR DIRECT PAYMENT.** I authorize and direct that payment of any insurance or health care benefits otherwise payable to me for health care services or goods be made directly to the Hospital and my physicians, to include any hospital-basec radiologists, pathologists, anesthesiologists and emergency department physicians. I understand that I am financially responsible tc the Hospital or my physicians for charges not covered or paid pursuant to this authorization.

9. **PERSONAL VALUABLES.** The Hospital maintains a safe for the safekeeping of any money or valuables. I understand that the Hospital does not assume responsibility for the loss, damage, or disposal of my personal property or money including jewelry clothing, false teeth, eyeglasses, contact lenses, hearing aids, prosthetic devices, or any other item unless such money or property is deposited with the Hospital. I take full responsibility for any money or property retained in my possession/room or brought to me while I am a patient at the Hospital.

I ACKNOWLEDGE I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS AND HAVE RECEIVED A COPY HEREOF. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE, TO SIGN THIS AGREEMENT, CONSENT TO, AND ACCEPT ITS TERMS.

Myrtle McNally
SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PERSON

NAME (PRINT)

RELATIONSHIP REASON WHY PATIENT IS UNABLE TO SIGN

5-10-01 DATE

1225 TIME

WITNESS SIGNATURE

WITNESS SIGNATURE

ADDRESSOGRAPH

EHR1
PH
MCNALLY, MYRTLE
05/10/01 WELCH MICHAEL DO
01/17/29 NONE
4905 10

Penrose-St. Francis Health Services

Centura Health

Patient Registration and Consent for Medical Treatment

27605 (12/00)

CHART MEDICAL RECORDS

Note: During this visit we have attempted to provide an emergency examination and treatment only. For this acute problem, please follow the instructions listed below. If you have any questions about these instructions, please ask the doctor or nurse.

If x-rays were taken, the reading given to you today by the physician is a preliminary report. An x-ray specialist will review these films and notify you and your regular physician within 24 hours if there is a change in the diagnosis.

It is important that you obtain follow-up medical treatment to complete the care you have received in the Emergency Department. It is recommended that you contact your regular physician or clinic or the physician provided who is on-call for this care and your ongoing health needs.

Call to make an office appointment to see:

Physician Welch in _____ days.

Address _____ Phone 632-5700

If today's symptoms persist or worsen, or you are unable to see a physician, please return to the Emergency Department.

Instruction Sheet # 13 is pertinent to your condition and is attached for your referral.

(1) Take 3 Advil three times A day with meals.

(2) See your doctor in 2-3 days if Symptoms no better.

(3) Return to E.R. if Symptoms no better or headache worsens.

I have read the contents of this document and have had my questions answered. By signing below, I indicate that I have been informed and understand.

X Myrtle McNeely
Patient's Signature

X M Welch RVC
Witness

5/10/01 1530
Date/Time

5/10/01 1530
Date/Time

FINANCIAL INFORMATION

You may receive separate statements from physicians involved in your care in the Emergency Department. If you have any questions regarding those charges, please call the number shown on the bill in question (i.e., Emergency Physician, Radiologist, Pathologist).

If you have provided complete insurance information, Penrose-St. Francis Health Services will bill health insurance carriers with whom we have appropriate agreements as a courtesy. Please remember that you are ultimately responsible for payment of all charges.

You may pay your account by using check, cash, Mastercard, Visa, or American Express. If you have further questions, please contact the Patient Accounts Department at 776-5900.

	Original to Patient	Copy to Patient Record
Penrose Hospital Emergency Department	776-5333	ADDRESSOGRAPH
Penrose Community Hospital Emergency Department	776-3216	PH
Flagstaff Brown Urgent Care Center	686-0551	MCNEELY, MYRTLE 05/10/01 WELCH MICHAEL DO F 73 01/17/29 NONE 4294906 1016

Penrose-St. Francis Health Services
Centura Health

Emergency Department
Patient Aftercare Instruction Sheet

28667 03/00

RESPONSIVENESS SCALE (KEY)		
EYE OPENING (E)	VERBAL RESPONSE (V)	MOTOR RESPONSE (M)
4 Spontaneous	5 Oriented	6 Obeys
3 To Speech	4 Confused	5 Localizes
2 To Pain	3 Inapp. Words	4 Withdraws
NIL	2 Inapp. Sounds	3 Abn. Flexion
	1 NIL	2 Extends
		1 NIL

PUPIL RESPONSE (KEY)

● 1mm ● 3mm ● 5mm ● 7mm

S = SLUGGISH B = BRISK NR = NON REACTIVE

Allergies: MSO4, Codeine, Penicillin, Sulfa

Date: 5/10/01

Time: 1158

Mode of Arrival: ☐ POV ☐ W/C ☐ Ambulance ☐ Cart ☐ ~~Ambulatory~~ ☐ Carried

Medications: See list.

Family notified: Daughter Private Phys.: Welch

Wt: _____ LMP: _____ Last Tetanus: _____

VITAL SIGNS						Response Scale	Pupils	Visual Acuity
Time	T	P	R	BP	P.Ox			Time
1200	98.3	80	20	165/85	96	Time E 4	Rt. Lt.	OD
~~1230~~	error	mud				V 5		
1400	error	mud				M 6		OS
~~1520~~	0	error	mud			Time E 4	Rt. Lt.	
1430		74	20	158/74		1540 V 5		OU
						M 4		
						Nurse		Initials
						R Childs		RH
						M McLewson		RNC MVJ

MEDICATIONS/PROCEDURES					
Time	Medication	Dosage	Route	Site	Initials

PMH: CAD c Cabg, Endarterectomies, HTN

TB SCREEN Have you had a persistent cough for over 2 weeks? ☐YES ~~☐NO~~
If YES, see attached checklist.

DV SCREEN Are you currently in a relationship where you are being hit, kicked, slapped or otherwise hurt? ☐YES ~~☐NO~~
Do you feel safe at home? ☐YES ☐NO

DAR: 72 yr F here for C/O Neck, foot & Shoulder pain p fall @ retail ~~outlet~~ outlet. 1320 - Amb to RM 8 of 1330. Dr. Pionkwski for exam; c/o pain c movement of neck. Now tender to palp; c/o L shoulder/chest pain. No obvious trauma noted. - mud. 1400. to X-ray. - mud 1430: At back from X-ray. - mud. 1500: Dr. Pionkwski ofc. NC. Ext on And init. - mud. 1540: Pt voiced good understanding of DC inst given - mud

NURSING DIAGNOSIS

- ☐ Altered Body Temp
- ☐ Airway
- ☐ Anxiety
- ☐ Breathing
- ☐ Elimination
- ☐ Knowledge Deficit
- ☐ Mobility Impaired
- ☑ Pain
- ☐ Perfusion
- ☐ Self-Care Deficit
- ☐ Skin Integrity Impaired
- ☐ Volume Deficit
- ☐ _____

Siderails UX2 Initials mud

INTAKE	OUTPUT
IV _____	Urine _____
PO _____	Other _____
Other _____	

Disposition: Home Time: 1540

Mode of Travel: Ftn Report Time - To: _____

Rose-St. Francis Health Services
Centura Health

ADDRESSOGRAPH

MC Nally, Myrtle
[illegible] WELCH MICHAEL DO
[illegible] WINTERS MORE
1/17/29 [illegible] 1015

26645 4/01 **Emergency Nursing Assessment Record Part I**

TO BE COMPLETED BY STORE PERSONNEL

STORE AUTHORIZATION FOR FIRST AID

STORE STAMP
4332 Kmart
3020 N. NEVADA ST.
COLORADO SPRINGS, CO 80907

To: _____
Name of Doctor, Clinic or Hospital

Authorized By: _____

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

Patient Name Myrtle McNally Incident Date 5-10-01 Incident Time 11:10 AM

Address 340 No. El Paso FDL DOB 1-17-29 Soc. Sec. No. 509-26-8820

Co. Spgs, Co. 80907 Height 5'4" Weight 180#
(City) (State) (Zip Code)

Patient's Employer NA

TO BE COMPLETED BY PATIENT

PATIENT AUTHORIZATION TO RELEASE INFORMATION

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

Patient Signature Myrtle McNally Date 5-10-2001
(Parent should sign for patient under age 18 and print child's name next to parent's signature.)

TO BE COMPLETED BY PHYSICIAN

PHYSICIAN'S MEDICAL REPORT

Date of examination / treatment 5/10/01

History of incident given by patient Tripped on pallet 1110 AM

Patient's complaints (L) Lat Neck, (L) shoulder, (L) upper chest, (R) toes Ache

Clinical findings _____

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

Diagnosis _____

Treatment rendered X Rays

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

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

Signature of physician _____ Date 5-10-01

Name of physician Pionkowski Fed ID _____

Office address 2131 N Tejon CS, C 80907

ER

#8

Date: 5-10-01

Patient Name: McNally, Myrtle

...R#: 42 94 90 6

Imaging done:

- ☑ CXR
- ☑ C-Spine 2-View
- ☐ T-Spine
- ☐ L-Spine
- ☑ Other Lt Shoulder
- ☑ Other Lt Foot Mult. Digit
- ☐ CT - Head
- ☐ CT - Abdomen
- ☐ CT – Pelvis
- ☐ Other _____
- ☐ US – Abdomen
- ☐ US – Venous
- ☐ US – OB
- ☐ US - Pelvis

Nuclear Med:

- ☐ Lung
- ☐ Hida
- ☐ Other _____

Radiology Report:

- ☐ Normal
- ☐ Unchanged
- ☐ Other*

* Shoulder/Foot (–)

Cspine (–)

CXR – MILD ANT WEDGING @ MID Tspine. SIP CARG. OK (–)

Agree with above:

___R.J. Asleson	___ K. Limbird
___P. Barrett	___ C.T. McMullen
___T.R. Bates	___ C. Peeters
___J.P. Borgstede	___ M. Pitman
___D. Burdick	___ W.F. Rogers
___J. Campbell	___ D. Shaeffer
___K. Davis	___ J.F. Snider
___C. Gregory	___ J. Sweeney
___S. Jensen	___ F. Van Wagenen

Other _____

Penrose-St. Francis
H h Services
Catura Health

ADDRESSOGRAPH

Radiology Department
Call Report

27067 4/01

DATE	MEDICATION	DOSAGE	FREQUENCY
7/18	CARDURA	4 MG	2 DAILY
	~~TAMOXIFEN~~	~~10 MG~~	~~2 DAILY~~
	LEVOTABS	0.125 MG	1 DAILY
	~~PRAVACHOL~~	~~40 MG~~	~~1 DAILY~~
	ADALAT	30 MG	1 DAILY
	POT CHLORIDE	10 MG.	2 DAILY
	SPIRONOLACTONE	25 MG	2 DAILY
	Lipitor ~~10~~	10 mg	1 Daily
	RYTHMOL	225 MG.	2. DAILEY

EM' GENCY DEPARTMENT & AHC 'CUITY MASTER

MEDICAL ACUIT.

INFUSION THERAPY	POINT VALUE = 10	POINT VALUE = 20	POINT VALUE = 30
IV INFUSION THERAPY (SEE CHARGE LEVEL BELOW) INCLUDES IV START PRN NO NEED TO MARK OTHER CATEGORIES	AMBULANCE TRIAGE	ADMISSION: SIMPLE (MEDICAL FLOOR)	ADMISSION: RN ACCOMPANY (ICU/CCU)
TRIAGE/ LWBS	USE OF MONITORING EQUIPMENT: EKG / NIBP / SAO2	1:1 CARE & / OR CONSCIOUS SEDATION: (X EACH HOUR) (MAY BE USED IN CONJUNCTION W/ MULTIPLE RN PRESENCE)	BLOOD TRANSFUSION MULTIPLE IV DRIPS LEVEL I
POINT VALUE = 0	NEBULIZER TREATMENT: GIVEN BY ED STAFF	REASSESSMENT ONGOING CARE / REPEAT VITALS MARK ONLY FOR EXTENDED VISITS	RESTRAINT/SECLUSION COMBATIVE / CONFUSED INCONTINENT
SUTURE REMOVAL/ WOUND CHECK/	PELVIC EXAM: MAY INCLUDE SPECIMEN COLLECTION	IRRIGATION: EYE - MORGAN LENSES EAR BLADDER / NG	INTUBATED PATIENTS: ARRIVES INTUBATED / INTUBATED IN ED
POINT VALUE = 5	IV SOLUTIONS & IVPB (MULTIPLY BY # OF BAGS)	IV STARTS: (MARK # OF IVS)	VENTILATOR
WALK / POV TRIAGE	DISCHARGE: COMPLEX DISPENSE MEDICATIONS ARRANGE HOME O2		MULTIPLE RN PRESENCE: CODE BLUE TRAUMA & MERIT TEAMS THROMBOLYTICS
THROAT CULTURE / BLOOD DRAW	MEDICATIONS ADMINISTRATION: (PO / SL / IM / SQ/ IV) FIRST DOSE (MARK ONCE)	MEDICATION ADMINISTRATION: (PO / SL/ IM /SQ /IV) SUBSEQUENT DOSES (MARK 1 X ONLY)	THROMBOLYTIC THERAPY: FOR ACUTE MI / STROKE TPA/ REOPRO / TNK / INTEGRELIN
D/C IV	FOLEY CATH/ MINICATH	NG TUBE	GD LAVAGE
VISUAL ACUITY	ENEMA	DEATH PACKET	SEXUAL ASSAULT
OXYGEN THERAPY	TRANSFERS: NO RN DETOX, PPMH, NURSING HOMES	ABG BY ED STAFF	DECONTAMINATION- EXTENSIVE
FETAL HEART TONES	EKG: STAT DONE BY ED STAFF	ARTERIAL LINE SETUP	TRANSFERS: RN ACCOMPANY RN GOES WITH PATIENT TO OTHER FACILITY
AHC (MARK ONLY)	BAIR HUGGER	RSV WASHING / PEDIATRIC BLOOD DRAW	NEWBORN CARE: POST BIRTH RESUSC & CARE
DISCHARGE: SIMPLE RX GIVEN, NO MEDS DISPENSED	MINOR WOUND CARE: CLEANSING, SMALL DRESSING (OINT. & BANDAID)	INTERMEDIATE WOUND CARE: CLEANSING > 10 MINUTES. MULTIPLE MINOR WOUNDS, MEDIUM DRESSING (OINT., KLING)	COMPLEX WOUND CARE: EXTENSIVE OR LENGTHY CLEANSING / IRRIGATION. LARGE DRESSINGS (BULKY, OINTMENT, TUBE GUAZE, FLUFF)
TOTAL THIS COLUMN (10)	TOTAL THIS COLUMN	TOTAL THIS COLUMN	TOTAL THIS COLUMN

PROCEDURAL ACUITY *(NOTE POINT VALUE DIFFERENCES)*

POINT VALUE = 5	POINT VALUE = 20	POINT VALUE =30	POINT VALUE =50
THYROID BIOPSY -FINE NEEDLE	WOUND REPAIR: MINOR STERI STRIPS / DERMABOND (ADD MINOR WOUND CARE)	WOUND REPAIR- INTERMEDIATE: WOUND ANESTHESIA / SUTURE TRAY / SINGLE PACK OF SUTURES / STAPLES (add wound care)	WOUND REPAIR - COMPLEX: MULTIPLE WOUNDS / MULTI-LAYERED CLOSURE / WOUND REVISIONS/ LENGTHY REPAIR (add wound care)
		EYE EXAM	EXTERNAL PACING
	NOSEBLEED- MINOR: MINIMAL INTERVENTIONS / SILVER NITRATE	NOSEBLEED - INTERMEDIATE: RETURN VISIT / MODERATE INTERVENTIONS / VASELINE GUAZE	NOSEBLEED - COMPLEX: MULTIPLE INTERVENTIONS/ IVS/ POSTERIOR PACKING/ POSSIBLE ADMISSION
POINT VALUE = 10		**POINT VALUE = 40**	**POINT VALUE = 60**
MULTIPLE WOUNDS OR MULTIPLE ORTHOPEDIC INJURIES *(ADD IF THERE ARE MULTIPLES OF A TYPE OF INJURY)*	MINOR ORTHO STABILIZATION: (ACE WRAP,SLINGS, PREFORMED SPLINTS)	INTERMEDIATE ORTHO: SPRAIN / FRACTURE OCU CASTING	COMPLEX ORTHO: MULTIPLE INTERVENTIONS / COMPLICATED STABILIZATION
	INTEROSSEOUS	RESET DISLOCATION	CARDIOVERSION
	ANOSCOPE	BONE FIXATION: INTERMEDIATE C MIRES FOR FINGERS	BONE FIXATION: COMPLEX: HALO TRACTION / STEINMAN PINS
		JOINT ASPIRATION/ COMPARTMENT	CHEST TUBE INSERTION
	NERVE BLOCK FOR PAIN CONTROL	THORACENTESIS	CARDIOPULMONARY RESUSCITATION
	DRAIN SUBUNGUAL HEMATOMA	DIRECT LARYNGOSCOPE	TRACH/ CRICH/ INTUBATE
	FB REMOVE - SIMPLE	TREAT VAGINAL HEMORRHAGE	PERICARDIOCENTESIS
	INCISION AND DRAINAGE	LUMBAR PUNCTURE	THORACOTOMY
		CENTRAL LINE PLACEMENT	VAGINAL DELIVERY
TOTAL PROCEDURE COLUMN	TOTAL PROCEDURE COLUMN	TOTAL PROCEDURE COLUMN	TOTAL PROCEDURECOLUMN

MEDICAL LEVELS: CIRCLE	PROCEDURE LEVELS: CIRCLE
IV INFUSION THERAPY	LEVEL I =0 -10
TRIAGE/LWBS	LEVEL II = 15 - 20
LEVEL 0/ suture removal	LEVEL III =25 -30
AHC	LEVEL IV = 35- 40
LEVEL I = 5 -15 (10)	LEVEL V =45 -55
LEVEL II =20 - 45	LEVEL VI =60 & OVER
LEVEL III = 50 - 85	
LEVEL IV = 90 -125	
LEVEL V = 130 - 245	
LEVEL VI = 250 -& OVER	

STAMPER

E N R 1

P N

PLEASE KEEP WITH MEDICAL RECORD.

