(1)

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

(33) FLORENCE KING	)	ARBITRATION DIVISION
	)	
Plaintiff,	)	No.: 00-908-CD
	)	
v.	)	Issue No.:
	)	
(22) WAL-MART STORES, INC.,	)	Type of Document:
	)	
Defendant.	)	**COMPLAINT IN CIVIL ACTION**

Filed on Behalf of Plaintiff, Florence King

Counsel of Record for this Party:

Cynthia M. Porta, Esquire
P.A. ID#: 82111

WOOMER & FRIDAY, LLP
1701 McFarland Road
Pittsburgh, PA 15216

(412) 563-7980

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING	)	ARBITRATION DIVISION
	)	
Plaintiff,	)	No.:
	)	
v.	)	Issue No.:
	)	
WAL-MART STORES, INC.,	)	
	)	
Defendant	)	

NOTICE

You have been sued in court. If you wish to defend against the claims set forth in the following pages, you must take action within twenty (20) days after this Complaint and Notice are served, by entering a written appearance personally or by an attorney and by filing in writing with the Court your defenses or objections to the claims set forth against you. You are warned that if you fail to do so the case may proceed without you and a judgment may be entered against you by the Court without further notice for any money claimed in the Complaint or for any other claim or relief requested by the plaintiff. You may lose money or property or other rights important to you.

YOU SHOULD TAKE THIS PAPER TO YOUR LAWYER AT ONCE. IF YOU DO NOT HAVE A LAWYER OR CANNOT AFFORD ONE, GO TO OR TELEPHONE THE OFFICE SET FORTH BELOW TO FIND OUT WHERE YOU CAN GET LEGAL HELP.

David S. Meholick, Court Administrator
Clearfield County Courthouse
1 North Second Street
Clearfield, PA 16830
(814) 765-2641 ext. 32

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING	)	ARBITRATION DIVISION
	)	
Plaintiff,	)	No.:
	)	
v.	)	Issue No.:
	)	
WAL-MART STORES, INC.,	)	
	)	
Defendant	)	

COMPLAINT IN CIVIL ACTION

1. At all times relevant hereto, plaintiff, Florence King, is an adult individual residing at 253 West Main Street, Sykesville, Jefferson County, Pennsylvania 15865.

2. At all times relevant hereto, defendant, Wal-Mart Stores, Inc., is a Delaware Corporation, licensed to do business in the state of Pennsylvania, with a principle place of business located at RD 3 Box 176D, DuBois, Clearfield County, Pennsylvania 15801.

3. On or about February 28, 1999, plaintiff was lawfully upon defendant's premises as a business invitee.

4. At all times relevant and material hereto, defendant acted by and through its authorized agents, servants, employees, and/or representatives within the scope of their authority and employment with defendant.

5. At all material times, defendant had under its care, supervision, control, maintenance and/or was responsible for the merchandise contained on the shelving units throughout the aforementioned store.

6. On February 28, 1999, and for a period of time prior thereto, there existed a defective, unsafe, dangerous, and/or irregular condition on the shelving units throughout the aforementioned Wal-Mart store in that hot curling iron sets were not affixed, placed, set properly and/or securely upon the shelving units.

7. While shopping in the Wal-Mart store, on or about February 28, 1999, plaintiff sustained serious and severe injuries as a result of the aforementioned defective condition when a hot curling iron set fell from the shelf, striking plaintiff on the head.

8. Defendant knew or should have known of the existence of the aforementioned defective condition prior to February 28, 1999, and defendant was obligated to remedy, repair, and eliminate the defect or to warn plaintiff of its existence.

9. Injuries and damages sustained by plaintiff were caused directly and proximately by the negligence of the defendant, generally and as more particularly set forth in the following lettered paragraphs:

a. Failure to provide a safe environment for their customers to shop;

b. Failure to generally maintain the merchandise in order to ensure a safe environment for their patrons;

c. Failure to stock merchandise on shelves in a safe manner;

d. Placing merchandise on the shelves in such a manner that a reasonable person would have known or should have known could cause injury;

e. Failure to use due care and to employ reasonable skill in the performance of its duties;

f. In knowing, or should have knowing, of the aforementioned defective and dangerous condition of its premises, but nevertheless permitting its stock to remain in an unsafe, unsuitable, and dangerous condition;

g. Failure to warn its customers and patrons, including but not limited to plaintiff, of the aforementioned dangerous and defective condition;

h. Failure to exercise reasonable care to inspect and/or discover the aforementioned dangerous condition of its merchandise; and

i. Failure to correct, remedy, repair, and/or eliminate the defect.

10. As a direct and proximate result of the defendant's negligence, plaintiff has suffered the following injuries, all or some of which may be permanent and lasting in nature:

a. severe sprains and strains of and injury and damage to the bones, joints, muscles, ligaments, tendons, disks, nerves, and tissues of the areas of the back, neck, and spine;

b. severe and serious injuries to the nerves and nervous system;

c. bruises, contusions, lacerations, and abrasions about the head;

d. nervousness, emotional tension, and anxiety;

e. headaches and dizziness.

11. As a direct and proximate result of the negligence of the defendant, plaintiff has suffered the following damages:

a. She has endured and will continue to endure great pain, suffering, inconvenience, embarrassment, mental anguish, and emotional and psychological trauma;

b. She has been and will be required to expend large sums of money for medical treatment and care, hospitalization, medical supplies, surgical appliances, rehabilitation and therapeutic treatment, medicines, and other attendant services;

c. She has sustained and will continue to sustain lost earnings, and her earning capacity has been reduced and may be permanently impaired;

d. Her general health, strength, and vitality have been impaired; and

e. She has been and will in the future be unable to enjoy various pleasures of life that she previously enjoyed.

WHEREFORE, plaintiff, Florence King, requests judgment in her favor and against defendant, Wal-Mart Stores, Inc., for compensatory damages in an amount not in excess of the jurisdictional limit for compulsory arbitration, together with court costs, interest and any other relief permitted by this Honorable Court.

Respectfully submitted,

By: Cynthia M. Porta

Cynthia M. Porta, Esquire
Attorney for Plaintiff
PA I.D. # 82111

WOOMER & FRIDAY, LLP
1701 McFarland Road
Pittsburgh, PA 15216
(412) 563-7980

VERIFICATION

I, FLORENCE KING, being duly sworn according to law, depose and say that the factual averments contained in the foregoing COMPLAINT IN CIVIL ACTION are true and correct to the best of my knowledge, information and belief, and I further understand that any false statements herein contained are made subject to the penalties set forth in 18 Pa.C.S.A. 4904 relating to falsification of statements to authorities.

Florence King

Signature

WAL.192

(2)

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,

Plaintiff,

vs.

WAL-MART STORES, INC.,

Defendant.

ARBITRATION DIVISION

No. 00-908-CD

JURY TRIAL DEMANDED

PRAECIPE FOR APPEARANCE

Filed on behalf of WAL-MART STORES, INC.,

Counsel of Record for this Party:

Patrick J. Loughney, Esq.
Pa. I.D. ##23163

Brad D. Trust, Esq.
Pa. I.D. #83748

GORR, MOSER, DELL & LOUGHNEY
Firm #753

1300 Frick Building
Pittsburgh, PA 15219

Phone: (412) 471-1180
Fax: (412) 471-9012

WAL.192

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,	ARBITRATION DIVISION
Plaintiff,	No. 00-908-CD
vs.	JURY TRIAL DEMANDED
WAL-MART STORES, INC.,	
Defendant.	

PRAECIPE FOR APPEARANCE

TO: Prothonotary

Please enter the appearance of Attorneys Patrick J. Loughney and Brad D. Trust and the law firm of Gorr, Moser, Dell & Loughney on behalf of Defendant, Wal-Mart Stores, Inc.

GORR, MOSER, DELL & LOUGHNEY

Patrick J. Loughney, Esquire

Suite 1300 Frick Building
437 Grant Street
Pittsburgh, PA 15219-6002

Phone: 412-471-1180

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of Defendant's Praecipe for Appearance was served by U.S. Mail, postage prepaid, this 6 day of Sept, 2000, upon all counsel of record or parties as follows:

Cynthia M. Porta, Esquire
WOOMER & FRIDAY, LLP
1701 McFarland Road
Pittsburgh, PA 15216
Counsel for Plaintiff

FILED

SEP 08 2000

William A. Shaw
Prothonotary

WAL.192

(3)

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,

Plaintiff,

vs.

WAL-MART STORES, INC.,

Defendant.

ARBITRATION DIVISION

No. 00-908-CD

JURY TRIAL DEMANDED

ANSWER AND NEW MATTER

Filed on behalf of WAL-MART STORES, INC.,

Counsel of Record for this Party:

Patrick J. Loughney, Esq.
Pa. I.D. ##23163

Brad D. Trust, Esq.
Pa. I.D. #83748

GORR, MOSER, DELL & LOUGHNEY
Firm #753

1300 Frick Building
Pittsburgh, PA 15219

Phone: (412) 471-1180
Fax: (412) 471-9012

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,	)	ARBITRATION DIVISION
	)	
Plaintiff,	)	No. 00-908-CD
	)	
vs.	)	
	)	
WAL-MART STORES, INC.,	)	
	)	
Defendant.	)	

ANSWER

AND NOW, comes Defendant, Wal-Mart Stores, Inc., by and through its attorneys, Gorr, Moser, Dell & Loughney and Patrick J. Loughney, Esquire, and files the following Answer and New Matter and in support thereof sets forth the following:

1. All averments of fact contained within Plaintiff's Complaint are denied pursuant to Pa. R.C.P. 1029(e).

WHEREFORE, Defendant Wal-Mart Stores, Inc. denies that it is liable to Plaintiffs and respectfully requests judgment be entered in its favor.

NEW MATTER

2. If, in the course of discovery or trial, there is evidence that the Statute of Limitations is not tolled, the defense of the Statute of Limitations is pled.

WHEREFORE, Defendant, Wal-Mart Stores, Inc., denies that it is liable to the Plaintiffs and respectfully requests judgment be entered in its favor.

GORR, MOSER, DELL & LOUGHNEY

Patrick J. Loughney, Esquire
Attorneys for Wal-Mart Stores, Inc.,

Wal. 192

VERIFICATION

I, Patrick J. Loughney, attorney for Wal-Mart Stores, Inc., pursuant to Pa.R.C.P. 1024(c)(2), verify that the averments of fact made in this foregoing ANSWER and NEW MATTER are true and correct and based upon my personal knowledge, information or belief. I understand that averments of fact in said document are made subject to the penalties of 18 Pa. C.S. §4904, relating to the unsworn falsifications to authorities. This Verification is made by the undersigned due to lack of sufficient time to obtain a Verification from Wal-Mart Stores, Inc., and will be provided when available.

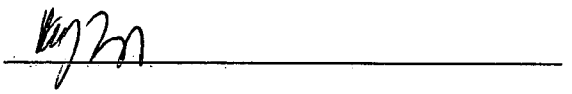
Date: 9/6/00

Patrick J. Loughney, Esquire
Attorney for Wal-Mart Stores, Inc,

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of Defendant's Answer and New Matter was served by U.S. Mail, postage prepaid, this 6 day of Sept, 2000, upon all counsel of record or parties as follows:

Cynthia M. Porta, Esquire
WOOMER & FRIDAY, LLP
1701 McFarland Road
Pittsburgh, PA 15216
Counsel for Plaintiff



FILED

SEP 08 2000

William A. Shaw
Prothonotary

(4)

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,

Plaintiff,

v.

WAL-MART STORES, INCORPORATED,

Defendant.

CIVIL DIVISION

No.: 00-908-CD

REPLY TO NEW MATTER

Filed on behalf of Plaintiff, Florence King

Counsel of record for this party:

Cynthia M. Porta, Esquire
P.A. I.D. # 82111

Woomer & Friday, LLP
1701 McFarland Road
Pittsburgh, PA 15216
(412) 563-7980

JURY TRIAL DEMANDED

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,	)	CIVIL DIVISION
	)	
Plaintiff,	)	No.: 00-908-CD
	)	
v.	)	
	)	
WAL-MART STORES, INCORPORATED,	)	
	)	
	)	
Defendant.	)	

REPLY TO NEW MATTER

AND NOW, comes plaintiff, Florence King, by and through her attorneys, Woomer & Friday, LLP, and files the following Reply to New Matter:

1. Paragraph 2 of defendant's New Matter states a conclusion of law to which no responsive pleading is required. To the extent that a response is warranted, plaintiff denies that the defense of statute of limitations is applicable in the instant matter.

WHEREFORE, plaintiff Florence King, requests judgement in her favor and against defendant, Wal-Mart Stores, Incorporated, for compensatory damages in an amount not in excess of the jurisdictional limit for compulsory arbitration together with court costs, interest, and other relief permitted by this Honorable Court

Respectfully submitted,

WOOMER & FRIDAY, LLP

By: Cynthia M. Porta

Cynthia M. Porta, Esquire
Attorney for Plaintiff
PA I.D. #82111

1701 McFarland Road
Pittsburgh, PA 15216
(412) 563-7980

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,	)	CIVIL DIVISION
	)	
Plaintiff,	)	No.: 00-908-CD
	)	
v.	)	
	)	
WAL-MART STORES, INCORPORATED,	)	
	)	
Defendant.	)	

CERTIFICATE OF SERVICE

I hereby certify that on this 25th day of September, 2000, a true and correct copy of the foregoing ***Reply to New Matter*** was served by First Class U.S. Mail, postage prepaid, upon the following:

Patrick J. Loughney, Esquire
437 Grant Street
1300 Frick Building
Pittsburgh, PA 15219

Respectfully Submitted,

WOOMER & FRIDAY

By: Cynthia M. Porta
Cynthia M. Porta, Esquire
PA I.D. # 82111

1701 McFarland Road
Pittsburgh, PA 15216
(412) 563-7980

WAL.192

(5)

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,

Plaintiff,

vs.

WAL-MART STORES, INC.,

Defendant.

ARBITRATION DIVISION

No. 00-908-CD

JURY TRIAL DEMANDED

DEFENDANT'S VERIFICATION TO ANSWER AND NEW MATTER

Filed on behalf of WAL-MART STORES, INC.,

Counsel of Record for this Party:

Patrick J. Loughney, Esq.
Pa. I.D. ##23163

Brad D. Trust, Esq.
Pa. I.D. #83748

GORR, MOSER, DELL & LOUGHNEY
Firm #753

1300 Frick Building
Pittsburgh, PA 15219

Phone: (412) 471-1180
Fax: (412) 471-9012

WAL.192

VERIFICATION

I verify that the averments of fact made in this foregoing ANSWER AND NEW MATTER are true and correct to the best of my knowledge, information or belief. I understand that averments of fact in said document are made subject to the penalties of 18 Pa. C.S. § 4904, relating to the unsworn falsifications to authorities.

I am authorized to make this verification on behalf of Wal-Mart Stores, Inc., because of my position as manager.

Date: 9/12/00

~~Kelli Maxwell~~, Manager
for John Dillon

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of Defendant's Verification to Answer and New Matter was served by U.S. Mail, postage prepaid, this 28th day of September, 2000, upon all counsel of record or parties as follows:

Cynthia M. Porta, Esquire
WOOMER & FRIDAY, LLP
1701 McFarland Road
Pittsburgh, PA 15216
Counsel for Plaintiff

Verna Kubina

(6)

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,

Plaintiff,

v.

WAL-MART STORES, INCORPORATED,

Defendant.

CIVIL DIVISION

No.: 00-908-CD

NOTICE OF SERVICE OF PLAINTIFF'S ANSWERS TO DEFENDANT'S FIRST SET OF INTERROGATORIES

Filed on behalf of Plaintiff, Florence King

Counsel of record for this party:

Cynthia M. Porta, Esquire
P.A. I.D. # 82111

Woomer & Friday, LLP
1701 McFarland Road
Pittsburgh, PA 15216
(412) 563-7980

JURY TRIAL DEMANDED

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,	)	ARBITRATION DIVISION
	)	
Plaintiff,	)	No.: 00-908-CD
	)	
v.	)	
	)	
	)	
WAL-MART STORES, INCORPORATED,	)	
	)	
	)	
Defendant.		

NOTICE OF SERVICE

I hereby certify that on this 10th day of October, 2000, a true and correct copy of ***Plaintiff's Answers to Defendant's First Set of Interrogatories*** was served by First Class U.S. Mail, postage prepaid, upon the following:

Patrick J. Loughney, Esquire
Gorr, Moser, Dell & Loughney
1300 Frick Building
Pittsburgh, PA 15219

Respectfully Submitted,

WOOMER & FRIDAY

By: Cynthia M. Porta
Cynthia M. Porta, Esquire
PA I.D. # 82111

1701 McFarland Road
Pittsburgh, PA 15216
(412) 563-7980

(7)

IN THE COURT OF COMMON PLEASE OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,

Plaintiff,

v.

WAL-MART STORES, INCORPORATED,

Defendant.

CIVIL DIVISION

No.: 00-908-CD

Notice of Service of Interrogatories and Request for Production of Documents Directed to Defendant

Filed on behalf of plaintiff:
Florence King

Counsel of Record for this Party:

Cynthia M. Porta, Esquire
PA I.D. #: 82111

WOOMER & FRIDAY, LLP
1701 McFarland Road
Pittsburgh, PA 15216
(412) 563-7980

JURY TRIAL DEMANDED

IN THE COURT OF COMMON PLEASE OF CLEARFIELD
COUNTY, PENNSYLVANIA

FLORENCE KING, CIVIL DIVISION

Plaintiff, No.: 00-908-CD

v.

WAL-MART STORES, INCORPORATED,

Defendant.

NOTICE OF SERVICE

I, Cynthia M. Porta, Esquire, hereby certify that on this 13th day of November, 2000, a true and correct copy of Interrogatories and Request for Production of Documents Directed to Defendant were served upon the following via first class United States mail, postage pre-paid:

Patrick J. Loughney, Esquire
Gorr, Moser, Dell & Loughney
1300 Frick Building
Pittsburgh, PA 15219

Respectfully submitted,

Cynthia M. Porta

Cynthia M. Porta, Esquire
Attorney for Plaintiff
PA I.D. #: 82111

WAL.192

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,

Plaintiff,

vs.

WAL-MART STORES, INC.,

Defendant.

ARBITRATION DIVISION

No. 00-908-CD

JURY TRIAL DEMANDED

PRAECIPE TO PLACE CASE ON ARBITRATION LIST

Filed on behalf of WAL-MART STORES, INC.,

Counsel of Record for this Party:

Patrick J. Loughney, Esq.
Pa. I.D. ##23163

Patrick J. Doheny, Esq.
Pa. I.D. #85547

GORR, MOSER, DELL & LOUGHNEY
Firm #753

1300 Frick Building
Pittsburgh, PA 15219

Phone: (412) 471-1180
Fax: (412) 471-9012

WAL.192

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,	ARBITRATION DIVISION
Plaintiff,	No. 00-908-CD
vs.	JURY TRIAL DEMANDED
WAL-MART STORES, INC.,	
Defendant.	

PRAECIPE TO PLACE CASE ON ARBITRATION LIST

To: Prothonotary

Kindly place the above-captioned matter on the next available arbitration list as all discovery has been completed, pleadings are closed and all preliminary motions have been resolved. The value of this case is unknown.

Parties:

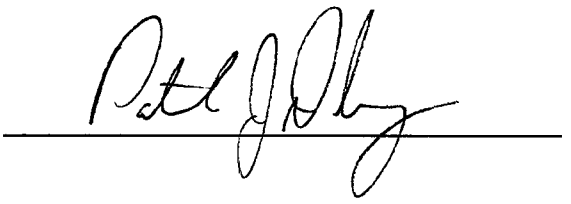
Florence King, Plaintiff	Cynthia M. Porta, Esquire
Wal-Mart Stores, Inc., Defendant	Patrick J. Doheny, Esquire

Patrick J. Doheny, Esquire
Gorr, Moser, Dell & Loughney
437 Grant Street
1300 Frick Building
Pittsburgh, PA 15219
Counsel for Defendant Wal-Mart Stores, Inc.

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of Defendant's Praecipe to Place Case on Arbitration List was served by U.S. Mail, postage prepaid, this 19th day of FEBRUARY, 2001, upon all counsel of record or parties as follows:

Cynthia M. Porta, Esquire
WOOMER & FRIDAY, LLP
1701 McFarland Road
Pittsburgh, PA 15216
Counsel for Plaintiff



FILED

FEB 26 2001
m/10:13/no cc
William A. Shaw
Prothonotary

atty Loughney
pd $20.00
Copy to CA

GORR, MOSER, DELL & LOUGHNEY, LLC
ATTORNEYS AT LAW

1300 FRICK BUILDING
437 GRANT STREET
PITTSBURGH, PENNSYLVANIA 15219-6002

TELEPHONE: 412/471-1180
FAX: 412/471-9012
E-MAIL: gmdl@gmdl-law.com
www.gorrmoser.com

February 22, 2001
File No. Wal.192

William A. Shaw, Prothonotary
Clearfield County Courthouse
One North 2nd Street
P.O. Box 549
Clearfield, PA 16830

Re: Florence King v. Wal-Mart Stores, Inc.
Clearfield County No. 00-908-CD

Dear Mr. Shaw:

Enclosed please find the original and one extra cover sheet of Defendant Wal-Mart Stores, Inc.'s Praecipe to Place Case on Arbitration List in the above-captioned matter. Kindly file the original, date stamp the extra cover sheet, and return it to me in the self-addressed, stamped envelope I have provided.

I have also enclosed a check payable to "Clearfield County Prothonotary" in the amount of $20.00.

Thank you for your attention to this matter.

Very truly yours,

Mickey A. Engstler
Paralegal to Patrick J. Doheny

:me
Enclosures

cc: Cynthia M. Porta, Esq. (w/Enc.)

WAL.192

9

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,

Plaintiff,

vs.

WAL-MART STORES, INC.,

Defendant.

ARBITRATION DIVISION

No. 00-908-CD

JURY TRIAL DEMANDED

MOTION FOR CONTINUANCE

Filed on behalf of WAL-MART STORES, INC.,

Counsel of Record for this Party:

Patrick J. Loughney, Esq.
Pa. I.D. ##23163

Patrick J. Doheny, Esq.
Pa. I.D. #85547

GORR, MOSER, DELL & LOUGHNEY
Firm #753

1300 Frick Building
Pittsburgh, PA 15219

Phone: (412) 471-1180
Fax: (412) 471-9012

WAL.192

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,	ARBITRATION DIVISION
Plaintiff,	No. 00-908-CD
vs.	JURY TRIAL DEMANDED
WAL-MART STORES, INC.,	
Defendant.	

MOTION FOR CONTINUANCE

AND NOW, comes Defendant Wal-Mart Stores, Inc., by and through it's counsel, Gorr, Moser, Dell & Loughney, Patrick J. Loughney, Esquire and Patrick J. Doheny, Esquire, who moves your Honorable Court as follows:

1) The Arbitration Hearing in the above-captioned matter is scheduled to commence on May 25, 2001.

2) Wal-Mart's only witness, former employee Kelli Maxwell, is unavailable to testify on the date of the hearing.

3) Plaintiff's counsel has consented to continuing the Arbitration Hearing

WHEREFORE, Wal-Mart respectfully moves your Honorable Court to reschedule the Arbitration Hearing in the above-captioned matter.

Respectfully submitted,

GORR, MOSER, DELL & LOUGHNEY

Patrick J. Doheny, Esquire
437 Grant Street
1300 Frick Building
Pittsburgh, PA 15219
Counsel for Wal-Mart Stores, Inc.

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY,
PENNSYLVANIA
CIVIL DIVISION

FLORENCE KING	:	
	:	
vs.	:	No. 00-908-CD
	:	
WAL-MART STORES, INC.	:	

ORDER

AND NOW, this 15th day of May, 2001, upon presentation and consideration of Defendant's Motion for Continuance filed in the above-captioned matter, it is the ORDER of this Court that said Arbitration Hearing be and is hereby CONTINUED. The Court Administrator is directed to rescheduled this on the next available Hearing date.

BY THE COURT:

JOHN K. REILLY, JR.
President Judge

FILED
MAY 15 2001
William A. Shaw
Prothonotary

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of Defendant's Motion for Continuance was served by U.S. Mail, postage prepaid, this 2nd day of May, 2001, upon all counsel of record or parties as follows:

Cynthia M. Porta, Esquire
WOOMER & FRIDAY, LLP
1701 McFarland Road
Pittsburgh, PA 15216
Counsel for Plaintiff

IN THE COURT OF COMMON PLEASE OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,

Plaintiff,

v.

WAL-MART STORES, INCORPORATED,

Defendant.

CIVIL DIVISION

No.: 00-908-CD

Notice of Service of Plaintiff's Rule 1305 Disclosure

Filed on behalf of plaintiff:
Florence King

Counsel of Record for this Party:

Cynthia M. Porta, Esquire
PA I.D. #: 82111

WOOMER & FRIDAY, LLP
3220 West Liberty Ave., Suite 200
Pittsburgh, PA 15216
(412) 563-7980

JURY TRIAL DEMANDED

IN THE COURT OF COMMON PLEASE OF CLEARFIELD
COUNTY, PENNSYLVANIA

FLORENCE KING, CIVIL DIVISION

Plaintiff, No.: 00-908-CD

v.

WAL-MART STORES, INCORPORATED,

Defendant.

NOTICE OF SERVICE

I, Cynthia M. Porta, Esquire, hereby certify that on this 25th day of July, 2001, a true and correct copy of Plaintiff's Rule 1305 Disclosure was served upon the following via first class United States mail, postage pre-paid:

Patrick J. Loughney, Esquire
Gorr, Moser, Dell & Loughney
1300 Frick Building
Pittsburgh, PA 15219

Respectfully submitted,

Cynthia M. Porta

Cynthia M. Porta, Esquire
Attorney for Plaintiff
PA I.D. #: 82111

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY
PENNSYLVANIA

Florence King
Vs.
Wal-Mart Stores, Inc.

No. 2000-00908-CD

OATH OR AFFIRMATION OF ARBITRATORS

Now, this 13th day of August, 2001, we the undersigned, having been appointed arbitrators in the above case do hereby swear, or affirm, that we will hear the evidence and allegations of the parties and justly and equitably try all matters in variance submitted to us, determine the matters in controversy, make an award, and transmit the same to the Prothonotary within twenty (20) days of the date of hearing of the same.

James A. Naddeo, Esq. — James A. Naddeo Chairman

Ronald L. Collins, Esq.

Theron G. Noble, Esq.

Sworn to and subscribed before me this
August 13, 2001

William A. Shaw

Prothonotary

AWARD OF ARBITRATORS

Now, this 13th day of August, 2001, we the undersigned arbitrators appointed in this case, after being duly sworn, and having heard the evidence and allegations of the parties, do award and find as follows: Medical bills in the amount of 5,168 00/00

Pain & Suffering in the amount of 14,000

Total award $ 19,168 00/00

James A. Naddeo Chairman

(Continue if needed on reverse.)

FILED
AUG 13 2001
William A. Shaw
Prothonotary

ENTRY OF AWARD

Now, this 13th day of August, 2001, I hereby certify that the above award was entered of record this date in the proper dockets and notice by mail of the return and entry of said award duly given to the parties or their attorneys.

WITNESS MY HAND AND THE SEAL OF THE COURT

Prothonotary

~~By~~ William A. Shaw

Florence King	:	IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY
Vs.	:	No. 2000-00908-CD
Wal-Mart Stores, Inc.	:	

NOTICE OF AWARD

TO: PATRICK J. DOHENY

You are herewith notified that the Arbitrators appointed in the above case have filed their award in this office on August 13, 2001 and have awarded:

Medical bills in the amount of $5,168.00, pain and suffering in the amount of $14,000.00. Total award $19,168.00.

William A. Shaw
Prothonotary
By_____

August 13, 2001
Date

In the event of an Appeal from Award of Arbitration within thirty (30) days of date of award.

COPY

Florence King	:	IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY
Vs.	:	No. 2000-00908-CD
Wal-Mart Stores, Inc.	:	

NOTICE OF AWARD

TO: CYNTHIA M. PORTA ESQ

You are herewith notified that the Arbitrators appointed in the above case have filed their award in this office on August 13, 2001 and have awarded:

Medical bills in the amount of $5,168.00, pain and suffering in the amount of $14,000.00. Total award $19,168.00.

William A. Shaw
Prothonotary
By_____

August 13, 2001
Date

In the event of an Appeal from Award of Arbitration within thirty (30) days of date of award.

Florence King	:	IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY
Vs.	:	No. 2000-00908-CD
Wal-Mart Stores, Inc.	:	

NOTICE OF AWARD

TO: BRAD D. TRUST

You are herewith notified that the Arbitrators appointed in the above case have filed their award in this office on August 13, 2001 and have awarded:

Medical bills in the amount of $5,168.00, pain and suffering in the amount of $14,000.00. Total award $19,168.00.

William A. Shaw
Prothonotary
By_____

August 13, 2001
Date

In the event of an Appeal from Award of Arbitration within thirty (30) days of date of award.

IN THE COURT OF COMMON PLEASE OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,

Plaintiff,

v.

WAL-MART STORES, INCORPORATED,

Defendant.

CIVIL DIVISION

No.: 00-908-CD

Plaintiff's Pre-Trial Memorandum

Filed on behalf of plaintiff:
Florence King

Counsel of Record for this Party:

Cynthia M. Porta, Esquire
PA I.D. #: 82111

WOOMER & FRIDAY, LLP
3220 West Liberty Ave., Suite 200
Pittsburgh, PA 15216
(412) 563-7980

JURY TRIAL DEMANDED

IN THE COURT OF COMMON PLEASE OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING, CIVIL DIVISION

Plaintiff, No.: 00-908-CD

v.

WAL-MART STORES, INCORPORATED,

Defendant.

PLAINTIFF'S PRE-TRIAL MEMORANDUM

AND NOW comes plaintiff, Florence King, by and through her attorneys, Woomer & Friday, LLP, and files the following Plaintiff's Pre-Trial Memorandum:

Brief Statement of the Case

This matter arises from an accident occurring on or about February 28, 1999 at approximately 12:45 p.m. On or about the aforementioned date and time, plaintiff, Florence King, was shopping at the Wal-Mart Store located on Route 255 in DuBois, Pennsylvania. Miss King attempted to remove a hot curling iron set from the second shelf in the store. Unbeknownst to plaintiff, the box that she was attempting to remove was entangled with another box, casing the second box to fall from the shelf and strike plaintiff in the head. As a result of this event, plaintiff immediately developed neck pain and a severe headache.

On or about August 3, 2000, plaintiff initiated suit against defendant, Wal-Mart Stores, Inc., alleging that the defendant was negligent in allowing the box of hot curlers

to be in such a position, inter alia., either improperly secured or in such a position as to cause injury to the prospective customers. Plaintiff seeks damages for embarrassment, mental anguish, medical treatment, lost earnings, and impairment of her health and enjoyment of life. These damages stem directly from injuries to the neck, head and back which resulted from the aforementioned accident.

Citations of Relevant Cases and/or Statutes

Paul v. Hess Brothers, Inc., 226 Pa.Super. 92, 312 A.2d 65 (1973).

McNett v. Bringgs, 217 Pa.Super. 322, 272 A.2d 202 (19970).

Murphy v. Bargain City, U.S.A., 203 Pa.Super. 406, 201 A.2d 299 (1964).

Lyttle v. Denny, 222 Pa. 395, 71 A. 841 (1909).

Doerflinger v. Davis, 412 Pa. 401, 194 A.2d 897 (1963).

Dougherty v. Great Atlantic and Pacific Tea Co., Inc., 221 Pa.Super. 221, 289 A.2d 747 (1972).

Hampton v. S.S. Kresge Co., 224 Pa.Super. 543, 307 A.2d 366 91973).

Stewart v. Morow, 403 Pa. 459, 170 A.2d 338 (1961).

Coehn v. Penn Fruit Co., 192 Pa.Super. 244, 159 A.2d 558 (1960).

Witnesses

1. Florence King
2. Jenn Brown
3. Eric Yount
4. Sue Dodge
5. Kelly Maxwell

Statement of Damages

A. Medical Bills

1.	Casteel Chiropractic Center	-	$ 1,465.00
2.	DuBois Regional Medical Center	-	$ 1,289.00

3.	Henry G. DelaTorre, M.D.	-	$ 80.00
4.	Advanced Imaging Associates	-	$ 2,080.00
5.	DuBois Regional Medical Center Department of Physical Therapy	_	$ 254.00

B. Other

1. Pain, suffering, inconvenience, embarrassment, mental anguish and emotional and psychological trauma;

2. Loss of earnings and earning capacity;

3. Loss of general health, strength, and vitality; and

4. Loss of enjoyment of various pleasures of life.

Plaintiff reserves the right to supplement this Pre-Trial Memorandum at any time prior to the commencement of arbitration.