SKIN
✓ intact
✓ warm, dry

__see diagram
__crepitus / diaphoresis

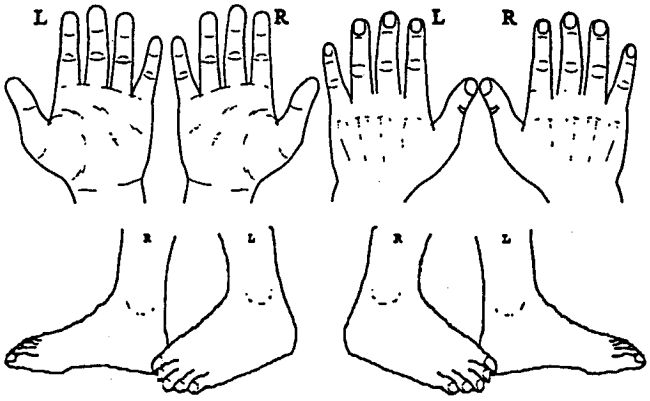
BACK
✓ no CVA tenderness
✓ no vertebral tenderness

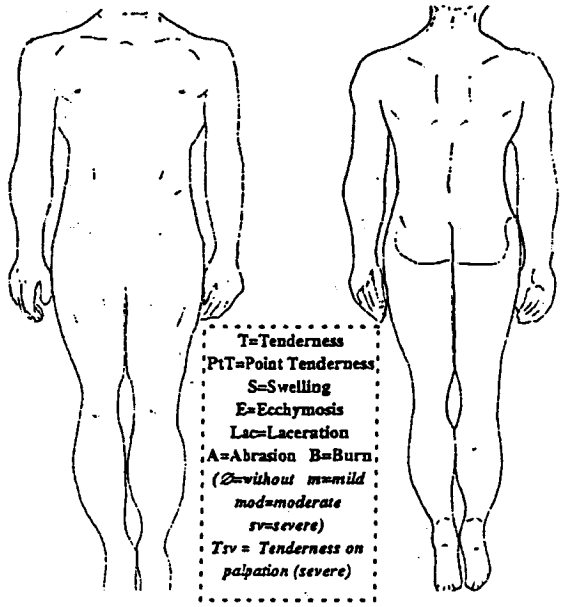
__see diagram
__vertebral point-tenderness
__CVA tenderness
__muscle spasm / limited ROM

EXTREMITIES
✓ atraumatic
✓ pelvis stable
__hips non-tender
__no pedal edema
__nml ROM

__see diagram
__bony point-tenderness
__painful / unable to bear weight
__pulse deficit

Joint Exam:
__limited ROM / ligaments laxity / joint effusion





PROGRESS:

XRAYS ☐ Interp. by me ☒ Reviewed by me ☐ Discsd w/radiologist

C-Spine *D-Spine* *LS-Spine*
✓ nml / NAD
✓ no fracture
✓ nml alignment
✓ soft tissues nml
__reversal / straightening of cerv. lordosis
__DJD / spondylosis / spurring

CXR
✓ nml / NAD
✓ no infiltrates
✓ nml heart size
✓ nml mediastinum
__rib fracture
__infiltrate / atelectasis

OTHER ☐ See separate report
(R) toes NL

__Discussed with Dr.
will see patient in: office / ED / hospital
✓ Counseled patient / family regarding:
lab results diagnosis need for follow-up
__Rx given __Admit orders written

__CRIT CARE- *30-74 min* *75-104 min* ____ *min*
__Prior records ordered
__Additional history from:
family caretaker paramedics

CLINICAL IMPRESSION: *Fall*

contusion

head		wrist	R / L		
face		hand	R / L		
chest		hip	R / L		
abdomen		thigh	R / L		
back		knee	R / L		
shoulder	R / (L)	leg	R / L		
arm	R / L	ankle	R / L		
elbow	R / L	(foot)	(R) / L		
forearm	R / L				

sprain / strain
neck dorsal lumbar

concussion
with LOC *w/o LOC*

laceration

DISPOSITION- ☒ home ☐ admitted ☐ transferred
CONDITION- ☐ unchanged ☐ improved ☒ stable

PA
MD / DO

☐ Dictated addendum ☑ Template Complete

Wound Description/Repair
length ____ cm. location
__superficial __SQ __muscle __linear __*stellate __*irregular
__clean __contaminated *moderately / *heavily*
distal NVT: __neuro & vascular status intact __no tendon injury
anesthesia: __local __digital block ____ cc
__lidoc 1% 2% epi / bicarb __marcaine .25% .5% __LET
prep:
__Shur-Clens / Betadine
__irrigated / washed w/saline *extensively
__explored
__*debrided / undermined *extensively
__foreign material removed *minimal moderate *extensive*
repair: *Wound closed with: wound adhesive / steri-strips*
SKIN- #____ ____-0 nylon / prolene / staples
*SUBCU- #____ ____-0 vicryl / chromic
*may indicate intermediate repair *may indicate intermediate or complex repair

EMR 1
PH
MCNALLY, MYRTLE
05/10/01 WELCH MICHAEL DO
F 72 01/17/29 NONE
4294906 1016

19 **Fall** (5)

TIME SEEN: 1330 ROOM: 8 __ EMS arrival

HISTORIAN: __patient __spouse __paramedics

__HX / __EXAM LIMITED BY:

HPI **chief complaint:** Fall *Injury to:*

occurred:
- just PTA 1110 Am
- __today
- __yesterday
- ____ days PTA

where:
- __home __school
- __neighbor's __city park
- __work __street
- Kmart

context:
- tripped / slipped / lost balance __alleged assault
- __became dizzy / fainted __bicycle (helmet? Y N)
- Fell from (standing position / from height)
- fell back.

location of pain/injuries:

head face mouth
neck chest abdomen
back *upper mid- lower*
radiating to R / L thigh / leg

–right–		–left–	
shldr	hip	shldr	hip
arm	thigh	arm	thigh
elbow	knee	elbow	knee
f-arm	leg	f-arm	leg
wrist	ankle	wrist	ankle
hand	foot	hand	foot

severity of pain:
- mild
- moderate
- severe

associated symptoms:
- __lost consciousness / dazed
  duration:
  remembers:
  impact *coming to hospital*
- __seizure

ROS ☐all systems neg except as markd
- __loss feeling/power arms/legs
- __headache
- __double vision / hearing loss
- __trouble breathing / chest pain
- __nausea / vomiting
- __loss of bladder function
- __skin laceration
- __recent fever / illness

SOCIAL HISTORY __recent ETOH __smoker __drug abuse

PAST HISTORY __negative
- ↑BP
- ↑Chol

Meds- __none / ✓see nurses note

Allergies- __NKDA / ✓see nurses note

© 2000 T-System, Inc. Circle or check affirmatives, backslash (\) negatives.

Penrose St. Francis Health Services
EMERGENCY PHYSICIAN RECORD

☑ Nurses note reviewed ☑ Tetanus immun. UTD ☐ Vital signs reviewed

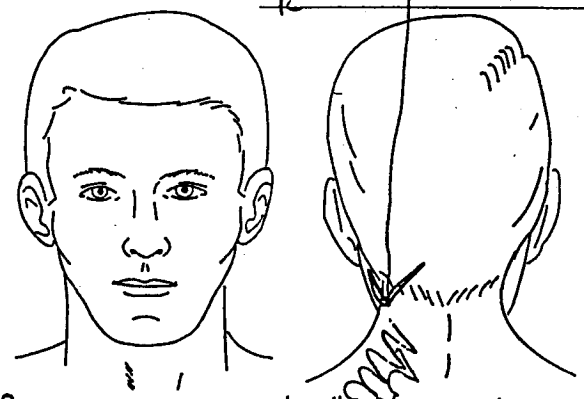
PHYSICAL EXAM Alert __Lethargic __Anxious

Distress- __NAD __mild __moderate __severe

Other- __c-collar (PTA / in ED) __back-board __IV __splint

HEAD
- no evidence of trauma
- __see diagram
- __Battle's sign / Raccoon Eyes

NECK
- non-tender
- painless ROM
- trachea midline
- __see diagram
- __vertebral point-tenderness
- __muscle ~~spasm / decreased~~ ROM
- pain on movement of neck



EYES
- PERRL
- EOMI
- __unequal pupils R-___mm L-___mm
- __EOM entrapment / palsy
- __subconjunctival hemorrhage

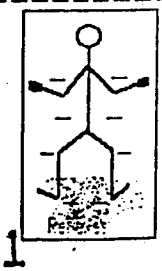
ENT
- nml external inspection
- no dental injury
- __hemotympanum
- __TM obscured by wax
- __clotted nasal blood
- __dental injury / malocclusion

RESP & CVS
- chest non-tender
- breath sounds nml
- heart sounds nml
- see diagram (on reverse)
- __decreased breath sounds
- __wheezing / rales
- __splinting / paradoxical movements

ABDOMEN
- non-tender
- no organomegaly
- __see diagram (on reverse)
- __tenderness / guarding / rebound
- __mass / organomegaly

GENITAL / RECTAL
- __nml genital exam
- __nml vaginal exam
- __nml rectal exam
- __heme negative stool
- __perineal hematoma
- __blood at urethral meatus
- __decreased rectal tone

NEURO / PSYCH
- oriented x3
- mood & affect
- CN'S nml as tested
- sensation & motor nml
- __confusion / disorientation
- __EOM palsy / anisocoria
- __facial asymmetry
- __unsteady / ataxic gait
- __sensory / motor deficit



EHR 1
PH

MCNALLY, MYRTLE
05/10/01 WELCH MICHAEL DO
F 72 01/17/29 NONE
4294906 1016

MCNALLY, MYRTLE F 72
MR#: 4294906-1-016 ADM: 05/10/01
SERV: TRAU EMR1
MD: WELCH MICHAEL DO 8045
DX: NECK, FOOT, SHOULDER PAIN

PRIMARY MD: WELCH MICHAEL DO 8045
ORDER: LT FOOT MULT DIGIT 13.01

XRAY

VERIFIED RADIOLOGY RESULTS
-PERMANENT CHART COPY-
REQ#: I130-0240

DATE OF EXAM: 05/10/2001 ORDERING MD ID #: 047 PIONKOWSKI RICK MD

RIGHT FOOT

COMPARISONS: NONE.

HISTORY:

TRAUMA AND PAIN.

FINDINGS:

THERE IS MILD OSTEOPENIA. THERE IS NO RADIOGRAPHIC EVIDENCE, HOWEVER, FOR FRACTURE, DISLOCATION, OR SUBLUXATION.

IMPRESSION:

NO EVIDENCE OF FRACTURE OR DISLOCATION WITH MILD CALCANEAL SPURRING.

STEVEN JENSEN M.D., ≡1000≡ SPJ/SJS
THIS TEST WAS PERFORMED AT PENROSE HOSPITAL.
D: 05/10/2001 15:14 T: 05/10/2001 15:16:50

LAST PAGE

Penrose-St. Francis
Health Services
Centura Health

Langstaff-Brown Urgent Care / 686-0551
41 Highway 67
Woodland Park, CO 80863

Penrose Hospital
Emergency Department / 776-5333
2215 N. Cascade Avenue, Colorado Springs, CO 80907

Penrose Community Hospital
Emergency Department / 776-3216
3205 N. Academy, Colorado Springs, CO 80917

CONTUSIONS:

A contusion is a bruise, usually caused by hitting a part of your body against some hard object. This leads to some damage to the skin, fat, muscle, blood vessels, nerves, and outside of the bone. The damaged blood vessels leak blood, causing swelling and sometimes a black and blue mark. The swelling can stretch the nerves and cause more pain. Treatments described below are aimed at stopping the bleeding under the skin.

In general, an injury that is severe enough to cause a great deal of swelling, pain, and inability to walk or support weight requires medical attention and will probably need x-ray examination to look for a fracture. Remember, some fractures do not show up right away on an x-ray; therefore, the x-ray may need to be repeated in 7 - 10 days to look for a fracture if you are not better.

TREATMENT:

Time and rest alone are the best ways to promote healing. One or two weeks of disability, discomfort and pain are not unusual.

- Elevate the injured area. Keep it higher than your heart by resting your arm or leg on some cushions for the first 24 - 48 hours. This will help cut down the swelling and throbbing.
- Ice packs reduce the pain and swelling. The sooner they are applied after the injury, the better. Use crushed ice wrapped in cloth or a plastic bag. Apply for 15 - 20 minutes at a time, and do this off and on for the first 48 hours. Two or three days after the injury, heat may feel better than ice.
- An ace or elastic bandage around the injured area keeps motion to a minimum and will aid healing - do not apply this so tightly that it makes the area feel uncomfortable or the limb turns blue.
- Avoid using the injured area until it is not painful to do so. This may mean staying off your feet or using crutches for several days.
- As pain decreases, gentle use of the muscles can begin. Soaking is a tub of warm water may help when starting to exercise.
- Slowly increase walking or use of the muscles. Rest if pain or swelling returns.
- Acetaminophen is excellent for minor pain and discomfort. Follow the dosage directions on the package. Aspirin should be avoided, unless prescribed by your doctor. Other medicines may be prescribed by your doctor for pain.

CONTACT YOUR DOCTOR OR RETURN TO THE EMERGENCY DEPARTMENT IF ANY OF THE FOLLOWING OCCUR:

- Fever (greater than 101F/38.3C by mouth) or shaking chills begin or worsen.
- Swelling, pain, or difficulty bearing weight continue for a week or more.
- Increased pain, cold, color change, numbness, tingling or weakness in the injured area.

X-RAYS

If x-rays were taken, the reading given to you by the doctor may be a preliminary report. The x-ray specialist will review these films and, if a change in diagnosis is discovered, you and/or your doctor will be notified.

Note: During this visit we have attempted to provide an emergency examination and treatment only. For this acute problem, please follow the instructions listed below. If you have any questions about these instructions, please ask the doctor or nurse.

If x-rays were taken, the reading given to you today by the physician is a preliminary report. An x-ray specialist will review these films and notify you and your regular physician within 24 hours if there is a change in the diagnosis.

It is important that you obtain follow-up medical treatment to complete the care you have received in the Emergency Department. It is recommended that you contact your regular physician or clinic or the physician provided who is on-call for this care and your ongoing health needs.

Call to make an office appointment to see:

Physician Welch in _____ days.

Address _____ Phone 632-5700

If today's symptoms persist or worsen, or you are unable to see a physician, please return to the Emergency Department.

Instruction Sheet # 13 is pertinent to your condition and is attached for your referral.

(1) Take 3 Advil three times a day with meals.

(2) See your doctor in 2-3 days if symptoms no better.

(3) Return to E.R. if symptoms no better or headache worsens.

I have read the contents of this document and have had my questions answered. By signing below, I indicate that I have been informed and understand.

(+) Myrtle McNally
Patient's Signature

X M Welch RVC
Witness

5/10/01 1530
Date/Time

5/10/01 1530
Date/Time

FINANCIAL INFORMATION

You may receive separate statements from physicians involved in your care in the Emergency Department. If you have any questions regarding those charges, please call the number shown on the bill in question (i.e., Emergency Physician, Radiologist. Pathologist).

If you have provided complete insurance information, Penrose-St. Francis Health Services will bill health insurance carriers with whom we have appropriate agreements as a courtesy. Please remember that you are ultimately responsible for payment of all charges.

You may pay your account by using check, cash, Mastercard, Visa, or American Express. If you have further questions, please contact the Patient Accounts Department at 776-5900.