Respectfully submitted,

Cynthia M. Porta

Cynthia M. Porta, Esquire
Attorney for Plaintiff
PA I.D. #: 82111

WOOMER & FRIDAY, LLP
3220 West Liberty Ave., Suite 200
Pittsburgh, PA 15216
(412) 563-7980

Dela Torre Medical Cl
231 E Highland Street

Sykesville,PA 15865
814-894-2448

ACCOUNT	AMOUNT DUE	CLOSE DATE	PAGE
kingfl-00	0.00	06/25/01	01

TO: Florence I King
130 W Main St

Sykesville,PA 15865

PREVIOUS BALANCE--> 0.00

DATE	DR.	PATIENT	PROC	DESCRIPTION	DIAG	AMOUNT
03/16/99	hgd	Florenc	99214	Office Visit Detailed	714.0	70.00
03/16/99				Payment-Thank You		1.00-
05/04/99				Adj:Medicaid Write Medicaid		69.00-
03/16/99	hgd	Florenc	93000	Ekg	786.59	47.50
05/04/99				Plan Payment:08367 Medicaid		39.50-
05/04/99				Adj:Medicaid Write Medicaid		8.00-
04/13/99	hgd	Florenc	99213	Office Visit Expanded	724.2	45.00
04/13/99				Payment-Thank You		1.00-
06/01/99				Plan Payment:01190 Medicaid		19.00-
06/01/99				Adj:Medicaid Write Medicaid		25.00-
06/09/99	phu	Florenc	99212	Office Visit Focused	466.0	30.00
06/09/99				Payment-Thank You		1.00-
10/22/99				Plan Payment:unkno Medicaid		19.00-
10/22/99				Adj:Medicaid Write Medicaid		10.00-
06/15/99	phu	Florenc	99212	Office Visit Focused	466.0	30.00
10/22/99				Plan Payment:unkno Medicaid		19.00-
10/22/99				Adj:Medicaid Write Medicaid		11.00-
07/20/99	phu	Florenc	99212	Office Visit Focused	462	30.00
12/23/99				Plan Payment:09225 Medicaid		0.00
02/14/00				Plan Payment:09307 Medicaid		19.00-
02/14/00				Adj:Medicaid Write Medicaid		11.00-
11/05/99	hgd	Florenc	99214	Gyn Exam Established Patient	616.10	60.00
11/05/99				Payment-Thank You		1.00-
12/23/99				Plan Payment:09225 Medicaid		19.00-

CONT'D

ACCOUNT NO	CURRENT	31-60	61-90	91-120	OVER 120
kingfl-00	0.00	0.00	0.00	0.00	0.00

Dela Torre Medical Cl
231 E Highland Street

Sykesville,PA 15865
814-894-2448

ACCOUNT	AMOUNT DUE	CLOSE DATE	PAGE
kingfl-00	0.00	06/25/01	02

TO: Florence I King
130 W Main St

Sykesville,PA 15865

DATE	DR.	PATIENT	PROC	DESCRIPTION	DIAG	AMOUNT
12/23/99				Adj:Medicaid Write Medicaid		40.00-
12/15/99	hgd	Florenc	45330	Sigmoid Flex	569.3	150.00
02/14/00				Plan Payment:09289 Medicaid		61.50-
02/14/00				Adj:Medicaid Write Medicaid		88.50-
12/20/99	hgd	Florenc	99212	Office Visit Focused	487.1	30.00
12/20/99				Payment-Thank You		1.00-
02/14/00				Plan Payment:09289 Medicaid		19.00-
02/14/00				Adj:Medicaid Write Medicaid		10.00-
01/17/00	hgd	Florenc	99213	Office Visit Expanded	465.9	50.00
01/17/00				Payment-Thank You		1.00-
03/03/00				Plan Payment:08389 Medicaid		19.00-
03/03/00				Adj:Medicaid Write Medicaid		30.00-
02/09/00	phu	Florenc	99213	Office Visit Expanded	401.9	50.00
03/31/00				Plan Payment:07803 Medicaid		19.00-
03/31/00				Adj:Medicaid Write Medicaid		31.00-
03/27/00	hgd	Florenc	99213	Office Visit Expanded	401.9	50.00
05/26/00				Plan Payment:08508 Medicaid		19.00-
05/26/00				Adj:Medicaid Write Medicaid		31.00-
03/27/00	hgd	Florenc	93000	Ekg	401.9	47.50
05/26/00				Plan Payment:08508 Medicaid		20.50-
05/26/00				Adj:Medicaid Write Medicaid		27.00-
04/25/00	phu	Florenc	99212	Office Visit Focused	922.9	40.00
06/05/00				Plan Payment:08860 Medicaid		19.00-
06/05/00				Adj:Medicaid Write Medicaid		21.00-

CONT'D

ACCOUNT NO	CURRENT	31-60	61-90	91-120	OVER 120
kingfl-00	0.00	0.00	0.00	0.00	0.00

Dela Torre Medical Cl
231 E Highland Street

Sykesville,PA 15865
814-894-2448

ACCOUNT	AMOUNT DUE	CLOSE DATE	PAGE
kingfl-00	0.00	06/25/01	03

TO: Florence I King
130 W Main St

Sykesville,PA 15865

DATE	DR.	PATIENT	PROC	DESCRIPTION	DIAG	AMOUNT
04/25/00	phu	Florenc	90702	Dt	922.9	16.00
06/05/00				Adj:Medicaid Write Medicaid		16.00-
06/26/00	hgd	Florenc	99213	Office Visit Expanded	729.1	50.00
09/05/00				Plan Payment:01884 Medicaid		50.00-
06/26/00	hgd	Florenc	94010	Spirometry	786.09	66.00
09/05/00				Plan Payment:01884 Medicaid		2.00-
09/05/00				Adj:Medicaid Write Medicaid		64.00-
07/03/00	hgd	Florenc	99214	Office Visit Detailed	729.1	75.00
07/03/00				Payment-Thank You		1.00-
11/28/00				Plan Payment:03473 Medicaid		0.00
12/05/00				Plan Payment:09126 Medicaid		0.00
01/19/01				Plan Payment:09802 Medicaid		0.00
01/19/01				Adj:Medicaid Write Medicaid		74.00-
07/18/00	phu	Florenc	99213	Office Visit Expanded	386.30	50.00
09/05/00				Plan Payment:01887 Medicaid		19.00-
09/05/00				Adj:Medicaid Write Medicaid		31.00-
09/07/00	phu	Florenc	99213	Office Visit Expanded	723.9	50.00
10/20/00				Plan Payment:03424 Medicaid		19.00-
10/20/00				Adj:Medicaid Write Medicaid		31.00-
10/09/00	hgd	Florenc	99213	Office Visit Expanded	780.4	50.00
10/09/00				Payment-Thank You		1.00-
11/28/00				Plan Payment:03473 Medicaid		19.00-
11/28/00				Adj:Medicaid Write Medicaid		30.00-
10/19/00	hgd	Florenc	99213	Office Visit Expanded	724.2	50.00

CONT'D

ACCOUNT NO	CURRENT	31-60	61-90	91-120	OVER 120
kingfl-00	0.00	0.00	0.00	0.00	0.00

Dela Torre Medical Cl
231 E Highland Street

Sykesville,PA 15865
814-894-2448

ACCOUNT	AMOUNT DUE	CLOSE DATE	PAGE
kingfl-00	0.00	06/25/01	04

TO: Florence I King
130 W Main St

Sykesville,PA 15865

DATE	DR.	PATIENT	PROC	DESCRIPTION	DIAG	AMOUNT
10/19/00				Payment-Thank You		1.00-
12/05/00				Plan Payment:09126 Medicaid		19.00-
12/05/00				Adj:Medicaid Write Medicaid		30.00-
11/16/00	hgd	Florenc	99214	Office Visit Detailed	272.4	75.00
11/16/00				Payment-Thank You		1.00-
01/08/01				Plan Payment:09779 Medicaid		19.00-
01/08/01				Adj:Medicaid Write Medicaid		55.00-
03/15/01	hgd	Florenc	99214	Office Visit Detailed	715.09	75.00
03/15/01				Payment-Thank You		1.00-
05/07/01				Plan Payment:09965 Medicaid		19.00-
05/07/01				Adj:Medicaid Write Medicaid		55.00-
04/16/01	hgd	Florenc	99213	Office Visit Expanded	386.30	55.00
04/16/01				Payment-Thank You		1.00-
06/07/01				Plan Payment:03682 Medicaid		19.00-
06/07/01				Adj:Medicaid Write Medicaid		35.00-
				*** PENDING AT CARRIER ***		
03/12/01	hgd	Florenc	g0001	Venipucture Specimen And Coll	272.4	4.00
04/16/01				Adj:Medicaid Write Medicaid		4.00-

PAY THIS AMOUNT --> 0.00

ACCOUNT NO	CURRENT	31-60	61-90	91-120	OVER 120
kingfl-00	0.00	0.00	0.00	0.00	0.00

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] MEDICAID [ ] CHAMPUS [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [ ]
(Medicare #) (Medicaid #) [X] (Sponsor's SSN) [ ] (VA File #) [ ] (SSN or ID) [ ] (SSN) [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 0019202555

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): King Florence I

3. PATIENT'S BIRTH DATE MM DD YY: 10 14 1941 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 253 W Main Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Sykesville STATE: PA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 15865 TELEPHONE (Include Area Code): (814) 894-5410

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 10 14 1941 SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
Signature Exception 062501
SIGNED _____ DATE _____

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

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: John Markley MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 722.10 Lumbar Disc Herniati
2. 724.2 Lumbar Spine Pain
3. 729.5 Limb Pain
4. 782.0 Numbness, P

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
01 29 98		01	54	72148	00	1 2	680 00	1				311 00
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN: 25-1732853 [X]

26. PATIENT'S ACCOUNT NO.: kingfl033956

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ 680 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
C Hobbie MD
SIGNED DATE 062501

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
Indiana MRI
Indiana, PA 15701

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Advanced Imaging Associates
P O Box 450
New Stanton PA 15672
PIN# 1604197 /01 GRP# 1496090 /08

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500 APPROVED OMB-0720-0001 (CHAMPUS)

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 0019202555

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): King Florence I

3. PATIENT'S BIRTH DATE MM DD YY: 10 14 1941 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 253 W Main Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Sykesville STATE: PA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 15865 TELEPHONE (Include Area Code): (814) 894-5410

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 10 14 1941 SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature Exception DATE: 062501

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

SIGNED:

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Henry Delatorre MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 780.4 Vertigo
2. 784.0 Headache
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
11 07 00		01	54	70553	00	1 2	1400 00	1				338 00
2												
3												
4												
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 25-1732853

26. PATIENT'S ACCOUNT NO.: kingfl057306

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ 1400 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

B Mariano MD

SIGNED DATE 062501

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Indiana MRI
Indiana, PA 15701

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Advanced Imaging Associates
P O Box 450
New Stanton PA 15672
7249282830

PIN# 0921037 /13 GRP# 1496090 /08

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

APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

ALL CHARGES/PAYMENTS

I T E M I Z E D S T A T E M E N T

CLAIM:

DATE: 05/16/2001

IRS#: 251542351

PATIENT: FLORENCE I. KING 100667
253 W MAIN STREET
SYKESVILLE PA 15865
SS#184-32-4880 POL#0019202555
DATE/INJ: GRP#

EMPLOYER:

TO: MEDICAL ASSISTANCE
PO BOX 8297
HARRISBURG PA 17105

CASTEEL CHIROPRACTIC CENTER
10 N MAIN ST-814/371-8686
DUBOIS PA 15801
814/371-8686 Fax:814/371-8618

DIAGNOSIS:
839.02 VERTEBRAL SUBLUXATION OF CERVICAL SPINE C2

723.1 NECK PAIN/CERVICALGIA

FC: MEDICAID
DATE OF LAST BILL: 05/01/2001 PR# 422127J9D ID# 422127J9D

DATE	CPT	DESCRIPTION	*	POS	TOS	#	AMOUNT
12/02/1999	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
12/28/1999	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
01/19/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
01/26/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
02/02/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
02/08/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
02/18/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
03/02/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
04/26/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
05/02/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
05/03/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
05/15/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
05/22/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
07/07/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
07/15/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
07/16/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
07/30/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
09/11/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
09/27/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
10/25/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
11/13/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
01/19/2001	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
01/26/2001	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
02/02/2001	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
02/16/2001	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
02/26/2001	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
03/16/2001	W9960	BRIEF OFFICE VISIT		01	60	1	30.00
		CONTINUED					
					SUBTOTAL:		810.00

ALL CHARGES/PAYMENTS

I T E M I Z E D S T A T E M E N T

CLAIM:

DATE: 05/16/2001

IRS#: 251542351

PATIENT: FLORENCE I. KING 100667
253 W MAIN STREET
SYKESVILLE PA 15865
SS#184-32-4880 POL#0019202555
DATE/INJ: GRP#

EMPLOYER:

TO: MEDICAL ASSISTANCE
PO BOX 8297
HARRISBURG PA 17105

CASTEEL CHIROPRACTIC CENTER
10 N MAIN ST-814/371-8686
DUBOIS PA 15801
814/371-8686 Fax:814/371-8618

DIAGNOSIS:
839.02 VERTEBRAL SUBLUXATION OF CERVICAL SPINE C2

723.1 NECK PAIN/CERVICALGIA

FC: MEDICAID
DATE OF LAST BILL: 05/01/2001 PR# 422127J9D ID# 422127J9D

DATE	CPT	DESCRIPTION	*	POS	TOS	#	AMOUNT
03/21/2001	W9960	BRIEF OFFICE VISIT		01	60	1	30.00
04/16/2001	W9960	BRIEF OFFICE VISIT		01	60	1	30.00
04/23/2001	W9960	BRIEF OFFICE VISIT		01	60	1	30.00
12/02/1999	PAYMENT	PA CASH					-1.00
12/28/1999	PAYMENT	PA CASH					-1.00
01/11/2000	PAYMENT	IN 98940G 11/04/99	#102567				-12.00
01/11/2000	ADJUST	IA XFER TO PATIENT	#102567				-1.00
01/11/2000	DEBIT	DE XFER FR INSUR	#102567				1.00
01/11/2000	ADJUST	IA FORGIVE	#102567				-17.00
01/11/2000	PAYMENT	IN 98940G 11/16/99	#102567				-12.00
01/11/2000	ADJUST	IA XFER TO PATIENT	#102567				-1.00
01/11/2000	DEBIT	DE XFER FR INSUR	#102567				1.00
01/11/2000	ADJUST	IA FORGIVE	#102567				-17.00
01/12/2000	PAYMENT	IN 98940G 11/12/99	#102568				-12.00
01/12/2000	ADJUST	IA XFER TO PATIENT	#102568				-1.00
01/12/2000	DEBIT	DE XFER FR INSUR	#102568				1.00
01/12/2000	ADJUST	IA FORGIVE	#102568				-17.00
01/17/2000	PAYMENT	IN 98940G 09/01/99	#101690				-12.00
01/17/2000	ADJUST	IA XFER TO PATIENT	#101690				-1.00
01/17/2000	DEBIT	DE XFER FR INSUR	#101690				1.00
01/17/2000	ADJUST	IA FORGIVE	#101690				-17.00
01/17/2000	PAYMENT	IN 98940G 09/23/99	#101691				-12.00
01/17/2000	ADJUST	IA XFER TO PATIENT	#101691				-1.00
01/17/2000	DEBIT	DE XFER FR INSUR	#101691				1.00
01/17/2000	ADJUST	IA FORGIVE	#101691				-17.00
01/17/2000	PAYMENT	IN 98940G 10/22/99	#101691				-12.00
		CONTINUED					
			SUBTOTAL:				741.00

ALL CHARGES/PAYMENTS

I T E M I Z E D S T A T E M E N T

CLAIM:

DATE: 05/16/2001

IRS#: 251542351

PATIENT: FLORENCE I. KING 100667
253 W MAIN STREET
SYKESVILLE PA 15865
SS#184-32-4880 POL#0019202555
DATE/INJ: GRP#

EMPLOYER:

TO: MEDICAL ASSISTANCE
PO BOX 8297
HARRISBURG PA 17105

CASTEEL CHIROPRACTIC CENTER
10 N MAIN ST-814/371-8686
DUBOIS PA 15801
814/371-8686 Fax:814/371-8618

DIAGNOSIS:
839.02 VERTEBRAL SUBLUXATION OF CERVICAL SPINE C2

723.1 NECK PAIN/CERVICALGIA

FC: MEDICAID
DATE OF LAST BILL: 05/01/2001 PR# 422127J9D ID# 422127J9D

DATE	CPT	DESCRIPTION	* POS TOS	#	AMOUNT
01/17/2000	ADJUST	IA XFER TO PATIENT		#101691	-1.00
01/17/2000	DEBIT	DE XFER FR INSUR		#101691	1.00
01/17/2000	ADJUST	IA FORGIVE		#101691	-17.00
01/17/2000	PAYMENT	IN 98940G 10/29/99		#101691	-12.00
01/17/2000	ADJUST	IA XFER TO PATIENT		#101691	-1.00
01/17/2000	DEBIT	DE XFER FR INSUR		#101691	1.00
01/17/2000	ADJUST	IA FORGIVE		#101691	-17.00
01/19/2000	PAYMENT	PA CASH			-1.00
01/26/2000	PAYMENT	PA CASH			-6.00
02/02/2000	PAYMENT	PA CASH			-1.00
02/08/2000	PAYMENT	IN W9960 12/02/99		#102978	-12.00
02/08/2000	ADJUST	IA XFER TO PATIENT		#102978	-1.00
02/08/2000	DEBIT	DE XFER FR INSUR		#102978	1.00
02/08/2000	ADJUST	IA FORGIVE		#102978	-17.00
02/08/2000	PAYMENT	IN W9960 12/28/99		#102978	-12.00
02/08/2000	ADJUST	IA XFER TO PATIENT		#102978	-1.00
02/08/2000	DEBIT	DE XFER FR INSUR		#102978	1.00
02/08/2000	ADJUST	IA FORGIVE		#102978	-17.00
02/08/2000	PAYMENT	PA CASH			-1.00
02/18/2000	PAYMENT	PA			-1.00
03/02/2000	PAYMENT	PA CASH			-1.00
03/06/2000	PAYMENT	IN W9960 01/19/00		#104236	-12.00
03/06/2000	ADJUST	IA FORGIVE		#104236	-18.00
03/06/2000	PAYMENT	IN W9960 01/26/00		#104236	-12.00
03/06/2000	ADJUST	IA XFER TO PATIENT		#104236	-1.00
03/06/2000	DEBIT	DE XFER FR INSUR		#104236	1.00
03/06/2000	ADJUST	IA FORGIVE		#104236	-17.00
		CONTINUED			

SUBTOTAL: 567.00

ALL CHARGES/PAYMENTS

I T E M I Z E D S T A T E M E N T

CLAIM:

DATE: 05/16/2001

IRS#: 251542351

PATIENT: FLORENCE I. KING 100667
253 W MAIN STREET
SYKESVILLE PA 15865
SS#184-32-4880 POL#0019202555
DATE/INJ: GRP#

EMPLOYER:

TO: MEDICAL ASSISTANCE
PO BOX 8297
HARRISBURG PA 17105

CASTEEL CHIROPRACTIC CENTER
10 N MAIN ST-814/371-8686
DUBOIS PA 15801
814/371-8686 Fax:814/371-8618

DIAGNOSIS:
839.02 VERTEBRAL SUBLUXATION OF CERVICAL SPINE C2

723.1 NECK PAIN/CERVICALGIA

FC: MEDICAID
DATE OF LAST BILL: 05/01/2001 PR# 422127J9D ID# 422127J9D

DATE	CPT	DESCRIPTION	* POS TOS #	AMOUNT
04/12/2000	PAYMENT	IN W9960 02/02/00	#104580	-12.00
04/12/2000	ADJUST	IA XFER TO PATIENT	#104580	-1.00
04/12/2000	DEBIT	DE XFER FR INSUR	#104580	1.00
04/12/2000	ADJUST	IA FORGIVE	#104580	-17.00
04/12/2000	PAYMENT	IN W9960 02/18/00	#104580	-12.00
04/12/2000	ADJUST	IA XFER TO PATIENT	#104580	-1.00
04/12/2000	DEBIT	DE XFER FR INSUR	#104580	1.00
04/12/2000	ADJUST	IA FORGIVE	#104580	-17.00
04/12/2000	PAYMENT	IN W9960 02/08/00	#104581	-12.00
04/12/2000	ADJUST	IA XFER TO PATIENT	#104581	-1.00
04/12/2000	DEBIT	DE XFER FR INSUR	#104581	1.00
04/12/2000	ADJUST	IA FORGIVE	#104581	-17.00
05/02/2000	PAYMENT	PA CASH		-2.00
05/03/2000	PAYMENT	PA CASH		-1.00
05/16/2000	PAYMENT	IN W9960 03/02/00	#105386	-12.00
05/16/2000	ADJUST	IA XFER TO PATIENT	#105386	-1.00
05/16/2000	DEBIT	DE XFER FR INSUR	#105386	1.00
05/16/2000	ADJUST	IA FORGIVE	#105386	-17.00
06/09/2000	PAYMENT	IN W9960 04/26/00	#106094	-12.00
06/09/2000	ADJUST	IA XFER TO PATIENT	#106094	-1.00
06/09/2000	DEBIT	DE XFER FR INSUR	#106094	1.00
06/09/2000	ADJUST	IA FORGIVE	#106094	-17.00
07/07/2000	PAYMENT	PA CASH		-4.00
07/15/2000	PAYMENT	PA CASH		-1.00
07/16/2000	PAYMENT	PA CASH		-1.00
07/17/2000	PAYMENT	IN W9960 05/03/00	#106950	-12.00
07/17/2000	ADJUST	IA XFER TO PATIENT	#106950	-1.00
		CONTINUED		
			SUBTOTAL:	400.00

ALL CHARGES/PAYMENTS

I T E M I Z E D S T A T E M E N T

CLAIM:

DATE: 05/16/2001

IRS#: 251542351

PATIENT: FLORENCE I. KING 100667
253 W MAIN STREET
SYKESVILLE PA 15865
SS#184-32-4880 POL#0019202555
DATE/INJ: GRP#

EMPLOYER:

TO: MEDICAL ASSISTANCE
PO BOX 8297
HARRISBURG PA 17105

CASTEEL CHIROPRACTIC CENTER
10 N MAIN ST-814/371-8686
DUBOIS PA 15801
814/371-8686 Fax:814/371-8618

DIAGNOSIS:
839.02 VERTEBRAL SUBLUXATION OF CERVICAL SPINE C2

723.1 NECK PAIN/CERVICALGIA

FC: MEDICAID
DATE OF LAST BILL: 05/01/2001 PR# 422127J9D ID# 422127J9D

DATE	CPT	DESCRIPTION	* POS TOS #	AMOUNT
07/17/2000	DEBIT	DE XFER FR INSUR	#106950	1.00
07/17/2000	ADJUST	IA FORGIVE	#106950	-17.00
07/17/2000	PAYMENT	IN W9960 05/15/00	#106950	-12.00
07/17/2000	ADJUST	IA XFER TO PATIENT	#106950	-1.00
07/17/2000	DEBIT	DE XFER FR INSUR	#106950	1.00
07/17/2000	ADJUST	IA FORGIVE	#106950	-17.00
07/17/2000	PAYMENT	IN W9960 05/22/00	#106950	-12.00
07/17/2000	ADJUST	IA XFER TO PATIENT	#106950	-1.00
07/17/2000	DEBIT	DE XFER FR INSUR	#106950	1.00
07/17/2000	ADJUST	IA FORGIVE	#106950	-17.00
07/17/2000	PAYMENT	IN W9960 05/02/00	#106949	-12.00
07/17/2000	ADJUST	IA XFER TO PATIENT	#106949	-1.00
07/17/2000	DEBIT	DE XFER FR INSUR	#106949	1.00
07/17/2000	ADJUST	IA FORGIVE	#106949	-17.00
09/11/2000	PAYMENT	IN W9960 07/30/00	#108366	-12.00
09/11/2000	ADJUST	IA XFER TO PATIENT	#108366	-1.00
09/11/2000	DEBIT	DE XFER FR INSUR	#108366	1.00
09/11/2000	ADJUST	IA FORGIVE	#108366	-17.00
09/11/2000	PAYMENT	IN W9960 07/15/00	#108365	-12.00
09/11/2000	ADJUST	IA XFER TO PATIENT	#108365	-1.00
09/11/2000	DEBIT	DE XFER FR INSUR	#108365	1.00
09/11/2000	ADJUST	IA FORGIVE	#108365	-17.00
09/11/2000	PAYMENT	IN W9960 07/16/00	#108365	-12.00
09/11/2000	ADJUST	IA XFER TO PATIENT	#108365	-1.00
09/11/2000	DEBIT	DE XFER FR INSUR	#108365	1.00
09/11/2000	ADJUST	IA FORGIVE	#108365	-17.00
09/11/2000	PAYMENT	PA CASH		-1.00

CONTINUED

SUBTOTAL: 209.00

ALL CHARGES/PAYMENTS

I T E M I Z E D S T A T E M E N T

CLAIM:

DATE: 05/16/2001

IRS#: 251542351

PATIENT: FLORENCE I. KING 100667
253 W MAIN STREET
SYKESVILLE PA 15865
SS#184-32-4880 POL#0019202555
DATE/INJ: GRP#

EMPLOYER:

TO: MEDICAL ASSISTANCE
PO BOX 8297
HARRISBURG PA 17105

CASTEEL CHIROPRACTIC CENTER
10 N MAIN ST-814/371-8686
DUBOIS PA 15801
814/371-8686 Fax:814/371-8618

DIAGNOSIS:
839.02 VERTEBRAL SUBLUXATION OF CERVICAL SPINE C2

723.1 NECK PAIN/CERVICALGIA

FC: MEDICAID
DATE OF LAST BILL: 05/01/2001 PR# 422127J9D ID# 422127J9D

DATE	CPT	DESCRIPTION	*	POS	TOS	#	AMOUNT
09/13/2000	PAYMENT	IN W9960 07/07/00				#108364	-12.00
09/13/2000	ADJUST	IA XFER TO PATIENT				#108364	-1.00
09/13/2000	DEBIT	DE XFER FR INSUR				#108364	1.00
09/13/2000	ADJUST	IA FORGIVE				#108364	-17.00
10/25/2000	PAYMENT	PA CASH					-1.00
11/13/2000	PAYMENT	PA CASH					-3.00
11/16/2000	PAYMENT	IN W9960 09/11/00				#110217	-12.00
11/16/2000	ADJUST	IA XFER TO PATIENT				#110217	-1.00
11/16/2000	DEBIT	DE XFER FR INSUR				#110217	1.00
11/16/2000	ADJUST	IA FORGIVE				#110217	-17.00
11/16/2000	PAYMENT	IN W9960 09/27/00				#110217	-12.00
11/16/2000	ADJUST	IA XFER TO PATIENT				#110217	-1.00
11/16/2000	DEBIT	DE XFER FR INSUR				#110217	1.00
11/16/2000	ADJUST	IA FORGIVE				#110217	-17.00
12/15/2000	PAYMENT	IN W9960 10/25/00				#110836	-12.00
12/15/2000	ADJUST	IA XFER TO PATIENT				#110836	-1.00
12/15/2000	DEBIT	DE XFER FR INSUR				#110836	1.00
12/15/2000	ADJUST	IA FORGIVE				#110836	-17.00
01/15/2001	PAYMENT	IN W9960 11/13/00				#111299	-12.00
01/15/2001	ADJUST	IA XFER TO PATIENT				#111299	-1.00
01/15/2001	DEBIT	DE XFER FR INSUR				#111299	1.00
01/15/2001	ADJUST	IA FORGIVE				#111299	-17.00
01/19/2001	PAYMENT	PA CASH					-1.00
01/26/2001	PAYMENT	PA CASH					-1.00
02/16/2001	PAYMENT	PA CASH					-1.00
02/26/2001	PAYMENT	PA CASH					-1.00
03/20/2001	PAYMENT	IN W9960 01/19/01				#113107	-12.00
		CONTINUED					
					SUBTOTAL:		44.00

ALL CHARGES/PAYMENTS

I T E M I Z E D S T A T E M E N T

CLAIM:

DATE: 05/16/2001

IRS#: 251542351

PATIENT: FLORENCE I. KING 100667
253 W MAIN STREET
SYKESVILLE PA 15865
SS#184-32-4880 POL#0019202555
DATE/INJ: GRP#

EMPLOYER:

TO: MEDICAL ASSISTANCE
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HARRISBURG PA 17105

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10 N MAIN ST-814/371-8686
DUBOIS PA 15801
814/371-8686 Fax:814/371-8618

DIAGNOSIS:
839.02 VERTEBRAL SUBLUXATION OF CERVICAL SPINE C2

723.1 NECK PAIN/CERVICALGIA

FC: MEDICAID
DATE OF LAST BILL: 05/01/2001 PR# 422127J9D ID# 422127J9D

DATE	CPT	DESCRIPTION	* POS TOS #	AMOUNT
03/20/2001	ADJUST	IA XFER TO PATIENT	#113107	-1.00
03/20/2001	DEBIT	DE XFER FR INSUR	#113107	1.00
03/20/2001	ADJUST	IA FORGIVE	#113107	-17.00
03/20/2001	PAYMENT	IN W9960 01/26/01	#113107	-12.00
03/20/2001	ADJUST	IA XFER TO PATIENT	#113107	-1.00
03/20/2001	DEBIT	DE XFER FR INSUR	#113107	1.00
03/20/2001	ADJUST	IA FORGIVE	#113107	-17.00
03/21/2001	PAYMENT	PA CASH		-1.00
04/16/2001	PAYMENT	IN W9960 02/02/01	#113323	-12.00
04/16/2001	ADJUST	IA FORGIVE	#113323	-18.00
04/16/2001	PAYMENT	IN W9960 02/16/01	#113323	-12.00
04/16/2001	ADJUST	IA XFER TO PATIENT	#113323	-1.00
04/16/2001	DEBIT	DE XFER FR INSUR	#113323	1.00
04/16/2001	ADJUST	IA FORGIVE	#113323	-17.00
04/16/2001	PAYMENT	IN W9960 02/26/01	#113323	-12.00
04/16/2001	ADJUST	IA XFER TO PATIENT	#113323	-1.00
04/16/2001	DEBIT	DE XFER FR INSUR	#113323	1.00
04/16/2001	ADJUST	IA FORGIVE	#113323	-17.00
04/16/2001	PAYMENT	PA CASH		-1.00

PROVIDER: SCOTT CASTEEL DC TOTAL: $ -92.00
SS# 160565186 BALANCE 05/16/2001: $ 118.00

 PA/PK/CC/IN=Csh/Check/CC/Ins. paymnt; CR/DE=Credit/Debit; IA=Ins adj; *=Ins Pd

APPROVED OMB-0938-0008

WALMART STORE
ROUTE 255
DUBOIS
PA
15801

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
(Medicare#)	(Medicaid #)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	X (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): KING, FLORENCE I.

3. PATIENT'S BIRTH DATE MM DD YY: 10 14 41 — SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): KING, FLORENCE I.

5. PATIENT'S ADDRESS (No., Street): 130 WEST MAIN ST

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 130 WEST MAIN ST

CITY: SYKESVILLE — STATE: PA

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]

CITY: SYKESVILLE — STATE: PA

ZIP CODE: 15865 — TELEPHONE (Include Area Code): (814)-894-5400

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 15865 — TELEPHONE (INCLUDE AREA CODE): (814)-894-5400

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 10 14 41 — SEX: M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME: MOUSE LODGE

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [X] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE — DATE:

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY: 02 20 99 — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE:

17a. I.D. NUMBER OF REFERRING PHYSICIAN:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO

19. RESERVED FOR LOCAL USE:

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 839.06
2. 723.1
3. 784.0
4.

22. MEDICAID RESUBMISSION CODE: — ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	03	01	99			11		99202		1,2,3,	$80.00	1				
2	03	01	99			11		72072		1,2,3,	$75.00	1				
3																
4																
5																
6																

25. FEDERAL TAX I.D. NUMBER: 25-1542351 — SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 3323

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 155.00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 155.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

TYSON L. DIXON, D.C.
SIGNED: 9770515J9D — DATE: 04/01/99

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office):

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE

CENTRAL CHIROPRACTIC CTR
10 NORTH MAIN STREET
DUBOIS, PA

814-371-8

PIN# — GRP# GA655686

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
HCFA-1500-2-N-90 (3-95)

PLEASE PRINT OR TYPE

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

APPROVED OMB-0938-0008

CLAIMS MANAGEMENT, INC
P O BOX 8083

BENTONVILLE, AR
72712-8083

HEALTH INSURANCE CLAIM FORM

PICA ☐ PICA ☐

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
☐ (Medicare#)	☐ (Medicaid #)	☐ (Sponsor's SSN)	☐ (VA File #)	☐ (SSN or ID)	☐ (SSN)	X (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): CL# 99518770

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): KING, FLORENCE I.

3. PATIENT'S BIRTH DATE: MM 10 DD 14 YY 41 SEX: M ☐ F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): KING, FLORENCE I.

5. PATIENT'S ADDRESS (No., Street): 130 WEST MAIN ST

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): 130 WEST MAIN ST

CITY: SYKESVILLE STATE: PA

8. PATIENT STATUS: Single ☐ Married ☐ Other X

CITY: SYKESVILLE STATE: PA

ZIP CODE: 15865 TELEPHONE (Include Area Code): (814)-894-5400

Employed X Full-Time Student ☐ Part-Time Student ☐

ZIP CODE: 15865 TELEPHONE (INCLUDE AREA CODE): (814)-894-5400

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES X NO

a. INSURED'S DATE OF BIRTH: MM 10 DD 14 YY 41 SEX: M ☐ F X

b. OTHER INSURED'S DATE OF BIRTH: MM DD YY SEX: M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES X NO PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME: MOOSE LODGE

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? X YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES X NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE:

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM 02 DD 28 YY 99 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 839.06
2. 723.1
3. 784.0
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FO LOCAL USE
1 03 08 99		11		99202		1, 2, 3,	$50.00	1				
2 03 12 99		11		98940		1, 2, 3,	$30.00	1				
3 03 15 99		11		98940		1, 2, 3,	$30.00	1				
4 03 26 99		11		98940		1, 2, 3,	$30.00	1				
5 03 29 99		11		98940		1, 2, 3,	$30.00	1				
6 03 31 99		11		98940		1, 2, 3,	$30.00	1				

25. FEDERAL TAX I.D. NUMBER: 25-1542351 SSN ☐ EIN X

26. PATIENT'S ACCOUNT NO.: 3323

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES ☐ NO

28. TOTAL CHARGE: $ 200.00

29. AMOUNT PAID: $

30. BALANCE DU: $ 200.

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SCOTT B. CASTEEL, D.C
422127J9D
SIGNED DATE: 04/01/99

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

CASTEEL CHIROPRACTIC CTR
10 NORTH MAIN STREET
DUBOIS, PA
814-37

PIN# GRP# CA655686

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

WHCFA-1500-2-N-90 (3-95)

PLEASE PRINT OR TYPE

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

APPROVED OMB-0938-0008

CLAIMS MANAGEMENT, INC
P O BOX 8083

BENTONVILLE, AR
72712-8083

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER
(Medicare#) | (Medicaid #) | (Sponsor's SSN) | (VA File #) | (SSN or ID) | (SSN) | X (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): CL# 99518770

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): KING, FLORENCE I.

3. PATIENT'S BIRTH DATE: MM 10 DD 14 YY 41 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): KING, FLORENCE I.

5. PATIENT'S ADDRESS (No., Street): 130 WEST MAIN ST

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 130 WEST MAIN ST

CITY: SYKESVILLE STATE: PA

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]

CITY: SYKESVILLE STATE: PA

ZIP CODE: 15865 TELEPHONE (Include Area Code): (814)-894-5400

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 15865 TELEPHONE (INCLUDE AREA CODE): (814)-894-5400

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH: MM 10 DD 14 YY 41 SEX: M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH: MM DD YY SEX: M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME: MOOSE LODGE

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? [X] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM 02 DD 28 YY 99 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 839.06
2. 723.1
3. 784.0
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 04 02 99		11		98940		1,2,3,	$30.00	1				
2 04 05 99		11		98940		1,2,3,	$30.00	1				
3 04 23 99		11		98940		1,2,3,	$30.00	1				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 25-1542351

26. PATIENT'S ACCOUNT NO.: 3323

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE: $ 90.00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 90.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SCOTT B. CASTEEL, D.C
SIGNED 422127J9D DATE 05/03/99

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE

CASTEEL CHIROPRACTIC CTR
10 NORTH MAIN STREET
DUBOIS, PA

814-371-80

PIN# GRP# CA655686

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
WHCFA-1500-2-N-90 (3-95)

PLEASE PRINT OR TYPE

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

APPROVED OMB-0938-0008

CLAIMS MANAGEMENT, INC
P O BOX 8083

BENTONVILLE, AR
72712-8083

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER
( ) (Medicare#) ( ) (Medicaid #) ( ) (Sponsor's SSN) ( ) (VA File #) ( ) (SSN or ID) ( ) (SSN) (X) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
CL# 99518770

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
KING, FLORENCE I.

3. PATIENT'S BIRTH DATE MM DD YY 10 14 41 SEX M ( ) F (X)

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
KING, FLORENCE I.

5. PATIENT'S ADDRESS (No., Street)
253 W MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED
Self (X) Spouse ( ) Child ( ) Other ( )

7. INSURED'S ADDRESS (No., Street)
253 W MAIN STREET

CITY: SYKESVILLE | STATE: PA

8. PATIENT STATUS
Single (X) Married ( ) Other ( )
Employed (X) Full-Time Student ( ) Part-Time Student ( )

CITY: SYKESVILLE | STATE: PA

ZIP CODE: 15865 | TELEPHONE (Include Area Code): (814)894-5410

ZIP CODE: 15865 | TELEPHONE (INCLUDE AREA CODE): (814)894-5410

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ( ) YES (X) NO

a. INSURED'S DATE OF BIRTH MM DD YY 10 14 41 SEX M ( ) F (X)

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ( ) F ( )

b. AUTO ACCIDENT? ( ) YES (X) NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? (X) YES ( ) NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ( ) YES (X) NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY 05 26 99 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ( ) YES ( ) NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 839.06
2. 723.1
3. 784.0
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 05 26 99		11		98940		1,2,3,	$30.00	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ( ) EIN (X)
25-1542351

26. PATIENT'S ACCOUNT NO.
3323

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) (X) YES ( ) NO

28. TOTAL CHARGE $ 30.00

29. AMOUNT PAID $

30. BALANCE DUE $ 30.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SCOTT B. CASTEEL, D.C
422127J9D 06/01/99
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SCOTT B. CASTEEL, D.C
10 NORTH MAIN STREET
DUBOIS, PA
814-371-8(

PIN# GRP# CA655686

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

WHCFA-1500-2-N-90 (3-95)

PLEASE PRINT OR TYPE

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

PLEASE DO NOT STAPLE IN THIS AREA

CLAIMS MANAGEMENT, INC
P O BOX 8083

BENTONVILLE, AR
72712-8083

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): CL# 99518770

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): KING, FLORENCE I.

3. PATIENT'S BIRTH DATE MM DD YY: 10 14 41 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): KING, FLORENCE I.

5. PATIENT'S ADDRESS (No., Street): 253 W MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 253 W MAIN STREET

CITY: SYKESVILLE STATE: PA

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: SYKESVILLE STATE: PA

ZIP CODE: 15865 TELEPHONE (Include Area Code): (814)-894-5410

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 15865 TELEPHONE (INCLUDE AREA CODE): (814)-894-5410

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 10 14 41 SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [X] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE:

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SIGNED: SIGNATURE ON FILE

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15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 839.06
2. 723.1
3. 784.0
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 06 07 99		11		98940		1,2,3,	$30.00	1				
2 06 11 99		11		98940		1,2,3,	$30.00	1				
3 06 30 99		11		98940		1,2,3,	$30.00	1				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 25-1542351

26. PATIENT'S ACCOUNT NO.: 3323

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 90.00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 90.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SCOTT B. CASTEEL, D.C

SIGNED 422127J9D DATE 07/01/99

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

CASTEEL CHIROPRACTIC CTR
10 NORTH MAIN STREET
DUBOIS, PA
814-371-8

PIN#

GRP# CA655686

790-0120 (12/90) (OCR) 2 pt.

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

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

APPROVED OMB-0938-0008

CLAIMS MANAGEMENT, INC
P O BOX 8083

BENTONVILLE, AR
72712-8083

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] MEDICAID [ ] CHAMPUS [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [X]
(Medicare#) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): CL# 99518770

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): KING, FLORENCE I.

3. PATIENT'S BIRTH DATE: MM 10 DD 04 YY 41 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): KING, FLORENCE I.

5. PATIENT'S ADDRESS (No., Street): 253 W MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 253 W MAIN STREET

CITY: SYKESVILLE — STATE: PA

8. PATIENT STATUS: Single [X] Married [ ] Other [ ] Employed [X] Full-Time Student [ ] Part-Time Student [ ]

CITY: SYKESVILLE — STATE: PA

ZIP CODE: 15865 — TELEPHONE (Include Area Code): (814)-894-5410

ZIP CODE: 15865 — TELEPHONE (INCLUDE AREA CODE): (814)-894-5410

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH: MM 10 DD 04 YY 41 SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH: MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? [X] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE:

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM 07 DD 28 YY 99 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 839.06
2. 723.1
3. 784.0
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07 14 99		11		98940		1,2,3,	$30.00	1				
2 07 28 99		11		98940		1,2,3,	$30.00	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 25-1542351 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 3323

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE: $ 60.00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 60.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SCOTT B. CASTEEL, D.C
422127J9D 08/02/99
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE#

10 NORTH MAIN STREET
DUBOIS, PA
814-371-8

PIN# GRP# CA655686

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

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

HCFA-1500-2-N-90 (3-95)

APPROVED OMB-0938-0008

CLAIMS MANAGEMENT, INC
P O BOX 8083

BENTONVILLE, AR
72712-8083

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): CL# 99518770

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): KING, FLORENCE I.

3. PATIENT'S BIRTH DATE: MM 10 DD 14 YY 41 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): KING, FLORENCE I.

5. PATIENT'S ADDRESS (No., Street): 253 W MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 253 W MAIN STREET

CITY: SYKESVILLE — STATE: PA

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: SYKESVILLE — STATE: PA

ZIP CODE: 15865 — TELEPHONE (Include Area Code): (814)-894-5410

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 15865 — TELEPHONE (INCLUDE AREA CODE): (814)-894-5410

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: MM 10 DD 14 YY 41 SEX: M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH: MM DD YY SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [X] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM 02 DD 28 YY 99 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 839.06
2. 723.1
3. 784.0
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 08 16 99		11		98940		1,2,3,	$30.00	1				
2 08 20 99		11		98940		1,2,3,	$30.00	1				
3 08 27 99		11		98940		1,2,3,	$30.00	1				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 25-1542351 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 3323

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 90.00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 90.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SCOTT B. CASTEEL, D.C
422127J9D 09/01/99
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

CASTEEL CHIROPRACTIC CTR
10 NORTH MAIN STREET
DUBOIS, PA
814-371-0

PIN# GRP# CA655686

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

WHCFA-1500-2-N-90 (3-95)

PLEASE PRINT OR TYPE

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

APPROVED OMB-0938-0008

CLAIMS MANAGEMENT INC
P O BOX 8083
BENTONVILLE AK 72712

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
(Medicare#)	(Medicaid #)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	X (ID)	99518770

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
KING FLORENCE I	10 14 1941 M F X	SAME
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
253 W MAIN STREET	Self X Spouse Child Other	
CITY: SYKESVILLE / STATE: PA	8. PATIENT STATUS: Single X Married Other	CITY / STATE
ZIP CODE: 15865 / TELEPHONE (Include Area Code): (814) 894-5410	Employed Full-Time Student Part-Time Student	ZIP CODE / TELEPHONE (INCLUDE AREA CODE): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES X NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F	b. AUTO ACCIDENT? YES X NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? X YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: CLAIMS MANAGEMENT INC
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNATURE ON FILE — 11 01 1999
SIGNED _____ DATE _____

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

14. DATE OF CURRENT: MM DD YY / ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO
02 28 1999 INJURY		
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES X NO / $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. L839.06 3. L___.__
2. L723.1 4. L___.__

22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 09 01 1999	11	01	98940		1 2	30 00	001				
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
251542351 X	100667-101690	YES NO	$ 30 00	$ 0 00	$ 30 0

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SCOTT CASTEEL DC	SAME	CASTEEL CHIROPRACTIC CENTER 10 N MAIN ST-814/371-8686 DUBOIS PA 15801
SIGNED 11 01 DATE 1999		PIN# 422127J9D GRP# 655686

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
HCFA-1500-2-N-90 (3-95)

PLEASE PRINT OR TYPE

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

APPROVED OMB-0938-0008

CLAIMS MANAGEMENT INC
P O BOX 8083
BENTONVILLE AK 72712

XXX PICA

HEALTH INSURANCE CLAIM FORM

PICA XX

1. MEDICARE [ ] MEDICAID [ ] CHAMPUS [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [X]
(Medicare#) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 99518770

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): KING FLORENCE I

3. PATIENT'S BIRTH DATE: 10 14 1941 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 253 W MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: SYKESVILLE STATE: PA

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 15865 TELEPHONE (Include Area Code): (814) 894-5410

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [X] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: CLAIMS MANAGEMENT INC

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNATURE ON FILE 11 01 1999
SIGNED DATE

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

14. DATE OF CURRENT: MM DD YY 02 28 1999 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) INJURY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 839.06
2. L723.1
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 09 23 99		11	01	98940		1 2	30 00	001				
2 10 22 99		11		98940		1 2	30 00	001				
3 10 29 99		11		98940		1 2	30 00	001				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 251542351

26. PATIENT'S ACCOUNT NO.: 100667-101691

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ 90 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 90

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
STEVEN SORBERA DC
SIGNED 11 0 DATE 1999

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
SAME

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
CASTEEL CHIROPRACTIC CENTER
10 N MAIN ST-814/371-8686
DUBOIS PA 15801
PIN# 075685J9D GRP# 655686

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
WHCFA-1500-2-N-90 (3-95)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500
FORM RRB-15(

APPROVED OMB-0938-0008

XXX PICA

HEALTH INSURANCE CLAIM FORM

PICA [X]

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 0019202555

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): KING FLORENCE I

3. PATIENT'S BIRTH DATE (MM DD YY): 10 14 1941 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 253 W MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: SYKESVILLE STATE: PA

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 15865 TELEPHONE (Include Area Code): (814) 894-5410

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH (MM DD YY): SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY): SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME: MOOSE LODGE

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [X] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICAL ASSISTANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNATURE EXCEPTION 12 01 1999

SIGNED _____ DATE _____

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

SIGNATURE EXCEPTION

SIGNED _____

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY: 02 28 1999

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY: 02 28 1999

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 839.06
2. 723.1
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11041999		11		98940	GA	1 2	30 00	001	0			
2 11161999		11		98940	GA	1 2	30 00	001	0			
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 251542351

26. PATIENT'S ACCOUNT NO.: 100667-102567

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ 60 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

STEVEN SORBERA DC

SIGNED 12 01 DATE 1999

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

SAME

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

CASTEEL CHIROPRACTIC CENTER
10 N MAIN ST-814/371-8686
DUBOIS PA 15801
01705860/02

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

WHCFA-1500-2-N-90 (3-95)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)

FORM OWCP-1500

FORM RRB-1500

APPROVED OMB-0938-0008

XXX PICA

HEALTH INSURANCE CLAIM FORM

PICA XX

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 0019202555

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): KING FLORENCE I

3. PATIENT'S BIRTH DATE: 10 14 1941 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 253 W MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: SYKESVILLE STATE: PA

8. PATIENT STATUS: Single [X] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 15865 TELEPHONE (Include Area Code): (814) 894-5410

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME: MOOSE LODGE

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [X] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICAL ASSISTANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNATURE EXCEPTION 12 01 1999

SIGNED _____ DATE _____

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

SIGNATURE EXCEPTION

SIGNED _____

14. DATE OF CURRENT: MM DD YY 02 28 1999 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 02 28 1999

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 839.06 3. ____.__

2. 723.1 4. ____.__

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 12 1999		11		98940	GA	1 2	30 00	001	0			
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 251542351 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 100667-102568

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ 30 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SCOTT CASTEEL DC

SIGNED 12 01 DATE 1999

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

SAME

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

CASTEEL CHIROPRACTIC CENTER
10 N MAIN ST-814/371-8686
DUBOIS PA 15801

PIN# 1060068/02 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

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

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid #) X | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 001920255S

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): KING FLORENCE I

3. PATIENT'S BIRTH DATE MM DD YY: 10 14 1941 SEX M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 253 W MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street):

CITY: SYKESVILLE | STATE: PA

8. PATIENT STATUS: Single X | Married | Other | Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE: 15865 | TELEPHONE (Include Area Code): (814) 894-5410

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES | NO X

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. AUTO ACCIDENT? YES | NO X | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME: MOOSE LODGE

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES X | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICAL ASSISTANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO X — *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNATURE EXCEPTION 01 01 2000

SIGNED _____ DATE _____

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

SIGNATURE EXCEPTION

SIGNED _____

14. DATE OF CURRENT: MM DD YY 02 28 1999 — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY: 02 28 1999

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM _____ TO _____

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM _____ TO _____

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 839.06
2. 723.1
3. _____
4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 12 02 1999		01	60	W9960		1 2	30 00	001	0			
2 12 31 1999		01	60	W9960		1 2	30 00	001	0			
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 251542351 | SSN | EIN X

26. PATIENT'S ACCOUNT NO.: 100667 102978

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE: $ 60 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

STEVEN SORBERA DC

SIGNED 01 01 DATE 2000

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

SAME

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

CASTEEL CHIROPRACTIC CENTER
10 N MAIN ST-814/371-8686
DUBOIS PA 15801

PIN# 0170586002 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

WHCFA-1500-2-N-90 (3-95)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)

FORM OWCP-1500 FORM RRB-1500

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF FINANCIAL OPERATIONS
TPL SECTION CASUALTY UNIT
PO BOX 8486
HARRISBURG, PA 17105-8486

July 19, 2001

WOOMER & FRIDAY LLP
CYNTHIA M PORTA ESQ
3220 WEST LIBERTY AVE STE 200
PITTSBURGH PA 15216

Re: FLORENCE KING
CIS #: 001920255
Incident Date: 2/27/1999

Dear Ms. Porta:

Enclosed please find the itemized bills you have requested from the provider.

If you have any further questions, please contact me. Thank you for your cooperation in this matter.

Sincerely,

Jessica L. Bupp

Jessica L. Bupp
TPL Program Investigator
717-772-6617
717-772-6553 FAX

Enclosure

DuBois Regional Medical Center

P.O. Box 447 - DuBois, PA 15801-0447
(814) 375-4200
FEDERAL I.D. NO. 25-1490707

DETAIL STATEMENT

TYPE OF BILL	DATE OF BILL	PAGE NO.
D1-ER	07/21/00	1

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
FLORENCE I KING	00198-00262	F	59Y	07/16/00	07/17/00	

INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER	PAYMENT AMOUNT
200012 MA OUTPATIENT		0019202555	

GUARANTOR NAME AND ADDRESS
FLORENCE I KING
253 WEST MAIN ST
SYKESVILLE PA 15865

☐ MasterCard ☐ VISA ☐ DISCOVER

CARD NO. _____
EXPIRATION DATE _____
SIGNATURE _____

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE

DATE	ITEM NO.	DESCRIPTION	CLM CODE	ORDER NO.	QTY	UNIT PRICE	TOTAL CHARGES
07/16/00	58846	MECLIZINE HCL 25MG,TABLET	250	1	2	1.00	2.00
		TOTAL PHARMACY					2.00
07/16/00	95312	SLIPPERS LARGE	270	8	1	3.00	3.00
		TOTAL SUPPLIES					3.00
07/16/00	22498	SPECIMEN COLLECTION - CHRG ONLY	300	3	1	5.00	5.00
07/16/00	24047	CBC & DIFF	305	1	1	42.00	42.00
07/16/00	68519	02 SATURATION DIRECT MEASURE	300	5	1	21.00	21.00
07/16/00	68917	ARTERIAL BLOOD GASES	300	4	1	96.00	96.00
		TOTAL LABORATORY					164.00
07/16/00	23008	CALCIUM SERUM	301		1	22.00	22.00
07/16/00	23089	BASIC METABOLIC PANEL	301	1	1	66.00	66.00
		TOTAL chemistry lab					88.00
07/16/00	16078	EMERGENCY VISIT	450	10	1	0.00	0.00
07/16/00	16213	EMERGENCY DEPARTMENT VISIT L4	450	9	1	350.00	350.00
		TOTAL EMERGENCY ROOM					350.00
07/16/00	34900	EKG TRACING ONLY WO INT&RPT	730	6	1	68.00	68.00
		TOTAL EKG					68.00
07/16/00	518	PC ECG REESE INT&RPT	730	7	1	26.00	26.00
		TOTAL Professional fee--general					26.00
		TOTAL CHARGES					701.00
09/11/00	I1075	960 MEDICAL ASSISTANCE OUTPATIEN	T				-22.00
10/30/00	I1075	496 MEDICAL ASSISTANCE OUTPATIEN	T				-679.00
		TOTAL PAYMENTS/ADJUSTMENTS					-701.00

PATIENT NUMBER
00198-00262

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY

TOTAL AMOUNT DUE	0.00

PAYMENTS may be taken to the East or West registration areas or to the Business Office located at 207 Hospital Avenue.

PLEASE RETAIN FOR YOUR RECORDS

DuBois Regional Medical Center

P.O. Box 447 - DuBois, PA 15801-0447
(814) 375-4200
FEDERAL I.D. NO. 25-1490707

DETAIL STATEMENT

TYPE OF BILL	DATE OF BILL	PAGE NO.
D1-OPW	10/21/00	1

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
FLORENCE I KING	00287-00489	F	59Y	10/17/00	10/17/00	

INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER	PAYMENT AMOUNT
200012 MA OUTPATIENT		0019202555	

GUARANTOR NAME AND ADDRESS
FLORENCE I KING
253 WEST MAIN ST
SYKESVILLE PA 15865

☐ MasterCard ☐ VISA ☐ DISCOVER

CARD NO. _____
EXPIRATION DATE _____
SIGNATURE _____

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE

DATE	ITEM NO.	DESCRIPTION	CLM CODE	ORDER NO	QTY	UNIT PRICE	TOTAL CHARGES
10/17/00	72787	CT ORB/SELLA/POST FOSSA, NO CONT	350	1	1	503.00	503.00
10/17/00	72817	CT - EACH ADDITIONAL FILM	351	1	5	17.00	85.00
		TOTAL CT SCAN					588.00
		TOTAL CHARGES					588.00
04/30/01	I1075	136 MEDICAL ASSISTANCE OUTPATIEN	T				-587.00
05/17/01	A1710	000 SMALL BALANCE WRITE OFFS					-1.00
		TOTAL PAYMENTS/ADJUSTMENTS					-588.00

PATIENT NUMBER
00287-00489

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY

TOTAL AMOUNT DUE	0.00

PAYMENTS may be taken to the East or West registration areas or to the Business Office located at 207 Hospital Avenue.

PLEASE RETAIN FOR YOUR RECORDS

DuBois Regional Medical Center

P.O. Box 447 - DuBois, PA 15801-0447
(814) 375-4200
FEDERAL I.D. NO. 25-1490707

DETAIL STATEMENT

TYPE OF BILL	DATE OF BILL	PAGE NO.
D1-MAB	01/23/01	1

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
FLORENCE I KING	01014-00126	F	59Y	01/19/01	01/19/01	

INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER	PAYMENT AMOUNT
200012 MA OUTPATIENT		0019202555	

GUARANTOR NAME AND ADDRESS
FLORENCE I KING
253 WEST MAIN ST
SYKESVILLE PA 15865

☐ MasterCard ☐ VISA ☐ DISCOVER

CARD NO. _____

EXPIRATION DATE _____

SIGNATURE _____

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE

DATE	ITEM NO.	DESCRIPTION	CLM CODE	ORDER NO.	QTY	UNIT PRICE	TOTAL CHARGES
01/19/01	48025	MAMMOGRAPHY SCREENING	403	1	1	106.00	106.00
		TOTAL Mammo Screening					106.00
		TOTAL CHARGES					106.00
01/23/01	P1145	3 PATIENT PAYMENT OUTPATIENT					-1.00
03/09/01	I1075	685 MEDICAL ASSISTANCE OUTPATIEN	T				-105.00
		TOTAL PAYMENTS/ADJUSTMENTS					-106.00

PATIENT NUMBER	TOTAL AMOUNT DUE	0.00
01014-00126		

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY

PAYMENTS may be taken to the East or West registration areas or to the Business Office located at 207 Hospital Avenue.

PLEASE RETAIN FOR YOUR RECORDS

DuBois Regional Medical Center

P.O. Box 447 - DuBois, PA 15801-0447
(814) 375-4200
FEDERAL I.D. NO. 25-1490707

DETAIL STATEMENT

TYPE OF BILL	DATE OF BILL	PAGE NO.
D1-SER	05/04/01	1

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
FLORENCE I KING	01106-00704	F	59Y	04/16/01	04/30/01	

INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
200012 MA OUTPATIENT 200003 MEDICAL ASSISTANCE PR		0019202555 0019202555

PAYMENT AMOUNT

GUARANTOR NAME AND ADDRESS
FLORENCE I KING
253 WEST MAIN ST
SYKESVILLE PA 15865

☐ MasterCard ☐ VISA ☐ DISCOVER

CARD NO. _____
EXPIRATION DATE _____
SIGNATURE _____

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE

DATE	ITEM NO.	DESCRIPTION	CLM. CODE	ORDER NO	QTY	UNIT PRICE	TOTAL CHARGES
04/19/01	70530	THERAPEUTIC EXERC STRENGTH/15 MI	420	2	2	50.00	100.00
04/24/01	70530	THERAPEUTIC EXERC STRENGTH/15 MI	420	3	1	50.00	50.00
		TOTAL PHYSICAL THERAPY					150.00
04/17/01	70021	EVALUATION EXTENDED	424	1	1	110.00	110.00
		TOTAL EVAL/RE-EVAL PT					110.00
		TOTAL CHARGES					260.00
06/21/01	I1075	591 MEDICAL ASSISTANCE OUTPATIEN	T				-254.00
		TOTAL PAYMENTS/ADJUSTMENTS					-254.00

PATIENT NUMBER	PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY	TOTAL AMOUNT DUE	6.00
01106-00704			

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

PAYMENTS may be taken to the East or West registration areas or to the Business Office located at 207 Hospital Avenue.

PLEASE RETAIN FOR YOUR RECORDS

FLORENCE I KING 99348-00357 F 59Y 12/15/99 12/15/99

200015 MA OUTPATIENT SURGERY 0019202555
200003 MEDICAL ASSISTANCE PP 0019202555

FLORENCE I KING
253 WEST MAIN ST
SYKESVILLE PA 15865

12/15/99	60082	LAVAGE,4000 ML	360	1	1	40.30	40.30
		TOTAL PHARMACY					40.30
12/15/99	95033	CRD SUCTION CANISTER	270	5	1	5.00	5.00
12/15/99	95070	SLIPPERS - MED	270	2	1	3.00	3.00
12/15/99	95882	TUBING SUCTION PN-59	270	6	1	3.00	3.00
12/15/99	96900	WHISTLE CLEANING BRUSH	270	3	1	18.00	18.00
12/15/99	96901	STERIS 20 STERILANT	270	4	1	20.00	20.00
		TOTAL SUPPLIES					49.00
12/15/99	15320	SIGMOIDOSCOPY (FLEXIBLE SCOPE)	360	1	1	890.00	890.00
		TOTAL OPERATING ROOM					890.00

		TOTAL CHARGES	979.30
02/15/00	I1080	583 MEDICAL ASSISTANCE OUTPT SPU	-197.00
02/07/00	A1380	738 MEDICAL ASSISTANCE- SPU	-779.30
02/16/00	A1710	000 SMALL BALANCE WRITE OFFS	-3.00
		TOTAL PAYMENTS/ADJUSTMENTS	-979.30

99348-00357 0.00

FLORENCE I KING 99332-00393 F 59Y 12/14/99 12/14/99

200012 MA OUTPATIENT 0019202555

FLORENCE I KING
253 WEST MAIN ST
SYKESVILLE PA 15865

12/14/99	48025	MAMMOGRAPHY SCREENING	401	1	1	101.00	101.00
		TOTAL RADIOLOGY					101.00
		TOTAL CHARGES					101.00
02/04/00	I1075	469 MEDICAL ASSISTANCE OUTPATIENT					-26.50
02/04/00	A1375	469 MEDICAL ASSISTANCE OUTPATIENT					-73.50
02/16/00	A1710	000 SMALL BALANCE WRITE OFFS					-1.00
		TOTAL PAYMENTS/ADJUSTMENTS					-101.00

99332-00393 0.00

CERTIFICATE OF SERVICE

I, Cynthia M. Porta, Esquire, hereby certify that on this 26th day of July, 2001 a true and correct copy of the foregoing *Plaintiff's Pre-Trial Memorandum* was served upon the following via first class United States mail:

Patrick J. Loughney, Esquire
Gorr, Moser, Dell & Loughney
1300 Frick Building
Pittsburgh, PA 15219

James A. Naddeo, Esquire
P.O. Box 552
Clearfield, PA 16830

Ronald L. Collins, Esquire
Sobel, Collins & Knaresboro
218 South Second Street
Clearfield, PA 16830

Theron G. Noble, Esquire
Ferraraccio & Noble
301 East Pine Street
Clearfield, PA 16830

Respectfully submitted,

Cynthia M. Porta

Cynthia M. Porta, Esquire
Attorney for Plaintiff
PA I.D. #: 82111

WOOMER & FRIDAY LLP

Attorneys at Law
3220 West Liberty Avenue
Suite 200
Pittsburgh, PA 15216

(412) 563-7980
Fax (412) 563-0120
E-mail woomerandfriday@aol.com

Robert B. Woomer
Peter D. Friday*
Thomas D. Hall*
Cynthia M. Porta*
Brian D. Cox
James C. Ward
*Also admitted in West Virginia

July 26, 2001

Arb 8-13-01

David S. Meholick
Court Administrator
Clearfield County Courthouse
230 East Market Street, Suite 228
Clearfield, PA 16830

Re: Florence King v. Wal-Mart Stores, Inc.
Docket No.: 00-908-CD

Dear Mr. Meholick:

Enclosed herein for filing please find the original Plaintiff's Pre-Trial Memorandum regarding the foregoing matter.

Thank you for your attention to the foregoing. Should you have any questions, please do not hesitate to contact me.

Very truly yours,

Cynthia M. Porta

Cynthia M. Porta

CMP/cp
Enclosure

cc: Patrick J. Loughney, Esquire (w/encl.)
James A. Naddeo, Esquire (w/encl.)
Ronald L. Collins, Esquire (w/encl.)
Theron G. Noble, Esquire (w/encl.)

GORR, MOSER, DELL & LOUGHNEY, LLC
ATTORNEYS AT LAW

1300 FRICK BUILDING
437 GRANT STREET
PITTSBURGH, PENNSYLVANIA 15219-6002

TELEPHONE: 412/471-1180
FAX: 412/471-9012
E-MAIL: gmdl@gmdl-law.com
www.gormoser.com

MELISSA A. CORCINO♦
RICHARD W. DELL, JR.
PATRICK J. DOHENY, JR.
SEAN P HANNON‡
MARK R. LANE†
PATRICK J. LOUGHNEY†
SHARON M. MACENCZAK
SCOTT A. MATTHEWS†

DONALD J. McCORMICK†‡
PETER MOLINARO, JR.
MELVIN L. MOSER*†
GEORGE A. POWER
BRAD D. TRUST†
CARY W. VALYO
JOHN H. WILLIAMS, JR.
ELEONORA M. ZYCH

Of Counsel
ARTHUR R. GORR†
GEORGE RAYNOVICH, JR.

♦ ALSO ADMITTED IN CA, DC, NJ
* ALSO ADMITTED IN FL
‡ ALSO ADMITTED IN OH
† ALSO ADMITTED IN WV

August 1, 2001
File No. Wal.192

William A. Shaw, Prothonotary
Clearfield County Courthouse
One North 2nd Street
P.O. Box 549
Clearfield, PA 16830

Marcy

Arb 8/3/01

Re: Florence King v. Wal-Mart Stores, Inc.
Clearfield County No. 00-908-CD

Dear Mr. Shaw:

Enclosed please find the original and one extra cover sheet of Defendant Wal-Mart Stores, Inc.'s Pretrial Statement in the above-captioned matter. Please file the original, date stamp the extra cover sheet and return it to me in the self-addressed, stamped envelope provided.

If you have any questions or need anything additional, please call me. Thank you for your attention to this matter.

Very truly yours,

Mickey Engstler

Mickey A. Engstler
Paralegal to Patrick J. Doheny

:me
Enclosures

cc: Cynthia M. Porta, Esq. (w/Enc.)

RECEIVED
AUG 03 2001
COURT ADMINISTRATOR'S OFFICE

WAL.192

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,

Plaintiff,

vs.

WAL-MART STORES, INC.,

Defendant.

ARBITRATION DIVISION

No. 00-908-CD

JURY TRIAL DEMANDED

DEFENDANT'S PRETRIAL STATEMENT

Filed on behalf of WAL-MART STORES, INC.,

Counsel of Record for this Party:

Patrick J. Loughney, Esq.
Pa. I.D. ##23163

Patrick J. Doheny, Esq.
Pa. I.D. #85547

GORR, MOSER, DELL & LOUGHNEY
Firm #753

1300 Frick Building
Pittsburgh, PA 15219

Phone: (412) 471-1180
Fax: (412) 471-9012

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,	ARBITRATION DIVISION
Plaintiff,	No. 00-908-CD
vs.	JURY TRIAL DEMANDED
WAL-MART STORES, INC.,	
Defendant.	

DEFENDANT'S PRETRIAL STATEMENT

AND NOW, comes Defendant, Wal-Mart Stores, Inc. by and through its attorneys, Gorr, Moser, Dell & Loughney, LLC, and Patrick J. Doheny, Esquire and files the following Pretrial Statement:

Brief Statement of the Defense

This case arises out of an incident which allegedly occurred on or about February 28, 1999 at approximately 12:45 p.m. at the Wal-Mart store located in DuBois, Pennsylvania. On or about that date and time, Plaintiff claims that she attempted to remove a hot curling iron set from the second shelf of an unidentified aisle somewhere in the DuBois Wal-Mart. Thereafter, Plaintiff claims that another box fell from the shelf and struck her on the head. However, no competent or credible evidence has been uncovered that would indicate that Wal-Mart was negligent or was responsible for Plaintiff's alleged injuries.

Additionally, with respect to damages, Plaintiff has submitted a number of medical records which she claims are related to the incident complained of in this case. However, it

appears many if not all of these reports, bills and/or records are entirely unrelated to any injuries Plaintiff may have sustained at Wal-Mart.

Citations of Relevant Cases and/or Statutes

Cohen v. Penn Fruit Co., 192 Pa. Super. 244, 159 A.2d 558 (1960).

Stewart v. Morow, 403 Pa. 459, 170 A.2d 338 (1961).

Dougherty v. Great Atlantic & Pacific Tea Co., Inc. 221 Pa. Super. 221, 289 A.2d 747 (1972).

Kelly v. St. Mary Hospital, 2001 PA Super 175, ____, A.2d _____ (2001).

Witnesses

1. Florence King
2. Jenn Brown
3. Eric Yount
4. Kelly Maxwell

Statement of Damages

None. See attached documents which may be offered as evidence at the arbitration hearing.

Defendant reserves the right to supplement this Pretrial Statement at any time prior to the commencement of arbitration.

Respectfully submitted,

Patrick J. Doheny, Esquire
Gorr, Moser, Dell & Loughney
437 Grant Street
1300 Frick Building
Pittsburgh, PA 15219
Counsel for Defendant Wal-Mart Stores, Inc.

01-4151877C Lot 6 10

PLEASE PRINT CLEARLY

WAL-MART STORES, INC.
REPORT OF CUSTOMER INCIDENT

(1) Store Location: RD#3 BOX 176D DUBOIS PA 15801 (2) Store No. 1769

(3) Management member who took the report: KELLI MAXWELL S.S. 200-54-3172

(4) Date of incident: 2-28-99 Time 11:00 a.m. (p.m.)
Date incident reported to store: 3-01-99 Time 11:00 (a.m.) p.m.

(5) What exact location in the store did the incident occur (example: Dept.) HOUSEWARES DEPT.

(6) Name of customer: FLORENCE KING
Phone # 814-849-5410 Sex: F S.S.: D.L. #:
Home address: 130 WEST MAIN ST. Age:
City: SYKESVILLE State: PA Zip: 15865 Date of Birth:
Did customer wear glasses or contacts? Yes ___ No ___
What type of shoes did customer have on?

(7) Name of Companion: Phone #: ( )
Address: City: State Zip:

(8) Customer(s) who may have observed something relating to the incident:
Name: S.S.: Phone #: ( )
Address: City: State: Zip:
Name: S.S: Phone #: ( )
Address: City: State: Zip:

(9) Associate responsible for this area/zoning (example: Dept. Mgr.):

(10) Associate(s) who may have facts relating to the incident:
Name: S.S:
Address: Phone: ( )
Name: S.S:
Address: Phone: ( )

(11) Name, address of manufacturer or supplier of product or machine in the accident:
COVAIR HAIR DRYER

(12) What did customer say happened **(if attached form has not been completed by the customer):** REACHED FOR HAIR DRYER ON SHELF - BOX WAS OPENED HAIR DRYER HIT HER ON HEAD

(13) Nature of alleged injury: BUMP ON FOREHEAD

(14) Did alleged injured customer go to the doctor or hospital?
Yes ✓ No ___ If yes, where: CASTEEL CHIROPRACTIC CENTER

(15) Ambulance called?: Yes ___ No ✓

(16) Manager on duty at the time of the incident: ERIC YOUNT / SUE DODGE

(17) Person reporting the incident: KELLI MAXWELL

(18) Date incident reported to CMI: 3-2-99 Time 11:00 (a.m.) p.m.

White Copy: Send immediately to CMI Yellow Copy: Send to District Manager Pink: Store file copy SHARON

WMP-73 REV. 10/97

MAR 12 1999

INDIANA OPEN MRI

119 Professional Center, Suite 305 ◆ Indiana, Pennsylvania 15701 Toll Free 888-270-9222 (412) 349-3110
Fax (412) 349-3119

FLORENCE I. KING
SS # 184-32-4880
Dr. John Markley
January 29, 1998
Patient # 05700

MRI OF THE LUMBAR SPINE

HISTORY: Left leg coldness and numbness, lateral aspect. Occasional low back pain.

TECHNIQUE: Images were performed in the sagittal and axial planes. The axial images were angled through each disc space from L2-3 through L5-S1. Routine pulse sequences were used.

FINDINGS: Comparison is made with a CT scan of the lumbosacral spine of October 9, 1997.

There is some desiccation of L4-5 and L5-S1 and to a lesser extent L3-4.

There is slight retro-listhesis of L5 posterior relative to S1.

A disc herniation is noted on the left at L5-S1. There is left sided neuroforaminal narrowing at this level. There is lesser right sided neuroforaminal narrowing noted at this level. There is some degree of bilateral neuroforaminal narrowing of L4-5.

A disc bulge is noted at L4-5 and L3-4. The disc bulge that is noted at L3-4 is best visualized on the axial images. This is slightly more prominent on the left.

Ligamentum flavum and facet hypertrophy is noted from L2-3 through L5-S1. Mild central canal narrowing is noted at L2-3. Mild central canal narrowing is noted at L3-4. Mild central canal narrowing is noted at L4-5.