	Original to Patient	Copy to Patient Record
Penrose Hospital Emergency Department	776-5333	ADDRESSOGRAPH
enrose Community Hospital Emergency Department	776-3216	PH
angstaff Brown Urgent Care Center	686-0551	MCNALLY, MYRTLE 05/10/01 WELCH MICHAEL DO F 72 01/17/29 NONE 4294906 1016

Penrose-St. Francis Health Services
Centura Health

Emergency Department
Patient Aftercare Instruction Sheet

28667 03/00

1. **CONSENT FOR HEALTH CARE SERVICES:** I voluntarily consent to and authorize the rendering of health care services, including routine hospital services, diagnostic procedures, intravenous therapy, medications, injections, laboratory services, and other services or procedures, including the use or potential use of restraint, which my attending physician or others holding clinical privileges consider necessary. I understand that health care services may be rendered by students, interns or residents under physician supervision. I further understand that the practice of medicine is not an exact science and I acknowledge that no promises or guarantees have been made to me regarding treatment or services rendered in this health care facility.

2. **AUTHORIZATION FOR RELEASE OF INFORMATION.** I authorize the hospital and my physicians to release information from my medical records to any health care provider involved in any way in my care and treatment, to any party assisting the hospital in the collection of hospital charges and to any person or entity which is or may be liable for all or part of the hospital charges, including but not limited to, my insurance carrier, any third-party payor, the Medicare/Medicaid programs, and my employer's workers' compensation carrier, and any third party utilization and quality review agent, if any, used by the payor. I also authorize the release of information needed for discharge planning, transfer, and follow-up purposes.

3. **MEDICARE and/or MEDICAID CERTIFICATION.** I certify that the information given by me in applying for payment under the Medicare and/or Medicaid programs is correct, and I authorize the release of all information needed to act on this request. I request that payment of authorized benefits be made to the Hospital on my behalf for the Hospital's and physicians' charges for which the Hospital is authorized to bill in connection with these health care services.

4. **RETENTION OF SPECIMENS.** I authorize the Hospital to take, retain, preserve and use for scientific or teaching purposes, or dispose of at its convenience, all specimens, tissues, parts, or organs taken from my body during my hospitalization.

5. **INDEPENDENT PRACTITIONERS.** I understand that I may be billed separately by professionals, including but not limited to emergency department physicians, radiologists, pathologists, and anesthesiologists, who are independent contractors and are not agents or employees of the Hospital for health care services rendered to me. I further understand that it is my responsibility to verify my insurance benefits and coverage, if any.

6. **FINANCIAL AGREEMENT.** I understand that there is no guarantee of reimbursement or payment from any insurance company or other payor. I acknowledge full financial responsibility for, and agree to pay, all charges of the Hospital and of physicians rendering services not otherwise paid by my health insurance or other payor. All charges are due and payable upon receipt of the bill. If payment is not made within 90 days after receipt of the bill, a delinquent charge or interest at the maximum legal rate may be applied. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I acknowledge and understand that any refund that I may be owed will be forwarded to the address on file with the Hospital.

   PREAUTHORIZATION REQUIREMENTS. I understand that it is my sole responsibility to obtain all preauthorizations and to comply with all requirements of any insurance or medical/hospital coverage plan upon which I am relying for coverage of the Hospital's and physician's charges.

8. **ASSIGNMENT FOR DIRECT PAYMENT.** I authorize and direct that payment of any insurance or health care benefits otherwise payable to me for health care services or goods be made directly to the Hospital and my physicians, to include any hospital-based radiologists, pathologists, anesthesiologists and emergency department physicians. I understand that I am financially responsible to the Hospital or my physicians for charges not covered or paid pursuant to this authorization.

9. **PERSONAL VALUABLES.** The Hospital maintains a safe for the safekeeping of any money or valuables. I understand that the Hospital does not assume responsibility for the loss, damage, or disposal of my personal property or money including jewelry, clothing, false teeth, eyeglasses, contact lenses, hearing aids, prosthetic devices, or any other item unless such money or property is deposited with the Hospital. I take full responsibility for any money or property retained in my possession/room or brought to me while I am a patient at the Hospital.

I ACKNOWLEDGE I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS AND HAVE RECEIVED A COPY HEREOF. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE, TO SIGN THIS AGREEMENT, CONSENT TO, AND ACCEPT ITS TERMS.

Myrtle McNally
SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PERSON

NAME (PRINT)

RELATIONSHIP/REASON WHY PATIENT IS UNABLE TO SIGN

5-10-01
DATE

1225
TIME

Deborah Engel
WITNESS SIGNATURE

WITNESS SIGNATURE

Penrose-St. Francis Health Services

Centura Health.

Patient Registration and Consent for Medical Treatment

ADDRESSOGRAPH

EMR1
PH
MCNALLY, MYRTLE
05/10/01 WELCH MICHAEL DO
F 72 01/17/29 NONE
4294906 1016

27605 (12/00)

PATIENT

MYRTLE MCNALLY
3410 N EL PASO D10

COLORADO SPGS CO 80907

05/16/01

Colorado Springs Radiologists provided the following services for:

Account number: 343833 MYRTLE MCNALLY

05/10/01 XRAY FOOT MIN 3V LEFT INTERP PENROSE HOSPITAL EMERG 05
05/10/01 XRAY CHEST PA & LAT INTERP PENROSE HOSPITAL EMERG 05
05/10/01 XRAY SHOULDER MIN 2V LT INTERP PENROSE HOSPITAL EMERG 05
05/10/01 XRAY CERVICAL SPINE INTERP PENROSE HOSPITAL EMERG 05

We have billed CO MEDICARE, ID Number 510220438D for these services.
We will bill you at a later date for any amounts determined to be your responsibility.

If any of the above information is incorrect, please call us immediately at (719) 593-1799. Our Business Office hours are 8:30 AM - 12:00, and 1:00 - 5:00 PM, Monday through Friday.

Thank you,

Colorado Springs Radiologists Billing Department

COMMUNITY HEALTH

Progress Notes

Date	5-14-01	Age	72	Wt.	132	Temp	98.5	Pulse	80	Resp.		BP	142/76
LMP		BC		HgB		Time	Acute	Last Pap Smear					

Allergies: Prinivil, codiene, morphine, sulfa

Current Meds: See med flow sheet

EDUCATIONAL MATERIAL PROVIDED: ☐Yes ☐No | TOBACCO USE | CURRENT | FORMER | NEVER

IF YES, EXPLAIN:

Acute Care

Cl: PT fell @ K-mart Lt breast pain & swelling x 5 days

A Hodges

Pr welsh x 10 yr - New Pt. fell on something on Kmart floor

fell on 10th.

(C) landed on (L) side

neck & shoulder - Pennrose - neck mouth - no fr.

Deep achy pain

swelling.

test (B) Breast to CA / Tell.

test mam - 5-6 mo ago.

Nymcard - (PT)

- meds.

Saw Pr welsh wens. Arthritis/

[signature]

Ordinary - Many Sizymeans.

Myrtle McNally

PATIENT IDENTIFICATION

LABEL GOES HERE

5-14

CHC00.06-570.01

1-17-29

EXHIBIT

ALL-STATE LEGAL

C

COMMUNITY HEALTH

Progress Notes

Date	6/8/01	Age	72yr	Wt.	186#	Temp	97.7	Pulse	72	Resp	—	BP	132/85
LMP	—	BC	—	Hgt	—	Temp	—	Last Pap Smear					—

Allergies: Primivil, Codeine, Morphine, Sulfa

Current Meds: ⊖ Δ's since last visit

EDUCATIONAL MATERIAL PROVIDED: ☐Yes ☐No
IF YES, EXPLAIN:

TOBACCO USE	CURRENT	FORMER	NEVER

C/o fell on 5/10 onto a plastic pallet, still having neck, (L) shoulder, & upper back pain (at base of neck) [illegible]

-- ✗ she looks to (B) ↑↑ cervical

(Pennsaid EA)

(PT starting today —

- ASA/tylenol — improving some +

- Xrays - send for - hot in dark.

[illegible] MS ✓

[illegible]

Flexalit. 10 mg BTD
Arthrotec 75 samples #2
PT

MCNALLY , MY[illegible]
Acct#/Pt#: [illegible]
MEDICAID #: 510 [illegible]
REVIEW DATE: MEDIC [illegible]
PRIMARY INS: [illegible]
SECONDARY INS: [illegible]
TERTIARY INS: [illegible]
MEDICAL RECORD # : 157

PATIENT IDENTIFICATION
LABEL GOES HERE

IMMUNI

MCNALLY, MYRTLE
MR# 000157

DATE OF VISIT: 6-8-2001
DATE OF BIRTH:

Date
LMP
Allergies
Current Meds
EDUCATI
IF YES, E

S. This is a 72-year-old female who is here for follow-up. She was seen last month on 5/10/01. She fell on a plastic pallet that was in the aisle at K-Mart and after her fall, she was transported to the emergency room. She was evaluated there and according to her, she had numerous x-rays and she was told that those were all normal without any fractures evident. I did see her on 5/14/01 and determined that this was soft tissue pain that she was complaining of and her pain at that time was primarily in her left breast. Her fall was primarily on her left side. She does have a history of breast cancer on the right and she was very concerned about this causing cancer on the left side. I did refer her to Physical Therapy on her last visit. Unfortunately, she is has not been able to get in and is having her first physical therapy visit this afternoon. Today she presents with primarily pain in her left lateral neck musculature. Motion of her neck, primarily bending to the right, causes her an increase in pain. It sounds like it is muscle spasm. She denies any neurological symptoms distal to this area. There is no numbness or tingling and basically no other complaints other than a sharp, stabbing, pulling pain that is in the right lateral neck area. She has a lot of improvement of the pain in her breast. That seems to have resolved nicely.

O. HEENT: Unremarkable. CHEST: Lungs clear A&P. CVR: S1 and S2. No murmurs, rubs, clicks, S3 or S4. ABDOMEN: Moderately obese, soft, nontender. EXTREMITIES: Without swelling today. She does have some pain to palpation on her left trapezius muscle and this extends to the cervical spine area. This pain does increase when she flexes her neck to the right side. There is a slight amount of swelling that seems to be evident in this area. No other abnormalities noted.

A. 1. Muscle strain of the left trapezius causing cervical neck tenderness and left lateral neck tenderness.

P. I would like her to keep her appointment with physical therapy as I think they can give her a lot of help in this area. Have started her on Flexeril 10 mg b.i.d. Asked her not to do any driving. Asked her to get up very slowly while she is on this medication and if she has a lot of dizziness, she needs to discontinue it. Also gave her samples of Arthrotec 75 mg #24 and asked her to take this once a day. She should follow-up in 2 weeks to see how she is doing.

MARY SZYMANSKI, NP-C/rtm

MSO

CHC00.06-570.01

MEMORIAL HOSPITAL

1400 East Boulder Stre
Colorado Springs, CO
(719) 365-5000

PATIENT REGISTRATION

ACCOUNT NBR	PATIENT TYPE	NURSE STA	ROOM	BED	ACC	ADMIT DATE	ADM TIME	DISCH DATE	DISCH TIME	DTE OF LST SVC	INIT	MED REC NBR
3187069	R					6/08/01	14:00			03/13/01	TAHA	380568

PATIENT NAME	PATIENT ADDRESS	PATIENT CITY	STATE	PAT ZIP
MCNALLY, MYRTLE	3410 N EL PASO ST LOT D10	COLORADO SPGS	CO	80907

PAT PHONE	AGE	CO	BIRTH DATE	RACE	REL	SEX	MAR STAT	SPC HDL	PAT SOC SEC NBR	MED CD	FC	SRC	ADM CAT
719 632-2080	072Y		1/17/29	1	AG	F	W		509-26-1820	MED	M		

ADMITTING DIAGNOSIS

NECK AND SHOULDER PAIN

COMMENTS

BS PT MED A AND B 010194 NEED T AND C SIGNED CC AND MSP NEEDS TO BE DONE

EMERGENCY CONTACT	RELATION	EMER PHONE	TREAT AUTH	CLINICS
PENNY HURLEY	09	719 594-4375		RH

GUARANTORS NAME	GUARANTORS ADDRESS	GUARANTORS CITY	STATE	GRT ZIP
MCNALLY, MYRTLE	3410 N EL PASO ST LOT D10	COLORADO SPGS	CO	80907

GRT PHONE	RELATION	GRT EMPLOYER	GRT EMPLOYERS ADDRESS	GRT EMPLOYERS CITY	STATE	GRT EMP ZIP
719 632-2080	01					

INSURANCE COMPANY NAME	INSURANCE PLAN NAME	INSURANCE ADDRESS
65 MEDICARE	1 MEDICARE OP B	

INS CITY	STATE	INS ZIP	GROUP NUMBER	POLICY NUMBER	SUBSCRIBERS NAME	RELATION
				510220438D	MCNALLY, MYRTLE	01

INSURANCE COMPANY NAME	INSURANCE PLAN NAME	INSURANCE ADDRESS
65 MEDICARE	2 MEDICARE PF	

INS CITY	STATE	INS ZIP	GROUP NUMBER	POLICY NUMBER	SUBSCRIBERS NAME	RELATION
				510220438D	MCNALLY, MYRTLE	01

INSURANCE COMPANY NAME	INSURANCE PLAN NAME	INSURANCE ADDRESS
19 MEDICAID	22 MEDICAID OP	700 BROADWAY

INS CITY	STATE	INS ZIP	GROUP NUMBER	POLICY NUMBER	SUBSCRIBERS NAME	RELATION
DENVER	CO	80273	PCP COMMUNITY HEA	T574448	MCNALLY, MYRTLE	01

ATTENDING PHYSICIAN
AUSMAN, EDWARD J., D.O.

PRINCIPAL DIAGNOSIS: 6/19 - [illegible] a [illegible] plan [illegible] in chart - ([illegible])
Thx Mary

CODE NUMBERS

COMPLICATIONS: (INCURRED AFTER ADMISSION TO HOSPITAL)

OPERATIONS AND PROCEDURES:

CONSULTANT	TRANSFERRED TO

DISCHARGE STATUS	AUTOPSY	PHYSICIAN SIGNATURE	DATE
	YES NO		

FORM NO. 0000002 (1/97)

FACE SHEET - MEDICAL RECORDS

ALL-STATE LEGAL EXHIBIT D

TREATMENT AND CONSENT

MEMORIAL HOSPITAL
1400 East Boulder Street
Colorado Springs, CO 80909

Whenever used herein the word "Patient" means MCNALLY, MYRTLE
Whenever used herein the word "Responsible Party" means MCNALLY, MYRTLE

DATE:	TIME:	ACCOUNT # THIS ADMISSION:	MEDICAL RECORDS #:
6-8-01	1:30	3187069	380568

TREATMENT AND CONSENT

1. MEDICAL, SURGICAL AND HOSPITAL CARE CONSENT: The undersigned, knowing the Patient is suffering from a condition requiring hospital care, diagnostic and medical or surgical treatment, does hereby voluntarily consent to and authorize such hospital care and services, diagnostic procedures, intravenous feedings, injections and medical or surgical procedures which may be performed on the Patient under the general or special instructions of or by Dr. AUSMAN, EDWARD J., D.O. his/her assistants or designee as is necessary in his/her judgment.

2. HEALTH CARE: The undersigned understands that the patient's care in Hospital is under the control and direction of the patient's attending Physician. It is the attending Physician's responsibility to provide informed consent for all medical procedures to the patient. The undersigned is aware that the practice of medicine and surgery is not an exact science and acknowledges that no guarantees have been made as to the result of treatments or examination in the hospital. The Hospital provides supervised clinical experience for nursing science students and other health care fields. Should you have a concern about students observing or participating in your care, please discuss it with your nurse.

3. RELEASE OF INFORMATION: I authorize the Hospital (for purposes of this treatment and consent form which includes all other professional services) to release information from the patient's medical records which may be necessary for any insurance company, entity or agency to make a determination of its obligation to make reimbursment or payment for any or all of the patient's charges. In addition, I authorize the Hospital to release medical information to other health care providers involved with the patient's ongoing care as a result of this visit. This release may include AIDS diagnosis or HIV antibody test results.
I acknowledge that upon disclosure of medical record information to an insurance company or other parties pursuant to this authorization, the Hospital and the attending physician are hereby released from any liability and no longer responsible for the confidentiality of this information. The information may be transmitted by photocopy, fax and/or computer.

4. MEDICARE OR MEDICAID REQUEST FOR PAYMENT --- CHECK IF APPLICABLE:
☐ I certify that the information given by me in applying for payment of charges under Title XVIII or XIX of the Social Security Act or other governmental medical assistance program is correct, and I authorize the release of all information necessary to act on this request. I request that payment of authorized benefits under the Social Security Act or other program be made to the health care facility on behalf of the patient for the health care facility's charges and the physician's charges for which the health care facility is authorized to bill in connection with its services.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, RECEIVING A COPY THEREOF, AND IS THE PATIENT, OR IS DULY AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE AND ACCEPTS ITS TERMS.

AGREEMENT FOR PAYMENT AND DISCLOSURE STATEMENT

THIS AGREEMENT AND DISCLOSURE STATEMENT is entered into by Memorial Hospital, (hereinafter referred to as "Hospital") and above named Responsible Party.

In consideration of the admission of above named patient as a patient of the Hospital, Responsible Party (jointly and severally, if more than one person) does hereby expressly agree to pay and guarantee payment in full, according to established policies, of any and all charges for hospital services rendered and materials furnished to or for patient by Hospital pursuant to the admission of such patient. The Responsible Party agrees with Hospital as follows:

1. PAYMENTS: Payment for all hospital services, in-patient and out-patient, are due in full by time of discharge. The patient understands that the agreement for payment applies only to hospital charges. The patient may also receive separate statements of charges for professional and physician services including, but not limited to ER Physicians, Radiology, Pathology and Anesthesiology.

2. FINANCE CHARGE: Hospital may add a FINANCE CHARGE to the account at the rate of ONE AND ONE HALF PERCENT (1-1/2%) per month of the unpaid balance, which is an ANNUAL PERCENTAGE RATE OF EIGHTEEN PERCENT (18%). FINANCE CHARGE will be computed on the unpaid balance outstanding beginning on the thirty-first (31st) day after discharge and each calendar month thereafter. The Responsible Party may avoid paying all FINANCE CHARGE by payment of the entire unpaid balance within thirty (30) days after such discharge.

3. INSURANCE: Patients having hospitalization insurance are requested to assign benefits from said insurance to Hospital. If so assigned, Hospital's initial billing will be sent to the insurance company. Any portion of the account not received from said insurance company will be billed to the Responsible Party in accordance with the provisions hereof.
I understand there is no guarantee of reimbursement or payment from any insurance company or other payer and that I am financially responsible for all charges incurred for services or items provided to the patient. By signing the Treatment and Consent form, the patient waives right to claim any insurance payment made to the hospital up to the hospital charges for services rendered regardless of any limitation hospital may be bound in any participation agreement.

4. ADVANCED BENEFICIARY NOTIFICTION: Your insurance carrier, including Medicare, under section 1862(a)(1) of the Medicare law, will only pay for services that it determines to be reasonable and necessary. We believe that, in your case, your insurance carrier is likely to deny payment for _____ for the following reasons _____

I have been advised by the Hospital that, in my case, the insurance carrier, including Medicare, under section 1862(a)(1) of the Medicare law, is likely to deny payment for the services identified above , for the reasons stated. If payment is denied, I agree to be personally and fullr responsible for payment.

5. DEFAULT: If the Responsible Party defaults in any of the obligations to Hospital, the balance of the account then outstanding shall, at Hospital's election, without notice or demand become immediately due and payable. The Responsible Party promises to pay all costs, including reasonable attorney fees, incurred by Hospital in the enforcement of the obligation to the extent permitted by law. The undersigned authorizes the hospital to obtain a credit bureau report in case the hospital deems it necessary.

6. PERSONAL VALUABLES: The undersigned understands that Memorial Hospital maintains a safe for the safekeeping of money and other articles of value and agrees that Memorial Hospital shall not be liable for the loss or damage to Patient's property, articles of value or money not deposited into the custody of Memorial Hospital for safekeeping. Upon Patient's discharge the undersigned shall remove from Memorial Hospital all of Patient's property including clothing and agrees that the hospital shall not be responsible for loss, damage or disposal of any of the Patient's property not removed at discharge.

ASSIGNMENT OF BENEFITS

Patient hereby assigns to Memorial Hospital, and/or representatives and attending physicians, all hospitalization and medical benefits (including Medicare and Medicaid) payable by reason of Patient's hospitalization and treatment and any recoveries upon any cause of action for any injuries treated to the extent of charges for services rendered and authorizes direct payment of such benefits or recoveries to Memorial Hospital or provider of services. Patient accepts responsibility for payment of all charges, regardless of insurance coverage.

NOTICE TO SIGNATORIES

1. Do not sign this contract before you read it.
2. You are entitled to an exact copy of the contract you sign.
3. The undersigned hereby acknowledges receipt of a copy of the above conditions containing all pertinent information and agrees to be bound by the same.
4. These conditions shall be valid and shall remain in effect for all services provided by hospital for the above-referenced patient number.

Myrtle McNally
SIGNATURE OF PATIENT/RESPONSIBLE PARTY

RELATIONSHIP TO THE PATIENT

SIGNATURE OF SPOUSE

WITNESS FOR MEMORIAL HOSPITAL

6/8/01
DATE

6/8/01
DATE

Form TREATCP

White copy --- Medical Records Yellow copy--- Patient

DATE_____

MEMORIAL HOSPITAL OUTPATIENT REHABILITATION

Welcome!
We are committed to providing you with the most effective treatment. To accomplish this, it is essential that you be involved in the rehabilitation process. The following information will assist our team in helping you regain your pre-injury functional levels in a safe and timely manner. Please assist us in this goal by responding to the following questions.

Name MYRTLE MCNALLY Age 72 DOB 1-17-29
Business phone_____ Home phone 719-632-2080
Are you presently working? ☐ Yes ☒ No; Restrictions_____
Employer_____
Job duties_____
Treating physician_____ Diagnosis_____
Attorney_____
When are you scheduled to see the physician again? _____
Do you rely on public transportation or another party to bring you to therapy? ☐ Yes ☒ No
If yes, please specify:_____
Chief complaints (List problems for which you are coming to therapy for help)
1. _____ 3. _____
2. _____ 4. _____

I. GENERAL HEALTH AND INFORMATION:

1. Are you in good general health? ☐ Yes ☒ No; If no, please specify:_____
2. When did your injury occur? 5-10-2001
3. Is your illness or injury job related? ☐ Yes ☒ No
4. How did you injure yourself? _____
5. Is liability insurance or Workman's Compensation involved? ☐ Yes ☐ No
   Is there a lawsuit pending? ☐ Yes ☐ No
6. Do you have any limitations? _____
7. Have you had any diagnostic tests related to this injury? ☐ Yes ☐ No
   Circle (X-rays) Blood work MRI scan CT scan Bone scan EMG
   Other tests:_____
8. Has your doctor explained your illness to you? ☒ Yes ☐ No
9. Have you ever received therapy? ☐ Yes ☒ No; If yes, when? _____
   What type of therapy was it? _____
   Was the therapy helpful? ☐ Yes ☐ No
10. Are you presently being seen by a chiropractor? ☐ Yes ☒ No; If yes, how long? _____
11. Do you smoke? ☐ Yes ☒ No; If yes, Packs per day_____ Years_____
12. Are you able to care for yourself at home? ☒ Yes ☐ No
13. Do you have children at home? ☐ Yes ☒ No
14. What sports or hobbies do you participate in? NONE
15. What activities are restricted because of your injury? _____
16. At the present time, is there a lot of stress at home or work? ☐ Yes ☒ No
17. Are you on a special diet? ☐ Yes ☒ No; Explain _____
18. How often do you consume alcoholic beverages? NONE
19. Have you been treated for alcohol and/or drug abuse? ☐ Yes ☒ No
20. Is English your primary language? ☒ Yes ☐ No; If no, please specify:_____

"Please turn over"

MEMORIAL HOSPITAL

PATIENT: Myrtle McNally **DATE: 6-8-01**
PHYSICIAN: Ed Ausman, D.O. **MRN: 380568**
DIAGNOSIS: Neck and shoulder pain

PHYSICAL THERAPY INITIAL EVALUATION

Prescription: Eval and treat with low impact methods.
Frequency: Not given. Patient will be seen 2-3x a week.
Initial Insurance Authorization: Medicare.

MEDICAL HISTORY:

Medications: Please see list in chart.
Diagnostic Tests: X-rays.
Past Medical History: Significant for breast cancer with right mastectomy as well as a CABG x2 and endarterectomy x3.

SUBJECTIVE: This 72 year old woman presents with complaints of left sided neck pain after slipping and falling on a pallet at K-Mart on 5-10-01. Patient reports that she did have shoulder and rib pain on the left side but that has resolved. Patient currently complains of neck pain which increases with all activities and states that she is unable to do lifting activities or her own laundry due an increase in pain. Patient denies dizziness or numbness and tingling in her upper extremities and reports that she would like to be able to return to independent activities. Patient reports she currently has help with her household activities.

OBJECTIVE: Database available upon request.

ASSESSMENT:

Primary Problems:

1. Pain in left cervical region.
2. Decreased cervical region and joint movement dysfunction of cervicothoracic junction.
3. Difficulty performing housework due to pain.
4. Inability to lift heavy objects due to pain.
5. Decreased activity tolerance due to cervical pain.

Short and long term goals were developed with patient/family.

Short term Goals: 6 visits.

1. Patient to report that her activity tolerance is 30 minutes before an onset of pain.
2. Patient to demonstrate equal ROM of cervical spine without pain.
3. Patient to maintain neutral sitting posture without leaning to left for compensation.

Long term Goals: 12 treatments.

1. Patient to be able to lift a laundry basket in order to do laundry independently.
2. Patient to report ability to do household tasks without an increase in pain.

Impression: Patient presents with signs and symptoms of cervical strain as well as a joint movement dysfunction in CT junction.

Precautions/Warnings: Patient was instructed not to perform activities which increase pain.

Prognosis For Meeting Goals: Good.

Estimated Time Needed For Rehabilitation: 4-5 weeks.

PLAN: We will see this patient 2x a week for heat as well as manual techniques, instruction in home exercise program and postural education in order to decrease pain and increase function.

DICTATED BUT NOT PROOFREAD

Brenda L. Stegner, MS, PT

BLS/bs
File

D: 6-8-01
T:; 6-12-01

PATIENT: Myrtle McNally
PHYSICIAN:

DATE: 1/18/01
MRN:

PHYSICAL THERAPY CERVICAL SPINE DATA BASE

APPEARANCE: Tends to lean on (L) UE during sitting, forward head-fixed

POSTURE: Forward head + shoulders

CERVICAL ROM:

	Percent of Normal					MMT	Gross Degrees
Flexion	0	25	(50)	75	100	Pain	
Extension	0	25	50	(75)	100	↑	
Rotation right	0	25	50	(75)	100	↓ Pain (L)	
Rotation left	0	25	50	(75)	100		
Side bend right	0	25	(50)	75	100	↓	
Side bend left	0	25	(50)	75	100	Pain in throat	

REFLEXES: ☒ Not tested ☐ Normal

	Left				Right			
Deltoid	0	+1	+2	+3	0	+1	+2	+3
Triceps	0	+1	+2	+3	0	+1	+2	+3
Biceps	0	+1	+2	+3	0	+1	+2	+3

SENSATION: ☒ Not tested ☐ Normal (pin prick/light touch)

	Left			Right		
C5	↑	NL	↓	↑	NL	↓
C6	↑	NL	↓	↑	NL	↓
C7	↑	NL	↓	↑	NL	↓
C8	↑	NL	↓	↑	NL	↓
T1	↑	NL	↓	↑	NL	↓

BABINSKI: ☒ Not tested ☐ Absent ☐ Present

STRENGTH: (out of five) ☐ Not tested ☐ Normal throughout

Key Muscles:		Left	Right	Comments
Levator/Diaphragm	(C4)	4/5	4/5	
Shoulder Abd/ER	(C5)			
Forearm sup./Wrist ext.	(C6)			
Triceps/Wrist flexion	(C7)			
Thumb ext./Ulnar dev.	(C8)			
Finger adduction	(T1)			

SHOULDER SCREEN: ☐ Not tested ☒ Normal ☐ Abnormal

THORACIC SCREEN: ☐ Not tested ☐ Normal ☒ Abnormal ↓ mobility + ↑ tenderness C-T junction

SPECIAL TESTS:

VERTEBRAL ARTERY TEST: ☒ Not tested ☐ Normal ☐ Abnormal unable 2° pain/guarded

PALPATION: Tenderness (L) side C-spine, C-T junction

TREATMENT: See flow sheet

CSPDB-1/96

Physical Therapist: Brenda J. Hagen MSPT

Pain (L) side neck

5/10/01

Tripped on pallett
Landed on (L)
Shoulder

Most of time
↑ c̄ housework
& lie down

Deep pressure helps.

~~[illegible]~~

CABG -
2 ~~Open~~
(R) mastectomy - CA

Ø dizziness
ØNT.
occ nausea.

has help c̄ laundry
dif lifting
Lives alone

heart meds.

activity to 1
10-20 min

Pain
& Rom/CT it
not
Dif housework
lifting
V act to 1

6
Act to 1 30 min
equal
~~full~~ Rom's pn.

12
Lift to do laundry
Household tasks

Date /Time	200-300 6/8/01	6/11/01 3:30 - 4:00	6-14-01 3:30 - 4:20
Charges	Eval	RV HP STM	RV HP, ES Ice Mass STM
Assessment	C-spine	C-spine	assess mobility, cerv ROM
Treatment	Trig - see dictation	Lymphedema massage goals C7-T2.	———
	HP to C-spine x 15 min	Same	same as 6/8/01
	STM to C-spine pt supine to upper T-spine/UT.	Same	• ice massage to STM • gentle manual stretch cerv spine
	Pt to use ice/heat @ home	gentle manual traction, contract relax lt rotation S.L.R. Gentle right rotation mobilization C3-4	
Problems, Conditions, Precautions	/	Same	
Subjective	hx breast CA. & (L) mastectomy. CA Bx x 2 exc. tissue x 3	Same	Hx of CA
	12 y.o. ♀ c/o (L) side C-spine pain since trip & fall on pallett 5/10/01. Shoulder & Rib pain resolved but c/o neck pain & stiffness, unable to do laundry / lifting / lives Alone	Pt states she felt last treatment helped & using heat at home	pt reports that treatments only giving relief when TX ; c/o pain 8/10 capable pt tenderness (L) anterior shld
Activity tolerance Goals	30 min 3 pain		limited 2° → pain
Equal cerv. ROM & no lift to do laundry			continue gentle stretching
Household detail	3/5 pain		limited 2° → pain
Post-treatment Assessment	Sat 3 cervical motions & C-T jt. end movement decreased	Tight (L) scalenes noted this date	pt reports ↓'d cerv ROM & ↓ pain
Plan	See 2-3x/wk for heat, manual tech, therex & posture	Cont c 1° PT per plan	cont CP/HP, DC Therex as tolerated
Signature	[signature]	[signature] Licensed PT	[signature] PTA [signature] PT

MEMORIAL HOSPITAL
1400 E. BOULDER ST.
COLORADO SPRINGS, CO 80909
OP REHABILITATION CENTERS
FLOW SHEET

380568
MCNALLY, MYRTLE
AUSNIT, EDWARD J., D

3187069
072?F
1/7/2

330-415 6/18/21	330-415 6/21/01	130-215 6/25/01
RU, Mob, STM, HD	RU, STM, TE, Txn	RU, TE, STM, E-stm
Subjective Vert Art test	Pain/Subjective	Same
Vert artery test (-) (B)	STM to C-spine UT & sub-occipitals	UBEX 4 min Assess ribs &
STM to C-spine & UT, sub-occipitals	Anat in posture Maintain neutral	C-T jct - no dysfunction
Manual cerv Txn x 5 min	spine & rest frequently throughout	Reviewed posture
Ht mobs to upper T-spine	day	STM to C-spine
	Mechanical cerv. txn x 10 min 10 lbs	IFC x 15 min to (B) UT.
/	30 m/100 ft.	/
Same	→	→
Heat works better than ice. Feeling a little better	Still sore, UT mn hurt. Frustrated that it is not any better.	Relief x 1.5 hrs p last. Ry. Very painful this weekend. Overall pain decreasing but still constant
		Still unable
Good tolerance to traction	Symptoms continue c little, [illegible] relief	Posture exacerbating symptoms
Cont	assess ribs & T-spine Cont to [illegible] pain	Cont
Brandi L Hegerman	Brandi L Hegerman	Brandi L Hegerman

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1/17/29

1200284 5/99
Page 2 of 4

_____ DC Code

MEMORIAL HOSPITAL
OUTPATIENT REHAB CENTER
PHONE – 365-5642 FAX – 365-6821

PATIENT: Myrtle McNally DATE: 6/21/01
PHYSICIAN: Ed Ausman D.O. MR#: 387069
DIAGNOSIS: Neck & shoulder pain

PROGRESS NOTE

X PT ____ OT ____ SPEECH ____ ACUPUNCTURE ____ BIOFEEDBACK

DATE OF INITIAL EVALUATION: 6/18/01 NUMBER OF TREATMENTS TO DATE: 5
CONSISTENCY OF ATTENDANCE: Good PERIOD OF REVIEW: 6/18/01 to 6/21/01

PATIENT COMMENTS: Reports continued pain, requires frequent rest breaks during the day.