IMPRESSION: CENTRAL CANAL AND NEUROFORAMINAL NARROWING AS NOTED. A DISC HERNIATION IS NOTED ON THE LEFT AT L5-S1. THIS IMPINGES UPON THE EXITING L5 NERVE ROOT AT THIS LEVEL. DISC BULGING AS NOTED. THERE ARE NO FOCAL ABNORMALITIES OF THE CAUDA EQUINA OR CONUS MEDULLARIS.

Thank you for giving us the opportunity to examine your patient.

Christopher N. Hobbie

Christopher N. Hobbie, MD

CH\gca

INDIANA OPEN MRI

A MEMBER OF THE MEDICAL COMMUNITY SINCE 1999

119 Professional Center, Suite 305 ◆ Indiana, Pennsylvania 15701 Toll Free 888-270-9222 (724) 349-3110
Fax (724) 349-3119

#08266
FLORENCE I. KING
SS # 184-32-4880
Dr. Henry Delatorre
November 7, 2000

MRI OF THE BRAIN WITH AND WITHOUT CONTRAST

HISTORY: Patient is 59 year old female with the history of vertigo, occasional headaches and neck pain.

TECHNIQUE: Routine pulse sequences were obtained in thin axial slices of the internal auditory canal and also in the coronal pulse sequences following intravenous administration of gadolinium.

FINDINGS: There is normal signal intensity of the grey and white matter. There is no increased signal in the periventricular region. There is no shift of the midline structures, hydrocephalus or mass effect.

The cerebellopontine angle as well as the seventh and eighth cranial nerve complexes are identified on either side and appear to be within normal limits. The right and left orbits are normal on either side. The sinuses are developed showing no gross abnormalities. There is prominence of the inferior turbinate of both nasal cavities.

Thin slices obtained of the internal auditory canal with and without administration of gadolinium shows no evidence of abnormalities or asymmetry of the internal auditory canals. The seventh and eighth cranial nerve complexes appear normal. There is no abnormal focal enhancing lesions identified.

The temporal lobes appear symmetrical. There is no abnormal signals noted in the mid brain.

CONCLUSION: ESSENTIALLY NORMAL CRANIAL MRI.

ESSENTIALLY NORMAL MRI OF THE INTERNAL AUDITORY CANALS.
Thank you for ~~giving us~~ the opportunity to examine your patient.

Benedict Mariano, MD
BM/kly

WAL 1/2
7/16/01

INDIANA OPEN MRI

A MEMBER OF THE MEDICAL COMMUNITY SINCE 1992

119 Professional Center, Suite 305 ◆ Indiana, Pennsylvania 15701 Toll Free 888-270-9222 (724) 349-3110
Fax (724) 349-3149

#08266
FLORENCE I. KING
SS # 184-32-4880
Dr. Henry Delatorre
November 7, 2000

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Thank you for ~~giving us the~~ opportunity to examine your patient.

Benedict Mariano, MD
BM/kly

DUBOIS REGIONAL MEDICAL CENTER
100 Hospital Ave, DuBois, PA 15801

KING,FLORENCE I
253 WEST MAIN ST
SYKESVILLE PA 15865

DIS - OPW
Age 59Y

Unit # 000303556
Acct # D0028700489

Date:10/17/00 Time:1533

DELATORRE,HENRY G
SYKESVILLE PA 15865

DELATORRE,HENRY G
SYKESVILLE PA 15865

Chk-in #	Order	Exam	
428206	0001	72787	CT-ORB. SELLA POST. FOSSA UNENHAN

Ord Diag: 780.4-DIZZINESS

CT TEMPORAL BONES:

Computerized tomographic axial and coronal sections were obtained. The patient refused intravenous contrast enhancement.

The internal auditory canals are unremarkable. The osseous structures are intact. The mastoids are normal. The parapharyngeal soft tissues are unremarkable. The middle ear structures are unremarkable.

IMPRESSION: THE STUDY IS LIMITED, SINCE THE PATIENT REFUSED INTRAVENOUS CONTRAST ENHANCEMENT.
THERE ARE NO DEFINITE ABNORMALITIES VISUALIZED.
AN MRI STUDY OF THE BRAIN MAY BE OF BENEFIT FOR FURTHER EVALUATION OF THIS PATIENT.

NIA CODE: P

/READ BY/ GEORGE M KOSCO
/Released By/ GEORGE M KOSCO

10/19/00 0958
LLW

pt. notified
10-19-00

Complete

Quest Diagnostics

CLINICAL LABORATORY REPORT

875 GREENTREE ROAD
4 PARKWAY CENTER
PITTSBURGH, PA 15220-3610

Patient Name	Client Services Helpline	Billing Helpline	Date Collected	Time Collected
KING, FLORENCE I	(412) 920-7700	(412) 920-7800	03/12/2001	10:08

Patient Phone Number	Patient I.D./Social Security Number	Referring Physician
814 894-5410	K-0083	HENRY DELATORRE, M

49371 87-54-345
DELA TORRE MEDICAL CLINIC
231 HIGHLAND STREET
SYKESVILLE, PA 15865

Date Received	Date of Report
03/12/2001	03/13/2001

Sex	Age	ID Number
F	59	B0013900867

Specimen Number	Accession Number
B0013900867	RT2907060

TEST PROCEDURE		TEST RESULT		UNITS	REFERENCE RANGE
AST		16		U/L	@@@ 5-35 P
UREA NITROGEN		21		MG/DL	@@@ 8-25 P
LIPID PANEL					
CHOLESTEROL, TOTAL		256	H	MG/DL	120-199 P
HDL CHOLESTEROL	=A=	28	L	MG/DL	35-59 P
CHOLESTEROL/HDL RATIO	=B=	9.14	H		@@@1.00-5.50 P
LDL CHOL, CALCULATED	=C=			MG/DL	P
TRIGLYCERIDES		409	H	MG/DL	40-199 P

FOOTNOTES =

low sweets exercise Repeat 4 wks

A= A HDL CONCENTRATION LESS THAN 35 MG/DL CONSTITUTES A CHD RISK FACTOR. A CONCENTRATION EQUAL TO OR GREATER THAN 60 MG/DL CONSTITUTES A NEGATIVE RISK FACTOR.

B= THE RANGE FOR CHOLESTEROL/HDL CHOLESTEROL REPRESENTS THE 75TH PERCENTILE FOR THE SPECIFIED AGE AND GENDER OF THIS PATIENT. THE HIGHER THE VALUE, THE HIGHER THE RISK FOR CHD.

C= LDL CHOLESTEROL CANNOT BE CALCULATED WHEN THE TRIGLYCERIDE CONCENTRATION EXCEEDS 400 MG/DL. A DIRECT MEASUREMENT OF LDL CHOLESTEROL MAY BE ORDERED ON THIS SPECIMEN, AT AN ADDITIONAL CHARGE. PLEASE CONTACT THE LABORATORY WITHIN ONE DAY TO ADD THIS TEST.

Attempts 3/13/01 4:15 BUSY BUSY @ 5:

ALT		16		U/L	@@@ 5-40 P
CREATININE		0.6		MG/DL	@@@ 0.5-1.1 P
TSH	6.80		H	UU/ML	@@@0.40-5.50 P

~~Repeat 4 wks~~

REFERENCE RANGES PROVIDED BY QUEST DIAGNOSTICS PERFORMING SITES ARE ADULT/NON-SEX SPECIFIC UNLESS
@ = AGE RELATED, @@ = SEX RELATED, @@@ = AGE & SEX RELATED PRINTED

PERFORMING SITE CODE BREAKDOWN

CODE	PERFORMING SITE	ADDRESS
P	QUEST DIAGNOSTICS	875 GREENTREE RD., PGH. PA

Synthroid .1 Xenical TID

Synthroid to .125

KING, FLORENCE I FASTING: YES *CONSOLIDATED FINAL REPORT* 5
DELA TORRE MEDICAL CLINIC *NOTE: SOME OR ALL RESULTS WERE PREVIOUSLY REPORTED

Pt-Notified 3-15-01

Quest Diagnostics

CLINICAL LABORATORY REPORT

875 GENTREE ROAD
4 PARKWAY CENTER
PITTSBURGH, PA 15220-3610

Patient Name	Client Services Helpline	Billing Helpline	Date Collected	Time Collected
KING, FLORENCE I	(412) 920-7700	(412) 920-7800	11/14/2000	10:26

49371 09-54-099
DELA TORRE MEDICAL CLINIC
231 HIGHLAND STREET
SYKESVILLE, PA 15865

Patient Phone Number	Date Received	Date of Report
814 894-5410	11/15/2000	11/15/2000

Patient I.D./Social Security Number	Sex	Age	ID Number
K-0083	F	59	B0013900820

Referring Physician	Specimen Number	Accession Number
HENRY DELATORRE, M	B0013900820	AT713308P

TEST PROCEDURE		TEST RESULT		UNITS	REFERENCE RANGE
COMP METABOLIC PANEL					
SODIUM		141		MMOL/L	@@@ 136-145 P
POTASSIUM		4.5		MMOL/L	@@@ 3.5-5.2 P
CHLORIDE		107		MMOL/L	@@@ 99-109 P
CARBON DIOXIDE		25.9		MMOL/L	@@@21.3-30.5 P
CALCIUM		9.2		MG/DL	@@@ 8.5-10.3 P
ALKALINE PHOSPHATASE		76		U/L	@@@ 30-130 P
AST		19		U/L	@@@ 5-35 P
ALT		18		U/L	@@@ 5-40 P
BILIRUBIN, TOTAL		0.4		MG/DL	@@@ 0.2-1.1 P
GLUCOSE		90		MG/DL	65-109 P
UREA NITROGEN		16		MG/DL	@@@ 8-25 P
CREATININE		0.8		MG/DL	@@@ 0.5-1.1 P
BUN/CREATININE RATIO		20.0			@@@ 9.0-28.0 P
PROTEIN, TOTAL		6.7		GM/DL	@@@ 6.3-8.2 P
ALBUMIN		3.9		GM/DL	@@@ 3.7-4.7 P
GLOBULIN, CALCULATED		2.8		GM/DL	@@@ 2.2-3.8 P
A/G RATIO		1.4			@@@ 1.0-1.8 P
GT		19		U/L	@@@ 5-35 P
LIPID PANEL					
CHOLESTEROL		244	H	MG/DL	120-199 P
HDL CHOLESTEROL	=A=	28	L	MG/DL	35-59 P
CHOLESTEROL/HDL RATIO	=B=	8.71	H		@@@1.00-5.50 P
LDL CHOL, CALCULATED		144	H	MG/DL	75-129 P
TRIGLYCERIDES		358	H	MG/DL	40-199 P

FOOTNOTES =

A= A HDL CONCENTRATION LESS THAN 35 MG/DL CONSTITUTES A CHD RISK FACTOR. A CONCENTRATION EQUAL TO OR GREATER THAN 60 MG/DL CONSTITUTES A NEGATIVE RISK FACTOR.

B= THE RANGE FOR CHOLESTEROL/HDL CHOLESTEROL REPRESENTS THE 75TH PERCENTILE FOR THE SPECIFIED AGE AND GENDER OF THIS PATIENT. THE HIGHER THE VALUE, THE HIGHER THE RISK FOR CHD.

CBC W/ DIFF & PLT				
WBC	5.7	X1000	@@@ 3.9-11.2 P	
RBC	4.42	XMILLION	@@@ 3.8-5.2 P	

PAGE 1: CONTINUED ON PAGE: 2

Pt notified 11-16-00

Quest Diagnostics

CLINICAL LABORATORY REPORT

875 G. ENTREE ROAD
4 PARKWAY CENTER
PITTSBURGH, PA 15220-3610

Patient Name	Client Services Helpline	Billing Helpline	Date Collected	Time Collected
KING, FLORENCE I	(412) 920-7700	(412) 920-7800	11/14/2000	10:26

49371 09-54-099
DELA TORRE MEDICAL CLINIC
231 HIGHLAND STREET
SYKESVILLE, PA 15865

Patient Phone Number	Date Received	Date of Report
814 894-5410	11/15/2000	11/15/2000

Patient I.D./Social Security Number	Sex	Age	ID Number
K-0083	F	59	B0013900820

Referring Physician	Specimen Number	Accession Number
HENRY DELATORRE, M	B0013900820	AT713308P

EST	PROCEDURE	TEST RESULT	UNITS	REFERENCE RANGE	
	HEMOGLOBIN	13.8	G/DL	@@@11.6-15.5	P
	HEMATOCRIT	41.1	%	@@@34.0-46.0	P
	MCV	92.9	FL	@@@80.0-98.0	P
	MCH	31.3	PG	@@@27.0-34.0	P
	MCHC	33.7	%	32.0-36.0	P
	TOTAL NEUTROPHILS, %	58	%	38-80	P
	BANDS, %	0	%	0-10	P
	TOTAL LYMPHOCYTES, %	34	%	15-49	P
	MONOCYTES, %	5	%	0-13	P
	EOSINOPHILS, %	2	%	0-8	P
	BASOPHILS, %	1	%	0-2	P
	ATYPICAL LYMPHOCYTES, %	0	%	0-5	P
	METAMYELOCYTES, %	0	%		P
	MYELOCYTES, %	0	%		P
	PROMYELOCYTES, %	0	%		P
	WBC DIFF SAMPLE	10	X10		P
	RBC	NORMAL			P
	PLATELET SUFFICIENCY	NORMAL			P
	PLATELET COUNT	177000	/CU.MM	@@@ 150000-400000	P
	RDW	12.6	%	@@@11.0-15.5	P
	LT	18	U/L	@@@ 5-40	P
	GH	8.11 H	UU/ML	@@@0.40-5.50	P

REFERENCE RANGES PROVIDED BY QUEST DIAGNOSTICS PERFORMING SITES
ARE ADULT/NON-SEX SPECIFIC UNLESS
@ = AGE RELATED, @@ = SEX RELATED, @@@ = AGE & SEX RELATED PRINTED

PERFORMING SITE CODE BREAKDOWN

CODE	PERFORMING SITE	ADDRESS
P	QUEST DIAGNOSTICS	875 GREENTREE RD., PGH. PA

pt-notified 11-16-00

Quest Diagnostics

CLINICAL LABORATORY REPORT

875 GREENTREE ROAD
4 PARKWAY CENTER
PITTSBURGH, PA 15220-3610

Patient Name: KING, FLORENCE I
Client Services Helpline: (412) 920-7700
Billing Helpline: (412) 920-7800
Date Collected: 09/25/2000
Time Collected: 11:44

Patient Phone Number: 814 894-5410
Patient I.D./Social Security Number: K-0083
Referring Physician: HENRY DELATORRE, M

49371 93-54-099
DELA TORRE MEDICAL CLINIC
231 HIGHLAND STREET
SYKESVILLE, PA 15865

Date Received: 09/26/2000
Date of Report: 09/26/2000
Sex: F
Age: 58
ID Number: B0013900798
Specimen Number: B0013900798
Accession Number: AT529765H

TEST PROCEDURE	TEST RESULT	UNITS	REFERENCE RANGE
TSH	3.31	UU/ML	@@@0.40-5.50 P

REFERENCE RANGES PROVIDED BY QUEST DIAGNOSTICS PERFORMING SITES
ARE ADULT/NON-SEX SPECIFIC UNLESS
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PERFORMING SITE CODE BREAKDOWN

CODE	PERFORMING SITE	ADDRESS
P	QUEST DIAGNOSTICS	875 GREENTREE RD., PGH. PA

Notified by msg. 9-28-00

Triple i/CliniForms

DATE | NOTES | NAME

MAR 15 2001 WT 174 BP 132/84 P 72 R 18
11:50AM Protocol checkup for Hypothyroidism, PAT, Hyperlipidemia
Review of labs
stopped Lipitor due to diarrhea

03-15-01

Florence King

Patient is here for follow up of Hypothyroidism, PAT and Hyperlipidemia. Patient apparently stopped the Lipitor for her cholesterol due to diarrhea. Patient is being very tired with some things secondary to the Chronic Fatigue Syndrome which she had before. Patient's Dad had died of questionable PE and went into CHF. Grandfather with history of MI. Patient still smokes about 1/2 pack of cigarettes per day and strongly advised the patient to stop smoking. Patient is told of the dangers and problems with smoking. Patient also has swelling of the PIP joint of the second finger of both hands. Some mild limitation of motion. Advised the patient to just soak it for now. Will try the patient on Voltaren 75mg BID and start Plavix 75mg one tablet daily. Reviewed the patient's blood tests which showed high cholesterol of 256, HDL is low at 28, triglycerides were high at 409. TSH is slightly high at 6.8. Patient is advised to increase the Synthroid to 125 mcg for now. Patient is also taking Xenecal without any problems.

EXAM: Showed the patient to be in no distress. Color and hydration are fine. No thyromegaly. Lungs are clear. Heart is regular. Abdomen is soft and nontender. Extremities with no edema. Patient has the swelling of the PIP joint of both second fingers.

IMX: Chronic Fatigue Syndrome; Hyperlipidemia; Hypothyroidism; History of PAT; Osteoarthritis

PLAN: Drink lots of fluids. Advised the patient to exercise.

RTC: 1 month and PRN

Henry G. dela Torre, MD/lsm

APR 16 2001 WT 176 1/2 BP 130/86 P 72 R 16
2:53pm CC: f/up osteoarthritis, depression
dizziness - can't lay on (L) side
Can't take Wellbutrin - couldn't concentrate

04-16-01

Florence King

Patient is here for follow up of Osteoarthritis and Depression. Also complaining of dizziness. Unable to lay on her left side. Severe dizzy spells. Rhomberg test is positive. Patient had similar problem a year ago and symptoms restarted two days ago. Patient is still depressed. Also having dry skin patch on the right leg. Patient also has high cholesterol problems, chronic anxiety as well as Hypothyroidism.

EXAM: Showed the patient to be slightly obese. Weight is 176 1/2 pounds. BP is good at 130/86. Pulse is 76. Resp. is 16. HEENT is unremarkable. Color and hydration are fine. Ears are unremarkable but rhomberg test is positive. Lungs are clear with decreased breath sounds. Heart is regular. Abdomen is soft and nontender. Extremities with no edema.

IMX: Labyrinthitis; Vertigo; Dry Skin Right Leg; Depression

PLAN: Patient will be referred to the Balance Disorder Clinic and to Physical Therapy. Meanwhile, will keep the patient on Prozac 20mg daily.

RTC: 2 weeks and PRN

Henry G. dela Torre, MD/lsm

Triple i / CliniForms

NAME

DATE	NOTES
1-31-00	patient's insurance will cover Xenical Rx as Dx is not for weight reduction but used for Hyperlipidemia as long as written Rx provided to pharmacy with Dx of 272.0 pharmacy. Patient called to state and written script given to patient to give to pharmacy. JS

TELEPHONE RECORD

FORM # F282 REV (8/95) TO REORDER CALL INHEALTH RECORDS SYSTEMS (800) 477-7374 OR IN ATLANTA (770) 396-4994

MESSAGE: URGENT ☐YES ☐NO

for Dr.	Caller	Relation to pt.
Pt. name: Flo King	Pt. age	Date of message: / /	Time of Message AM PM

Xenical - can't afford ins won't cover
Lipitor
K83

Caller's phone #: 894-5537 | Call back at AM PM | Pharmacy # | Pt. Chart # | Initials

Physician's orders/Followup action:
pt should have Xenical is covered under Medicaid for Hyperlipidemia
Left message for pt.

TELEPHONE RECORD # 069765

Call Back? Yes ☐ No ☐ | Chart Msg.? Yes ☐ No ☐ | Followup Comp. AM PM | Initials

TELEPHONE RECORD

FORM # F282 REV (8/95) TO REORDER CALL INHEALTH RECORDS SYSTEMS (800) 477-7374 OR IN ATLANTA (770) 396-4994

MESSAGE: URGENT ☐YES ☐NO

for Dr.	Caller	Relation to pt.
Pt. name: Flo King	Pt. age	Date of message: 12/14/00	Time of Message AM PM

pt has vaginal yeast infection has been on Erythromycin 500mg bid since 11-17. Also takes Antivert 25mg. Can she get Diflucan?

Caller's phone # | Call back at AM PM | Pharmacy #: Walmart | Pt. Chart #: K83 | Initials

Physician's orders/Followup action:
D/C the antibiotic
Diflucan 150
x1 dose
pt notified
JS

TELEPHONE RECORD # 448215

Call Back? Yes ☐ No ☐ | Chart Msg.? Yes ☐ No ☐ | Followup Comp. AM PM | Initials

© 1998

Triple i / CliniForms

DATE | NOTES | NAME

NOV 16 2000 W 173 BP 156/80 P 72 R 16 T
11:40AM Protocol c weekup & Review of labs
Still dizzy off & on

F Murphy, CMA

11-16-00 Florence King 83

Patient is here protocol check up. Patient is feeling dizzy on and off which is moderately severe. Patient is taking Meclizine about 3-4 times a day but don't seem to be taking it on a regular basis. Patient denies any ear aches. No headache. No nausea, vomiting or diarrhea. No blurred vision. No chest pain.

EXAM: Showed the patient to be in no distress. Blood pressure is borderline at 156/80. Pulse is 72. Afebrile. Weight is 173 1/2 pounds which is slightly over the 171 3/4 pounds in October. Ears are clear. No inflammation of the tympanic membrane. No nasal congestion. Throat is not inflamed. Lungs are clear. Heart is regular. Abdomen is soft and nontender. Extremities with no edema. No neurologic deficits noted. Reviewed the patient's blood test which showed the chemistries are normal. Cholesterol however is high with total cholesterol of 244. HDL is low at 28. LDL is high at 144 with Triglycerides high at 358. CBC is unremarkable. Patient's TSH however is elevated at 8.11. Patient is complaining of being tired also. Rhomberg test is positive.

IMX: Labyrinthitis; Hypothyroidism; Hyperlipidemia

PLAN: At this point, will start the patient on EES 400mg one tablet QID. Also Synthroid is increased from .088 to 0.1mg one tablet daily. Start Lipitor 20mg at bedtime. Patient is advised on low fat diet, exercise and try to lose weight. Advised of the possible complications especially liver enzyme elevation. Patient is to have a liver test in one month. Will schedule the patient for Mammogram. Patient was given Flu Vaccine and Pneunovax due to history of chronic smoking.

RTC: Protocol

Henry G. dela Torre, MD/lsm

TELEPHONE RECORD
FORM # F202 REV (0/05)
TO REORDER CALL INHEALTH RECORDS SYSTEMS
(800) 477-7374 OR IN ATLANTA (770) 396-4994

MESSAGE: URGENT ☐YES ☐NO

for Dr.	Caller		Relation to pt.
Pt. name Flo King	Pt. age	Date of message 11.17.00	Time of Message AM PM

pt has Lipitor at home you mentioned Xenical which do you want Lipitor not working well

Caller's phone # 894-5410	Call back at AM PM	Pharmacy's	Pt. Chart #	Initials

Physician's orders/Followup action

Xenical - ACTID
take 1
Broth
ac
4:55 No
Answer

TELEPHONE RECORD # 069755

Call Back? Yes No
Chart Mes.? Yes No
Followup Comp. AM PM
Initials

Triple i / CliniForms

DATE	NOTES

OCT 19 2000 WT 171 3/4 BP 150/84 P 64 R T 98.2
11:25am CC: f/up on CT Scan
(R) side neck hurts
coughing - phlegm tan colored
congested
plugged nose

10-19-00 Florence King

Patient is here for follow up of CT Scan. Right side of the neck apparently is still hurting her. Coughing and phlegm is slightly colored. Patient is congested in the chest and the nose. Patient smokes 1/2 pack of cigarettes per day. CT Scan of the Temporal Bones are unremarkable. MRI study of the brain was suggested so the patient will be scheduled for one if necessary. Physiologic functions are otherwise unremarkable. Patient denies any significant dizzy spell or headaches. Patient persists to have low back pain and also some discomfort in the ears.

EXAM: Ears look good. No tenderness of the mastoids. Lungs are clear with decreased breath sounds. Heart is regular. Abdomen is soft and nontender. Patient has some tenderness of the low back area. Rhomberg test is still positive although the dizziness itself is much improved.

IMX: LBS; Labyrinthitis

PLAN: Patient is to continue with Meclizine 25mg QID. Continue Voltaren since the patient don't seem to have side effects from it. Use a heating pad and avoid bending, twisting or sitting to long.

RTC: PRN and Protocol

Henry G. dela Torre, MD/lsm

NAME

TELEPHONE RECORD

FORM # F282 REV (8/95) TO REORDER CALL INHEALTH RECORDS SYSTEMS (800) 477-7374 OR IN ATLANTA (770) 396-4994

MESSAGE: URGENT ☐YES ☐NO

for Dr.	Caller	Relation to pt.
Pt. Name: Flo King	Pt. age	Date of message: 10/20/00	Time of Message AM PM

Message: Got bad (sore throat) Just been yesterday was given Allegra D but got diarrhea after taking it. Also would like antibiotic for

Caller's phone #	Call back at AM PM	Pharmacy #	Pt. Chart # 185	Initials

Physician's orders/Followup action: sore throat Allergic to Sulfa & PCN. Minocin 100mg BID 10 days

TELEPHONE RECORD # 090100

Call Back? Yes ☐ No ☐
Chart Msg.? Yes ☐ No ☐
Followup Comp. AM PM
Initials

10/26/[illegible] Still dizzy.
Dr. MRI

10-[illegible] (King Florence)

SEP 07 2000 WT 165 3/4 BP 130/78 P 60 R 24 F

3:30

CC: swelling (R) side neck, clicking in (R) ear pain shots from ear to neck into shoulder, started 4 days ago. bruise to (R) arm appeared today.

Dr. Wirths/Thompson MA

9-7-00 Florence King - DOB: 10-14-1941

Patient is here complaining of swelling on her right side of her neck and a clicking in her right ear. Further questioning patient she stated, that she had been doing alot of health cleaning for the last few days. There is also one bruise site on the right arm which is consistent with ecchymosis.

EXAM: Her B/P is 130/78. HEENT appears to be normal with her heart being regular rhythm without any murmur. Lungs are very clear. Her abdomen is soft and nontender. Positive bowel sounds. She does have some cervical motion restriction with moderate muscle spasm of the cervical area is noted.

IMX: 1. Probable Cervical Strain 2. Hypothyroidism 3. Ecchymosis on the Right Arm

PLAN: Which regards to Ecchymosis is concerned will observe at this time. Maybe treat with heating pad to the area. Will continue with Voltaren. I have suggested to the patient about muscle relaxer, but patient refused that option at this point because it makes her tired. Heating pad to the area will also help. Do alot of stretching and will follow-up with myself or Dr. delaTorre later in the month or PRN.

RTC: 1 month or prn.

Phuong T. Wirths, DO/mt

OCT 09 2000 WT 170 1/2 BP 140/80 P 62 R 18 T

11:30AM Complains of dizziness again took Antivert in July and has been taking Antivert since then without Relief.

J Matthews MA

10-09-00 Florence King K83

Patient is here complaining of dizziness again. Took Antivert in July and has been taking Antivert again since then without relief. Patient also has some pain to the left supraclavicular shoulder area and also some right flank pain. Patient is taking the Antivert TID. Denies any significant cold symptoms. No nasal drainage. No fever or chills.

EXAM: Showed the patient to be in no distress. The rest of the physiologic functions are unremarkable. Weight is 170 1/2 pounds. BP is 140/80. Pulse is 62. Resp. is 18. HEENT is unremarkable. Ears are clear. Tympanic membranes are normal. No significant nasal congestion. Rhomberg test is positive. Throat is clear. Neck is supple. No thyromegaly. Lungs are clear. Heart is regular. No PVC's. No gallop. No murmur. Abdomen is soft and nontender. Extremities with no edema. No neurologic deficits. No mastoid tenderness. There is also some fullness and soft tissue swelling of the supraclavicular space both sides, a little bit more prominent on the left. No significant edema of the upper extremities but there is a prominence of the veins.

IMX: Left Supraclavicular Swelling; Rule Out Venous Thrombosis; Right Flank Pain; Vertigo

PLAN: Advised the patient to increase the Antivert to QID. Will schedule the patient for CT of the inner ears and the mastoids. Will start the patient on Maxzide 25mg one tablet daily.

RTC: 1 week

Henry G. delaTorre, MD/lsm

11-11-14

DATE | NOTES | NAME

JUL 03 2000 W 7169 BP 152/96 P 64 R 16
10:15a Here for trigger point injection to (lt) thigh + (lt) hip
Also c lump Rt side of nose x 1 week TKW

07-03-00 Florence King
Patient is here for trigger point injection. Persists to have pain to the left thigh lateral aspect along a portion of the fascia lata and also on the left buttocks upper inner quadrant close to the sacrum. This is somehow several centimeters above the area of the sciatic nerve. Patient also has a lump on the lateral aspect of the right side of the nose which looks very small and may be early form of keratosis.
PROCEDURE: Patient was given trigger point injections to the left thigh and also on the left buttocks upper inner quadrant for a total of 1.5 cc of Kenalog 40 mg with 2 cc of Xylocaine 2%. The patient had almost complete relief and was able to move around without much problem.
PLAN: Patient is advised to use a heating pad as soon as she gets home.
RTC: PRN

Henry G. dela Torre, MD/lsm

JUL 18 2000 W 1163 BP 138/82 P 100 R 18
1:50p ffup ER visit for inner ear infection
c/o dizziness
Taking Antivert Q 6 hrs TKW
Dict

07-18-2000 Florence King - DOB: 10-14-1941
Patient is here for follow up of ER visit for dizziness. She was started on Antivert samples given of 3 doses. She feels a little bit better while taking the medication but ran out.
PHYSICAL EXAM: HEENT - Appears to be normal. No sign of infection found. No nasal congestion. No post nasal drip. No throat erythema. Heart is regular rhythm without any murmur. Lungs are quite clear. Abdomen is soft and non-tender. Positive bowel sounds. Extremities without any edema.
IMX: 1. Acute Labyrinthitis 2. COPD
PLAN: Continue with Antivert at this point. Increase fluid intake. Advise patient to try to quit smoking. Follow up if needed.

Phuong T. Wirths, DO/tkw

Triple i / CliniForms

TELEPHONE RECORD
FORM # F282 REV (6/95)
TO REORDER CALL INHEALTH RECORDS SYSTEMS (800) 477-7374 OR IN ATLANTA (770) 399-4984

MESSAGE: URGENT ☐YES ☐NO

for Dr.	Caller KB	Relation to pt.	Physician's orders/Followup action
Pt. name Florence King	Pt. age	Date of message 7/24/00	Time of Message AM PM
was seen at ER Sunday for inner			after 5 days to
Ear inflamation and placed on			2 wks.
Antivert 25 mg QID, Still c Dizziness			no infection seen on exam per Dr. Wirths
despite the Antivert. Is there			
something else she should be taking			Pt- Notified 7-24-00
w the Antivert?			

Caller's phone # | Call back at | Pharmacy # | Pt. Chart # | Initials

TELEPHONE RECORD # 341083
Call Back? Yes ☐ No ☐
Chart Mes.? Yes ☐ No ☐
Followup Comp AM PM
Initials

Triple i / CliniForms

DATE	NOTES

04-25-2000 Florence King - DOB: 10-14-1941

Patient is here requesting Tetanus shot because she was bitten by a dog yesterday on her right flank. The wound is very superficial and the dog is in custody of the vet right now to observe with questionable shot status.

PHYSICAL EXAM: Heart is regular rhythm without any murmur. Lungs are quite clear.

Right Flank Exam - Find the wound is very superficial as described in the history. There is no sign of infection at this point. Tetanus shot was given in the office and patient appeared to be taking it well without any complications or reaction.

IMX: 1. Dog Bite

PLAN: Will observe at this point. Advise patient to clean wound with Peroxide daily and use Neosporin 1-2 times a day and follow up if needed.

Phuong T. Wirths, DO/tkw

JUN 26 2000 W 166 BP 130/72 P 64 166

245pm Protocol f/up Anxiety/Depression, Hypothyroidism
c/o lump upper (Lt) leg + (Lt) buttocks
c/o (Lt) knee giving out on + off TKW. cma
8 40 [illegible]

06-26-00 Florence King 483

Patient is here for follow up of anxiety/depression and Hypothyroidism. Still has the problem basically because of persistent pain and aches all over worse in the lower sacral area where the patient has a tender lump and also in the left lateral mid thigh where the patient has a bunch of nodular tender area maybe about 2.5 x 3 cm in diameter. This is moderately tender. Patient's pain is apparently 5-6/10 in intensity. No nausea, vomiting or diarrhea. Weight is 166 pounds. BP is 130/72. Pulse is 64.

EXAM: HEENT is unremarkable. Color and hydration are fine. No thyromegaly. Lungs are clear but with decreased breath sounds and occasional rhonchi on the bases. Patient smokes about 1/2 pack of cigarettes per day. Heart is regular, no PVC's. Abdomen is soft and nontender. Extremities are symmetrical with no edema. Tender spots to the left thigh.

IMX: Fibromyalgia; Hypothyroidism; Anxiety/Depression

PLAN: Patient is advised about possibly giving Kenalog injections with Xylocain to the trigger point areas on the left thigh and also the lower back. Patient however will just think about it. Patient is to increase the Oscal D 600mg once a day to twice a day. Patient is to return for steroid as necessary. Patient is also advised to take the Premarin only 25 days per month. Recent Mammogram in December was normal.

RTC: Protocol and PRN

Henry G. delaTorre, MD/lsm

NAME King, Florence

02-09-2000 Florence King - DOB: 10-14-1941

Patient is here because she was a little bit concerned about her elevated blood pressure. It was checked yesterday at 160/88 and today at 162/88. She complains of having 1 episode of dizziness yesterday but none today. Her ears feel somewhat plugged. No fever or chills.

PHYSICAL EXAM: HEENT - appears to be normal. Ears do not show any sign of impacted cerumen. TM's are quite clear without any effusion. Heart is regular rhythm without any murmur. Lungs are quite clear.

IMX: 1. Elevated Blood Pressure - most likely secondary to excitation or some mental Anxiety.

PLAN: I rechecked her blood pressure after letting patient rest about 10 minutes and it was 130/78. Therefore at this point, I advised patient to continue with low sodium diet and continue with current medication. I strongly advised patient to quite smoking, but I really doubt that patient will follow my instructions. Follow up as protocol visit.

Phuong T. Wirths, DO/tkw

AP 27 2000 #7 BP 160/90 P 62 R 18 ?
2:00pm
Protocol check-up
EKG to f/up HPN
lump noted in throat
wants to stop smoking

A. Matthews

03-27-00 Florence King

Patient is here for protocol check up. Patient has history of HPN. Complaining of a lump in the throat. Patient would like to stop smoking. Discussed with the patient her lab reports with Lipid Profile. Patient's Cholesterol medications are very high. Patient is to be on Zocor 20mg once a day but apparently is taking it probably 1-2 times a week so strongly advised the patient to take it regularly and will repeat the Lipid Profile, FBS, SGPT in one month.