CURRENT TREATMENT PLAN: Soft tissue mobilization, modalities, gentle stretching, posture ed

HOME PROGRAM: Posture & stretching

OBJECTIVE CHANGES AND PROGRESSION TOWARD GOALS: Slight ↑ in sitting tolerance. Gaining only temporary relief from treatments

PRECAUTIONS/WARNINGS: _____

PROGNOSIS: Excellent (Good) Fair Guarded Poor

ASSESSMENT/RECOMMENDATION/PLAN: Recommend continue c above treatment plan to ↓ pain & ↑ function.

Brenda Stephenson PT
Therapist

ADDENDUM: _____

Please make any additional recommendations below, sign and return entire sheet with patient and/or fax to (719) 365-6821.
✓ Medicare certification/recertification I certify that therapy ordered is medically necessary.

Continue therapy: ____ Daily ____ TIW ____ BIW ____ Weeks ____ Discontinue therapy

Special instructions: _____

Physician Signature: _____ Date: _____

175 S. Union, Colorado Springs, Colorado 80910
Phone – (719) 365-5642 Fax – (719) 365-6821

MEMORIAL HOSPITAL

PATIENT: Myrtle McNally CHOIC
PHYSICIAN: Ed Ausman, D.O. MRN: 380568
DIAGNOSIS: Neck and shoulder pain

PHYSICAL THERAPY DISCHARGE SUMMARY

DATE OF INITIAL EVALUATION: 6-8-01

DATE OF FINAL TREATMENT: 6-25-01

NUMBER OF TREATMENTS: 6

CONSISTENCY OF ATTENDANCE: Good.

PATIENT'S COMMENTS: At time of patient's last visit, she was reporting short term relief of approximately 1-2 hours after therapy. Patient reported that her overall pain level was decreasing but that it was still constant.

TREATMENT PROGRAM: Modalities and manual techniques as well as instruction in gentle stretching and postural modification.

HOME PROGRAM: Patient was given a home exercise program consisting of cervical stretches and postural modification.

OBJECTIVE CHANGES: Patient was demonstrating improved cervical ROM and a slight increase in her activity tolerance, however, patient was still complaining of difficulty performing household duties and laundry and reported that she required frequent breaks throughout the day.

PROGRESSION TOWARDS GOALS: Goals were unmet as patient only attended for 6 visits and then discontinued therapy by choice.

PLAN FOR DISCHARGE: As patient has not returned for therapy, she is being discharged at this time.

DICTATED BUT NOT PROOFREAD

Brenda L. Stegner, MS, PT

BLS/bs
File
D: 7-18-01 T: 7-19-01

1400 East Boulder Street, Colorado Springs, Colorado 80909-5599
Post Office Box 1326 80901-1326
(719) 365-5000

SPRINGS
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fax 719 636.0025

Kenneth P. Finn, M.D.

Eric O. Ridings, M.D.

Michael C. Sparr, M.D.

INITIAL EVALUATION

June 28, 2001

RE: Myrtle McNally
DOI: 05-10-01

Mrs. McNally was seen in initial evaluation today for her neck and left shoulder pain relating to a fall in K-Mart. She was referred by her attorney, Daniel Kay, Esq.

Mrs. McNally is a 72 year old woman who on 05-10-01 was rounding a corner in a shopping aisle at K-Mart when she tripped over a plastic pallet that had been left in the aisle. She fell onto her left side. She was confused for a minute. A male shopper helped her up. Immediately thereafter she noted some pain and swelling of her left breast. She is not sure if perhaps her left elbow struck the breast, or whether it was caused by the pallet. She notes that an employee immediately picked up the pallet and put it behind some boxes. She also had pain in the left neck and shoulder.

She was unable to get in to her regular doctor, Dr. Welch, and instead saw Dr. Schemanski. She was prescribed Ultram which she has not found beneficial, and referred to Memorial for physical therapy.

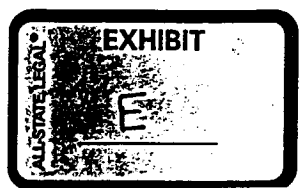
At this point she has had six PT visits which involve massage and a trial of cervical traction which made her worse. She has also had electrical stimulation which was somewhat helpful. She has not been taught any kind of comprehensive stretching; rather, only head tilts.

Currently her symptoms are left more than right neck pain. She notes a "knot" at the base of the left neck. Heat especially has been helpful at home. She has no numbness, tingling, or weakness in the extremities. The breast discomfort and shoulder pain have resolved, other than across the superior aspect of the left shoulder.

Medications, past medical history, family history, social history and review of systems were reviewed with the patient and recorded on the patient's intake form. She has PVOD and coronary artery disease, status post CABG x two, right renal artery stent, and CEA x four. She has had breast cancer status post mastectomy.

She is widowed and does not work. She does not smoke or drink.

PHYSICAL EXAMINATION:
General: Pleasant older woman in no acute distress.
Neurologic: Upper extremity strength, reflexes, and sensation are intact.



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Michael C. Sparr, M.D.

Structural: She has tenderness and tightness on palpation in the left greater than right cervical paraspinals, as well as in the scalenes. Cervical range of motion is decreased in all planes, particularly in right side bending with pain at end range. She again has myofascial tightness and tenderness in the left shoulder elevators, but not in the interscapular region. Trigger points are identified in the levator scapula, upper trapezius, and right cervical paraspinals.

IMPRESSION: Cervical and left upper quadrant myofascial pain syndrome.

PLAN: The patient to this point has not made progress with her current physical therapist. I have referred her for further physical therapy to Penrose Main Hospital with either Kathy Chewakin, PT or Cathy Kuebler, PT. I called and discussed her case with Cathy Kuebler today. Her program will involve more substantial myofascial release and manual physical therapy, in addition to a more aggressive home stretching program. I see nothing here that cannot be resolved with a more aggressive physical therapy program.

She is prescribed Mobic 7.5 mg daily, as well as Skelaxin 400 mg 1-2 po t.i.d. as needed and tolerated for muscle spasm. Samples were given of each. She was also prescribed a cervical pillow, and will receive a trial of home electrical stimulation through PT.

I will see her in follow-up in four weeks.

Eric O. Ridings, M.D. DICTATED BUT NOT PROOFED
Board Certified, Physical Medicine and Rehabilitation
Subspecialty Board Certified, Pain Management

cc: Daniel G. Kay, Esq
3 S. Tejon St, Suite 200
Colorado Springs, CO 80903

EOR:pmk

D: 06-28-01
T: 06-30-01

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Kenneth P. Finn, M.D.

Eric O. Ridings, M.D.

Michael C. Spurr, M.D.

OFFICE NOTE

July 26, 2001

RE: Myrtle McNally
DOI: 05-10-01

Mrs. McNally was seen in follow-u today relating to injuries in a fall. She has completed seven visits of physical therapy and is very please with her progress. Overall, she feels 70% improved in terms of her neck and upper quadrant pain. She has had significant help with the TENS unit, and she also feels Skelaxin has been helpful. She did not tolerate Mobic due to hot flashes.

On exam, she has significantly improved cervical and bilateral upper quadrant muscle tone, without tenderness on palpation.

The patient will finish up her physical therapy with Kathy Chewakin, PT, continue her home exercise program, and continue her home TENS usage. She plans to visit relatives in early August, and that should be fine. She should be finished with her physical therapy and discharged to a home program by then. I have not scheduled follow-up for her at this point, but would be happy to see her again if problems arise.

Eric O. Ridings, M.D.
DICTATED BUT NOT PROOFED
Board Certified, Physical Medicine and Rehabilitation
Subspecialty Board Certified, Pain Management

cc: Daniel G. Kay, Esq
3 S. Tejon St, Suite 200
Colorado Springs, CO 80903

EOR:pmk

D: 07-26-01
T: 07-27-01

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Eric O. Ridings, M.D.

Michael C. Sparr, M.D.

September 27, 2001

Daniel G. Kay, Esq
3 S. Tejon St, Suite 200
Colorado Springs, CO 80903

RE: Myrtle McNally
DOI: 05-10-01

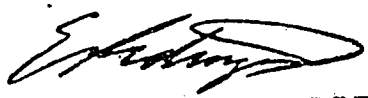
Dear Mr. Kay:

My apologies on not earlier responding to your questions regarding Ms. McNally. I have not seen her since July 26, 2001. At that point, as you know, she had had significant improvement, but still had some remaining symptoms in the neck and upper quadrants. She was to finish up her physical therapy.

In response to your request, we called the patient to see how she was doing at this point. She states that she has some neck pain, but it is intermittent. She is doing her home exercise program and states that she is not limited in terms of her activities due to the fall. Given this patient report, I believe that Ms. McNally is at maximum medical improvement. She appears not to have sustained any permanent impairment and does not require an impairment rating. She should continue her home exercise program, but I do not see indication for any further treatment regarding her fall injury. I would be happy to see her in follow-up, should her condition deteriorate in any way, but I would not expect that.

I hope this has been helpful. Please contact my office with any further questions.

Sincerely,



DICTATED BUT NOT PROOFED

Eric O. Ridings, M.D.
Board Certified, Physical Medicine and Rehabilitation
Subspecialty Board Certified, Pain Management

EOR:pmk

D: 09-27-01
T: 09-28-01

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Kenneth P. Finn, M.D.

Eric O. Ridings, M.D.

Michael C. Sparr, M.D.

November 8, 2001

Brian Polvi, DC
2300 Powers Business Plaza, Suite 2480
Colorado Springs, CO 80915

Daniel G. Kay, Esq
3 S. Tejon St, Suite 200
Colorado Springs, CO 80903

RE: Myrtle McNally
DOI: 05-10-01
ID # 510220438DB; Medicare

Dear Dr. Polvi and Mr. Kay:

Myrtle McNally was seen in follow-up today relating to injuries in a fall at K-Mart. She was last seen July 26, 2001. At that point she had had significant improvement with physical therapy. Unfortunately, she tells me that about two weeks after the PT ended, she had gradually increasing discomfort in the same areas, that is the left neck and left superior shoulder. Unfortunately, she did not call to reschedule, and so I was not aware of her return of symptoms.

At this point the patient states that her pain has returned to approximately the level it was right after the accident. She has fairly constant pain in the left neck and left superior shoulder, exacerbated with use. She has difficulty turning her head due to pain, and difficulty with upper extremity use, particularly things like laundry, due to left shoulder elevator pain.

On examination, she has tightness in the left suboccipitals, down the left cervical paraspinals, and into the left upper trapezius. A number of trigger points are appreciated. Additionally, she has tightness in the left scalene muscles. She has tenderness on palpation in all of these areas.

The patient states that she has tried to do some of the exercises that she learned in PT, but they are not effective. She tried changing the pillow, but that also was not helpful.

IMPRESSION: Cervical and left shoulder myofascial pain syndrome due to strain injuries to these muscles in the fall on 05-10-01.

PLAN: We have had some good success in chronic myofascial pain with a series of trigger point injections followed by soft tissue work. The patient is referred to Dr. Polvi for evaluation,

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Eric O. Ridings, M.D.

Michael C. Sparr, M.D.

with the intent of implementing that protocol. She will be seen first here for trigger point injections in the left neck and left upper quadrant, followed immediately by soft tissue work with Dr. Polvi in his office, performed once a week for three weeks, with one week off and re-evaluation. Dr. Polvi will also instruct her in stretching for the involved areas. With the above program, I anticipate resolution of her symptoms.

We will also contact the vendor for the TENS unit that she had had to get that back for her. Although I had written for her to keep the TENS unit, apparently it was sent back prior to the company receiving that authorization.

The patient is no longer at maximum medical improvement relating to the fall on 05-10-01.

Sincerely,

DICTATED BUT NOT PROOFED

Eric O. Ridings, M.D.
Board Certified, Physical Medicine and Rehabilitation
Subspecialty Board Certified, Pain Management

EOR:pmk

D: 11-08-01
T: 11-09-01

Centura Rehabilitation

13 CONVENIENT LOCATIONS

825 E. Pikes Peak Ave, 80903	719-776-8997	6015 Lehman Dr. #205, 80918	719-260-1313
801 N. Cascade #16, 80903	719-630-1282	7015 Tall Oak Dr., Ste. B, 80919	719-593-1989
160 W. Fillmore, 80907	719-227-2145	4025 Family Place, 80920	719-282-8192
1625 Medical Center Pt. #100, 80907	719-475-1404	Woodland Park	
2215 N. Cascade Ave., 80907	719-776-5200	Highway 24 and 67, 80863	719-686-0853
320 E. Fontanero #106, 80907	719-578-9511	Monument	
4182 Center Park Dr., 80916	719-574-3447	550 Highway 105, 80132	719-481-0161
3205 N. Academy Blvd., 80917	719-776-3250		

Patient's Name: Myrtle McNally

Diagnosis: Cervical + LUQ Myofascial Pain

Precautions/Special Instructions: _____

Insurance/Payor: Medicare Authorization #: _____

Cathy or Kathy

- ☒ Physical Therapy Evaluation and Treatment
- ☐ Occupational Therapy Evaluation and Treatment
- ☐ Speech Therapy Evaluation and Treatment
- ☐ Psychological Consultation

- ☐ Skin, Wound and Burn Care
- ☐ Hand Therapy
- ☒ Manual Therapy
- ☒ Modalities as indicated
- ☒ Soft Tissue Mobilization
- ☐ Pool Therapy
- ☒ Therapeutic Exercise
- ☐ Home Exercise Program
- ☒ Home Electrical Stimulation
- ☐ Other_____

Special Programs

- ☐ Back/Neck School
- ☐ Biofeedback/Relaxation
- ☐ U/E CTD School
- ☐ Home Assessment
- ☐ Orthosis/Orthotics
- ☐ Psych Testing
  - ☐ MMPI
  - ☐ NeuroPsych
- ☐ Splint Fabrication
- ☐ Vestibular Rehab
- ☐ Continence Care Program
- ☐ Lymphedema Program

Industrial Rehabilitation

- ☐ Functional Capacity Evaluation
- ☐ Job Site Analysis
- ☐ Work Hardening/Work Readiness
- ☐ Work Tolerance Screening

Frequency: ☐ Daily ☐ 3X/wk ☒ 2X/wk ☐ PRN ☐ Other_____

Duration: 4 wks

Physician Signature: _____ Date: 6/28/0

IT IS THE PATIENT'S RESPONSIBILITY TO CONTACT THEIR INSURANCE COMPANY TO VERIFY AUTHORIZED THERAPY SITES.

White: Clinic Yellow: Physician

SEE MAP ON REVERSE

EXHIBIT F

Dr. Ridings.

Medicare

Myrtle McNalie

trip over a pallate + fall At K-mart

Cervical + © upper quadrant MFP.

Neck + shoulder ⇒ needs Better

P.T. STM, MET.

Manual therapy needed.

(KC) This is a pt. that Dr. Ridings called to talk to me about — he's not happy c̄ her current care, + basically said he wants better manual, soft tissue Rx for her, not just the Rom ex's the current P.T. is giving her. He said he'd write both our names on script for whenever was available 1st FS

Penrose-St. Francis Health Services
Centura Health

PHYSICAL THERAPY INITIAL EVALUATION — NON-OPERATIVE CERVICAL STRAIN

Patient Name: Myrtle McNally	Date: 7/2/01	Time: 1310	DOB: 11/1/29	Sex: M (F)
Primary Diagnosis: 847			Pts. Social Security #: 509-26-1820	
Clinical Condition: Non-Operative Cervical Strain/Category			Pts. Medical Record #: 042-94906	
Employer: NA			Insurance: Care	
Primary Referral Source: Kidys			Primary Care Physician: Comm. Health Ctr.	
Onset Date: 5/10/01	# Lost Work Days:	Type of Injury: ☐ Work Comp ☐ MVA ☒ Other	Clinic Name: Penrose	

SUBJECTIVE (C6 Emulation, Prior LOC, PMH)

OBJECTIVE % of Pain in Neck 100, % of Pain in Arm ___ Has Yes ☐ No ☐ Location: ___

Posture: ☐ Poor ☐ Fair ☐ Normal Describe: Rt shift ↑, ↑ thoracic kyphosis, TL lordosis, forward head

Cervical Range Of Motion:
FB 25% SB [R] 50% pn+ ROT [R] 75% pn++
BB 75% SB [L] 50% ROT [L] 75%

Palpation: exquisite TP count: Tender ++ C6/7, subscap CSSR, Rt post ↑ tone, ant rib 2 Tender

Passive Mobility/Screening Tests: (If positive, do not perform passive mobility testing.)
1. Vertebral Artery Test: not done in full ext ☺
2. Alar Ligament Laxity + ☺
3. Transverse Ligament + ☺

Passive Mobility: ant shear ++ C6 & C6/7
exp ☺ rib 2
kyph ↑ th. upper crvl

Optional Tests: (as indicated)
1. Shoulder Range Of Motion: ant flex pn ≥ elevation ☺. Mild-Mod ↓ flex ↑ kyphosis
   Neural Mobility: Median ant/axillary pn Ulnar ___, Radial ___
   Sensation: ___
4. Reflexes: R/L (Increased, Normal, Diminished, Absent)
   Biceps (C_5): Right ___ Left ___. Brachioradialis (C_6): Right ___ Left ___.
   Triceps (C_7): Right ___ Left ___.

Strengths: deferred 2° pn.

1.	Short neck flexors (C_3)	/5	/5	3.	Biceps (C_6)	/5	/5	5.	Thumb EXT (C_8)	/5	/5
2.	Shoulder ABD (C_5)	/5	/5	4.	Triceps (C_7)	/5	/5	6.	Finger Flex (C_8T_1)	/5	/5

Pain: /10 on analog pain scale.

ASSESSMENT

Severe ant sheer $C_{6/7}$ & painful/blocked flexion of same. Postural Dysfunction and Myofascial TP's upper cervical thoracic kyphosis

STG #1 See HCFA

STG #2 ___

DC GOAL #1 ___

DC GOAL #2 ___

GOALS DISCUSSED/ESTABLISHED WITH PATIENT: ☑ REHABILITATION POTENTIAL: ☑ Good ☐ Fair ☐ Poor

PLAN

☐ Issue Home Exercise Program	☐ Soft Tissue Mobilization	☐ Therapeutic Exercise	☐ Ultrasound	
☐ Neuromuscular Re-Education	☐ Joint Mobilization	☐ Ice/Heat	☐ Manual Therapy Techniques	
☐ Cervical Traction	☐ Electrical Muscle Stimulation	☐ Stretching Activities	☐ Other ___	

Frequency and Duration of Treatment ___ visits.

Clinical Condition: ☐ Cervical Strain Category:
☐ I-Neck Pain and/or Proximal Extremity Symptoms, Low Demand: ☐ Mod. Symptoms ☐ Severe Symptoms
☐ II - Neck Pain and/or Proximal Extremity Symptoms, Mod- High Demand: ☐ Mod. Symptoms ☐ Severe Symptoms
☐ III- Distal Extremity Symptoms with/without Neck Pain and/or Proximal Extremity Sxs, Low Demand: ☐ Mod. Sxs ☐ Severe Sxs
☐ IV - Distal Extremity Symptoms with/without Neck Pain and/or Proximal Extremity Sxs, Mod-High Demand: ☐ Mod. Sxs ☐ Sev. Sxs

Therapist	License #:	Date faxed:
T. Chwalek	2754	

Date/ Time	Charge	Note
7/2/01		6 visits of PT at Memorial
		Hx: - helped some
		ROM ex, Massage, Estim
		Mech Tx ⇒ worse
		gr pn flx and Rot (c)
		csp pn + upper Trap
		Stopped Meds 7/1 - getting hot - then
		cold + AS (from Skelaxin).
		rev 7/26 c̄ Ridings
		PMHx: Mass Tenny RO.
		RO dom
		Position of comfort (c̄ sidelying
		c̄ hand under head
		- presses into (c) csp (+ Cs Cu) c̄
		fingers when walking
		Sitting Tol. >> standing/walking

Addressograph

McNally, Myrtle

Penrose-St. Francis Rehabilitation

Centura Health.

PROGRESS NOTES

Discipline PT

27693 1/94

Date/ Time	Charge	Note
7/2/01 #1/8 13:10-14:20	Eval x45 HP/ESU x22	C: Eval for c/o (L) cerv & UT pn - see data sheet & NCFA. HP c̄ NMS to L&R Cu/2 & upper Trap TP. Intensity to tol. 50pps. A: See eval. P: Cont manual therapy. Assess response to estim for appropriate choice for home unit. Chuwa PT 275
7/19/01 #2/8 13:00-13:52	ESU 26 Man 26'	S: Feels like a rope tenth. O: IFU to cervical region c̄ HP x 20 min supine. Man therapy prior to estim of man cerv tx, subocc. release, post glides c̄ tx to Cu. A: ↓ tenderness, especially to subocc. pt. A, ↑ Rx. P: Cont c̄ man. ther & estim. Assess response to IFC. Chuwa PT 275
7/13/01 15:57 #3/8	Man 21' ESU 25'	S: Sharp pns on the (L) when I look to the RE. Sharp pn at base of head is less. Getting better. O: post glides Cu c̄ distraction crossfriction STM at mechal line. STM (L) supraclavic & pot/ing positioning of (L) shoulder. HP/NMS to TP's in lower cerv PNM & upper Trap. Chuwa PT 275
7/16/01 15:10-16:00 #4/8	Man 22' ESU/HP x24	S: Whenever I look over to drive, it hurts. O: STM paracerv. Post glides Cu as by HP/ESU as by. -LM c̄ Rehabilitation re home rental of IFC. P: STG: Look RE in Rar S sharp pns. Chuwa PT 275

Penrose-St. Francis Rehabilitation
Centura Health.

PROGRESS NOTES

Discipline PT

Myrtle McNally
04294906

27623 1/94

Date/ Time/	Charge	Note
7/18/01 #5/6	Man 25'	S: You've helped me get a lot better
1530-1620	ESU 14'	O: Post glides C_4. C_1 + C_2 + Rt Rt. JM + pos. stretch. Man distraction esp. TENS instruct + issue TENS to pt from Rehabilitation contracting through Centura Home Oxygen
		A: ↑ C_1 Rt Rt to reach STG set last visit
		P: rev AROM esp. Nit. to doc
		X Chewa KPT 2754
7/23/01 #6/8 1330-1422	Man x 25' HP 21'	S: Using TENS at home. Pain not waking me at night anymore. Still can't vacuum. Carry laundry → ↑ pain.
		O: rev AROM - see HCFA form Man cervex and post glides c distraction at C_6. STM AMAS to tol a upp Traps. Pressure suf occipitals
		A+P: Refer to HCFA.
		STG: Rt Rot 75% 5 pn for conversation + driving
		X Chewa KPT 2754
7/27/01 #7/8 1334-1355	Man x21	S: Dr Riding released me. Said continue. PT is up to my therapist & me. Think still do it on my own for a while.
		O: STM + man stretch to esp + upper traps. Reviewed home programs. A: Concerned that goals not met. P: Hold chart for possible restart if pt can't manage
		X Chewa KPT 2754

Penrose-St. Francis Rehabilitation
Centura Health.

PROGRESS NOTES

Discipline PT

Addressograph

Myrtle McNally

04294906

27693 1/94

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

☐ Part A ☐ Part B ☐ Other Specify

FORM APPROVED
OMB NO. 0938-0227

PLAN OF TREATMENT FOR OUTPATIENT REHABILITATION (COMPLETE FOR INITIAL CLAIMS ONLY)

1. PATIENT'S LAST NAME: McNALLY	FIRST NAME: MYRTLE M.I.	2. PROVIDER NO: 060031	3. HICN: 409-26-1820
4. PROVIDER NAME: PENROSE ST FRANCIS	5. MEDICAL RECORD NO. (Optional): 04294906	6. ONSET DATE: 5/10/01	7. SOC. DATE: 7/2/01
8. TYPE: ☒ PT ☐ OT ☐ SLP ☐ CR ☐ RT ☐ PS ☐ SIN ☐ SW	9. PRIMARY DIAGNOSIS (Pertinent Medical D.X.): 847.0	10. TREATMENT DIAGNOSIS: 728.85 723.1	11. VISITS FROM SOC.

12. PLAN OF TREATMENT FUNCTIONAL GOALS

GOALS (Short Term) 2 wks

1) Mild - Mod tenderness to palpation to allow for ↑ tol. to manual techs

2) + pain enough to allow pt to ambulate without holding pressure against neck

OUTCOME (Long Term) 1) AROM csp 75% of normal c̄ pain 2) sleep c̄ awakening 2° pain 3) Return to household ADL's i.e. vacuum 4) lift/carry laundry/groceries c̄ pain

PLAN: Manual Therapy Home ex Modalities PRN

13. SIGNATURE (professional establishing POC including prof. designation): K. Chuwakin PT 275Y

14. FREQ/DURATION (e.g., 3/Wk x 4 Wk): BIW x 4 wk.

I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE ☐ N/A

15. PHYSICIAN SIGNATURE: [signature]

16. DATE: 7/17/01

17. CERTIFICATION FROM 7/2/01 THROUGH 7/31/01 ☐ N/A

18. ON FILE (Print/type physician's name): ☐ E. RIDING

19. PRIOR HOSPITALIZATION FROM TO ☒ N/A

20. INITIAL ASSESSMENT (History, medical complications, level of function at start of care. Reason for referral).

Fell over a pallet at K. Mart. c/o ⓐ cervical + upper trap pain. Minimal tolerance to sitting. Holds neck when walking or standing. PHHx RE Masectomy

Sig. loss of csp AROM of forwardbend and Rot. right. Exquisite tenderness. ⓒ upper trap, C_6, C_5, and suboccipitals ⓒ + flexion mobility at $C_{6/7}$. Limited sidebending $C_{2/3}$ or Rot C_{11}

Treatment for loss of motion, pain c̄ ADL's, interrupted sleep, inability to lift or reach overhead or downward, poor sit, stand or walking tolerance 2° #8/10 pain levels

21. FUNCTIONAL LEVEL (End of billing period) PROGRESS REPORT ☐ CONTINUE SERVICES OR ☐ DC SERVICES

22. SERVICE DATES FROM THROUGH

FORM HCFA-700 (11-91)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

☐ Part A ☐ Part B ☐ Other Specify

FORM APPROVED
OMB NO. 0938-0227

PLAN OF TREATMENT FOR OUTPATIENT REHABILITATION (COMPLETE FOR INITIAL CLAIMS ONLY)

1. PATIENT'S LAST NAME	FIRST NAME M.I.	2. PROVIDER NO.	3. HICN
McNALLY	MYRTLE	060031	507-26-1820
4. PROVIDER NAME	**5. MEDICAL RECORD NO. (Optional)**	**6. ONSET DATE**	**7. SOC. DATE**
PENROSE ST FRANCIS	04294966	5/10/01	7/2/01
8. TYPE: ☒ PT ☐ OT ☐ SLP ☐ CR ☐ RT ☐ PS ☐ SN ☐ SW	**9. PRIMARY DIAGNOSIS (Pertinent Medical D.X.)** 847.0	**10. TREATMENT DIAGNOSIS** 728.85 723.1	**11. VISITS FROM SOC.**

12. PLAN OF TREATMENT FUNCTIONAL GOALS

GOALS (Short Term) 2wks.

1) Mild - Mod tenderness to palpation to allow for ↑ tol. to manual Techs.

2) ↓ pain enough to allow pt to ambulate without holding pressure against neck

3) AROM csp 75% of normal c pain

OUTCOME (Long Term) 4) sleep c awakening 2° pain

5) Return to household ADL's ie. vacuum

6) Lift/carry laundry/groceries c pain

PLAN

Manual Therapy
Home ex
Modalities PRN

13. SIGNATURE (professional establishing POC including prof. designation)

T. Chwatko PT 275

14. FREQ/DURATION (e.g., 3/Wk x 4 WK)

BIW x 4 w/c.

I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE ☐ N/A

15. PHYSICIAN SIGNATURE **16. DATE**

17. CERTIFICATION FROM 7/2/01 THROUGH 7/31/01 ☐ N/A

18. ON FILE (Print/type physician's name) ☐ E. RIDING

19. PRIOR HOSPITALIZATION FROM TO ☒ N/A

20. INITIAL ASSESSMENT (History, medical complications, level of function at start of care. Reason for referral)

Fell over a pallet at K-Mart. c/o ⓛ cervical + upper trap pain. Minimal tolerance to sitting. Holds neck when walking or standing. PMHx RE Masectomy.

Sig. loss of csp AROM of forwardbend and Rot. right. Exquisite tenderness: ⓛ upper trap, C6, C5, and suboccipitals ⓛ ↓ flexion mobility at C6/7. Limited sidebending C2/3 or Rot C1.

Treatment for loss of motion, pain c ADL's, interrupted sleep, inability to lift or reach overhead or downward, poor Sit, stand or walking tolerance 2° #8/10 pain levels

21. FUNCTIONAL LEVEL (End of billing period) PROGRESS REPORT ☐ CONTINUE SERVICES OR ☐ DC SERVICES

No longer holding pressure against neck c ambulation. Mild to mod. tenderness now allowing for tolerance to more Manual therapy. Cerv AROM: FB 75% RB 50% Rot ~75% c pn looking Rt SB 50-75%. UE - overhead reach c pain now.

STGS #1&2 met

LTGS #2 met.

22. SERVICE DATES FROM 7/2/01 THROUGH 7/31/01

FORM HCFA-700 (11-91)

Form 2700/3P BRIGGS, Des Moines, IA 50306 (800) 247-2343 Printed in U.S.A.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

☐ Part A ☐ Part B ☐ Other _____ Specify

FORM APPROVED
OMB NO. 0938-0227

UPDATED PLAN OF PROGRESS FOR OUTPATIENT REHABILITATION

(Complete for Interim to Discharge Claims. Photocopy of HCFA-700 or 701 is required)

1. PATIENT'S LAST NAME	FIRST NAME	M.I.	2. PROVIDER NO.	3. HICN
McNally	Myrtle		060031	569-26-1820

4. PROVIDER NAME	5. MEDICAL RECORD NO. *(Optional)*	6. ONSET DATE	7. SOC. DATE
Penrose St Francis	C4294906	5/10/01	7/2/01

8. TYPE:	9. PRIMARY DIAGNOSIS *(Pertinent Medical DX.)*	10. TREATMENT DIAGNOSIS	11. VISITS FROM SOC.
☒ PT ☐ OT ☐ SLP ☐ CR ☐ RT ☐ PS ☐ SN ☐ SW	847	728.85 723.1	

12. FREQ/DURATION *(e.g., 3/Wk x 4 Wk.)* BIW x 4wk.

13. CURRENT PLAN UPDATE, FUNCTIONAL GOALS *(Specify changes to goals and plan)*

GOALS *(Short Term)* 2wks.
1) Sit x30min. c pn ≤3/10 or less.
2) 75% equal Rt Rtc 5 sharp pn at endrange on the Rt.
3) Return to household ADL ie vacuum

OUTCOME *(Long Term)* (2-4wk)
2) Lift/carry laundry/groceries 5 pain.

PLAN
Manual Therapy
Home ex
Modalities.

I HAVE REVIEWED THIS PLAN OF TREATMENT AND RECERTIFY A CONTINUING NEED FOR SERVICES. ☐ N/A ☐ DC

14. RECERTIFICATION FROM 8/1/01 THROUGH 8/31/01 ☐ N/A

15. PHYSICIAN'S SIGNATURE

16. DATE 7/26/01

17. ON FILE *(Print/type physician's name)* ☐ E. RIDING MD

18. REASON(S) FOR CONTINUING TREATMENT THIS BILLING PERIOD *(Clarify goals and necessity for continued skilled care)*

still unable to tolerate pushing needed for vacuuming. Carrying laundry/groceries limited tolerance. Csp AROM still guarded and less than functional. Ant shear Cc limits cerv flexion and tolerance to sitting. Cervical pain c load.

19. SIGNATURE *(or name of professional, including prof. designation)*	20. DATE	21.
K. Chwalek PT 2754	7	☐ CONTINUE SERVICES OR ☐ DC SERVICES

22. FUNCTIONAL LEVEL *(at end of billing period - Relate your documentation to functional outcomes and list problems still present)*

23. SERVICE DATES FROM _____ THROUGH _____

FORM HCFA-701 (11-91)
Form 2701/19

Centura Health.

PATIENT ACCOUNTING SERVICES
PO BOX 7021
COLORADO SPRINGS, CO 80933

PASC: K3059172
PAGE: 1

4721

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

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
05-17-01	739.69	42949061016
SHOW AMOUNT PAID HERE $		

ADDRESSEE:

SPS 60 42949061016

MCNALLY, MYRTLE
3410 N EL PASO D10
COLORADO SPRINGS, CO 80907

REMIT TO:

CENTURA - PENROSE ST FRANCIS
DEPT 9104

DENVER CO 80291-9104

0042949061016O 000739698 600000910452

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

Thank you for choosing our facilities for your medical needs. This statement represents charges that are due from you, as our system shows no medical insurance is outstanding for payment. Please remit your payment or contact patient accounting for any assistance we can provide. If you have a question about how your insurance benefits or co-insurance amounts were determined, please contact your insurance company directly.

PATIENT NAME	PROVIDER	ACCOUNT #	SERVICE DATE	TOTAL CHARGES	PAYMENTS	ADJUST.	BALANCE OWING
MCNALLY, MYRTLE	Penrose St Fr	42949061016	05-10-01	739.69	0.00	0.00	739.69

YOU CAN CONTACT PATIENT ACCOUNTING FOR ASSISTANCE AT:

NTURA - PENROSE ST FRANCIS
DEPT 9104

DENVER CO 80291-9104

LOCAL PHONE:
719-328-0011
TOLL FREE:
800-970-5295

BEGINNING BALANCE	739.69
RECENT PAYMENTS	0.00
BALANCE DUE	739.69
STATEMENT DATE	05-17-01
ACCOUNT #	4294
STA	

IF PAYMENT HAS BEEN RECENTLY MADE, PLEASE DISREGARD THIS NOTICE.