EXAM: Otherwise, showed the patient to be in no distress. Ears and nose are unremarkable. No throat masses palpated. Neck is supple. No thyromegaly. No abnormal masses on the _____ or the neck. Lungs with decreased breath sounds. Heart is regular. Abdomen is soft and nontender. Extremities with no edema.

TESTING: EKG showed no acute changes.

IMX: Hyperlipidemia; Chronic Fatigue; Hypothyroidism; Chronic Smoking

PLAN: Patient is still feeling tired so will do another TSH and check C-Reactive Protein.

RTC: 5 weeks

Henry G. dela Torre, MD/lsm

R 25 2009 W 174 BP 134/82 P 64 R 16
Requests Tetanus Shot
Bit by a dog yesterday on (R) lower side (R flank)
TKW

? Dict

See following pg for dict

DEC 20 1999 WT scale is broke BP 112/60 P 60 R 28 T 98.5
11:15 am Here c cold sx
Hurt all over
Diarrhea
Hot then chills
cough - productive, clear in color
difficulty breathing
1 PPD Body aches
TKW, cma

12-20-99 Florence King
Patient is here complaining of cold symptoms. Has joint pains, muscle aches, diarrhea, hot spells then chills, productive cough with clear sputum, some mild difficulty breathing and no appetite. Has been running a temperature also and took Motrin before coming today.
EXAM: Showed the patient to be in no distress. Denies any chest pain or any significant shortness of breath. Patient is afrebrile. Ears, nose and throat are unremarkable although slightly congested. Lungs with mild rhonchi. Heart is regular. Abdomen is soft and nontender. No guarding. Extremities are symmetrical with no edema.
IMX: Influenza
PLAN: Start the patient on Relenza 2 inhalations BID for 5 days. Continue with Tylenol PRN. Advised the patient to drink lots of fluids.
RTC: PRN
Henry G. dela Torre, MD/lsm

17-00 BP = 160/80 am Pulse - 72 R16 → 146/80
Cough
Had flu last month - still c cough
feels dizzy when she bends over or turns head quick
L. Mathema
i. T

01-17-00 Florence King
Patient is here complaining of cough. Had the flu last month but still coughing. Feels dizzy when she bends over and turns her head quickly. Blood pressure was initially 160/80 but went down to 146/80. Pulse is 72. Patient denies any nausea, vomiting or diarrhea.
EXAM: Rhomberg test is negative. Ears are clear although with some dullness. Mild congestion of the nasal turbinates. Throat is not inflamed. No cervical adenitis. Lungs are clear. Heart is regular. Abdomen is soft and nontender. Extremities with no edema.
IMX: URTI; Insomnia; Chronic Anxiety/Depression
PLAN: Patient is to start Z-Pak 2 tablets today and one tablet daily for 4 days. Patient is also given Ambien 10mg one capsule PO at HS PRN for sleep. Refill of Xanax .5mg QID is given for #120 tablet with 2 refills.
RTC: PRN and Protocol
Henry G. dela Torre, MD/lsm

2-8-00 BP ✓ 160/88 she will stop Wed. to have it checked again LM, TKW
2-9-00 BP ✓ 160/88 P: 60 R: 16 → Rec ✓ 130/78
c/o ↑ increase in blood pressure
some dizziness yesterday
c/o ears feeling plugged
TKW, cma

f/u 894-5410

11-01-99 Pt called complaining of spotting starting yesterday evening. Slight cramping. Slight diarrhea. + spotting has an odor. Pt has appt Friday c̄ Dr Dela Torre. Should she come in or wait to see Dr Dela Torre. Pt had hysterectomy 1982, still c̄ 1 ovary stating patient. Also pt stated that this happened before + doctor prescribed antibiotic + cream

TKW, cmo

Wait to see Dr. Delatorre.

NOV 05 1999 WT 163 BP 120/80 P 62 R 16 T
:30AM Protocol check-up
Pap test. Hyster 1982 Rt ovary remains G5P5A0
Vaginal ~~spotting~~ x 4 days
(L) hip pain radiate to LLE
seeing chiropractor prn.
radiates to (L) ant. leg. Refused surgery

J. [illegible], cma.

11-05-99

Florence King 12-83

Patient is here for protocol check up and pap test. Patient is S/P Hysterectomy. Still with the right ovary. Had some vaginal spotting for 4 days. G5,P5,A0. Patient is also having left hip pain radiating to the left lower extremity. Patient is apparently seeing a Chiropractor on a PRN basis. Pain radiates from the left buttocks to the anterior lateral leg. Physiologic functions are otherwise unremarkable. No chest pain, shortness of breath, nausea, vomiting or diarrhea.

EXAM: Showed the patient to be in no distress. Color and hydration are fine. Lungs are clear. Breasts with no significant abnormal masses. Abdomen is soft and nontender. Pelvic exam: S/P Hysterectomy. No sign of bleeding noted. Patient apparently is not sexually active. Rectal exam with no abnormal masses palpated. Extremities with no edema. Pap test was done. History of Herniated Disc but the patient doesn't want any surgery. Patient is still having pain which has some radicular distribution suggesting persistence of HNP. Patient has cramps once in a while.

IMX: Vaginitis

PLAN: Will wait for the result of the pap test. Cannot rule out the possibility that the patient may have colonic bleeding and not vaginal bleeding. Will schedule the patient for Colonoscopy. Patient was started on Flagyl 250mg PO q 6 hours for 7 days.

Henry G. dela Torre, MD/lsm

12-02-99 Pt called asking if it is Okay to use Sudafed for her cold Sx. Dr Wirths said it was O'Kay. Patient notified

TKW, cmo

Triple i / CliniForms

DATE	NOTES
JUL 14 1999	WT 163 BP 124/76 P 62 R 18 T 99.3
12:45 pm	sore throat
	productive cough - yellow color
	ears feel plugged
	Dict TKW cma

07-14-99 Florence King - DOB: 10-14-1941

Patient is here complaining of sore throat, productive cough of yellow sputum. According to patient she does not feel well for quite some time. There is no fever or chills at home that she has noticed.

VS: Blood Pressure is 124/76. Temp. is 99.3.

PHYSICAL EXAM: HEENT - Positive nasal congestion. TM's are clear bilaterally without any effusion. Positive moderate throat erythema without any exudates. Positive few small anterior cervical adenopathies. Heart is regular rhythm without any murmur. Lungs are positive rhonchi on left lower lobe with a little bit of expiratory wheezing without any rales.

IMX: 1. Acute Bronchitis 2. Acute Pharyngitis

PLAN: Will collect throat culture today. Will start patient on Erythromycin 333 mg 1 tablet PO TID for 10 days. Gargle with salt water PRN for sore throat. Also may use Cloriseptic or Cepacol throat spray to help with symptoms.

Phuong T. Wirths, DO/tkw

DATE	NOTES
JUL 20 1999	WT 161 1/2 BP 130/78 P 60 R 18 T 98.6
3:00 pm	F/up Acute Bronchitis + Pharyngitis
	Also Protocol check up for multiple problems
	Dict TKW, cma

07-20-99 Florence King - DOB: 10-14-1941

Patient is here for follow up of Acute Bronchitis and Acute Strep Pharyngitis. She is doing alot better today. No more fever or any other problem.

VS: Weight is 161 1/2 pounds. Blood Pressure is 130/78. Pulse is 60. Resp. is 18. Temp. is 98.6.

PHYSICAL EXAM: HEENT - Unremarkable. Throat looks alot better. There is no exudates. No cervical adenopathy. Heart is regular rhythm without any murmur. Lungs are clear.

IMX: 1. Resolving Acute Strep Pharyngitis and Acute Bronchitis

PLAN: Will continue and finish Erythromycin. When she is finished, I would like her to come back for us to re-culture her throat since she does grow out Beta-hemolytic Strep Group A.

Phuong T. Wirths, DO/tkw

TELEPHONE RECORD

FORM # F282 REV (8/95) TO REORDER CALL BHEALTH RECORDS SYSTEMS (800) 477-7374 OR IN ATLANTA (770) 396-4994

MESSAGE: URGENT ☐ YES ☐ NO

for Dr.	Caller: Self	Relation to pt.	Physician's orders/Followup action
Pt. name: Flo King	Pt. age	Date of message: 8/4/99	Time of Message AM PM
pt would like letter due to medical necessity for air conditioner			per Dr Wirths pt does not have significant Dx to appropriate air conditioner

TELEPHONE RECORD # 426522

Call Back? ☐ Yes ☐ No

Chart Mes.? ☐ Yes ☐ No

Followup Comp: AM PM

NAME

Triple i / CliniForms

APR 27 1999

WT BP P R T

pt didn't show for appt. Attempted to reach pt. Got answering machine. Left message for her to return call.

CMF

JUN 09 1999 WT 161½ BP 140/78 P 68 R 16 T 99.0

10:30 AM Sore throat
clear nasal drainage
fever last night 102.3
Chills last night
took Motrin 1:30 AM today

L. Matthews RMA

06-09-99 Florence King - DOB: 10-14-1941

Patient is here because she complains of a sore throat, clear nasal drainage, fever last night of 102.3. Chills last night also. Took Motrin this morning at approximately 2 O'clock. She has coughing without any production. Weight is 161 pounds. Blood Pressure is 140/78. Temp. is 99 here in the office.

PHYSICAL EXAM: HEENT - I did not appreciate any sign of infection. Her throat is clear without any exudates. No cervical adenopathy appreciated. No sinus tenderness. TM's are clear. Heart is regular rhythm without any murmur. Lungs are positive for expiratory rhonchi. Without any wheezing. There is no rales. Left side is worse than the right side. Abdomen is soft and non-tender. Positive bowel sounds.

IMX: 1. Acute Bronchitis

PLAN: Start patient on Trovan 100 mg 1 tablet PO QHS. Follow up in 1 week if no improvement.

Phuong T. Wirths, DO/tkw

JUN 15 1999 WT 162½ BP 100/60 P 60 R 20 T 98.6

2:55 pm

ffup Bronchitis
productive cough - clear colored sputum
clear color nasal drainage also
Takes Tylenol for body aches

TKW, CMA

06-15-99 Florence King - DOB: 10-14-1941

Patient is here for follow up of Acute Bronchitis. Feeling alot better. No more fever. Still coughing up clear colored sputum. Otherwise feeling fine.

VS: Weight is 162 pounds. Blood Pressure is a little low today at 100/60. Temp. is 98.6.

PHYSICAL EXAM: HEENT - Positive nasal congestion. Otherwise without any sign of infection. Heart is regular rhythm without any murmur. Lungs - Positive crackles at right lower lobe which appears to be chronic for her according to the patient.

IMX: 1. Resolving Acute Bronchitis

PLAN: Start patient on Hycotuss 1 tsp. PO Q 4 - 6 hours PRN. Follow up if needed.

Triple i / CliniForms

DATE NOTES NAME

King, Florence
3/16/99
SUBJECTIVE: Pt. is here today for protocol check-up, follow-up of anxiety, COPD, and tachycardia. Pt. stopped Miacalcin nasal spray two to three months ago. Pt. still has aches and pains of the joints, but not seeing Dr. Kivitz now. Pt. doesn't sleep well at times. Pt. denies nausea, vomiting, diarrhea, or dysuria.
OBJECTIVE: Examination shows the pt. to be in no distress. Color and hydration are fine. Weight 165-1/2 lbs. BP 140/80, P 72, R 18. HEENT: unremarkable. LUNGS: clear, except there is some decreased breath sounds and rhonchi in the left lung field. HEART: regular. ABDOMEN: soft, nontender. EXTREMITIES: no edema. There is still swelling of the wrists and MP joint areas. There is still tenderness of the lower back and sacroiliac region as well as the hip.
EKG showed hear rate slow at 51.
Anxiety/depression scale by Zung was done, which showed moderate anxiety and mild to moderate depression. Pt. still smokes about ½ pack per day.
ASSESSMENT: 1. Fibromyalgia or possible rheumatoid arthritis. 2. Chronic anxiety and depression 3. Chronic smoking. 4. Tachyarrhythmia, controlled.
PLAN: Send the pt. for osteoporosis scan or Dexa Scan. Pt. is recovering from a respiratory infection now. She finished antibiotic. Then start Prednisone 10 mg. q.d. For depression and chronic smoking, try Zyban first, 1 tablet every night for three days, then Wellbutrin SR 150 mg. b.i.d. Use Celebrex 200 mg. PO q.d. RTC for blood tests.
3/16/99
3/21/99 HGD/drl

Henry G. dela Torre, MD

APR 13 1999 WT 164½ BP 140/80 P 74 R 20 T 98.4
5:30p Ffup Anxiety + Depression, Tachyarrhythmia
Has (R) buttock pain x 3-4 days → lat-aspect, bending area.
Ffup meds
TRW, cma

04-13-99
Florence King
Patient is for follow up of anxiety and depression and tachyarrhythmia. Patient's most pressing problem now is pain in the left buttocks area radiating from the lower back all the way to the lateral aspect of the left thigh. Patient has difficulty bending and bending makes the pain worse.
EXAM: Able to bend only up to 90 degrees with significant problem. Patient is having a little bit of problem getting up on the examining table. SLR on the right side is positive up to 30 degrees. Left side is barely 30 degrees or less than 30 degrees with positive Laseque sign. Patient is also having some reflux symptoms which apparently is bad. She took some Prevacid from her sister and this apparently helped her. There is tenderness in the lumbosacral region and also to the left sacroiliac region to the left buttocks. Having difficulty walking. No neurologic deficit otherwise. Bowel movements and urination are fine. Depression is stable. Patient is only taking Prednisone 10mg once a day. Patient also has nodules on the second finger or index finger DIP joints with some degree of lateral dislocation of both distal phalanges.
IMX: Fibromyalgia with Rheumatoid Arthritis; Anxiety/Depression; LBS Possibly Secondary to Herniated Disc; GERD
PLAN: Will send the patient for x-rays of the lumbosacral region. Use heating pad. Avoid bending and lifting. Start Voltaren 75mg PO BID PC and stop the Celebrex since this apparently is not helping her much. Lorcet Plus 3-4 times a day PRN for pain and start Prevacid one capsule PO BID. Increase the Prednisone to 20mg once a day for 5 days then go back to 10 mg daily.
RTC: 2 weeks
Henry G. delaTorre, MD/lsm

Dela Torre Medical Ci
231 E Highland Street

Sykesville,PA 15865
814-894-2448

ACCOUNT	AMOUNT DUE	CLOSE DATE	PAGE
kingfl-00	0.00	06/25/01	01

TO: Florence I King
130 W Main St

Sykesville,PA 15865

PREVIOUS BALANCE--> 0.00

DATE	DR.	PATIENT	PROC	DESCRIPTION	DIAG	AMOUNT
03/16/99	hgd	Florenc	99214	Office Visit Detailed	714.0	70.00
03/16/99				Payment-Thank You		1.00-
05/04/99				Adj:Medicaid Write Medicaid		69.00-
03/16/99	hgd	Florenc	93000	Ekg	786.59	47.50
05/04/99				Plan Payment:08367 Medicaid		39.50-
05/04/99				Adj:Medicaid Write Medicaid		8.00-
04/13/99	hgd	Florenc	99213	Office Visit Expanded	724.2	45.00
04/13/99				Payment-Thank You		1.00-
06/01/99				Plan Payment:01190 Medicaid		19.00-
06/01/99				Adj:Medicaid Write Medicaid		25.00-
06/09/99	phu	Florenc	99212	Office Visit Focused	466.0	30.00
06/09/99				Payment-Thank You		1.00-
10/22/99				Plan Payment:unkno Medicaid		19.00-
10/22/99				Adj:Medicaid Write Medicaid		10.00-
06/15/99	phu	Florenc	99212	Office Visit Focused	466.0	30.00
10/22/99				Plan Payment:unkno Medicaid		19.00-
10/22/99				Adj:Medicaid Write Medicaid		11.00-
07/20/99	phu	Florenc	99212	Office Visit Focused	462	30.00
12/23/99				Plan Payment:09225 Medicaid		0.00
02/14/00				Plan Payment:09307 Medicaid		19.00-
02/14/00				Adj:Medicaid Write Medicaid		11.00-
11/05/99	hgd	Florenc	99214	Gyn Exam Established Patient	616.10	60.00
11/05/99				Payment-Thank You		1.00-
12/23/99				Plan Payment:09225 Medicaid		19.00-

CONT'D

ACCOUNT NO	CURRENT	31-60	61-90	91-120	OVER 120

Dela Torre Medical Cl
231 E Highland Street

Sykesville,PA 15865
814-894-2448

ACCOUNT	AMOUNT DUE	CLOSE DATE	PAGE
kingfl-00	0.00	06/25/01	02

TO: Florence I King
130 W Main St

Sykesville,PA 15865

DATE	DR.	PATIENT	PROC	DESCRIPTION	DIAG	AMOUNT
12/23/99				Adj:Medicaid Write Medicaid		40.00-
12/15/99	hgd	Florenc	45330	Sigmoid Flex	569.3	150.00
02/14/00				Plan Payment:09289 Medicaid		61.50-
02/14/00				Adj:Medicaid Write Medicaid		88.50-
12/20/99	hgd	Florenc	99212	Office Visit Focused	487.1	30.00
12/20/99				Payment-Thank You		1.00-
02/14/00				Plan Payment:09289 Medicaid		19.00-
02/14/00				Adj:Medicaid Write Medicaid		10.00-
01/17/00	hgd	Florenc	99213	Office Visit Expanded	465.9	50.00
01/17/00				Payment-Thank You		1.00-
03/03/00				Plan Payment:08389 Medicaid		19.00-
03/03/00				Adj:Medicaid Write Medicaid		30.00-
02/09/00	phu	Florenc	99213	Office Visit Expanded	401.9	50.00
03/31/00				Plan Payment:07803 Medicaid		19.00-
03/31/00				Adj:Medicaid Write Medicaid		31.00-
03/27/00	hgd	Florenc	99213	Office Visit Expanded	401.9	50.00
05/26/00				Plan Payment:08508 Medicaid		19.00-
05/26/00				Adj:Medicaid Write Medicaid		31.00-
03/27/00	hgd	Florenc	93000	Ekg	401.9	47.50
05/26/00				Plan Payment:08508 Medicaid		20.50-
05/26/00				Adj:Medicaid Write Medicaid		27.00-
04/25/00	phu	Florenc	99212	Office Visit Focused	922.9	40.00
06/05/00				Plan Payment:06860 Medicaid		19.00-
06/05/00				Adj:Medicaid Write Medicaid		21.00-

CONT'D

ACCOUNT NO	CURRENT	31-60	61-90	91-120	OVER 120

Dela Torre Medical Ci
231 E Highland Street

Sykesville,PA 15865
814-894-2448

ACCOUNT	AMOUNT DUE	CLOSE DATE	PAGE
kingfl-00	0.00	06/25/01	03

TO: Florence I King
130 W Main St

Sykesville,PA 15865

DATE	DR.	PATIENT	PROC	DESCRIPTION	DIAG	AMOUNT
04/25/00	phu	Florenc	90702	Dt	922.9	16.00
06/05/00				Adj:Medicaid Write Medicaid		16.00-
06/26/00	hgd	Florenc	99213	Office Visit Expanded	729.1	50.00
09/05/00				Plan Payment:01884 Medicaid		50.00-
06/26/00	hgd	Florenc	94010	Spirometry	786.09	66.00
09/05/00				Plan Payment:01884 Medicaid		2.00-
09/05/00				Adj:Medicaid Write Medicaid		64.00-
07/03/00	hgd	Florenc	99214	Office Visit Detailed	729.1	75.00
07/03/00				Payment-Thank You		1.00-
11/28/00				Plan Payment:03473 Medicaid		0.00
12/05/00				Plan Payment:09126 Medicaid		0.00
01/19/01				Plan Payment:09802 Medicaid		0.00
01/19/01				Adj:Medicaid Write Medicaid		74.00-
07/18/00	phu	Florenc	99213	Office Visit Expanded	386.30	50.00
09/05/00				Plan Payment:01887 Medicaid		19.00-
09/05/00				Adj:Medicaid Write Medicaid		31.00-
09/07/00	phu	Florenc	99213	Office Visit Expanded	723.9	50.00
10/20/00				Plan Payment:03424 Medicaid		19.00-
10/20/00				Adj:Medicaid Write Medicaid		31.00-
10/09/00	hgd	Florenc	99213	Office Visit Expanded	780.4	50.00
10/09/00				Payment-Thank You		1.00-
11/28/00				Plan Payment:03473 Medicaid		19.00-
11/28/00				Adj:Medicaid Write Medicaid		30.00-
10/19/00	hgd	Florenc	99213	Office Visit Expanded	724.2	50.00

CONT'D

ACCOUNT NO	CURRENT	31-60	61-90	91-120	OVER 120

Dela Torre Medical Cl
231 E Highland Street

Sykesville,PA 15865
814-894-2448

ACCOUNT	AMOUNT DUE	CLOSE DATE	PAGE
kingfl-00	0.00	06/25/01	04

TO: Florence I King
130 w Main St

Sykesville,PA 15865

DATE	DR.	PATIENT	PROC	DESCRIPTION	DIAG	AMOUNT
10/19/00				Payment-Thank You		1.00-
12/05/00				Plan Payment:09126 Medicaid		19.00-
12/05/00				Adj:Medicaid Write Medicaid		30.00-
11/16/00	hgd	Florenc	99214	Office Visit Detailed	272.4	75.00
11/16/00				Payment-Thank You		1.00-
01/08/01				Plan Payment:09779 Medicaid		19.00-
01/08/01				Adj:Medicaid Write Medicaid		55.00-
03/15/01	hgd	Florenc	99214	Office Visit Detailed	715.09	75.00
03/15/01				Payment-Thank You		1.00-
05/07/01				Plan Payment:09965 Medicaid		19.00-
05/07/01				Adj:Medicaid Write Medicaid		55.00-
04/16/01	hgd	Florenc	99213	Office Visit Expanded	386.30	55.00
04/16/01				Payment-Thank You		1.00-
06/07/01				Plan Payment:03682 Medicaid		19.00-
06/07/01				Adj:Medicaid Write Medicaid		35.00-
				*** PENDING AT CARRIER ***		
03/12/01	hgd	Florenc	g0001	Venipucture Specimen And Coll	272.4	4.00
04/16/01				Adj:Medicaid Write Medicaid		4.00-

1086.00

PAY THIS AMOUNT --> 0.00

ACCOUNT NO	CURRENT	31-60	61-90	91-120	OVER 120

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 0019202555

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): King Florence I

3. PATIENT'S BIRTH DATE MM DD YY: 10 14 1941 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 253 W Main Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Sykesville STATE: PA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 15865 TELEPHONE (Include Area Code): (814) 894-5410

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 10 14 1941 SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
Signature Exception 062501

SIGNED _____ DATE _____

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

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: John Markley MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 722.10 Lumbar Disc Herniati 3. 729.5 Limb Pain
2. 724.2 Lumbar Spine Pain 4. 782.0 Numbness, P

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
01 29 98		01	54	72148	00	1 2	680 00	1				311 00
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN: 25-1732853 [ ] [X]

26. PATIENT'S ACCOUNT NO.: kingf1033956

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ 680 00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
C Hobbie MD

SIGNED DATE 062501

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
Indiana MRI
Indiana, PA 15701

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Advanced Imaging Associates
P O Box 450
New Stanton PA 15672

PIN# 1604197 /01 GRP# 1496090 /08

PATIENT AND INSURED INFORMATION — CARRIER

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 3/88) PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 0019202555

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): King Florence I

3. PATIENT'S BIRTH DATE MM DD YY: 10 14 1941 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 253 W Main Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Sykesville STATE: PA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 15865 TELEPHONE (Include Area Code): (814) 894-5410

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 10 14 1941 SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE:

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *if yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signature Exception 062501

SIGNED _____ DATE _____

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

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Henry Delatorre MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE:

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 780.4 Vertigo
2. 784.0 Headache
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
11 07 00		01	54	70553	00	1 2	1400 00	1				338 00
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN: 25-1732853 [X]

26. PATIENT'S ACCOUNT NO.: kingf1057306

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ 1400 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

B Mariano MD

SIGNED DATE 062501

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Indiana MRI
Indiana, PA 15701

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 724-465-2530

Advanced Imaging Associates
P O Box 450
New Stanton PA 15672

PIN# 0921037 /13 GRP# 1496090 /08

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

CONSENT FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

I hereby authorize Dubois Regional Medical Center PT department
(Health Care Facility)

to release information from the records of:

King (Patient's Name) (Please Print) 10/14/41 (Birth Date). The information

is to be released to Florence King
(Person or Organization)

for the purpose of: personal use

The information to be released is (itemize portions of record and time period):

4/17/01 to 4/24/01

I also understand that this consent is revocable, except to the extent that action has been taken in reliance thereon, and that this consent will remain in force for _____ months in order to effectuate the purposes for which it was given.

4/24/01 (Date of Signature)

Florence King (Patient's Signature)

(Signature of Responsible Party) (when applicable only)

Mildred Kay (Witness)

DuBois Regional Medical Center

P.O. Box 447
100 Hospital Avenue
DuBois, PA 15801-0447

Outpatient Therapy: (814) 375-3372
Fax: (814) 375-3049

Making the difference for life.

PHYSICAL THERAPY INITIAL EVALUATION

Patient: Florence I. King Date: 04/17/01
Diagnosis: Vertigo
Physician: Henry G. Dela Torre, MD
Primary Ins: MA Outpatient ID#0019202555

SUBJECTIVE:

HOW INJURY/EPISODE OCCURRED: Patient is a 59 year-old female who reports that her first episode of dizziness began last fall after she went on a fishing trip. Patient reports that she had dizziness off and on for approximately 3 months; it then resolved completely with the help of Antivert. She was without any dizziness until this past Saturday evening when she experienced a flare-up. She reports her dizziness is worse now with lying on her (L) side or in supine. Dizziness increases with head movements. She is taking Antivert currently with some relief. She denies any headache, nausea, or vomiting associated with this, denies any hearing loss or tinnitus. She does report that she has a hissing sensation in both of her ears. She states that she has some neck tension that makes her feel like it needs to crack. Patient denies any history of migraine. She did have a minor head trauma 3 years ago when a box of curlers fell on her head in a store. Patient had a MRI in the fall. It was negative for any significant findings.

PMH/MEDICATIONS: Medical history includes (L) Sciatica, OA, Thyroid difficulties, Fibromyalgia, Heart Palpations, and High Blood Pressure. Medications include Antivert, Xanax, Tenormin, Synthroid, Zorco, and Voltaren.

WORK TITLE/DESCRIPTION: Patient has been disabled since 1987.

PHYSICAL DEMAND CHARACTERISTICS OF WORK: Patient does live alone and takes care of all of her own household activities. She enjoys fishing and spending time in the outdoors.

OBJECTIVE:

FUNCTIONAL STATUS AT ADMISSION: Patient is currently experiencing an overall decrease in functional ability secondary to severe dizziness.

FUNCTIONAL STATUS PRIOR TO INJURY: Prior to last fall when her first episode of dizziness began, patient had a full activity level.

PAIN: Patient denies any pain. She does report that her dizziness ranges from a 2/10 to a 10/10.

AROM/PROM: AROM of the cervical spine is WNL's throughout. Patient does experience increased dizziness with (L) rotation and (L) side bending.

STRENGTH: Bilateral shoulder strength is 4/5, (L) elbow strength 4/5, bilateral hip strength is 3+/5, (L) knee flexion 3+/5, (R) knee flexion 4/5, bilateral knee extension 5/5, (L) ankle dorsiflexion 4-/5 otherwise ankle is 4/5 to 4+/5 throughout.

SPECIAL TESTS: 5 times sit to stand test was 10.59 seconds without any loss of balance but with an increase in dizziness. Romberg eyes opened was 30 seconds, eyes closed was 30 seconds with increase in sway. Standing on two pillows Romberg eyes closed 7.81 seconds with loss of balance to the (L). Tandem Romberg eyes opened was 30 seconds, eyes closed 30 seconds. (R) knee unilateral stance was 10.16 seconds (L) unilateral stance was 12.84 seconds. Activity Specific Balance Confidence Scale was a 22.5% out of 100%. Dynamic gait index was 18/24. Dizziness Handicap Inventory was 54 total points. Patient with a positive (L) Halpike, positive (R) Halpike and a negative horizontal roll test.

BALANCE: See special test section above.

OBSERVATION: Patient was very apprehensive about lying supine and rolling secondary to severe dizziness.

SENSATION/DTR'S: Intact and symmetrical.

GAIT: Patient presents with an unsteady gait pattern with veering bilateral directions. She is able to ascend and descend 12 stairs with one handrail independently; however she experienced significant dizziness upon descending the stairs.

TONE/PALPATION: Patient with increased tension in the (L) upper trap region with tenderness to palpation in this area.

TREATMENT: Treatment was initiated this date educating patient regarding anatomical structures involved was well as the pathology of BPPV. Completed the canalith repositioning maneuver x 2. Patient was given post positioning instructions including avoiding quick head movements, bending over, looking up, and lying supine for the next 24-48 hours.

GOALS:
1. Decrease subjective complaints of dizziness to a 2/10 at worst to improve patient's functional abilities.
2. Increase ABC scale to 60% or greater.
3. Decrease dizziness handicap inventory by 20 points or greater.
4. Increase Romberg with eyes closed standing on two pillows to 30 seconds as indicator of vestibular functioning.
5. Patient will be independent in a H.E.P. to minimize symptoms of vertigo.

FUNCTIONAL OUTCOMES: Patient to return to full prior activity level with decreased complaints of dizziness.

PATIENT/FAMILY PARTICIPATION IN PLAN: Patient and her sister understand the goals and agree to participate with the program.

UNDERSTANDING OF EXERCISE PROGRAM: N/A. Patient does understand the post positioning instructions and agrees to comply with these.

PATIENT EXPECTATIONS: Patient hopes to experience an overall decrease in dizziness and increase in functional abilities.

ASSESSMENT:

Patient is a 59-year-old female who presents with clinical signs and symptoms of BPPV as well as vertigo that is interfering with her daily activities. Patient will benefit from continued physical therapy.

PLAN:

Patient will be seen 1-2 times a week for an estimated duration of 4 weeks for vestibular rehab including re-positioning maneuvers, ROM activities, balance activities, and patient and family education.

Thank you for this referral. If you have any questions please feel free to contact me.

Holly M Tkacik, PT

Daily Progress Note

Patient Name King, Florence

4/17/01 3:00→4:00.

Initial evaluation completed. Evaluation time 50 min, tx time 10 minutes. See chart for complete report.

Holly Mitchell, PT

2)

4/19/01 3:30→4:00

S. "I feel really good since the last time, only very minimal dizziness now." Pt c/o Neck "Stiffness". "I've been afraid of moving because I don't want to get dizzy."

O: AROM C-spine All planes x10 ~ any ↑ in sxs. Manual stretching (B) upper traps + levator mms c pt seated. (10 min) STM to (B) upper traps + Manual distraction C-spine c pt supine (5 min). Re-assessed Hallpike maneuver: both (L) and (R) Hallpike -ve. Pt instructed in + completed Brandt-Daroff exercises x 5 (B), added these to HEP along c self-stretch upper traps + levators + AROM C-spine. (15 min).

A: Significant ↓ in dizziness, Neck discomfort relieved c tx.

P: Continue, Reassess symptoms Nxt visit, Review HEP

Holly Mitchell, PT

King Florence

3)

4/24/01 1:35 → 2:00.

S: "I'm feeling great, No dizziness at all." "I even went fishing without any trouble." Dizziness currently 0/10.

O: Pt completed HEP c good technique (I). ABC scale 86.875%, DHI 28 total, DGI 22/24. Romberg EC standing on 2 pillows >30 seconds, No LOB. 5x sit → stand 8.13 sec c LOB. AROM C-spine WNL all planes, No dizziness c any. Improved gait stability, improved cadence. (20 min).

A: All Goals met.

P: Pt wishes to DC to HEP at this time. Pt instructed to continue c HEP daily to minimize episodes of vertigo. ——— Holly Mitchell, PT.

DuBois Regional Medical Center
P.O. Box 447
DuBois, Pennsylvania 15801-0447

Making the difference for life.

PHYSICAL THERAPY DISCHARGE SUMMARY

Patient Name: Florence King **Referral Date:** 4/17/01

Physician: Dr. Delatorre **Discharge Date:** 4/24/01

Diagnosis: Vertigo **Number of Visits:** 3

Treatment Program: Vestibular rehab including positional maneuvers & pt & family education.

Level of Progress at Discharge: Dizziness 0/10 with all functional activity. Returned to full activity level. 5 Time sit→stand 8.13 Oseconds c LOB. standing on pillows EC Romberg >30sec No LOB. Activities Specific Balance Confidence Scale 86.875%/100%. Dynamic Gait Index 24/24. Dizziness Handicap Inventory 28. (-) Hallpike (B). No difficulty c supine or rolling. Gait much improved c veering one direction or the other. No dizziness c stairs. (E) c HEP.

Initial Findings: Dizziness Rating 2→10/10. Experiencing ltd functional abilities 2° dizziness c head movements. 5 Times sit→stand 10.59 sec. standing on 2 pillows Romberg EC 7.81 sec c LOB (L). Activities Specific Balance Confidence scale 22.5%/100%. Dynamic Gait Index 18/24. Dizziness Handicap Inventory 54. (+) Hallpike (L) and (R). Extremely apprehensive about supine, lying & rolling. Veering (B) directions c gait, dizziness c & stairs.

Goals/Functional Outcomes Not Achieved at Discharge and Why: All Goals met.

Home Exercise Program and Education: Edu Re: pathology of BPPV. Instructed in Brandt-Daroff exercises to minimize Recurrence of Vertigo and Neck ROM & stretching.

Employment Status at Discharge: Disabled

Comments: Pt doing very well, 0 Sxs. Good compliance c HEP.

Plan: DC to (I) HEP.

Helen Mercik, PT 4/26/01

4/19/01

Brandt - Daroff Exercises →

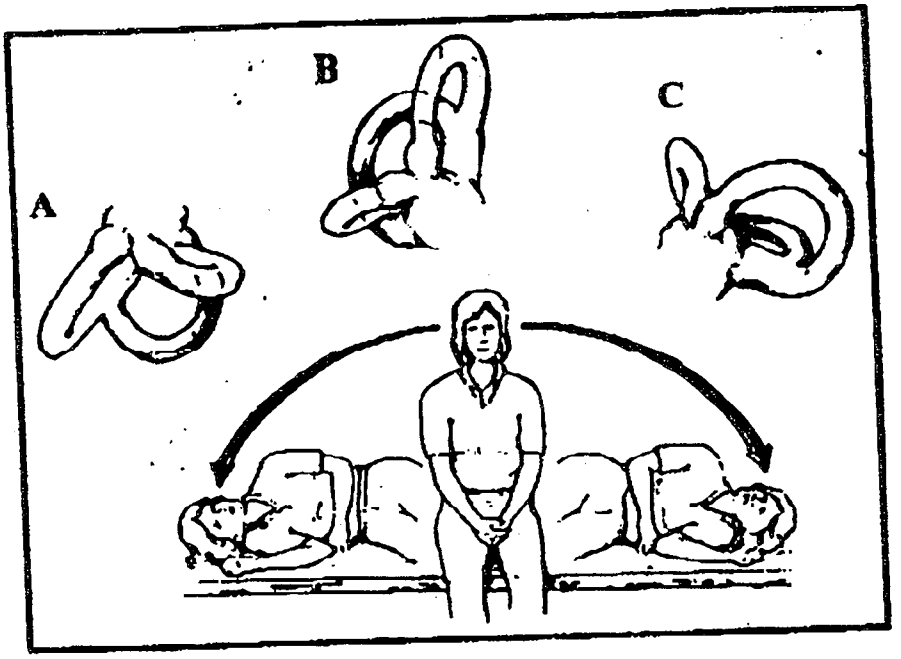
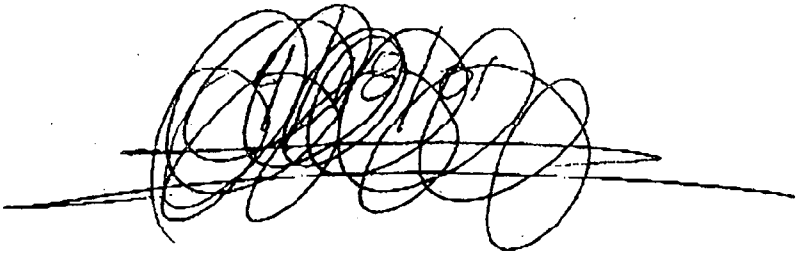


Figure 6.
Brandt-Daroff habituation exercises: The patient is first positioned sitting and then rapidly moves into the side-lying position (A). Torsional nystagmus may occur with the onset of the vertigo. The severity of the vertigo will be directly related to how rapidly the patient moves into the provoking position. The patient stays in that position until the vertigo stops, waits 30 seconds, and then sits up (B). Moving to the sitting position will usually result in vertigo, although this "rebound effect" will be less severe and of a shorter duration. Nystagmus, if it reoccurs, will be in the opposite direction. The patient remains in the upright position for 30 seconds and then moves rapidly into the mirror-image position on the other side (C), stays there for 30 seconds, and then sits up. The patient then repeats the entire maneuver 5 to 20 times, depending on the tolerance of the patient for vertigo and ony accompanying nausea, or until the vertigo no longer occurs. The entire sequence is repeated three times a day until the patient has 2 consecutive days without vertigo. (Adapted from Brandt and Daroff.[84])



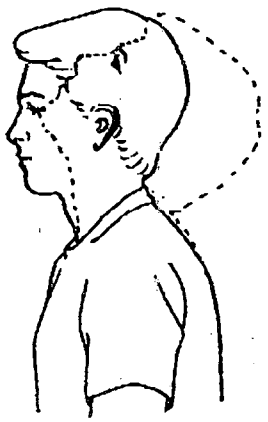
ICAL SPINE - 2
AROM Exercises: Neck Lateral Flexion

ad toward shoulder, then slowly toward
ite shoulder.
___seconds. Repeat 10 times.
_sessions per day.

CERVICAL SPINE - 1
AROM Exercises: Neck Rotation

Turn head slowly to look over left shoulder then turn to look over right shoulder.
Hold___seconds. Repeat 10 times.
Do 2 sessions per day.

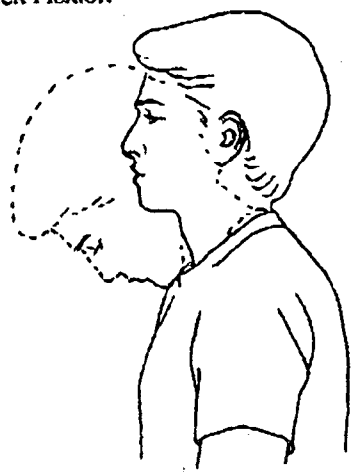
ICAL SPINE - 4
AROM Exercises: Neck Extension



head backward
eturn to starting
on.

___seconds.
at 10 times.
2 sessions per day.

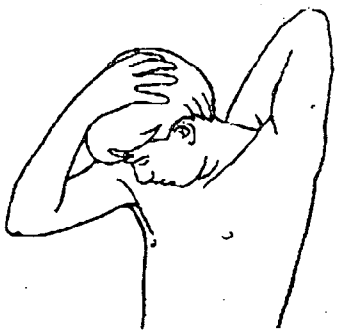
CERVICAL SPINE - 3
AROM Exercises: Neck Flexion



Bend head forward,
return to starting
position.

Hold___seconds.
Repeat 10 times.
Do 2 sessions per day.

/ICAL SPINE - 27 Levator Scapula Stretch



hand on same side shoulder blade. With other hand stretch head down and away.

30 seconds. Repeat 5 Repetitions/set.

__Sets/session. Do 2 Sessions/day.

CERVICAL SPINE - 22 Strengthening

Phase I: Shoulder Shrugs

Shrug shoulders up and down, forward and backward.

Hold 5 seconds.

Repeat 10 times.

Do 2-3 times per day.

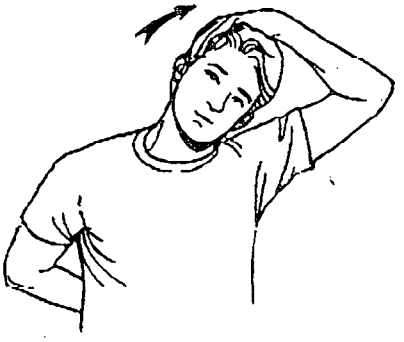
Phase II: Resistive Shoulder Shrugs

With Surgical tubing/dumbells _____lbs., shrug shoulders up and down, forward and backward.

Repeat _____ times.

Do _____ sessions per day.

CERVICAL SPINE - 23 Flexibility: Upper Trapezius Stretch



Gently grasp side of head while reaching behind back with other hand. Tilt head away until a gentle stretch is felt.

Hold 30 seconds. Repeat 5 times, both sides.

Do 2 times per day.

4/19/01

4 Scapular retraction.

4171

12344

SS# 184 - 32 - 4880

Dizziness Handicap Inventory (DHI)

The purpose of this scale is to identify difficulties that you may be experiencing because of your d
Please answer "yes", "no" or "sometimes" to each question. Answer each question as it pertains
dizziness problem only. Fill in each answer square completely.

	Yes	Sometimes	No
1. Does looking up increase your problem?	●	○	○
2. Because of your problem, do you feel frustrated?	○	●	○
3. Because of your problem do you restrict your tra for business or recreation?	○	●	○
4. Does walking down the aisle of a supermarket increase your problem?	○	●	○
5. Because of your problem, do you have difficulty getting out of bed?	○	●	○
6. Does your problem significantly restrict your participation in social activites such as going out dinner, going to the movies, dancing, or to partie	○	●	○
7. Because of your problem, do you have difficulty reading?	○	●	○
8. Does performing more ambitious activities like sports, dancing, household chores, such as sweeping putting dishes away increase your problem?	○	●	○
9. Because of your problem, are you afraid to leave yo home without having someone accompany you?	○	●	○
10. Because of your problem, have you been embarrassed in front of others?	○	●	○
11. Do quick movements of your head increase your problems?	●	○	○
12. Because of your problem, do you avoid heights?	●	○	○
13. Does turning over in bed increase your problem?	●	○	○

4/17/01

12344

SS# 184 - 32 - 4880

Dizziness Handicap Inventory (DHI)

The purpose of this scale is to identify difficulties that you may be experiencing because of your d
Please answer "yes", "no" or "sometimes" to each question. Answer each question as it pertains
dizziness problem only. Fill in each answer square completely.

	Yes	Sometimes	No
14. Because of your problem, is it difficult for y to do strenuous housework or yardwork?	○	●	○
15. Because of your problem, are you afraid people may think that you are intoxicated?	○	●	○
16. Because of your problem, is it difficult for yo walk by yourself?	○	○	●
17. Does walking down a sidewalk increase your problem?	○	●	○
18. Because of your problem, is it difficult for you to concentrate?	○	●	○
19. Because of your problem, is it difficult for you walk around your house in the dark?	○	●	○
20. Because of your problem, are you afraid to st home alone?	○	○	●
21. Because of your problem, do you feel handicapped?	○	●	○
22. Has your problem placed stress on your relationsh with members of your family or friends?	○	○	●
23. Because of your problem, are you depressed?	○	●	○
24. Does your problem interfere with your job or househ responsibilities?	○	●	○
25. Does bending over increase your problem?	●	○	○

20 + 34 = 54

4/17/01

Dynamic Gait Index

1. Gait level surface _____
Instructions: Walk at your normal speed from here to the next mark (20')
Grading: Mark the lowest category that applies.
(3) Normal: Walks 20', no assistive devices, good speed, no evidence for imbalance, normal gait pattern.
(2) Mild impairment: Walks 20', uses assistive devices, slower speed, mild gait deviations.
(1) Moderate impairment: Walks 20', slow speed, abnormal gait pattern, evidence for imbalance.
(0) Severe impairment: Cannot walk 20' without assistance, severe gait deviations or imbalance.

2. Change in gait speed _____
Instructions: Begin walking at your normal pace (for 5'), when I tell you "go," walk as fast as you can (for 5'). When I tell you "slow," walk as slowly as you can (for 5').
Grading: Mark the lowest category that applies.
(3) Normal: Able to smoothly change walking speed without loss of balance or gait deviation. Shows a significant difference in walking speeds between normal, fast, and slow speeds.
(2) Mild impairment: Is able to change speed but demonstrates mild gait deviations, or no gait deviations but unable to achieve a significant change in velocity, or uses an assistive device.
(1) Moderate impairment: Makes only minor adjustments to walking speed, or accomplishes a change in speed with significant gait deviations, or changes speed but loses significant gait deviations, or changes speed but loses balance but is able to recover and continue walking.
(0) Severe impairment: Cannot change speeds, or loses balance and has to reach for wall or be caught.

Little change btn. slow & normal

3. Gait with horizontal head turns _____
Instructions: Begin walking at your normal pace. When I tell you to "look right," keep walking straight, but turn your head to the right. Keep looking to the right until I tell you, "look left," then keep walking straight and turn your head to the left. Keep your head to the left until I tell you, "look straight," then keep walking straight, but return your head to the center.
Grading: Mark the lowest category that applies.
(3) Normal: Performs head turns smoothly with no change in gait
(2) Mild impairment: Performs head turns smoothly with slight change in gait velocity, i.e., minor disruption to smooth gait path or uses walking aid.
(1) Moderate impairment: Performs head turns with moderate change in gait velocity, slows down, staggers but recovers, can continue to walk.
(0) Severe impairment: Performs task with severe disruption of gait, i.e., staggers outside 15" path, loses balance, stops, reaches for wall.

4. Gait with vertical head turns _____
Instructions: Begin walking at your normal pace. When I tell you to "look up," keep walking straight, but tip your head and look up. Keep looking up until I tell you, "look down." Then keep walking straight and turn your head down. Keep looking down until I tell you, "look straight," then keep walking straight, but return your head to the center.
Grading: Mark the lowest category that applies.
(3) Normal: Performs head turns with no change in gait.
(2) Mild impairment: Performs task with slight change in gait velocity i.e., minor disruption to smooth gait path or uses walking aid.
(1) Moderate impairment: Performs task with moderate change in gait velocity, slows down, staggers but recovers, can continue to walk.
(0) Severe impairment: Performs task with severe disruption of gait, i.e., staggers outside 15" path, loses balance, stops, reaches for wall.

18/24

4/17

5. Gait and pivot turn _____
Instructions: Begin walking at your normal pace. When I tell you, "turn and stop," turn as quickly as you can to face the opposite direction and stop.
Grading: Mark the lowest category that applies.
(3) Normal: Pivot turns safely within 3 seconds and stops quickly with no loss of balance.
(2) Mild impairment: Pivot turns safely in > 3 seconds and stops with no loss of balance.
(1) Moderate impairment: Turns slowly, requires verbal cueing, requires several small steps to catch balance following turn and stop.
(0) Severe impairment: Cannot turn safely, requires assistance to turn and stop.

NO dizziness

6. Step over obstacle _____
Instructions: Begin walking at your normal speed. When you come to the shoe box, step over it, not around it, and keep walking.
Grading: Mark the lowest category that applies.
(3) Normal: Is able to step over box without changing gait speed; no evidence for imbalance.
(2) Mild impairment: Is able to step over box, but must slow down and adjust steps to clear box safely.
(1) Moderate impairment: Is able to step over box but must stop, then step over. May require verbal cueing.
(0) Severe impairment: Cannot perform without assistance.

7. Step around obstacles _____
Instructions: Begin walking at normal speed. When you come to the first cone (about 6' away), walk around the right side of it. When you come to the second cone (6' past first cone), walk around it to the left.
Grading: Mark the lowest category that applies.
(3) Normal: Is able to walk around cones safely without changing gait speed; no evidence of imbalance.
(2) Mild impairment: Is able to step around both cones, but must slow down and adjust steps to clear cones
(1) Moderate impairment: Is able to clear cones but must significantly slow, speed to accomplish task, or requires verbal cueing.
(0) Severe impairment: Unable to clear cones, walks into one or both cones, or requires physical assistance.

8. Steps _____
Instructions: Walk up these stairs as you would at home (i.e., using the rail if necessary. At the top, turn around and walk down.
Grading: Mark the lowest category that applies.
(3) Normal: Alternating feet, no rail.
(2) Mild impairment: Alternating feet, must use rail.
(1) Moderate impairment: Two feet to a stair, must use rail.
(0) Severe impairment: Cannot do safely.

Shumway-Cook A, Woollacott M. *Motor Control Theory and Applications*, Williams & Wilkins Baltimore, 1995 (p.323-324)

4/24

12344

SS# - -

Dizziness Handicap Inventory (DHI)

The purpose of this scale is to identify difficulties that you may be experiencing because of your d
Please answer "yes", "no" or "sometimes" to each question. Answer each question as it pertains
dizziness problem only. Fill in each answer square completely.

	Yes	Sometimes	No
1. Does looking up increase your problem?	O	●	O
2. Because of your problem, do you feel frustrated?	O	●	O
3. Because of your problem do you restrict your tra for business or recreation?	O	●	O
4. Does walking down the aisle of a supermarket increase your problem?	O	O	●
5. Because of your problem, do you have difficulty getting out of bed?	O	O	●
6. Does your problem significantly restrict your participation in social activites such as going out dinner, going to the movies, dancing, or to partie	O	●	O
7. Because of your problem, do you have difficulty reading?	O	O	●
8. Does performing more ambitious activities like sports, dancing, household chores, such as sweeping putting dishes away increase your problem?	O	●	O
9. Because of your problem, are you afraid to leave yo home without having someone accompany you?	O	●	O
10. Because of your problem, have you been embarrassed in front of others?	O	O	●
11. Do quick movements of your head increase your problems?	O	●	O
12. Because of your problem, do you avoid heights?	O	●	O
13. Does turning over in bed increase your problem?	O	●	O

Florence King 4/24/01

12344

SS# - -

Dizziness Handicap Inventory (DHI)

The purpose of this scale is to identify difficulties that you may be experiencing because of your d
Please answer "yes", "no" or "sometimes" to each question. Answer each question as it pertains
dizziness problem only. Fill in each answer square completely.

	Yes	Sometimes	No
14. Because of your problem, is it difficult for y to do strenuous housework or yardwork?	○	●	○
15. Because of your problem, are you afraid people may think that you are intoxicated?	○	○	●
16. Because of your problem, is it difficult for yo walk by yourself?	○	○	●
17. Does walking down a sidewalk increase your problem?	○	●	○
18. Because of your problem, is it difficult for you to concentrate?	○	○	●
19. Because of your problem, is it difficult for you walk around your house in the dark?	○	○	●
20. Because of your problem, are you afraid to st home alone?	○	○	●
21. Because of your problem, do you feel handicapped?	○	○	●
22. Has your problem placed stress on your relationsh with members of your family or friends?	○	●	○
23. Because of your problem, are you depressed?	○	●	○
24. Does your problem interfere with your job or househ responsibilities?	○	○	●
25. Does bending over increase your problem?	○	●	○

28 Total

THIS IS WAL-MART CASE NUMBER 192.

BY INTERVIEWER:

TODAY'S DATE IS JULY 29TH, AND WE'RE DISCUSSING FILE NUMBER 99518770, AN INCIDENT THAT DID OCCUR.

MS. KING: FEBRUARY 28TH, '99 IS WHEN I WENT TO THE DOCTOR, AND IT WAS THE DAY BEFORE THAT I THINK.

INTERVIEWER: OKAY.

BY INTERVIEWER:

Q: AND CAN I HAVE THE CORRECT SPELLING OF YOUR FIRST AND LAST NAME, MS. KING?

A: F-L-O-R-E-N-C-E, K-I-N-G.

Q: AND ARE YOU MARRIED MS. KING?

A: NO, I AM NOT.

Q: AND YOUR CORRECT MAILING ADDRESS?

A: 130 WEST MAIN STREET, SAXSVILLE, PENNSYLVANIA 15865.

Q: OKAY. AND YOUR CORRECT HOME PHONE NUMBER?

A: 814-894-5410.

Q: AND YOUR SOCIAL SECURITY NUMBER?

A: 184-32-4880.

Q: AND YOUR DATE OF BIRTH?

A: 10-14-41.

Q: AND YOUR REASON FOR BEING IN THE STORE THAT DAY?

A: I WAS DOING SOME SHOPPING AND I COME BY THE HOT CURLING IRONS FOR YOUR HAIR, YOU KNOW. AND I

THOUGHT WELL, I MIGHT AS WELL BUY A SET WHILE I'M IN HERE.

SO, I REACHED UP, AND I GOT A SET DOWN OFF THE THING, AND THE ONE THAT I GOT DOWN WAS HOOKED TO ANOTHER ONE THAT WAS OPENED, AND I DIDN'T KNOW IT. AND IT COME DOWN AND HIT ME ON THE MIDDLE OF MY FOREHEAD, RIGHT WHERE MY HAIRLINE STARTS.

AND I STARTED -- I SAW SOME STARS AND I FELT REALLY STRANGE, OKAY. ALMOST CUT MY HEAD OPEN.

AND MY GENTLEMEN FRIEND I WAS WITH, I TOLD HIM THAT I'M READY TO GO. I SAYS I'M READY TO GO AFTER I FOUND HIM AND HE SAID WHAT'S A MATTER. AND I TOLD HIM AND WE GOT BACK TO THE CHECK-OUT COUNTER AND I TOLD THE GIRL WHAT HAPPENED.

SHE SAYS, ARE YOU OKAY? I SAYS, NO, I'M NOT OKAY. SHE SAYS, OH, I'M SORRY TO HEAR THAT AND THAT WAS IT.

SO, I COME HOME, TOOK A ZANAC, WHICH IS A NERVE PILL, AND A COUPLE OF TYLENOL.

AND I CALLED THE STORE AND TALKED TO THE MANAGER UP THERE, THE WAL-MART IN DUBOIS. AND THEY HAD GIVEN ME A TOLL-FREE NUMBER TO CALL WHICH I DID. AND I DON'T, I CAN'T RECALL WHO I DID TALK TO AT THAT DATE AND TIME.

Q: AND YOU SAY IT WAS A CURLING IRON THAT CAME DOWN?

A: YEAH. THE BOX -- THE HOT CURLING IRON.

REMEMBER, I CAN THINK OF THE NAME I BOUGHT, WHICH WAS THE ONE SITTING BESIDE THE SAME KIND, AND SOMEBODY

HAD -- MUST HAVE OPENED IT. I DON'T KNOW.

AND IT WAS OPEN, AND I DIDN'T SEE IT WAS OPEN. I JUST PULLED IT DOWN, YOU KNOW, AND THE OTHER CAME WITH IT.

Q: DO YOU KNOW THE APPROXIMATE SIZE OF THIS ITEM, MA'AM?

A: I DON'T KNOW THE SIZE OF IT. IT'S PRETTY DARN HEAVY THOUGH.

I GOT MINE OUT. I COULD MEASURE IT FOR YOU REAL QUICK.

WOULD YOU LIKE FOR ME TO DO THAT?

Q: EXCUSE ME, MA'AM?

A: IF I GOT MINE OUT, I COULD MEASURE IT REAL QUICK.

WOULD YOU LIKE FOR ME TO DO THAT?

Q: SURE. DO YOU KNOW THE BRAND ON THAT?

A: I'M THINKING IT'S REMMINGTON, BUT I'M NOT FOR SURE. THE MEASURING THING, I CAN'T FIND IT.

Q: IT IS SQUARE SHAPED?

A: IT'S LONGER THAN IT IS WIDE.

Q: AND ON WHAT SHELF WAS THIS ON, MA'AM?

A: ONE, TWO, ABOUT THE THIRD UP.

Q: DID YOU, AT ANY TIME BEFORE THIS FELL ON YOU, SEE THAT THE BOX WAS OPENED?

A: NO, I DID NOT.

IT MEASURES 11 IN LENGTH BY 6 1/2. NOW, THAT'S NOT CONTAINING THE BOX. THE BOX IS IN THE CABINET PACKED

AWAY.

Q: NOW, WHEN YOU WERE IN THE STORE AND AFTER THIS HAPPENED, IT WAS NOT REPORTED TO A MEMBER OF MANAGEMENT?

A: IT'S CONAIR.

Q: OKAY.

A: EASY HOLDING HAIR SETTER.

NOW, WHAT WAS THE QUESTION?

Q: BEFORE YOU LEFT THE STORE, YOU DID NOT REPORT THIS TO A MEMBER OF MANAGEMENT?

A: NO, I DIDN'T KNOW I HAD TO UNTIL, YOU KNOW, I CAME HOME. AND, LIKE I SAID, I REALLY FELT WEIRD, AND I WAS DIZZY AND MY HEAD WAS ACHING ME AND MY NECK HURT ME.

SO, I HAD CALLED THEM AND TOLD HEM ABOUT IT AND THEY SAID -- WELL, I AM SEEKING PROFESSIONAL -- I'M GOING TO GO SEE MY DOCTOR, YOU KNOW.

SO, I HAD GONE UP TO MY CHIROPRACTOR. HE TOOK AN X-RAY AND SAID IT WAS A SLIGHT CONCUSSION -- OR A SLIGHT WHIPLASH. I STILL THINK I HAD A CONCUSSION TOO. IF I HAD WENT TO MY DOCTOR.

Q: THE NAME OF YOUR CHIROPRACTOR?

A: DR. SCOTT CASTIL.

Q: AND WHAT PART OF YOUR BODY DID YOU INJURE?

A: IT WAS MY NECK THAT HE WORKED ON. LIKE I SAID, I HAD LIKE A LITTLE CUT IN MY HEAD, BUT IT WAS MY NECK.

Q: SO, YOU WERE FACING THE SHELF WHEN IT CAME DOWN ON YOU?

A: RIGHT, RIGHT.

Q: WAS YOUR COMPANION STANDING RIGHT THERE BY YOU WHEN THIS HAPPENED?

A: NO, HE WAS NOT, 'CAUSE THAT WAS ANOTHER THING. I HAD TO STAND THERE FOR A FEW MINUTES.

I LOST -- IT WAS LIKE I DIDN'T KNOW WHAT WAS GOING ON AROUND ME. I THOUGHT FOR A MINUTE I WAS GOING TO PASS OUT, OKAY. AND THEN I FINALLY REALIZED WHERE HE SAID HE WAS GOING TO GO, WHICH WAS BACK BY THE AUTO DEPARTMENT. I WENT BACK THAT WAY, AND HE WAS COMING, AND I TOLD HIM WHAT HAPPENED.

Q: AFTER THIS FELL, DID YOU FALL DOWN AT ALL OR DID IT JUST HIT YOU AND STUN YOU?

A: IT JUST HIT ME AND I WAS REALLY STUNNED. I PROBABLY COULD'VE FELL IF, YOU KNOW, 'CAUSE I REALLY -- WHEN I HAD THE CURLING SET IN MY HAND THAT I WANTED, I JUST DROPPED IT RIGHT INTO MY CART.

Q: AND HAVE YOU INJURED YOUR HEAD OR YOUR NECK PRIOR TO THE INCIDENT AT THE WAL-MART STORE, MA'AM?

A: NO.

Q: YOU NEVER HAD ANY PRIOR PROBLEMS WITH THESE PARTS OF YOUR BODY THEN?

A: NO. HE WAS TREATING ME FOR MY F-M-S FOR MY HIP AND ARTHRITIS IN MY HIP AND SPINE, YOU KNOW, NOTHING TO MY UPPER PART OF MY NECK.

Q: HAVE YOU EVER HAD AN ACCIDENT OR YOUR A CLAIM AT A RETAIL STORE?

A: NO, I HAVE NOT.

Q: HAVE YOU EVER HAD A WORK RELATED ACCIDENT OR A WORK COMP CLAIM?

A: NO, I HAVE NOT.

Q: DID THE DOCTOR AT ANY TIME TAKE YOU OFF WORK IN REGARDS TO YOUR INCIDENT?

A: NO, I'M ON S-S-I DISABILITY.

Q: HAVE YOU HAD AN AUTOMOBILE ACCIDENT WHERE YOU RECEIVED ANY INJURES?

A: NO.

Q: AND YOU SAY YOU INJURED YOUR FOREHEAD?

A: YES. THAT'S WHERE IT HIT ME RIGHT ABOUT, LIKE I SAID, RIGHT IN THE MIDDLE OF WHERE MY HAIRLINE STARTS. I HAD A BUMP AND A LITTLE CUT THERE, BUT IT DID NOT BLEED.

Q: AND HOW MANY TIMES HAVE YOU GONE TO THE CHIROPRACTOR IN REGARDS TO THIS EVENT?

A: OH, GEEZ, I REALLY CAN'T SAY. I KNOW THE FIRST DAY WAS THE 28TH OF FEBRUARY, BUT I CAN'T RECALL HOW MANY TIMES I HAVE GONE.

Q: AND HAVE ALL YOUR ANSWERS BEEN ACCURATE?

A: EXCUSE ME?

Q: HAVE ALL YOUR ANSWERS BEEN ACCURATE?

A: YES, THEY HAVE.

Q: MA'AM, DO YOU REMEMBER THE NAME OF THE CASHIER THAT YOU WENT THROUGH THAT DAY?

DO YOU HAPPEN TO HAVE A RECEIPT FROM THE STORE?

A: YOU KNOW, I HAVE IT SOMEWHERE.

Q: YOU DO HAVE IT?

A: HER NAME WAS -- I DO, I THINK I DO. IT MIGHT BE IN MY OLD PURSE. I KNOW WHO SHE IS, IF I'D SEE HER. SHE'S A BLOND. I'M NOT MISTAKEN, HER NAME WAS JEN.

Q: JEN?

A: YEAH, I'M NOT MISTAKEN. BUT I COULD PROBABLY LOOK TO SEE IF I COULD FIND MY --

Q: OKAY. IF YOU CAN FIND IT, GIVE ME A CALL BACK.

A: OKAY.

Q: AND WE'LL GO FROM THERE.

AND WITH YOUR PERMISSION, MS. KING, I WILL TURN OFF THE RECORDER?

A: OKAY.

DuBois Regional
Medical Center

P.O. Box 447
DuBois, Pennsylvania 15801-0447

Making the difference for life.

PHYSICAL THERAPY INITIAL EVALUATION

Patient:	Florence I. King	Date: 9/24/96
Diagnosis:	Cervical Spine and Back Pain due to Osteoarthritis and FMS	
Physician:	Alan Kivitz, M.D.	
Primary Ins:	Medical Assistance	ID#0019202555

SUBJECTIVE:

This is a 54 year old female who reports to P.T. stating that for about a year to a half now she has been having pain in her neck and back. She reports she had no difficulty in these areas prior to the past year and a half. She reports that the pain is constant in her low back, and (R) arm and leg, as well as in her neck and hands (B). She has been using no treatments at home besides her waterbed, which seems to relieve her symptoms. She has difficulty falling asleep but when she is asleep she does not feel the pain. Her most comfortable position is sleeping on her (L) side. MEDS: Include Altram, Cataflam, and Daypro in the past. She reports that she has been to see a chiropractor previously for (R) hip pain several months ago, but that it did not seem to relieve her symptoms. She reports the doctor has been testing for Fibromyalgia. She reports a PMH of OA, depression, and heart palpitations, all of which she is taking medicine for. She is to see the doctor again on 10/24 or 10/25/96.

OBJECTIVE:

AROM/PROM: Trunk forward flexion 85% of normal, extension 0, side bending and rotation (B) 50% of normal with pain with all of these movements. Cervical flexion/extension WFL throughout. Cervical side bending to the (R) 23°, to the (L) 25°, rotation to the (R) 28°, to the (L) 34°. (L) Shoulder ROM decreased at end range due to pain but grossly WFL throughout. (R) Shoulder flexion 110° AA, abduction 90° AA, internal rotation 70° AA, and external rotation 53° AA.

STRENGTH: Upon MMT (R) LE 3+/5 grossly throughout except for hip 3/5 grossly throughout. (L) LE 4/5 grossly throughout. (L) UE 4-/5 grossly throughout. (R) UE 3/5 grossly throughout.

SPECIAL TESTS: Positive Phalan's on the (R), and positive Tinel at the (R) elbow. Cervical Compression and Distraction both reproduce painful symptoms. Supine and sitting SLR Tests are negative. She does have tight hamstrings noted (B).

MUSCULOSKELETAL/POSTURE: Significant forward head, rounded shoulder, and kyphotic posturing.

OBSERVATION: (R) Hand and arm appears to be pink in color with swelling present in the hand.

SENSATION/DTR'S: Sensation intact without deficit to light touch and sharp/dull. She does have complaints of tingling in her feet and hands. DTR's. were deferred due to acuteness of patient's condition.

TONE/PALPATION: Tender to palpation (B) cervical paraspinals, upper trapezius, rhomboid muscles, progressing down to the thoracic musculature into (B) LS region and hips. She has significant spasms present in the LS region as well as in the upper trapezius and cervical paraspinals.

Continued.....

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GOALS:

Short Term Goals:

1. Increase ROM in limited areas by 10°.
2. Increase strength by ½ MMT in limited areas.
3. Independent with H.E.P.
4. Decrease subjective complaints of pain.

Long Term Goals:

1. ROM WFL throughout cervical spine, trunk, and shoulder on the (R).
2. Strength 5/5 upon MMT (B) UE/LE's.
3. Tolerate ½ hr. exercise program in the gym.
4. Minimal complaints of pain.

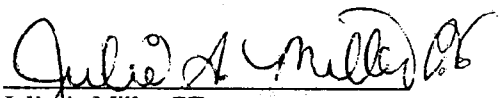
ASSESSMENT:

Problems:

1. Pain.
2. Decreased ROM.
3. Decreased strength.
4. Decreased function.

PLAN:

Patient will be seen for the above stated treatment program, progressing with therapeutic exercises as tolerated. Other modalities will be used as needed.



Julie A. Miller, PT

JAM/mm

DUBOIS REGIONAL MEDICAL CENTER
100 Hospital Ave, DuBois, PA 15801

KING,FLORENCE I *OPW Unit # 000303556
253 WEST MAIN ST
SYKESVILLE PA 15865 Age 59Y Acct # D9727800281

Date:10/09/97 Time:1435

MARKLEY,JON C DELATORRE,HENRY G
145 HOSPITAL AVENUE
DUBOIS PA 15801 SYKESVILLE PA 15865

Chk-in #	Order	Exam	
207576	0001	72710	CT-LUMBAR SPINE UNENHANCED Ord Diag: 722.10-LUMBAR DISC DISPLACEMEN
207576	0001	72810	CT-RECONSTRUCTION Ord Diag: 722.10-LUMBAR DISC DISPLACEMEN

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Computerized tomographic axial sections of the lumbar spine were obtained from the level of L1 to S1. Sagittal reconstruction views were obtained.

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IMPRESSION: THERE IS SPINAL STENOSIS AT THE L4-5 LEVEL.
THERE ARE CHANGES OF DEGENERATIVE DISC DISEASE WITHOUT EVIDENCE OF DISC HERNIATION AT THE L5-S1 LEVEL.
THE REMAINING FINDINGS ARE UNREMARKABLE.
AN MRI STUDY OF THE LUMBAR SPINE MAY BE OF BENEFIT FOR FURTHER EVALUATION.

/READ BY/ GEORGE M KOSCO
/Released By/ GEORGE M KOSCO

10/27/00 1154
JAH

Complete Duplicate

REPORT OF CONSULTATION
DUBOIS REGIONAL MEDICAL CENTER
DUBOIS, PENNSYLVANIA

PATIENT NAME: KING, FLORENCE I 9805500369 -000303556

ATTENDING PHYSICIAN:
H. G. delaTorre, M.D.
J. C. Markley, M.D.

CONSULTING PHYSICIAN:
00034015 R.M. Landfried, D.O.

DATE:

TIME:

REPORT REQUESTED REGARDING:
( ) Consult Only ( ) Consult and Write Appropriate Orders

( ) Consult, Write Orders and Follow ( ) Consult and Accept in Transfer
SIGNATURE OF ATTENDING PHYSICIAN:

HISTORY OF PRESENTING COMPLAINT: This 56 -year-old female presents from Dr. Markley for evaluation regarding left lower extremity pain and back pain. The patient states that her pain started in September of 1997. She could not remember any incident that may have caused her discomfort. Since that time, she has experienced at times severe low back discomfort with radiation into the left lower extremity. She has had physical therapy regarding her low back complaints and according to Dr. Markley has a brace at this time. She has had physical therapy at two different locations for several weeks. She has received steroid injections which have not proved overall helpful. on a long term basis. She has had a MRI performed at Indiana MRI which revealed central canal narrowing. Disc herniation was noted at the L5, S1 level impinging upon the exiting L5 nerve root on the left. There was disc bulging at the L3-4, and L4-5 levels. CT scan reportedly revealed significant arthritis in the lumbar spine area.

PAST MEDICAL HISTORY: Includes a hysterectomy with a unilateral salpingo-oophorectomy.

PSYCHOSOCIAL HISTORY: The patient does live alone. She currently is divorced for the past nine years but does have a male friend. She is currently unemployed.

HABITS: She smokes 1 ½ packs of cigarettes per day. She denies the use of alcohol or recreational drugs and denies use of caffeinated beverages.

DEVELOPMENTAL HISTORY: The patient did complete the 10th grade.

MEDICAL HISTORY: The patient states that she does have fibromyalgia syndrome which was diagnosed some time ago as well as asthma. Her last gynecologic exam was approximately one year ago with a PAP smear which was negative.