4721*0E30T6KW1000793

DEFENDANT'S EXHIBIT G

ALL-STATE LEGAL

STATEMENT

Front Range Emergency Spec PC
PO Box 7069
Colorado Springs CO 80933

Address Service Requested

IF PAYING BY MASTERCARD, VISA OR DISCOVER, FILL OUT BELOW AND CHECK CARD USING FOR PAYMENT

CARD NUMBER	AMOUNT
SIGNATURE	EXP. DATE
STATEMENT DATE: 05/22/2001 / ACCOUNT #: 42949061016	PAY THIS AMOUNT: $152.00

Office Hours: 7:30 AM to 5:00 PM Monday - Friday
Phone: 719/262-0511 Toll Free: 1-800-653-0780

Patient: MCNALLY MYRTLE

AMOUNT PAID

*2 *********3-DIGIT 809

MYRTLE MCNALLY
3410 N EL PASO D10
COLORADO SPRINGS CO 80907

MAKE CHECK PAYABLE & REMIT TO:

Front Range Emergency Spec PC
PO Box 7069
Colorado Springs CO 80933

PEAK0001-0041403-0009071-0110087-001-001186-#009305

☐ 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	CODE	DESCRIPTION OF SERVICES	AMOUNT
05/10/01	99283	EVALUATION AND MANAGEMENT	$152.00

PAYMENT IS DUE UPON RECEIPT IF YOU HAVE INSURANCE AND WISH OUR OFFICE TO FILE A CLAIM, PLEASE CALL WITHIN THE NEXT TEN DAYS AND GIVE US THAT INFORMATION. **THANK YOU**

BALANCE DUE: $152.00

Patient: MCNALLY MYRTLE	Account Number: 42949061016	Statement Date: 05/22/2001
Location of Service	Referring Physician	Performing Physician
PENROSE HOSPITAL	RICK PIONKOWSKI MD	RICK PIONKOWSKI MD

Esta cuenta está para los servicios proporcionados a usted. Si usted tiene cualesquiera preguntas con respecto a esta declaración, llame por favor nuestra oficina para la ayuda.

Front Range Emergency Spec PC
PO Box 7069
Colorado Springs CO 80933

Phone: 719/262-0511 Toll Free: 1-800-653-0780

PEAK0001-0041403-0009071-0110087-001-001186-#009305

STATEMENT

COLO SPRINGS RADIOLOGISTS
P O BOX 2989
COLO SPRINGS CO 80901
PHONE NO: (719) 593-1799 FED I.D. # 84-0467791

PLEASE ENTER THIS ACCOUNT NUMBER ON YOUR CHECK AND ALL CORRESPONDENCE

MYRTLE MCNALLY
3410 N EL PASO 010
COLORADO SPGS CO 80907

ACCOUNT NO. 34383

STATEMENT DATE 05/22/0

INS: 01 MEDICARE
PIONEERS CIRCLE 800019

AMOUNT ENCLOSED $

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

ATTENDING PHYSICIANS STATEMENT

DIAG. CODE	SERVICE DATE	PROCEDURE REFERENCE	PATIENT NAME	LOC	DESCRIPTION	CHARGES / PATIENT 1	2
729.5	05/10/01	73630	MYRTLE		FRXRAY FOOT MIN 2V LEFT INTERP	23.00	
	PLEASE REMIT THE AMOUNT SHOWN AS PATIENT BALANCE						
786.50	05/10/01	71020	MYRTLE		FRXRAY CHEST PA & LAT INTERP	28.50	
	PLEASE REMIT THE AMOUNT SHOWN AS PATIENT BALANCE						
719.41	05/10/01	73040	MYRTLE		FRXRAY SHOULDER MIN 2V LT INTE	23.50	
	PLEASE REMIT THE AMOUNT SHOWN AS PATIENT BALANCE						
723.1	05/10/01	72040	MYRTLE		FRXRAY CERVICAL SPINE INTERP	25.00	
	PLEASE REMIT THE AMOUNT SHOWN AS PATIENT BALANCE						

CURRENT	OVER 30 DAYS	OVER 60 DAYS	OVER 90 DAYS	OVER 120 DAYS
100.00	.00	.00	.00	.00

PLEASE PAY THIS AMOUNT 100.00 PATIENT

PATIENT IS RESPONSIBLE FOR "PATIENT BALANCE" SHOWN

STATEMENT DATE	PATIENT PAID YTD	ACCOUNT NUMBER
05/22/01	.00	343833

MAKE CHECKS PAYABLE TO: COLO SPRINGS RADIOLOGISTS

COMMUNITY HEALTH CENTERS (MED) ACCOUNT INQUIRY RUN DATE 09/13/01 PAGE 1

ACCOUNT: 6124 MYRTLE MCNALLY TEL #: (719) 632-2080
LOT D-10 COURTESY % : 0
3410 N EL PASO ST STMT GP: TYP:
COLORADO SPRINGS CO 80907 DUN CL: 1 RUN: 18
PYMT PLAN..:
ACCOUNT MISC 1.. BAD DEBT WO DATE 112594 ACCOUNT MISC 3..:
COMMENT.....

PERSONAL	INSURANCE	COLLECTION	WORK COMP	ACCOUNT TOTAL
2.00	0.00	0.00	0.00	2.00

LAST STMT: 05/05/94 STMT DELAY: STMT COUNTER: 0 LAST CHARGE: 06/08/01
LAST PERS PAY: 05/09/01 CUR PERS PAY: 211.50 YTD PERS PAY -4.00
CREDIT DATE: CREDIT MESSAGE:
PENDING LETTERS: BAD DEBT
LAST LETTERS...: WR-OFF: 2.00
DATES.....:

CHG-#	CTRL	PATIENT	DOC POS	TRNCODE/MO DX	DESCRIPTION SET#	NAME	INS HISTORY	AMOUNT #	DATE
2330412	456	MYRTLE	SZM	213	ESTABLISH PT		3FQC/IR	66.00	05/14/01
			SRC	61171	1			3*	
	456	*ADJMNT*		C06 -CORR	FQ CARE CONT			0.00	05/16/01
	550	*ADJMNT*		C06	FQ CARE CONT			25.62	06/07/01
	550	*PAYMNT*		P06	FQ CARE PAYM			78.42-	06/26/01
					CHECK#: 1640380		ABA#:		
		TRANSFR			3FQC/IR TO		3PCP/ID	13.20	
	354	*PAYMNT*		P02	FQ CAID PAYM			11.20-	07/05/01
	354	*ADJMNT*		C12	MEDICAID COP			2.00-	07/05/01
23 :12		**TOTAL**			DUE FROM		3PCP/ID	0.00	AGE= 0
2360796	460	MYRTLE	SZM	212	ESTABLISH PT		3FQC/IR	52.00	06/08/01
			SRC	8470	1			3*	
	805	*ADJMNT*		C06	FQ CARE CONT			36.82	06/15/01
	202	*PAYMNT*		P06	FQ CARE PAYM			78.42-	07/26/01
					CHECK#: 1655908		ABA#:		
		TRANSFR			3FQC/IR TO		3PCP/ID	10.40	
	354	*PAYMNT*		P02	FQ CAID PAYM			8.40-	08/07/01
	354	*ADJMNT*		C12	MEDICAID COP			2.00-	08/07/01
2360796		**TOTAL**			DUE FROM		3PCP/ID	0.00	AGE= 0
2360797	460	MYRTLE	SZM	COPAY	COPAYMENT CH		3FF /PB	2.00	06/08/01
			SRC	8470	1			3*	
2360797		**TOTAL**			DUE FROM		3FF /PB	2.00	AGE= 94

bills

MEMORIAL HOSPITAL
P.O. Box 460
Colorado Springs, CO 80901-0460
(719) 365-5242

7/10/01

Cycle: 1 INTERIM	Patient Representative:
Patient: 3187069 MCNALLY, MYRTLE 3410 N EL PASO ST LOT D10 COLORADO SPGS CO 80907-5448	**Guarantor:** 3187069 MCNALLY, MYRTLE 3410 N EL PASO ST LOT D10 COLORADO SPGS CO 80907-5448

Patient Bill Detail Transactions

Date Of Service	Date Of Posting	Charge Number	Description	Qty.	Extended Price
6/08/01	6/11/01	5220700	P EVAL	1	224.00
6/14/01	6/15/01	5220110	P HOT PACK	1	21.75
6/14/01	6/15/01	5220130	P ICE MASSAGE 15 MIN	1	34.25
6/14/01	6/15/01	5220173	P SOFT TISSUE MOB 15 MI	1	47.50
6/18/01	6/19/01	5220110	P HOT PACK	1	21.75
6/18/01	6/19/01	5220173	P SOFT TISSUE MOB 15 MI	1	47.50
6/18/01	6/19/01	5220175	P JOINT MOB 15 MIN	1	47.50
6/21/01	6/22/01	5220173	P SOFT TISSUE MOB 15 MI	1	47.50
6/21/01	6/22/01	5220230	P TRACTION 15 MIN	1	39.75
6/21/01	6/22/01	5220303	P THER EXER 15 MIN	1	34.25
6/25/01	6/26/01	5220084	P E-STIM UNATTEND	1	34.25
6/25/01	6/26/01	5220173	P SOFT TISSUE MOB 15 MI	1	47.50
6/25/01	6/26/01	5220303	P THER EXER 15 MIN	1	34.25
PATIENT	3187069	13	ITEMS T O T A L ----------	-----	681.75

Guarantor: 3187069

MCNALLY, MYRTLE
3410 N EL PASO ST LOT D10
COLORADO SPGS CO 80907-5448

Patient Ledger

SPRINGS REHABILITATION
SPRINGS REHABILITATION
Thursday, August 09, 2001

MYRTLE MCNALLY (0000004424)
Responsible: Self Home: (719) 632-2080 Work: (719) -
Primary: MEDICARE PART B (COMERICAR) Phone: (877) 908-8431 ID: 510220438D

Billing	Date	Provider	Procedure	Patient Billed	Primary Billed	Secondary Billed	Tertiary Billed	Debit	Credit	Balance
19614	06/28/2001	RIDIN00(	99204		07/30/2001			160.00	0.00	160.00
Billing Total								160.00	0.00	160.00
20332	07/26/2001	RIDIN00(	99213		07/27/2001			80.00	0.00	80.00
Billing Total								80.00	0.00	80.00
Patient Total								240.00	0.00	240.00
Provider Totals										
ERIC O RIDINGS MD								240.00	0.00	240.00
Report Totals								240.00	0.00	240.00

Patient Ledger

SPRINGS REHABILITATION
SPRINGS REHABILITATION
Wednesday, November 28, 2001

MYRTLE MCNALLY (0000004424)
Responsible: Self Home: (719) 632-2080 Work: (719) -
Primary: CO MEDICARE (COMERICAR) Phone: (877) 908-8431 ID: 510220438D
Secondary: CO MEDICAID (COMEDICAI) Phone: (800) 237-0757 ID: T574448

23141	11/08/2001	RIDIN00(99213	11/09/2001	80.00	0.00	80.00
Patient Total				**80.00**	**0.00**	**80.00**
Provider Totals						
ERIC O RIDINGS MD				**80.00**	**0.00**	**80.00**
Report Totals				**80.00**	**0.00**	**80.00**

C E N T U R A H E A L T H S O U T H S T A T E PAGE 1
PENROSE HOSPITAL 11/26/01 15:15
PATIENT STATEMENT OF ACCOUNT - DETAIL

PATIENT NAME: MCNALLY, MYRTLE
ACCOUNT NBR: 004294906-1017
BILLING PERIOD: 07/04/01 11/26/01

BILL TO
MYRTLE MCNALLY
3410 N EL PASO ST #D10
COLORADO SPRINGS CO 80907

SRV DATE	REF NBR	DESCRIPTION		
07/02/01	47260004	PT ELECT STIM UNATT		68.04
07/02/01	47260000	PT VISIT		0.00
07/02/01	47260030	PT EVAL		238.14
07/11/01	47260000	PT VISIT		0.00
07/11/01	47260004	PT ELECT STIM UNATT		68.04
07/11/01	47260004	PT ELECT STIM UNATT		68.04
07/11/01	47260021	PT MANUAL THER EA 15	(QTY OF 0002)	149.68
07/13/01	47260000	PT VISIT		0.00
07/13/01	47260004	PT ELECT STIM UNATT		68.04
07/13/01	47260021	PT MANUAL THER EA 15	(QTY OF 0002)	149.68
07/18/01	47260004	PT ELECT STIM UNATT		68.04
07/16/01	47260004	PT ELECT STIM UNATT		68.04
07/16/01	47260021	PT MANUAL THER EA 15		74.84
07/18/01	47260021	PT MANUAL THER EA 15	(QTY OF 0002)	149.68
07/16/01	47260000	PT VISIT		0.00
07/18/01	47260000	PT VISIT		0.00
07/27/01	47260021	PT MANUAL THER EA 15		74.84
07/27/01	47260000	PT VISIT		0.00
10/11/01	22400773	M/R TIMELY FILING ADJ MEDICARE PART B (F)	SERVICE ON 07/02/01	1245.10-
10/11/01	22500050	INACTIVATE IAR MEDICARE PART B (F)	SERVICE ON 07/02/01	
10/11/01	22500050	INACTIVATE IAR MEDICAID (K)	SERVICE ON 07/02/01	

REMIT TO
PENROSE HOSPITAL
DEPT 506
DENVER CO 802910506

BEGINNING BALANCE	0.00
NEW CHARGES/ADJUSTMENTS	1245.10
NEW PAYMENTS/CREDITS	1245.10-
CURRENT ACCOUNT BALANCE	0.00

MAKE CHECK PAYABLE TO: PENROSE HOSPITAL

IF YOU HAVE ANY QUESTIONS CONCERNING THIS STATEMENT PLEASE CONTACT:
CUSTOMER SERVICE PHONE: (719) 776-4181

STATE OF COLORADO

DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1575 Sherman Street
Denver, CO 80203-1714
(303) 866-2993
(303) 866-4411 FAX
(303) 866-3883 TTY

Bill Owens
Governor

Karen Reinertson
Executive Director

November 29, 2001

Daniel G. Kay
Attorney at Law
Attn: LeAnn Elliott, Paralegal
3 South Tejon Street, Suite 200
Colorado Springs, CO 80903

RE: Myrtle McNally
Medicaid State I.D. No: T574448

Dear Ms. Elliott:

Enclosed please find copies of updated claims in the amount of $92.79 for additional medical expenses for the above-named client.

The total of the updated claims $92.79; added to the previous expenditures of $302.82, make the total amount of monies paid by the Department, $395.61. The amount of the Department's claim is subject to change as additional claims are paid.

Please keep me informed on the progress of this case.