REVIEW OF SYSTEMS: Neurologically, the patient denies paralysis, multiple sclerosis, seizures, headaches. Hearing and vision, patient denies hearing problems or vision problems, scatoma or tinnitus. ENT, patient denies dysphasia, recurrent drainage or sinusitis. ENDOCRINE: Patient denies diabetes, thyroid disease, or other endocrine abnormalities. CARDIOVASCULAR: Patient denies myocardial infarction or angina or peripheral vascular disease. However, she does have occasional palpitations. Respiratory: Patient does have a history of asthma and COPD. GI: Patient denies diarrhea, constipation, blood in the stools. GU: Patient denies dysuria, hematuria or pyuria. Menstrual: Patient is postmenopausal. Hematologic: Patient denies anemia, leukemia or bleeding disorder. Skin, patient denies recurrent skin rash. Patient does have occasional hot flashes but denies fever or night sweats. She has had no weight gain or weight loss recently.

Chart Copy

MEDICATIONS: Include Alprazolam, 0.5 mg. 3-4 times per day, Atenolol 25 mg. one tablet q. day, Diclofenac 75 mg. one tablet b.i.d., Synthroid 0.025 mg. one tablet daily, Ultram 50 mg. 1-2 tablets every six hours, Premarin 0.625 mg. q. day, Os-Cal tablets 500 mg. two tablets per day and Vitamin C 400 mg. q. day.

ALLERGIES: PENICILLIN, SULFA, DARVON AND DARVOCET.

PHYSICAL EXAMINATION

GENERAL: Weight is 170 pounds, blood pressure is 120/80, pulse is 64. In general, this is an alert and oriented x 3, 56 -year-old female appearing her stated age in no acute distress. Mental status is appropriate. HEENT: Was noted to be within normal limits. Heart was regular rate and rhythm without murmur. Lungs were clear to auscultation throughout. Abdomen was soft, nontender without masses or organomegaly noted. There was no pulsatile masses or abdominal bruits auscultated. Extremities, the patient did demonstrate normal muscle mass tone with normal range of motion of joints, pulses were equal and symmetrical throughout. There is no deformity noted. The patient had a number of tender points consistent with fibromyalgia. There was no dystrophic changes, color changes or temperature changes noted. Neck range of motion was noted to be within normal limits. Examination of the lower extremities did not reveal straight leg raising to be positive. This was not exacerbated by ankle dorsiflexion, neck flexion and popliteal pressure or hamstring pressure. DTR's were normal and Hoffman's and Babinski's were negative. Strengths were grossly 5/5 throughout. Sensation to fine touch was equal. Cerebellar testing such as Romberg was negative. Gait appeared to be relatively normal.

IMPRESSION: L5-S1 with left lumbar radiculopathy at L5.

RECOMMENDATIONS: Were for epidural steroid injection. Consideration for three injections if the patient responds favorably to her first epidural steroid injection.

Thank you very much.
D: 02/27/98 8:23 P
T: 03/02/98 1:05 P RML/kp
DOCUMENT NO: 26031
Job/Tape ID: 5020

R.M. Landfried, D.O.

cc: H.G. delaTorre, M.D.
R.M. Landfried, D.O.
J.C. Markley, M.D.

Chart Copy

AWAY.

Q: NOW, WHEN YOU WERE IN THE STORE AND AFTER THIS HAPPENED, IT WAS NOT REPORTED TO A MEMBER OF MANAGEMENT?

A: IT'S CONAIR.

Q: OKAY.

A: EASY HOLDING HAIR SETTER.

NOW, WHAT WAS THE QUESTION?

Q: BEFORE YOU LEFT THE STORE, YOU DID NOT REPORT THIS TO A MEMBER OF MANAGEMENT?

A: NO, I DIDN'T KNOW I HAD TO UNTIL, YOU KNOW, I CAME HOME. AND, LIKE I SAID, I REALLY FELT WEIRD, AND I WAS DIZZY AND MY HEAD WAS ACHING ME AND MY NECK HURT ME.

SO, I HAD CALLED THEM AND TOLD HEM ABOUT IT AND THEY SAID -- WELL, I AM SEEKING PROFESSIONAL -- I'M GOING TO GO SEE MY DOCTOR, YOU KNOW.

SO, I HAD GONE UP TO MY CHIROPRACTOR. HE TOOK AN X-RAY AND SAID IT WAS A SLIGHT CONCUSSION -- OR A SLIGHT WHIPLASH. I STILL THINK I HAD A CONCUSSION TOO. IF I HAD WENT TO MY DOCTOR.

Q: THE NAME OF YOUR CHIROPRACTOR?

A: DR. SCOTT CASTIL.

Q: AND WHAT PART OF YOUR BODY DID YOU INJURE?

A: IT WAS MY NECK THAT HE WORKED ON. LIKE I SAID, I HAD LIKE A LITTLE CUT IN MY HEAD, BUT IT WAS MY NECK.

Q: SO, YOU WERE FACING THE SHELF WHEN IT CAME DOWN ON YOU?

A: RIGHT, RIGHT.

Q: WAS YOUR COMPANION STANDING RIGHT THERE BY YOU WHEN THIS HAPPENED?

A: NO, HE WAS NOT, 'CAUSE THAT WAS ANOTHER THING. I HAD TO STAND THERE FOR A FEW MINUTES.

I LOST -- IT WAS LIKE I DIDN'T KNOW WHAT WAS GOING ON AROUND ME. I THOUGHT FOR A MINUTE I WAS GOING TO PASS OUT, OKAY. AND THEN I FINALLY REALIZED WHERE HE SAID HE WAS GOING TO GO, WHICH WAS BACK BY THE AUTO DEPARTMENT. I WENT BACK THAT WAY, AND HE WAS COMING, AND I TOLD HIM WHAT HAPPENED.

Q: AFTER THIS FELL, DID YOU FALL DOWN AT ALL OR DID IT JUST HIT YOU AND STUN YOU?

A: IT JUST HIT ME AND I WAS REALLY STUNNED. I PROBABLY COULD'VE FELL IF, YOU KNOW, 'CAUSE I REALLY -- WHEN I HAD THE CURLING SET IN MY HAND THAT I WANTED, I JUST DROPPED IT RIGHT INTO MY CART.

Q: AND HAVE YOU INJURED YOUR HEAD OR YOUR NECK PRIOR TO THE INCIDENT AT THE WAL-MART STORE, MA'AM?

A: NO.

Q: YOU NEVER HAD ANY PRIOR PROBLEMS WITH THESE PARTS OF YOUR BODY THEN?

A: NO. HE WAS TREATING ME FOR MY F-M-S FOR MY HIP AND ARTHRITIS IN MY HIP AND SPINE, YOU KNOW, NOTHING TO MY UPPER PART OF MY NECK.

Q: HAVE YOU EVER HAD AN ACCIDENT OR YOUR A CLAIM AT A RETAIL STORE?

A: NO, I HAVE NOT.

Q: HAVE YOU EVER HAD A WORK RELATED ACCIDENT OR A WORK COMP CLAIM?

A: NO, I HAVE NOT.

Q: DID THE DOCTOR AT ANY TIME TAKE YOU OFF WORK IN REGARDS TO YOUR INCIDENT?

A: NO, I'M ON S-S-I DISABILITY.

Q: HAVE YOU HAD AN AUTOMOBILE ACCIDENT WHERE YOU RECEIVED ANY INJURES?

A: NO.

Q: AND YOU SAY YOU INJURED YOUR FOREHEAD?

A: YES. THAT'S WHERE IT HIT ME RIGHT ABOUT, LIKE I SAID, RIGHT IN THE MIDDLE OF WHERE MY HAIRLINE STARTS. I HAD A BUMP AND A LITTLE CUT THERE, BUT IT DID NOT BLEED.

Q: AND HOW MANY TIMES HAVE YOU GONE TO THE CHIROPRACTOR IN REGARDS TO THIS EVENT?

A: OH, GEEZ, I REALLY CAN'T SAY. I KNOW THE FIRST DAY WAS THE 28TH OF FEBRUARY, BUT I CAN'T RECALL HOW MANY TIMES I HAVE GONE.

Q: AND HAVE ALL YOUR ANSWERS BEEN ACCURATE?

A: EXCUSE ME?

Q: HAVE ALL YOUR ANSWERS BEEN ACCURATE?

A: YES, THEY HAVE.

Q: MA'AM, DO YOU REMEMBER THE NAME OF THE CASHIER THAT YOU WENT THROUGH THAT DAY?

DO YOU HAPPEN TO HAVE A RECEIPT FROM THE STORE?

A: YOU KNOW, I HAVE IT SOMEWHERE.

Q: YOU DO HAVE IT?

A: HER NAME WAS -- I DO, I THINK I DO. IT MIGHT BE IN MY OLD PURSE. I KNOW WHO SHE IS, IF I'D SEE HER. SHE'S A BLOND. I'M NOT MISTAKEN, HER NAME WAS JEN.

Q: JEN?

A: YEAH, I'M NOT MISTAKEN. BUT I COULD PROBABLY LOOK TO SEE IF I COULD FIND MY --

Q: OKAY. IF YOU CAN FIND IT, GIVE ME A CALL BACK.

A: OKAY.

Q: AND WE'LL GO FROM THERE.

AND WITH YOUR PERMISSION, MS. KING, I WILL TURN OFF THE RECORDER?

A: OKAY.

DuBois Regional
Medical Center

P.O. Box 447
DuBois, Pennsylvania 15801-0447

Making the difference for life.

PHYSICAL THERAPY INITIAL EVALUATION

Patient:	Florence I. King	Date: 9/24/96
Diagnosis:	Cervical Spine and Back Pain due to Osteoarthritis and FMS	
Physician:	Alan Kivitz, M.D.	
Primary Ins:	Medical Assistance	ID#0019202555

SUBJECTIVE:

This is a 54 year old female who reports to P.T. stating that for about a year to a half now she has been having pain in her neck and back. She reports she had no difficulty in these areas prior to the past year and a half. She reports that the pain is constant in her low back, and (R) arm and leg, as well as in her neck and hands (B). She has been using no treatments at home besides her waterbed, which seems to relieve her symptoms. She has difficulty falling asleep but when she is asleep she does not feel the pain. Her most comfortable position is sleeping on her (L) side. MEDS: Include Altram, Cataflam, and Daypro in the past. She reports that she has been to see a chiropractor previously for (R) hip pain several months ago, but that it did not seem to relieve her symptoms. She reports the doctor has been testing for Fibromyalgia. She reports a PMH of OA, depression, and heart palpitations, all of which she is taking medicine for. She is to see the doctor again on 10/24 or 10/25/96.

OBJECTIVE:

AROM/PROM: Trunk forward flexion 85% of normal, extension 0, side bending and rotation (B) 50% of normal with pain with all of these movements. Cervical flexion/extension WFL throughout. Cervical side bending to the (R) 23°, to the (L) 25°, rotation to the (R) 28°, to the (L) 34°. (L) Shoulder ROM decreased at end range due to pain but grossly WFL throughout. (R) Shoulder flexion 110° AA, abduction 90° AA, internal rotation 70° AA, and external rotation 53° AA.

STRENGTH: Upon MMT (R) LE 3+/5 grossly throughout except for hip 3/5 grossly throughout. (L) LE 4/5 grossly throughout. (L) UE 4-/5 grossly throughout. (R) UE 3/5 grossly throughout.

SPECIAL TESTS: Positive Phalan's on the (R), and positive Tinel at the (R) elbow. Cervical Compression and Distraction both reproduce painful symptoms. Supine and sitting SLR Tests are negative. She does have tight hamstrings noted (B).

MUSCULOSKELETAL/POSTURE: Significant forward head, rounded shoulder, and kyphotic posturing.

OBSERVATION: (R) Hand and arm appears to be pink in color with swelling present in the hand.

SENSATION/DTR'S: Sensation intact without deficit to light touch and sharp/dull. She does have complaints of tingling in her feet and hands. DTR's. were deferred due to acuteness of patient's condition.

TONE/PALPATION: Tender to palpation (B) cervical paraspinals, upper trapezius, rhomboid muscles, progressing down to the thoracic musculature into (B) LS region and hips. She has significant spasms present in the LS region as well as in the upper trapezius and cervical paraspinals.

Continued.....

West Unit (814) 371-2200 East Unit (814) 375-4321 Direct Dial: (814) 375-3372

TREATMENT: Treatment today consisted of MH with IFES, 80 to 150 Hz. quad polar x 20 mins. with 4 pads, 2 in the upper traps. (B), and 2 in the LS region (B). She was positioned in side lying on the (L). She was also instructed in starting a home therapeutic exercise program for using putty in the (R) hand, chin tucks with shoulder retraction, and pendulum exercises for the (R) UE.

GOALS:

Short Term Goals:

1. Increase ROM in limited areas by 10°.
2. Increase strength by ½ MMT in limited areas.
3. Independent with H.E.P.
4. Decrease subjective complaints of pain.

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3. Decreased strength.
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PLAN:

Patient will be seen for the above stated treatment program, progressing with therapeutic exercises as tolerated. Other modalities will be used as needed.

Julie A. Miller, PT

JAM/mm

D' ?IS REGIONAL MEDICAL CENTF
1c_ Hospital Ave, DuBois, PA ..?801

KING,FLORENCE I *OPW Unit # 000303556
253 WEST MAIN ST
SYKESVILLE PA 15865 Age 59Y Acct # D9727800281

Date:10/09/97 Time:1435

MARKLEY,JON C DELATORRE,HENRY G
145 HOSPITAL AVENUE
DUBOIS PA 15801 SYKESVILLE PA 15865

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Computerized tomographic axial sections of the lumbar spine were obtained from the level of L1 to S1. Sagittal reconstruction views were obtained.

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/READ BY/ GEORGE M KOSCO
/Released By/ GEORGE M KOSCO

10/27/00 1154
JAH

Complete Duplicate

REPORT OF CONSULTATION
DUBOIS REGIONAL MEDICAL CENTER
DUBOIS, PENNSYLVANIA

PATIENT NAME: KING, FLORENCE I 9805500369 -000303556

ATTENDING PHYSICIAN:
H. G. delaTorre, M.D.
J. C. Markley, M.D.

CONSULTING PHYSICIAN:
00034015 R.M. Landfried, D.O.

DATE:

TIME:

REPORT REQUESTED REGARDING:
( ) Consult Only ( ) Consult and Write Appropriate Orders

( ) Consult, Write Orders and Follow ( ) Consult and Accept in Transfer
SIGNATURE OF ATTENDING PHYSICIAN:

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Chart Copy

MEDICATIONS: Include Alprazolam, 0.5 mg. 3-4 times per day, Atenolol 25 mg. one tablet q. day, Diclofenac 75 mg. one tablet b.i.d., Synthroid 0.025 mg. one tablet daily, Ultram 50 mg. 1-2 tablets every six hours, Premarin 0.625 mg. q. day, Os-Cal tablets 500 mg. two tablets per day and Vitamin C 400 mg. q. day.

ALLERGIES: PENICILLIN, SULFA, DARVON AND DARVOCET.

PHYSICAL EXAMINATION

GENERAL: Weight is 170 pounds, blood pressure is 120/80, pulse is 64. In general, this is an alert and oriented x 3, 56 -year-old female appearing her stated age in no acute distress. Mental status is appropriate. HEENT: Was noted to be within normal limits. Heart was regular rate and rhythm without murmur. Lungs were clear to auscultation throughout. Abdomen was soft, nontender without masses or organomegaly noted. There was no pulsatile masses or abdominal bruits auscultated. Extremities, the patient did demonstrate normal muscle mass tone with normal range of motion of joints, pulses were equal and symmetrical throughout. There is no deformity noted. The patient had a number of tender points consistent with fibromyalgia. There was no dystrophic changes, color changes or temperature changes noted. Neck range of motion was noted to be within normal limits. Examination of the lower extremities did not reveal straight leg raising to be positive. This was not exacerbated by ankle dorsiflexion, neck flexion and popliteal pressure or hamstring pressure. DTR's were normal and Hoffman's and Babinski's were negative. Strengths were grossly 5/5 throughout. Sensation to fine touch was equal. Cerebellar testing such as Romberg was negative. Gait appeared to be relatively normal.

IMPRESSION: L5-S1 with left lumbar radiculopathy at L5.

RECOMMENDATIONS: Were for epidural steroid injection. Consideration for three injections if the patient responds favorably to her first epidural steroid injection.

Thank you very much.
D: 02/27/98 8:23 P
T: 03/02/98 1:05 P RML/kp
DOCUMENT NO: 26031
Job/Tape ID: 5020

R.M. Landfried, D.O.

cc: H.G. delaTorre, M.D.
R.M. Landfried, D.O.
J.C. Markley, M.D.

Chart Copy

DUBOIS REGIONAL MEDICAL CENTER
PAIN EVALUATION AND TREATMENT CLINIC

PHYSICIAN EVALUATION SUMMARY

Name: Florence King SS# 184-32-4880

Date of evaluation: 2/25/98 MD P Clough

IMPRESSIONS:

1. HNP L5-S1 c L5 Radiculopathy (R)
2.
3.
4.
5.
6.
7.
8.

MEDICATIONS AND DOSAGE:

1. Alprazolam 0.5 mg 3-4 x day
2. Medrol 4 mg qd.
3. Baclofen 75 mg BID
4. Synthroid 0.025 mg qd
5. Ultram 50 mg q4-6
6. Premarin 0.625 mg qd.
7. Ecotrin 325 mg 2 qd.
8. Vit C,

ALLERGIES:

1. PCN
2. Sulfa
3. Darvon
4. Darvocet
5.
6.
7.
8.

RECOMMENDATIONS:

- ☐ IPRP
- ☐ Phase I
- ☐ H/A Group
- ☐ Fibro Group
- ☐ PT Group
- ☐ OT Consult
- ☐ Individual PT
- ☐ Individual Psych
- ☐ Nerve Block:_____
- ☐ Other:_____
- ☐ F/U with MD in _____weeks/months
- ☐ Records requested:_____

_____

☐ Med Adjustment:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

REGIONAL MEDICAL CENTER

HOURS | DONOR | 000303556 BILLING NO.

NAME AND ADDRESS: KING,FLORENCE I, RD 1 BOX 82, DUBOIS PA 15801

PREVIOUS NAME:

COUNTY: 035

TELEPHONE NO.: (814)583-7119

S.S. NO.: 184-32-4880

REGISTRATION DATE: 03/16/98

TIME: :44

TYPE OF RECORD: ER - EMERGENCY ROOM; OP - OUTPATIENT DEPT.; SP - SHORT PROCEDURE

DEPT.: 9807200228

AGE	BIRTH DATE	METHOD ARRIVAL	SEX	RACE	M.S.
56Y	10/14/41	2 WALK IN	F	1	D

RELIGION-CHURCH	P.T.	FIN. CL.	ADMIT BY
METHODIST	OS	MA	

EMPLOYER, ADDRESS, OCCUPATION, PHONE: HOMEMAKER, PA, HOMEMAKER

ICD-9-CM CODES/CPT-4 CODES:

PATIENT / PATIENT REPRESENTATIVE STATES SYMPTOMS OR ACCIDENT: 724.5-BACKACHE NOS

LAST ADM. DATE: 02/25/98

WHERE:

PERSON TO NOTIFY IN CASE OF EMERGENCY: SONNIE,ROBYN, SYKESVILLE PA (814)894-5537

RELATIONSHIP: K, DAUGHTER

NAME AND ADDRESS: KING,FLORENCE I, RD 1 BOX 82, DUBOIS PA 15801, SELF

TELEPHONE: (814)583-7119, HOMEMAKER

SOC. SEC.: 184-32-4880

REL.:

EMPLOYER NAME AND ADDRESS: HOMEMAKER

INSURANCE COMPANY	PLAN	POLICY HOLDER	REL.	POLICY #	GROUP #
MA OUTPATIENT SURGER	200015	KING,FLORENCE;I	1	0019202555	
MEDICAL ASSISTANCE P	200003	KING,FLORENCE I		0019202555	

TREATING PHYSICIAN / FAMILY PHYSICIAN / REFERRING PHYSICIAN: LANDFRIED,ROBERT; REF: DELATORRE,HENRY

CONDITION ON ARRIVAL: ☒ SATISFACTORY ☐ POOR ☐ DOA

PT. PREGNANT: ☒ DNA

LAST TT:

LMP:

ALLERGIES: Ben, Sulfa, Darvon, Darvocet

CURRENT MEDS.: See front sheet

REASON FOR ADMISSION / CHIEF COMPLAINT / ASSESSMENT

Triage Status: ☐ Emergent ☐ Urgent ☒ Non-urgent

Pt. for Caudal Steroid injection (Dr Landfried) Pain level today "9" (on 0 → 10 scale)

WT.:

VITAL SIGNS

TIME	2:40P	3:10P
TEMP.	97.9/po	—
PULSE	63	62
RESP.	20	20
B.P.	144/76	146/65

PHYSICIAN'S REPORT

NURSE'S SIGNATURE: Mary Jo Kunzelek (signature)

EXAM TIME:

3/16/98 Note dictated

180

LAB:

X-RAY:

99% Sat

☐ O2 ☐ EKG ☐ ABG ☒ PULSE OXIMETER

☒ B/P MONITOR ☐ CARDIAC MONITOR ☐ SEE FLOW SHEET

MEDICATIONS / IV'S / NOTES

L5 Radiculopathy

Caudal Epidural Steroid & local anesthetic

DISPOSITION ☐ ADMITTED ROOM NO. ☒ SENT HOME ☐ RETURN TO WORK ☐ DECEASED ☐ TRANSFERRED

CONDITION ON DISCHARGE: ☒ SATIS. ☐ FAIR ☐ POOR TIME: 3:25P

F.D. NOTIFIED TIME: | CONSULTING PHYSICIAN TIME: | ☐ F.D. REQUEST ☐ PATIENT REQUEST ☐ ON CALL | ☐ CORONER NOTIFIED ☐ POLICE TIME: | FOLLOW-UP CARE ☒ FAMILY PHYS. ☐ XPRESS CARE ☐ ER PHYSICIAN

FOLLOW INSTRUCTIONS ON PATIENT'S INSTRUCTION COPY FOR: ☐ HEAD INJURY ☐ CULTURES ☐ STREP SCREEN ☐ DIAGNOSTIC TEST ☐ LAB TESTS ☐ X-RAY/EKG'S ☐ SPRAINS, STRAINS AND CONTUSIONS ☐ NOSEBLEEDS ☐ U.R.I. ☐ WOUND AND BURN CARE ☐ GASTROENTERITIS AND/OR ABDOMINAL PAIN ☐ ALLERGY INJ. ☐ URINARY INFECTIONS ☐ CARE OF CHILD AND FEVER ☐ ANIMAL BITES ☐ CASTS ☐ EYE CARE

OTHER INSTRUCTIONS: Bed today, No driving, Epidural sheet. F/U 3 wks.

☐ TETANUS INJECTION ☐ MEDICATION ALERT ☐ MEDICATION USE

Method of Validating Knowledge: ☒ Verbalization ☐ Return Demonstration ☐ Other: ______

PATIENT/RESPONSIBLE PARTY: Florence King (signature) | NURSE'S SIGNATURE: Mary Jo Kunzelek (signature) | PHYSICIAN'S SIGNATURE: (signature)

I hereby acknowledge receipt of these instructions, have read them and understand them. I further understand that I have had emergency treatment and that I may be released before all of my medical conditions/test results are known or treated. I will arrange for follow-up care. DuBois Regional Medical Center-DuBois, PA. 15801

CASTEEL CHIROPRACTIC CENTER
10 NORTH MAIN STREET
DUBOIS, PA. 15801
814-371-8686

Case # 7323 X-rays

CLAIMS MANAGEMENT INC

Name Florence King
Ins. PI ~~Wal Mart~~
Address 130 W MAIN ST SYKESVILLE PA
Phone (home) 814-894-5410
Employment
Phone (work) 500/ WIST
Address
Age 56 Sex F Ref. by
DATE OF INJURY FEB 28 1999
CLAIM # 99518770

DATE MO	DD	YR	ADJUSTMENT AND REMARKS	Total Fee	*PT/In* Paid	Adj.	Bal.
			PATIENT PREVIOUS BALANCE				
MAR	12	1999	S Dizzy, LB P.	30		25	15
			O L5 PL PI(L) C5(R) C2(L)				
			A F-				
			P 1wk 3/15 11:30				
MAR	15	1999	S Dizzy LB Pain	30		25	20
			O L5 PL PI(L) C5(R) C2(L) C6 PRT-L	T1 PL			
			A FO				
			P ~~1wk~~ 3-17 3/22 11:30				
MAR	26	1999	S Dizzy LB Pain neck pain (L) sho	30		25	25
			O L5 PL PI(L) C5(R) C2(L) C6 PRT-L	T1 PL	T2 PR		
			A FO				
			P 1wk 3/29 11:30				
MAR	29	1999	S Dizzy neck Pain	30		25	30
			O C2 ESL ~~MCB~~ ASRP L5 PL PI(L) T1	PL T2	PR	C6 PRT-L	
			A FO				
			P 4-2 3/31 11:30				
MAR	31	1999	S neck Pain Pain B/w shos	30		25	35
			O C2 ES(L) ASRP L5 PL PI(L) T1 PL	T2 PL	C6 PRT-L		
			A FO				
			P 4-5 11:30				
APR	2	1999	S neck pain Pain B/w shos LBP in hips	30		25	40
			O C2 ESL ASRP L5 PL PI(L) T1 PL	T2 PR	C6 PRT-L		
			A FO SARpain PI(R)				
			P 4-5 11:30				
APR	5	1999	S neck pain	30		25	45
			O C2 ESL ASRP L5 PL PI(L) T1 PL	T2 PR	C6 PRT-L		
			A FO				
			P 4-7 11:30				

CASTEEL CHIROPRACTIC CNTR

100 Main St.
DuBois, PA 15801

Name Florence King

Date Feb 12, 1999

OUCH! OUCH! OUCH!

Have you had an accident or an injury since your last Adjustment? Yes ✓ No ___

If so, please describe the injury and how it happened. ALSO GIVE DATE

I was getting out of my car slip & fall Landing on (R) side hit (R) knee (R) wrist (L) Arm hit concrete curb also Twisting in LB area

Did it happen at work? Yes ___ No X

Was it an automobile accident? Yes ___ No X

Where is your pain? Please describe the location. (Low back, leg pain, neck pain.)
Type of pain. (Sharp, dull, numbness, burning, etc.)

(R) Arm (R) hip Pain is severe sharp burning Type

Please fill out and give to our Receptionist.

Florence King

Signature

INDIANA OPEN MRI

119 Professional Center, Suite 305 ◆ Indiana, Pennsylvania 15701 Toll Free 888-270-9222 (412) 349-3110
Fax (412) 349-3149

FLORENCE I. KING
SS # 184-32-4880
Dr. John Markley
January 29, 1998
Patient # 05700

MRI OF THE LUMBAR SPINE

HISTORY: Left leg coldness and numbness, lateral aspect. Occasional low back pain.

TECHNIQUE: Images were performed in the sagittal and axial planes. The axial images were angled through each disc space from L2-3 through L5-S1. Routine pulse sequences were used.

FINDINGS: Comparison is made with a CT scan of the lumbosacral spine of October 9, 1997.

There is some desiccation of L4-5 and L5-S1 and to a lesser extent L3-4.

There is slight retro-listhesis of L5 posterior relative to S1.

A disc herniation is noted on the left at L5-S1. There is left sided neuroforaminal narrowing at this level. There is lesser right sided neuroforaminal narrowing noted at this level. There is some degree of bilateral neuroforaminal narrowing of L4-5.

A disc bulge is noted at L4-5 and L3-4. The disc bulge that is noted at L3-4 is best visualized on the axial images. This is slightly more prominent on the left.

Ligamentum flavum and facet hypertrophy is noted from L2-3 through L5-S1. Mild central canal narrowing is noted at L2-3. Mild central canal narrowing is noted at L3-4. Mild central canal narrowing is noted at L4-5.

IMPRESSION: CENTRAL CANAL AND NEUROFORAMINAL NARROWING AS NOTED. A DISC HERNIATION IS NOTED ON THE LEFT AT L5-S1. THIS IMPINGES UPON THE EXITING L5 NERVE ROOT AT THIS LEVEL. DISC BULGING AS NOTED. THERE ARE NO FOCAL ABNORMALITIES OF THE CAUDA EQUINA OR CONUS MEDULLARIS.

Thank you for giving us the opportunity to examine your patient.

Christopher N. Hobbie, MD

CH\gca

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of Defendant's Pretrial Statement was served by U.S. Mail, postage prepaid, this 1st day of August, 2001, upon all counsel of record or parties as follows:

Cynthia M. Porta, Esquire
WOOMER & FRIDAY, LLP
1701 McFarland Road
Pittsburgh, PA 15216
Counsel for Plaintiff

Patrick J. Doheny, Esquire

EX A

THIS IS WAL-MART CASE NUMBER 192.

BY INTERVIEWER:

TODAY'S DATE IS JULY 29TH, AND WE'RE DISCUSSING FILE NUMBER 99518770, AN INCIDENT THAT DID OCCUR.

MS. KING: FEBRUARY 28TH, '99 IS WHEN I WENT TO THE DOCTOR, AND IT WAS THE DAY BEFORE THAT I THINK.

INTERVIEWER: OKAY.

BY INTERVIEWER:

Q: AND CAN I HAVE THE CORRECT SPELLING OF YOUR FIRST AND LAST NAME, MS. KING?

A: F-L-O-R-E-N-C-E, K-I-N-G.

Q: AND ARE YOU MARRIED MS. KING?

A: NO, I AM NOT.

Q: AND YOUR CORRECT MAILING ADDRESS?

A: 130 WEST MAIN STREET, SAXSVILLE, PENNSYLVANIA 15865.

Q: OKAY. AND YOUR CORRECT HOME PHONE NUMBER?

A: 814-894-5410.

Q: AND YOUR SOCIAL SECURITY NUMBER?

A: 184-32-4880.

Q: AND YOUR DATE OF BIRTH?

A: 10-14-41.

Q: AND YOUR REASON FOR BEING IN THE STORE THAT DAY?

A: I WAS DOING SOME SHOPPING AND I COME BY THE HOT CURLING IRONS FOR YOUR HAIR, YOU KNOW. AND I

THOUGHT WELL, I MIGHT AS WELL BUY A SET WHILE I'M IN HERE.

SO, I REACHED UP, AND I GOT A SET DOWN OFF THE THING, AND THE ONE THAT I GOT DOWN WAS HOOKED TO ANOTHER ONE THAT WAS OPENED, AND I DIDN'T KNOW IT. AND IT COME DOWN AND HIT ME ON THE MIDDLE OF MY FOREHEAD, RIGHT WHERE MY HAIRLINE STARTS.

AND I STARTED -- I SAW SOME STARS AND I FELT REALLY STRANGE, OKAY. ALMOST CUT MY HEAD OPEN.

AND MY GENTLEMEN FRIEND I WAS WITH, I TOLD HIM THAT I'M READY TO GO. I SAYS I'M READY TO GO AFTER I FOUND HIM AND HE SAID WHAT'S A MATTER. AND I TOLD HIM AND WE GOT BACK TO THE CHECK-OUT COUNTER AND I TOLD THE GIRL WHAT HAPPENED.

SHE SAYS, ARE YOU OKAY? I SAYS, NO, I'M NOT OKAY. SHE SAYS, OH, I'M SORRY TO HEAR THAT AND THAT WAS IT.

SO, I COME HOME, TOOK A ZANAC, WHICH IS A NERVE PILL, AND A COUPLE OF TYLENOL.

AND I CALLED THE STORE AND TALKED TO THE MANAGER UP THERE, THE WAL-MART IN DUBOIS. AND THEY HAD GIVEN ME A TOLL-FREE NUMBER TO CALL WHICH I DID. AND I DON'T, I CAN'T RECALL WHO I DID TALK TO AT THAT DATE AND TIME.

Q: AND YOU SAY IT WAS A CURLING IRON THAT CAME DOWN?

A: YEAH. THE BOX -- THE HOT CURLING IRON.

REMEMBER, I CAN THINK OF THE NAME I BOUGHT, WHICH WAS THE ONE SITTING BESIDE THE SAME KIND, AND SOMEBODY

HAD -- MUST HAVE OPENED IT. I DON'T KNOW.

AND IT WAS OPEN, AND I DIDN'T SEE IT WAS OPEN. I JUST PULLED IT DOWN, YOU KNOW, AND THE OTHER CAME WITH IT.

Q: DO YOU KNOW THE APPROXIMATE SIZE OF THIS ITEM, MA'AM?

A: I DON'T KNOW THE SIZE OF IT. IT'S PRETTY DARN HEAVY THOUGH.

I GOT MINE OUT. I COULD MEASURE IT FOR YOU REAL QUICK.

WOULD YOU LIKE FOR ME TO DO THAT?

Q: EXCUSE ME, MA'AM?

A: IF I GOT MINE OUT, I COULD MEASURE IT REAL QUICK.

WOULD YOU LIKE FOR ME TO DO THAT?

Q: SURE. DO YOU KNOW THE BRAND ON THAT?

A: I'M THINKING IT'S REMMINGTON, BUT I'M NOT FOR SURE. THE MEASURING THING, I CAN'T FIND IT.

Q: IT IS SQUARE SHAPED?

A: IT'S LONGER THAN IT IS WIDE.

Q: AND ON WHAT SHELF WAS THIS ON, MA'AM?

A: ONE, TWO, ABOUT THE THIRD UP.

Q: DID YOU, AT ANY TIME BEFORE THIS FELL ON YOU, SEE THAT THE BOX WAS OPENED?

A: NO, I DID NOT.

IT MEASURES 11 IN LENGTH BY 6 1/2. NOW, THAT'S NOT CONTAINING THE BOX. THE BOX IS IN THE CABINET PACKED

AWAY.

Q: NOW, WHEN YOU WERE IN THE STORE AND AFTER THIS HAPPENED, IT WAS NOT REPORTED TO A MEMBER OF MANAGEMENT?

A: IT'S CONAIR.

Q: OKAY.

A: EASY HOLDING HAIR SETTER.

NOW, WHAT WAS THE QUESTION?

Q: BEFORE YOU LEFT THE STORE, YOU DID NOT REPORT THIS TO A MEMBER OF MANAGEMENT?

A: NO, I DIDN'T KNOW I HAD TO UNTIL, YOU KNOW, I CAME HOME. AND, LIKE I SAID, I REALLY FELT WEIRD, AND I WAS DIZZY AND MY HEAD WAS ACHING ME AND MY NECK HURT ME.

SO, I HAD CALLED THEM AND TOLD HEM ABOUT IT AND THEY SAID -- WELL, I AM SEEKING PROFESSIONAL -- I'M GOING TO GO SEE MY DOCTOR, YOU KNOW.

SO, I HAD GONE UP TO MY CHIROPRACTOR. HE TOOK AN X-RAY AND SAID IT WAS A SLIGHT CONCUSSION -- OR A SLIGHT WHIPLASH. I STILL THINK I HAD A CONCUSSION TOO. IF I HAD WENT TO MY DOCTOR.

Q: THE NAME OF YOUR CHIROPRACTOR?

A: DR. SCOTT CASTIL.

Q: AND WHAT PART OF YOUR BODY DID YOU INJURE?