Sincerely,

Sandy Drews

Sandy Drews
Third Party Resource Section
Office of Medical Assistance
(303) 866-3579

SAD
Enclosures

Colorado Department of Health Care Policy and Financing - Office of Medical Assistance - MMIS/Stars

MEDICAID PAID CLAIMS HISTORY - PHARMACY

CLIENT ID: T574448 - MCNALLY,MYRTLE SEX: F CLNT_DOB: 1/17/29

CLNT_AGE:	072	CLNT_MAJ_PROG:	M - Medicaid	TCN	01228305409110
FIRST DOS	8/16/01	CLAIM_TYPE:	A - Pharmacy Claim	PAYMENT:	$15.27
PAYMENT_DATE:	8/21/01	CAT_OF_SERV:	55 - Prescribed Drugs	BILLED_CHARGES	$31.39
ACTION_CODE:	P - Paid	INVOICE_TYPE:	CP - Pharmacy Claim	COMP_TOT_CHRG	$16.02
PROV_ID:	03465390 - K-MART CORPORATION			ALLOWED_AMT:	$16.02
PRESC_PHYS:	30149			ALLW_INGRED_COST:	$12.02
MC_PROV_ID:	05638267			DISP_FEE_AMT:	$4.00
PROV_GROUP:	03465390	PROV_TYPE:	09 - Pharmacy	SUBM_INGRED_COST:	$87.89
RX_NO:	6750060			DRUG_DED_AMT:	$0.00
NDC_CODE:	00378055505 - 35792 NAPROXEN 375MG TABLET			TOT_COPAY:	$0.75
GENERIC_XREF:	35792	GRNT_CD:	1 - Financial and Medical	DAYS_SUPPLY:	30
PA_NUMBER:	0000000	CLNT_TPL_CD:	23 - Medicaid, Medic	UNITS_ALLOWED:	90
DRUG_TYPE:	0 - Unspecified			DRUG_SUB_QTY:	90

CLNT_AGE:	072	CLNT_MAJ_PROG:	M - Medicaid	TCN:	01229307094910
FIRST DOS	8/17/01	CLAIM_TYPE:	A - Pharmacy Claim	PAYMENT:	$25.84
PAYMENT_DATE:	8/21/01	CAT_OF_SERV:	55 - Prescribed Drugs	BILLED_CHARGES	$31.79
ACTION_CODE:	P - Paid	INVOICE_TYPE:	CP - Pharmacy Claim	COMP_TOT_CHRG:	$26.59
PROV_ID:	03465390 - K-MART CORPORATION			ALLOWED_AMT:	$26.59
PRESC_PHYS:	20009			ALLW_INGRED_COST:	$22.59
MC_PROV_ID	05638267			DISP_FEE_AMT:	$4.00
PROV_GROUP	03465390	PROV_TYPE:	09 - Pharmacy	SUBM_INGRED_COST	$51.50
RX_NO:	4431362			DRUG_DED_AMT:	$0.00
NDC_CODE:	00378015505 - 70931 PROPOXY-N/APAP 100-650 TAB			TOT_COPAY:	$0.75
GENERIC_XREF:	70931	GRNT_CD:	1 - Financial and Medical	DAYS_SUPPLY:	30
PA_NUMBER:	0000000	CLNT_TPL_CD:	23 - Medicaid, Medic	UNITS_ALLOWED	90
DRUG_TYPE:	0 - Unspecified			DRUG_SUB_QTY:	90

CLNT_AGE	072	CLNT_MAJ_PROG	M - Medicaid	TCN:	01259303145010
FIRST DOS	9/16/01	CLAIM_TYPE:	A - Pharmacy Claim	PAYMENT	$25.84
PAYMENT_DATE:	9/25/01	CAT_OF_SERV:	55 - Prescribed Drugs	BILLED_CHARGES:	$30.99
ACTION_CODE:	P - Paid	INVOICE_TYPE	CP - Pharmacy Claim	COMP_TOT_CHRG	$26.59
PROV_ID	03465390 - K-MART CORPORATION			ALLOWED_AMT:	$26.59
PRESC_PHYS:	20009			ALLW_INGRED_COST:	$22.59
MC_PROV_ID	05638267			DISP_FEE_AMT:	$4.00
PROV_GROUP	03465390	PROV_TYPE:	09 - Pharmacy	SUBM_INGRED_COST:	$51.50
RX_NO:	4431362			DRUG_DED_AMT:	$0.00
NDC_CODE	00378015505 - 70931 PROPOXY-N/APAP 100-650 TAB			TOT_COPAY:	$0.75
GENERIC_XREF:	70931	GRNT_CD:	1 - Financial and Medical	DAYS_SUPPLY	30
PA_NUMBER:	0000000	CLNT_TPL_CD:	23 - Medicaid, Medic	UNITS_ALLOWED	90
DRUG_TYPE:	0 - Unspecified			DRUG_SUB_QTY	90

Colorado Department of Health Care Policy and Financing - Office of Medical Assistance - MMIS/Stars

PRESCRIBED DRUG CLAIM HISTORY - PHARMACY

CLIENT ID: T574448 - MCNALLY,MYRTLE SEX: F CLNT_DOB: 1/17/29

CLNT_AGE:	072	CLNT_MAJ_PROG:	M - Medicaid	TCN:	01289308870310
FIRST DOS	10/16/01	CLAIM_TYPE:	A - Pharmacy Claim	PAYMENT:	$25.84
PAYMENT_DATE:	10/23/01	CAT_OF_SERV:	65 - Prescribed Drugs	BILLED_CHARGES:	$30.99
ACTION_CODE:	P - Paid	INVOICE_TYPE:	CP - Pharmacy Claim	COMP_TOT_CHRG:	$26.59
PROV_ID:	03465390 - K-MART CORPORATION			ALLOWED_AMT:	$26.59
PRESC_PHYS:	01200096			ALLW_INCRED_COST:	$22.59
MC_PROV_ID:	05638267			DISP_FEE_AMT:	$4.00
PROV_GROUP:	03465390	PROV_TYPE:	09 - Pharmacy	SUBM_INCRED_COST	$51.60
RX_NO	4431382			DRUG_DED_AMT	$0.00
NDC_CODE:	00378015505 - 70931 PROPOXY-N/APAP 100-650 TAB			TOT_COPAY:	$0.75
GENERIC_XREF	70931	GRNT_CD:	1 - Financial and Medical	DAYS_SUPPLY:	30
PA_NUMBER:	00C0000	CLNT_TPL_CD:	23 - Medicaid, Medic	UNITS_ALLOWED	90
DRUG_TYPE:	0 - Unspecified			DRUG_SUB_QTY:	90

Colorado Department of Health Care Policy and Financing - Office of Medical Assistance - MMIS/Stars

MEDICAID PAID CLAIMS HISTORY - PHARMACY

CLIENT ID: T574448 - MCNALLY,MYRTLE SEX: F CLNT_DOB: 1/17/29

CLNT_AGE:	072	CLNT_MAJ_PROG:	M - Medicaid	TCN:	01206312557310
FIRST DOS	7/25/01	CLAIM_TYPE:	A - Pharmacy Claim	PAYMENT:	$25.84
PAYMENT_DATE:	7/31/01	CAT_OF_SERV:	55 - Prescribed Drugs	BILLED_CHARGES:	$31.79
ACTION_CODE:	P	INVOICE_TYPE:	CP - Pharmacy Claim	COMP_TOT_CHRG:	$26.59
PROV_ID:	03465390 - K-MART CORPORATION			ALLOWED_AMT:	$26.59
PRESC_PHYS:	20009			ALLW_INGRED_COST:	$22.59
MC_PROV_ID:	05638267			DISP_FEE_AMT:	$4.00
PROV_GROUP:	03465390	PROV_TYPE:	09 - Pharmacy	SUBM_INGRED_COST:	$51.50
RX_NO:	4431382			DRUG_DED_AMT:	$0.00
NDC_CODE:	00378015505 - 70931 PROPOXY-N/APAP 100-650 TAB			TOT_COPAY:	$0.75
GENERIC_XREF:	70931	GRNT_CD:	1 - Financial and Medical	DAYS_SUPPLY:	30
PA_NUMBER:	0000000	CLNT_TPL_CD:	23 - Medicaid, Medic	UNITS_ALLOWED:	90
DRUG_TYPE:	0 - Unspecified			DRUG_SUB_QTY:	90

CLNT_AGE:	072	CLNT_MAJ_PROG:	M - Medicaid	TCN:	01187307433810
FIRST DOS	7/6/01	CLAIM_TYPE:	A - Pharmacy Claim	PAYMENT:	$40.69
PAYMENT_DATE:	7/10/01	CAT_OF_SERV:	55 - Prescribed Drugs	BILLED_CHARGES:	$50.97
ACTION_CODE:	P	INVOICE_TYPE:	CP - Pharmacy Claim	COMP_TOT_CHRG:	$43.69
PROV_ID:	03465390 - K-MART CORPORATION			ALLOWED_AMT:	$43.69
PRESC_PHYS:	35179			ALLW_INGRED_COST:	$39.69
MC_PROV_ID:	05638267			DISP_FEE_AMT:	$4.00
PROV_GROUP:	03465390	PROV_TYPE:	09 - Pharmacy	SUBM_INGRED_COST:	$49.05
RX_NO:	6751768			DRUG_DED_AMT:	$0.00
NDC_CODE:	00086006210 - 17920 SKELAXIN 400MG TABLET			TOT_COPAY:	$3.00
GENERIC_XREF:	17920	GRNT_CD:	1 - Financial and Medical	DAYS_SUPPLY:	10
PA_NUMBER:	0000000	CLNT_TPL_CD:	23 - Medicaid, Medic	UNITS_ALLOWED:	60
DRUG_TYPE:	0 - Unspecified			DRUG_SUB_QTY:	60

CLNT_AGE:	072	CLNT_MAJ_PROG:	M - Medicaid	TCN:	01197313309910
FIRST DOS	7/16/01	CLAIM_TYPE:	A - Pharmacy Claim	PAYMENT:	$69.29
PAYMENT_DATE:	7/24/01	CAT_OF_SERV:	55 - Prescribed Drugs	BILLED_CHARGES:	$75.99
ACTION_CODE:	P	INVOICE_TYPE:	CP - Pharmacy Claim	COMP_TOT_CHRG:	$72.29
PROV_ID:	03465390 - K-MART CORPORATION			ALLOWED_AMT:	$72.29
PRESC_PHYS:	30149			ALLW_INGRED_COST:	$68.29
MC_PROV_ID:	05638267			DISP_FEE_AMT:	$4.00
PROV_GROUP:	03465390	PROV_TYPE:	09 - Pharmacy	SUBM_INGRED_COST:	$76.73
RX_NO:	6750059			DRUG_DED_AMT:	$0.00
NDC_CODE:	00045065960 - 07221 ULTRAM 50MG TABLET			TOT_COPAY:	$3.00
GENERIC_XREF:	07221	GRNT_CD:	1 - Financial and Medical	DAYS_SUPPLY:	30
PA_NUMBER:	0000000	CLNT_TPL_CD:	23 - Medicaid, Medic	UNITS_ALLOWED:	90
DRUG_TYPE:	0 - Unspecified			DRUG_SUB_QTY:	90

STATE OF COLORADO

DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1575 Sherman Street
Denver, CO 80203-1714
(303) 866-2993
(303) 866-4411 FAX
(303) 866-3883 TTY

Bill Owens
Governor

Karen Reinertson
Executive Director

July 2, 2001

LeAnn Elliott, Paralegal
Daniel G. Kay
Attorney at Law
3 South Tejon Street, Suite 200
Colorado Springs, CO 80903

RE: Myrtle McNally
State I.D. No: T574448
Date of Accident: May 10, 2001

Dear Ms. Elliott:

The Colorado Department of Health Care Policy and Financing, through its Medicaid program, has paid medical bills in the amount of $167.00 as of June 30, 2001 for Myrtle's injuries of May 10, 2001. The amount of the claims may increase if additional related claims are paid.

Section 26-4-403(3), C.R.S., (2000) gives the Department an enforceable right to recover medical assistance on behalf of a recipient for which a third party is liable. Additionally, Section 26-4-403(4), C.R.S., (2000) establishes a lien for all such medical assistance provided against any amounts recovered in a suit or claim against a liable third party.

I would appreciate your providing me with information regarding the present status of this case.

Please contact me if you have any questions.

Sincerely,

Sandy Drews

Sandy Drews
Third Party Resource Section
Office of Medical Assistance
(303) 866-3579

SAD
Enclosures

Colorado Department of Health Care Policy and Financing - Office of Medical Assistance - MMIS/Stars

MEDICAID PAID CLAIMS HISTORY - PHARMACY

CLIENT ID: T574448 - MCNALLY,MYRTLE **SEX:** F **CLNT_DOB:** 1/17/29

CLNT_AGE:	072	CLNT_MAJ_PROG:	M - Medicaid	TCN:	01162306686710
FIRST DOS	6/11/01	CLAIM_TYPE:	A - Pharmacy Claim	PAYMENT:	$15.60
PAYMENT_DATE:	6/19/01	CAT_OF_SERV:	55 - Prescribed Drugs	BILLED_CHARGES:	$24.29
ACTION_CODE:	P - Paid	INVOICE_TYPE:	CP - Pharmacy Claim	COMP_TOT_CHRG:	$16.10
PROV_ID:	03465390 - K-MART CORPORATION			ALLOWED_AMT:	$16.10
PRESC_PHYS:	30149			ALLW_INGRED_COST:	$12.02
MC_PROV_ID:	05638267			DISP_FEE_AMT:	$4.08
PROV_GROUP:	03465390	PROV_TYPE:	09 - Pharmacy	SUBM_INGRED_COST:	$87.89
RX_NO:	6750060			DRUG_DED_AMT:	$0.00
NDC_CODE:	00378055505 - 35792 NAPROXEN 375MG TABLET			TOT_COPAY:	$0.50
GENERIC_XREF:	35792	GRNT_CD:	1 - Financial and Medical	DAYS_SUPPLY:	30
PA_NUMBER:	0000000	CLNT_TPL_CD:	23 - Medicaid, Medic	UNITS_ALLOWED:	90
DRUG_TYPE:	0 - Unspecified			DRUG_SUB_QTY:	90

CLNT_AGE:	072	CLNT_MAJ_PROG:	M - Medicaid	TCN:	01130304785210
FIRST DOS	5/10/01	CLAIM_TYPE:	A - Pharmacy Claim	PAYMENT:	$67.90
PAYMENT_DATE:	5/15/01	CAT_OF_SERV:	55 - Prescribed Drugs	BILLED_CHARGES:	$75.99
ACTION_CODE:	P - Paid	INVOICE_TYPE:	CP - Pharmacy Claim	COMP_TOT_CHRG:	$69.90
PROV_ID:	03465390 - K-MART CORPORATION			ALLOWED_AMT:	$69.90
PRESC_PHYS:	30149			ALLW_INGRED_COST:	$65.82
MC_PROV_ID:	05638267			DISP_FEE_AMT:	$4.08
PROV_GROUP:	03465390	PROV_TYPE:	09 - Pharmacy	SUBM_INGRED_COST:	$73.13
RX_NO:	6750059			DRUG_DED_AMT:	$0.00
NDC_CODE:	00045065960 - 07221 ULTRAM 50MG TABLET			TOT_COPAY:	$2.00
GENERIC_XREF:	07221	GRNT_CD:	1 - Financial and Medical	DAYS_SUPPLY:	30
PA_NUMBER:	0000000	CLNT_TPL_CD:	23 - Medicaid, Medic	UNITS_ALLOWED:	90
DRUG_TYPE:	0 - Unspecified			DRUG_SUB_QTY:	90

CLNT_AGE:	072	CLNT_MAJ_PROG:	M - Medicaid	TCN:	01130304832610
FIRST DOS	5/10/01	CLAIM_TYPE:	A - Pharmacy Claim	PAYMENT:	$15.60
PAYMENT_DATE:	5/15/01	CAT_OF_SERV:	55 - Prescribed Drugs	BILLED_CHARGES:	$24.29
ACTION_CODE:	P - Paid	INVOICE_TYPE:	CP - Pharmacy Claim	COMP_TOT_CHRG:	$16.10
PROV_ID:	03465390 - K-MART CORPORATION			ALLOWED_AMT:	$16.10
PRESC_PHYS:	30149			ALLW_INGRED_COST:	$12.02
MC_PROV_ID:	05638267			DISP_FEE_AMT:	$4.08
PROV_GROUP:	03465390	PROV_TYPE:	09 - Pharmacy	SUBM_INGRED_COST:	$87.89
RX_NO:	6750060			DRUG_DED_AMT:	$0.00
NDC_CODE:	00378055505 - 35792 NAPROXEN 375MG TABLET			TOT_COPAY:	$0.50
GENERIC_XREF:	35792	GRNT_CD:	1 - Financial and Medical	DAYS_SUPPLY:	30
PA_NUMBER:	0000000	CLNT_TPL_CD:	23 - Medicaid, Medic	UNITS_ALLOWED:	90
DRUG_TYPE:	0 - Unspecified			DRUG_SUB_QTY:	90

MEDICAID PAID CLAIMS HISTORY - PHARMACY

CLIENT ID: T574448 - MCNALLY,MYRTLE SEX: F CLNT_DOB: 1/17/29

CLNT_AGE:	072	CLNT_MAJ_PROG:	M - Medicaid	TCN:	01162306690210
FIRST DOS	6/11/01	CLAIM_TYPE:	A - Pharmacy Claim	PAYMENT:	$67.90
PAYMENT_DATE:	6/19/01	CAT_OF_SERV:	55 - Prescribed Drugs	BILLED_CHARGES:	$75.99
ACTION_CODE:	P - Paid	INVOICE_TYPE:	CP - Pharmacy Claim	COMP_TOT_CHRG:	$69.90
PROV_ID:	03465390 - K-MART CORPORATION			ALLOWED_AMT:	$69.90
PRESC_PHYS:	30149			ALLW_INGRED_COST:	$65.82
MC_PROV_ID:	05638267			DISP_FEE_AMT:	$4.08
PROV_GROUP:	03465390	PROV_TYPE:	09 - Pharmacy	SUBM_INGRED_COST:	$73.13
RX_NO:	6750059			DRUG_DED_AMT:	$0.00
NDC_CODE:	00045065960 - 07221 ULTRAM 50MG TABLET			TOT_COPAY:	$2.00
GENERIC_XREF:	07221	GRNT_CD:	1 - Financial and Medical	DAYS_SUPPLY:	30
PA_NUMBER:	0000000	CLNT_TPL_CD:	23 - Medicaid, Medic	UNITS_ALLOWED:	90
DRUG_TYPE:	0 - Unspecified			DRUG_SUB_QTY:	90