A: IT WAS MY NECK THAT HE WORKED ON. LIKE I SAID, I HAD LIKE A LITTLE CUT IN MY HEAD, BUT IT WAS MY NECK.

Q: SO, YOU WERE FACING THE SHELF WHEN IT CAME DOWN ON YOU?

A: RIGHT, RIGHT.

Q: WAS YOUR COMPANION STANDING RIGHT THERE BY YOU WHEN THIS HAPPENED?

A: NO, HE WAS NOT, 'CAUSE THAT WAS ANOTHER THING. I HAD TO STAND THERE FOR A FEW MINUTES.

I LOST -- IT WAS LIKE I DIDN'T KNOW WHAT WAS GOING ON AROUND ME. I THOUGHT FOR A MINUTE I WAS GOING TO PASS OUT, OKAY. AND THEN I FINALLY REALIZED WHERE HE SAID HE WAS GOING TO GO, WHICH WAS BACK BY THE AUTO DEPARTMENT. I WENT BACK THAT WAY, AND HE WAS COMING, AND I TOLD HIM WHAT HAPPENED.

Q: AFTER THIS FELL, DID YOU FALL DOWN AT ALL OR DID IT JUST HIT YOU AND STUN YOU?

A: IT JUST HIT ME AND I WAS REALLY STUNNED. I PROBABLY COULD'VE FELL IF, YOU KNOW, 'CAUSE I REALLY -- WHEN I HAD THE CURLING SET IN MY HAND THAT I WANTED, I JUST DROPPED IT RIGHT INTO MY CART.

Q: AND HAVE YOU INJURED YOUR HEAD OR YOUR NECK PRIOR TO THE INCIDENT AT THE WAL-MART STORE, MA'AM?

A: NO.

Q: YOU NEVER HAD ANY PRIOR PROBLEMS WITH THESE PARTS OF YOUR BODY THEN?

A: NO. HE WAS TREATING ME FOR MY F-M-S FOR MY HIP AND ARTHRITIS IN MY HIP AND SPINE, YOU KNOW, NOTHING TO MY UPPER PART OF MY NECK.

Q: HAVE YOU EVER HAD AN ACCIDENT OR YOUR A CLAIM AT A RETAIL STORE?

A: NO, I HAVE NOT.

Q: HAVE YOU EVER HAD A WORK RELATED ACCIDENT OR A WORK COMP CLAIM?

A: NO, I HAVE NOT.

Q: DID THE DOCTOR AT, ANY TIME TAKE YOU OFF WORK IN REGARDS TO YOUR INCIDENT?

A: NO, I'M ON S-S-I DISABILITY.

Q: HAVE YOU HAD AN AUTOMOBILE ACCIDENT WHERE YOU RECEIVED ANY INJURES?

A: NO.

Q: AND YOU SAY YOU INJURED YOUR FOREHEAD?

A: YES. THAT'S WHERE IT HIT ME RIGHT ABOUT, LIKE I SAID, RIGHT IN THE MIDDLE OF WHERE MY HAIRLINE STARTS. I HAD A BUMP AND A LITTLE CUT THERE, BUT IT DID NOT BLEED.

Q: AND HOW MANY TIMES HAVE YOU GONE TO THE CHIROPRACTOR IN REGARDS TO THIS EVENT?

A: OH, GEEZ, I REALLY CAN'T SAY. I KNOW THE FIRST DAY WAS THE 28TH OF FEBRUARY, BUT I CAN'T RECALL HOW MANY TIMES I HAVE GONE.

Q: AND HAVE ALL YOUR ANSWERS BEEN ACCURATE?

A: EXCUSE ME?

Q: HAVE ALL YOUR ANSWERS BEEN ACCURATE?

A: YES, THEY HAVE.

Q: MA'AM, DO YOU REMEMBER THE NAME OF THE CASHIER THAT YOU WENT THROUGH THAT DAY?

DO YOU HAPPEN TO HAVE A RECEIPT FROM THE STORE?

A: YOU KNOW, I HAVE IT SOMEWHERE.

Q: YOU DO HAVE IT?

A: HER NAME WAS -- I DO, I THINK I DO. IT MIGHT BE IN MY OLD PURSE. I KNOW WHO SHE IS, IF I'D SEE HER. SHE'S A BLOND. I'M NOT MISTAKEN, HER NAME WAS JEN.

Q: JEN?

A: YEAH, I'M NOT MISTAKEN. BUT I COULD PROBABLY LOOK TO SEE IF I COULD FIND MY --

Q: OKAY. IF YOU CAN FIND IT, GIVE ME A CALL BACK.

A: OKAY.

Q: AND WE'LL GO FROM THERE.

AND WITH YOUR PERMISSION, MS. KING, I WILL TURN OFF THE RECORDER?

A: OKAY.

Ex "B"

DuBois Regional Medical Center

P.O. Box 447
100 Hospital Avenue
DuBois, PA 15801-0447

Outpatient Therapy: (814) 375-3372
Fax: (814) 375-3049

Making the difference for life.

PHYSICAL THERAPY INITIAL EVALUATION

Patient: Florence I. King Date: 04/17/01
Diagnosis: Vertigo
Physician: Henry G. Dela Torre, MD
Primary Ins: MA Outpatient ID#0019202555

SUBJECTIVE:

HOW INJURY/EPISODE OCCURRED: Patient is a 59 year-old female who reports that her first episode of dizziness began last fall after she went on a fishing trip. Patient reports that she had dizziness off and on for approximately 3 months; it then resolved completely with the help of Antivert. She was without any dizziness until this past Saturday evening when she experienced a flare-up. She reports her dizziness is worse now with lying on her (L) side or in supine. Dizziness increases with head movements. She is taking Antivert currently with some relief. She denies any headache, nausea, or vomiting associated with this, denies any hearing loss or tinnitus. She does report that she has a hissing sensation in both of her ears. She states that she has some neck tension that makes her feel like it needs to crack. Patient denies any history of migraine. She did have a minor head trauma 3 years ago when a box of curlers fell on her head in a store. Patient had a MRI in the fall. It was negative for any significant findings.

PMH/MEDICATIONS: Medical history includes (L) Sciatica, OA, Thyroid difficulties, Fibromyalgia, Heart Palpations, and High Blood Pressure. Medications include Antivert, Xanax, Tenormin, Synthroid, Zorco, and Voltaren.

WORK TITLE/DESCRIPTION: Patient has been disabled since 1987.

PHYSICAL DEMAND CHARACTERISTICS OF WORK: Patient does live alone and takes care of all of her own household activities. She enjoys fishing and spending time in the outdoors.

OBJECTIVE:

FUNCTIONAL STATUS AT ADMISSION: Patient is currently experiencing an overall decrease in functional ability secondary to severe dizziness.

FUNCTIONAL STATUS PRIOR TO INJURY: Prior to last fall when her first episode of dizziness began, patient had a full activity level.

PAIN: Patient denies any pain. She does report that her dizziness ranges from a 2/10 to a 10/10.

AROM/PROM: AROM of the cervical spine is WNL's throughout. Patient does experience increased dizziness with (L) rotation and (L) side bending.

STRENGTH: Bilateral shoulder strength is 4/5, (L) elbow strength 4/5, bilateral hip strength is 3+/5, (L) knee flexion 3+/5, (R) knee flexion 4/5, bilateral knee extension 5/5, (L) ankle dorsiflexion 4-/5 otherwise ankle is 4/5 to 4+/5 throughout.

SPECIAL TESTS: 5 times sit to stand test was 10.59 seconds without any loss of balance but with an increase in dizziness. Romberg eyes opened was 30 seconds, eyes closed was 30 seconds with increase in sway. Standing on two pillows Romberg eyes closed 7.81 seconds with loss of balance to the (L). Tandem Romberg eyes opened was 30 seconds, eyes closed 30 seconds. (R) knee unilateral stance was 10.16 seconds (L) unilateral stance was 12.84 seconds. Activity Specific Balance Confidence Scale was a 22.5% out of 100%. Dynamic gait index was 18/24. Dizziness Handicap Inventory was 54 total points. Patient with a positive (L) Halpike, positive (R) Halpike and a negative horizontal roll test.

BALANCE: See special test section above.

OBSERVATION: Patient was very apprehensive about lying supine and rolling secondary to severe dizziness.

SENSATION/DTR'S: Intact and symmetrical.

GAIT: Patient presents with an unsteady gait pattern with veering bilateral directions. She is able to ascend and descend 12 stairs with one handrail independently; however she experienced significant dizziness upon descending the stairs.

TONE/PALPATION: Patient with increased tension in the (L) upper trap region with tenderness to palpation in this area.

TREATMENT: Treatment was initiated this date educating patient regarding anatomical structures involved was well as the pathology of BPPV. Completed the canalith repositioning maneuver x 2. Patient was given post positioning instructions including avoiding quick head movements, bending over, looking up, and lying supine for the next 24-48 hours.

GOALS:
1. Decrease subjective complaints of dizziness to a 2/10 at worst to improve patient's functional abilities.
2. Increase ABC scale to 60% or greater.
3. Decrease dizziness handicap inventory by 20 points or greater.
4. Increase Romberg with eyes closed standing on two pillows to 30 seconds as indicator of vestibular functioning.
5. Patient will be independent in a H.E.P. to minimize symptoms of vertigo.

FUNCTIONAL OUTCOMES: Patient to return to full prior activity level with decreased complaints of dizziness.

PATIENT/FAMILY PARTICIPATION IN PLAN: Patient and her sister understand the goals and agree to participate with the program.

UNDERSTANDING OF EXERCISE PROGRAM: N/A. Patient does understand the post positioning instructions and agrees to comply with these.

PATIENT EXPECTATIONS: Patient hopes to experience an overall decrease in dizziness and increase in functional abilities.

ASSESSMENT:

Patient is a 59-year-old female who presents with clinical signs and symptoms of BPPV as well as vertigo that is interfering with her daily activities. Patient will benefit from continued physical therapy.

PLAN:

Patient will be seen 1-2 times a week for an estimated duration of 4 weeks for vestibular rehab including re-positioning maneuvers, ROM activities, balance activities, and patient and family education.

Thank you for this referral. If you have any questions please feel free to contact me.

Holly M. Tkacik, PT

Daily Progress Note

Patient Name King, Florence

4/17/01 3:00→4:00.

Initial evaluation completed. Evaluation time 50 min, tx time 10 minutes. See chart for complete report.

Polly Mitchell, Pt.

2)

4/19/01 3:30 →4:00

S. "I Feel really good since the last time, only very minimal dizziness now." Pt c/o Neck "Stiffness". "I've been afraid of moving because I don't want to get dizzy."

O: AROM C-spine All planes x10 ⊼ any ↑ in sxs. Manual stretching (B) upper traps + levator mms c pt seated. (10 min) STM to (B) upper traps + Manual distraction C-spine c pt supine (5 min). Re-assessed Hallpike maneuver: Both (L) and (R) Hallpike -ve. Pt instructed in + completed Brandt-Daroff exercises x 5 (B), added these to HEP along c self-stretch upper traps + levators + AROM C-spine. (15 min).

A: Significant ↓ in dizziness, Neck discomfort relieved c tx.

P: Continue, Reassess symptoms Nxt visit, Review HEP

Polly Mitchell, Pt.

King Florence

(3)

4/24/01 1:35 → 2:00.

S: "I'm feeling great, No dizziness at all." "I even went fishing without any trouble." Dizziness currently 0/10.

O: Pt completed HEP c good technique (I). ABC scale 86.875%, DHI 28 total, DGI 22/24. Romberg EC standing on 2 pillows >30 seconds, No LOB. 5x sit → stand 8.13 sec c LOB. AROM C-spine WNL all planes, No dizziness c any. Improved gait stability, improved cadence. (20 min).

A: All Goals met.

P: Pt wishes to DC to HEP at this time. Pt instructed to continue c HEP daily to minimize episodes of vertigo. ——— "Holly" Mitchell, PT.

DuBois Regional Medical Center
P.O. Box 447
DuBois, Pennsylvania 15801-0447

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PHYSICAL THERAPY DISCHARGE SUMMARY

Patient Name: Florence King **Referral Date:** 4/17/01

Physician: Dr. Delatorre **Discharge Date:** 4/24/01

Diagnosis: Vertigo **Number of Visits:** 3

Treatment Program: Vestibular rehab including positional maneuvers ↓ pt ↓ family education.

Level of Progress at Discharge: Dizziness 0/10 with all functional activity. Returned to Full activity level. 5 Time Sit → stand 8.13 seconds ∓ LOB. Standing ∞ pillows EC Romberg >30sec No LOB. Activities Specific Balance Confidence Scale 86.875% /100%. Dynamic Gait index 22/24. Dizziness Handicap Inventory 28. (-) Hallpike (B). No difficulty ↑ supine or rolling. Gait much improved ∓ veering one direction or the other. No dizziness ↑ stairs. (E) ↑ HEP.

Initial Findings: Dizziness Rating 2 → 10/10. Experiencing ↓ functional abilities 2° dizziness ↑ head movements. 5 Times sit → stand 10.59 sec. standing on 2 pillows Romberg EC 7.81 sec ↑ LOB (-). Activities Specific Balance Confidence scale 22.5% /100%. Dynamic Gait index 18/24 Dizziness Handicap Inventory 54. (+) Hallpike (L) and (R). Extremely apprehensive about supine. Lying ↓ Rollup. Veering (B) directions ↑ gait, dizziness ↑ ↓ stairs.

Goals/Functional Outcomes Not Achieved at Discharge and Why: All Goals met.

Home Exercise Program and Education: Educ Re: pathology of BPPV. Instructed in Brandt-Daroff exercises to minimize Recurrence of Vertigo and Neck ROM ↓ stretching.

Employment Status at Discharge: Disabled.

Comments: Pt doing very well, Ø Sxs. Good compliance ↑ HEP.

Plan: DC to (E) HEP.

[signature] PT 4/26/01

4/19/01

Brandt - Daroff Exercises →

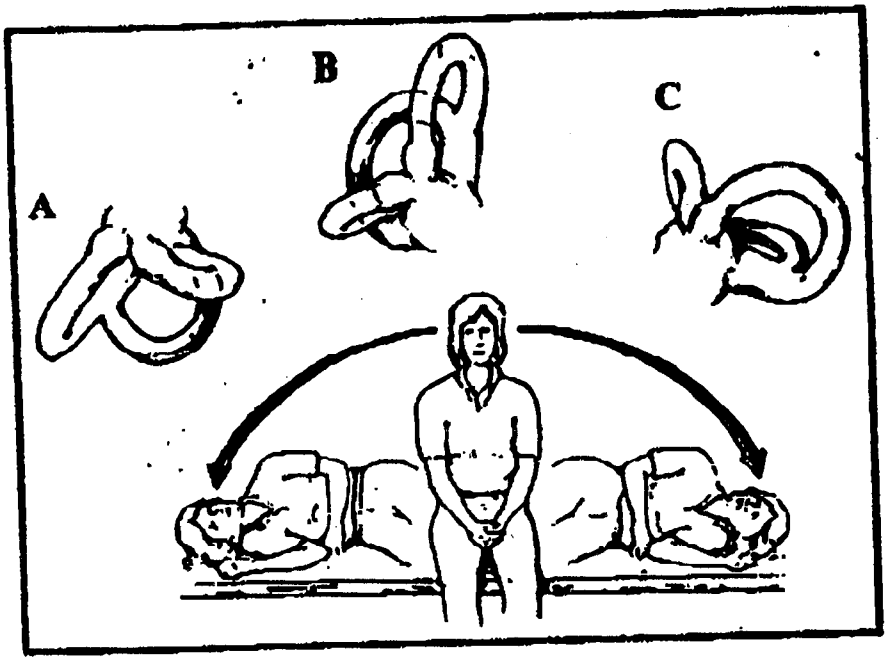


Figure 6.
Brandt-Daroff habituation exercises: The patient is first positioned sitting and then rapidly moves into the side-lying position (A). Torsional nystagmus may occur with the onset of the vertigo. The severity of the vertigo will be directly related to how rapidly the patient moves into the provoking position. The patient stays in that position until the vertigo stops, waits 30 seconds, and then sits up (B). Moving to the sitting position will usually result in vertigo, although this "rebound effect" will be less severe and of a shorter duration. Nystagmus, if it reoccurs, will be in the opposite direction. The patient remains in the upright position for 30 seconds and then moves rapidly into the mirror-image position on the other side (C), stays there for 30 seconds, and then sits up. The patient then repeats the entire maneuver 5 to 20 times, depending on the tolerance of the patient for vertigo and ony accompanying nausea, or until the vertigo no longer occurs. The entire sequence is repeated three times a day until the patient has 2 consecutive days without vertigo. [Adapted from Brandt and Daroff.[84]]

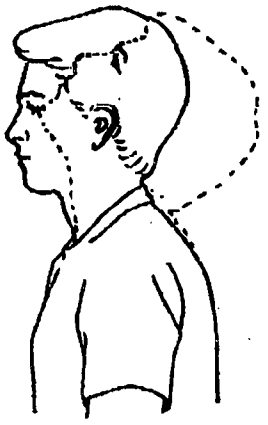
/ICAL SPINE - 2
AROM Exercises: Neck Lateral Flexion

ad toward shoulder, then slowly toward
ite shoulder.
___seconds. Repeat 10 times.
__sessions per day.

CERVICAL SPINE - 1
AROM Exercises: Neck Rotation

Turn head slowly to look over left shoulder then turn to look over right shoulder.
Hold ___seconds. Repeat 10 times.
Do 2 sessions per day.

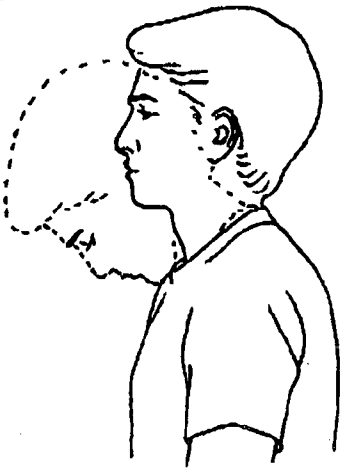
/ICAL SPINE - 4
AROM Exercises: Neck Extension



head backward
eturn to starting
on.

___seconds.
at 10 times.
2 sessions per day.

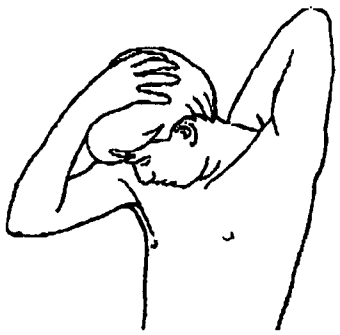
CERVICAL SPINE - 3
AROM Exercises: Neck Flexion



Bend head forward,
return to starting
position.

Hold ___seconds.
Repeat 10 times.
Do 2 sessions per day.

VICAL SPINE - 27 Levator Scapula Stretch



hand on same side shoulder blade. With other hand stretch head down and away.

30 seconds. Repeat 5 Repetitions/set.

__Sets/session. Do 2 Sessions/day.

CERVICAL SPINE - 22 Strengthening

Phase I: Shoulder Shrugs

Shrug shoulders up and down, forward and backward.

Hold 5 seconds.

Repeat 10 times.

Do 2 times per day.

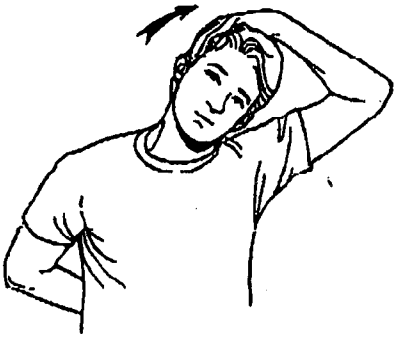
Phase II: Resistive Shoulder Shrugs

With Surgical tubing/dumbells ___ ___lbs., shrug shoulders up and down, forward and backward.

Repeat ____ times.

Do ____ sessions per day.

CERVICAL SPINE - 23 Flexibility: Upper Trapezius Stretch



Gently grasp side of head while reaching behind back with other hand. Tilt head away until a gentle stretch is felt.

Hold 30 seconds. Repeat 5 times, both sides.

Do 2 times per day.

4/19/01

4 Scapular retraction.

4171

12344

SS# 184 - 32 - 4880

Dizziness Handicap Inventory (DHI)

The purpose of this scale is to identify difficulties that you may be experiencing because of your d
Please answer "yes", "no" or "sometimes" to each question. Answer each question as it pertains
dizziness problem only. Fill in each answer square completely.

	Yes	Sometimes	No
1. Does looking up increase your problem?	●	○	○
2. Because of your problem, do you feel frustrated?	○	●	○
3. Because of your problem do you restrict your tra for business or recreation?	○	●	○
4. Does walking down the aisle of a supermarket increase your problem?	○	●	○
5. Because of your problem, do you have difficulty getting out of bed?	○	●	○
6. Does your problem significantly restrict your participation in social activites such as going out dinner, going to the movies, dancing, or to partie	○	●	○
7. Because of your problem, do you have difficulty reading?	○	●	○
8. Does performing more ambitious activities like sports, dancing, household chores, such as sweeping putting dishes away increase your problem?	○	●	○
9. Because of your problem, are you afraid to leave yo home without having someone accompany you?	○	●	○
10. Because of your problem, have you been embarrassed in front of others?	○	●	○
11. Do quick movements of your head increase your problems?	●	○	○
12. Because of your problem, do you avoid heights?	●	○	○
13. Does turning over in bed increase your problem?	●	○	○

4/17/01

12344

SS# 184 - 32 - 4880

Dizziness Handicap Inventory (DHI)

The purpose of this scale is to identify difficulties that you may be experiencing because of your d
Please answer "yes", "no" or "sometimes" to each question. Answer each question as it pertains
dizziness problem only. Fill in each answer square completely.

	Yes	Sometimes	No
14. Because of your problem, is it difficult for y to do strenuous housework or yardwork?	○	●	○
15. Because of your problem, are you afraid people may think that you are intoxicated?	○	●	○
16. Because of your problem, is it difficult for yo walk by yourself?	○	○	●
17. Does walking down a sidewalk increase your problem?	○	●	○
18. Because of your problem, is it difficult for you to concentrate?	○	●	○
19. Because of your problem, is it difficult for you walk around your house in the dark?	○	●	○
20. Because of your problem, are you afraid to st home alone?	○	○	●
21. Because of your problem, do you feel handicapped?	○	●	○
22. Has your problem placed stress on your relationsh with members of your family or friends?	○	○	●
23. Because of your problem, are you depressed?	○	●	○
24. Does your problem interfere with your job or househ responsibilities?	○	●	○
25. Does bending over increase your problem?	●	○	○

20 + 34 = 54

4/17/01

Dynamic Gait Index

1. Gait level surface _____
Instructions: Walk at your normal speed from here to the next mark (20')
Grading: Mark the lowest category that applies.
(3) Normal: Walks 20', no assistive devices, good speed, no evidence for imbalance, normal gait pattern.
(2) Mild impairment: Walks 20', uses assistive devices, slower speed, mild gait deviations.
(1) Moderate impairment: Walks 20', slow speed, abnormal gait pattern, evidence for imbalance.
(0) Severe impairment: Cannot walk 20' without assistance, severe gait deviations or imbalance.

2. Change in gait speed _____
Instructions: Begin walking at your normal pace (for 5'), when I tell you "go," walk as fast as you can (for 5'). When I tell you "slow," walk as slowly as you can (for 5').
Grading: Mark the lowest category that applies.
(3) Normal: Able to smoothly change walking speed without loss of balance or gait deviation. Shows a significant difference in walking speeds between normal, fast, and slow speeds.
(2) Mild impairment: Is able to change speed but demonstrates mild gait deviations, or no gait deviations but unable to achieve a significant change in velocity, or uses an assistive device.
(1) Moderate impairment: Makes only minor adjustments to walking speed, or accomplishes a change in speed with significant gait deviations, or changes speed but loses significant gait deviations, or changes speed but loses balance but is able to recover and continue walking.
(0) Severe impairment: Cannot change speeds, or loses balance and has to reach for wall or be caught.

Little change btn. slow & normal

3. Gait with horizontal head turns _____
Instructions: Begin walking at your normal pace. When I tell you to "look right," keep walking straight, but turn your head to the right. Keep looking to the right until I tell you, "look left," then keep walking straight and turn your head to the left. Keep your head to the left until I tell you, "look straight," then keep walking straight, but return your head to the center.
Grading: Mark the lowest category that applies.
(3) Normal: Performs head turns smoothly with no change in gait
(2) Mild impairment: Performs head turns smoothly with slight change in gait velocity, i.e., minor disruption to smooth gait path or uses walking aid.
(1) Moderate impairment: Performs head turns with moderate change in gait velocity, slows down, staggers but recovers, can continue to walk.
(0) Severe impairment: Performs task with severe disruption of gait, i.e., staggers outside 15" path, loses balance, stops, reaches for wall.

4. Gait with vertical head turns _____
Instructions: Begin walking at your normal pace. When I tell you to "look up," keep walking straight, but tip your head and look up. Keep looking up until I tell you, "look down." Then keep walking straight and turn your head down. Keep looking down until I tell you, "look straight," then keep walking straight, but return your head to the center.
Grading: Mark the lowest category that applies.
(3) Normal: Performs head turns with no change in gait.
(2) Mild impairment: Performs task with slight change in gait velocity i.e., minor disruption to smooth gait path or uses walking aid.
(1) Moderate impairment: Performs task with moderate change in gait velocity, slows down, staggers but recovers, can continue to walk.
(0) Severe impairment: Performs task with severe disruption of gait, i.e., staggers outside 15" path, loses balance, stops, reaches for wall.

18/24

4/17

5. Gait and pivot turn _____
Instructions: Begin walking at your normal pace. When I tell you, "turn and stop," turn as quickly as you can to face the opposite direction and stop.
Grading: Mark the lowest category that applies.
(3) Normal: Pivot turns safely within 3 seconds and stops quickly with no loss of balance.
(2) Mild impairment: Pivot turns safely in > 3 seconds and stops with no loss of balance.
(1) Moderate impairment: Turns slowly, requires verbal cueing, requires several small steps to catch balance following turn and stop.
(0) Severe impairment: Cannot turn safely, requires assistance to turn and stop.

NO dizziness

6. Step over obstacle _____
Instructions: Begin walking at your normal speed. When you come to the shoe box, step over it, not around it, and keep walking.
Grading: Mark the lowest category that applies.
(3) Normal: Is able to step over box without changing gait speed; no evidence for imbalance.
(2) Mild impairment: Is able to step over box, but must slow down and adjust steps to clear box safely.
(1) Moderate impairment: Is able to step over box but must stop, then step over. May require verbal cueing.
(0) Severe impairment: Cannot perform without assistance.

7. Step around obstacles _____
Instructions: Begin walking at normal speed. When you come to the first cone (about 6' away), walk around the right side of it. When you come to the second cone (6' past first cone), walk around it to the left.
Grading: Mark the lowest category that applies.
(3) Normal: Is able to walk around cones safely without changing gait speed; no evidence of imbalance.
(2) Mild impairment: Is able to step around both cones, but must slow down and adjust steps to clear cones
(1) Moderate impairment: Is able to clear cones but must significantly slow, speed to accomplish task, or requires verbal cueing.
(0) Severe impairment: Unable to clear cones, walks into one or both cones, or requires physical assistance.

8. Steps _____
Instructions: Walk up these stairs as you would at home (i.e., using the rail if necessary. At the top, turn around and walk down.
Grading: Mark the lowest category that applies.
(3) Normal: Alternating feet, no rail.
(2) Mild impairment: Alternating feet, must use rail.
(1) Moderate impairment: Two feet to a stair, must use rail.
(0) Severe impairment: Cannot do safely.

Shumway-Cook A, Woollacott M. *Motor Control Theory and Applications*, Williams & Wilkins Baltimore, 1995 (p.323-324)

4/24

12344

SS# ___-___-____

Dizziness Handicap Inventory (DHI)

The purpose of this scale is to identify difficulties that you may be experiencing because of your d
Please answer "yes", "no" or "sometimes" to each question. Answer each question as it pertains
dizziness problem only. Fill in each answer square completely.

	Yes	Sometimes	No
1. Does looking up increase your problem?	O	●	O
2. Because of your problem, do you feel frustrated?	O	●	O
3. Because of your problem do you restrict your tra for business or recreation?	O	●	O
4. Does walking down the aisle of a supermarket increase your problem?	O	O	●
5. Because of your problem, do you have difficulty getting out of bed?	O	O	●
6. Does your problem significantly restrict your participation in social activites such as going out dinner, going to the movies, dancing, or to partie	O	●	O
7. Because of your problem, do you have difficulty reading?	O	O	●
8. Does performing more ambitious activities like sports, dancing, household chores, such as sweeping putting dishes away increase your problem?	O	●	O
9. Because of your problem, are you afraid to leave yo home without having someone accompany you?	O	●	O
10. Because of your problem, have you been embarrassed in front of others?	O	O	●
11. Do quick movements of your head increase your problems?	O	●	O
12. Because of your problem, do you avoid heights?	O	●	O
13. Does turning over in bed increase your problem?	O	●	O

Florence King 4/24/01

12344

SS# - -

Dizziness Handicap Inventory (DHI)

The purpose of this scale is to identify difficulties that you may be experiencing because of your d
Please answer "yes", "no" or "sometimes" to each question. Answer each question as it pertains
dizziness problem only. Fill in each answer square completely.

	Yes	Sometimes	No
14. Because of your problem, is it difficult for y to do strenuous housework or yardwork?	○	●	○
15. Because of your problem, are you afraid people may think that you are intoxicated?	○	○	●
16. Because of your problem, is it difficult for yo walk by yourself?	○	○	●
17. Does walking down a sidewalk increase your problem?	○	●	○
18. Because of your problem, is it difficult for you to concentrate?	○	○	●
19. Because of your problem, is it difficult for you walk around your house in the dark?	○	○	●
20. Because of your problem, are you afraid to st home alone?	○	○	●
21. Because of your problem, do you feel handicapped?	○	○	●
22. Has your problem placed stress on your relationsh with members of your family or friends?	○	●	○
23. Because of your problem, are you depressed?	○	●	○
24. Does your problem interfere with your job or househ responsibilities?	○	○	●
25. Does bending over increase your problem?	○	●	○

28 Total

INDIANA OPEN MRI

119 Professional Center, Suite 305 ◆ Indiana, Pennsylvania 15701 Toll Free 888-270-9222 (412) 349-3110
Fax (412) 349-3110

FLORENCE I. KING
SS # 184-32-4880
Dr. John Markley
January 29, 1998
Patient # 05700

MRI OF THE LUMBAR SPINE

HISTORY: Left leg coldness and numbness, lateral aspect. Occasional low back pain.

TECHNIQUE: Images were performed in the sagittal and axial planes. The axial images were angled through each disc space from L2-3 through L5-S1. Routine pulse sequences were used.

FINDINGS: Comparison is made with a CT scan of the lumbosacral spine of October 9, 1997.

There is some desiccation of L4-5 and L5-S1 and to a lesser extent L3-4.

There is slight retro-listhesis of L5 posterior relative to S1.

A disc herniation is noted on the left at L5-S1. There is left sided neuroforaminal narrowing at this level. There is lesser right sided neuroforaminal narrowing noted at this level. There is some degree of bilateral neuroforaminal narrowing of L4-5.

A disc bulge is noted at L4-5 and L3-4. The disc bulge that is noted at L3-4 is best visualized on the axial images. This is slightly more prominent on the left.

Ligamentum flavum and facet hypertrophy is noted from L2-3 through L5-S1. Mild central canal narrowing is noted at L2-3. Mild central canal narrowing is noted at L3-4. Mild central canal narrowing is noted at L4-5.

IMPRESSION: CENTRAL CANAL AND NEUROFORAMINAL NARROWING AS NOTED. A DISC HERNIATION IS NOTED ON THE LEFT AT L5-S1. THIS IMPINGES UPON THE EXITING L5 NERVE ROOT AT THIS LEVEL. DISC BULGING AS NOTED. THERE ARE NO FOCAL ABNORMALITIES OF THE CAUDA EQUINA OR CONUS MEDULLARIS.

Thank you for giving us the opportunity to examine your patient.

Christopher N. Hobbie

Christopher N. Hobbie, MD

CH\gca

INDIANA OPEN MRI

A MEMBER OF THE MEDICAL COMMUNITY SINCE 1993

119 Professional Center, Suite 305 ◆ Indiana, Pennsylvania 15701 Toll Free 888-270-9222 (724) 349-3110
Fax (724) 349-3149

#08266
FLORENCE I. KING
SS # 184-32-4880
Dr. Henry Delatorre
November 7, 2000

MRI OF THE BRAIN WITH AND WITHOUT CONTRAST

HISTORY: Patient is 59 year old female with the history of vertigo, occasional headaches and neck pain.

TECHNIQUE: Routine pulse sequences were obtained in thin axial slices of the internal auditory canal and also in the coronal pulse sequences following intravenous administration of gadolinium.

FINDINGS: There is normal signal intensity of the grey and white matter. There is no increased signal in the periventricular region. There is no shift of the midline structures, hydrocephalus or mass effect.

The cerebellopontine angle as well as the seventh and eighth cranial nerve complexes are identified on either side and appear to be within normal limits. The right and left orbits are normal on either side. The sinuses are developed showing no gross abnormalities. There is prominence of the inferior turbinate of both nasal cavities.

Thin slices obtained of the internal auditory canal with and without administration of gadolinium shows no evidence of abnormalities or asymmetry of the internal auditory canals. The seventh and eighth cranial nerve complexes appear normal. There is no abnormal focal enhancing lesions identified.

The temporal lobes appear symmetrical. There is no abnormal signals noted in the mid brain.

CONCLUSION: ESSENTIALLY NORMAL CRANIAL MRI.

ESSENTIALLY NORMAL MRI OF THE INTERNAL AUDITORY CANALS.
Thank you for giving us the opportunity to examine your patient.

Benedict Mariano, MD
BM/kly

DUBOIS REGIONAL MEDICAL CENTER
100 Hospital Ave, DuBois, PA 15801

KING,FLORENCE I
253 WEST MAIN ST
SYKESVILLE PA 15865

DIS - OPW
Age 59Y

Unit # 000303556
Acct # D0028700489

Date:10/17/00 Time:1533

DELATORRE,HENRY G
SYKESVILLE PA 15865

DELATORRE,HENRY G
SYKESVILLE PA 15865

Chk-in #	Order	Exam	
428206	0001	72787	CT-ORB. SELLA POST. FOSSA UNENHAN

Ord Diag: 780.4-DIZZINESS

CT TEMPORAL BONES:

Computerized tomographic axial and coronal sections were obtained. The patient refused intravenous contrast enhancement.

The internal auditory canals are unremarkable. The osseous structures are intact. The mastoids are normal. The parapharyngeal soft tissues are unremarkable. The middle ear structures are unremarkable.

IMPRESSION: THE STUDY IS LIMITED, SINCE THE PATIENT REFUSED INTRAVENOUS CONTRAST ENHANCEMENT.
THERE ARE NO DEFINITE ABNORMALITIES VISUALIZED.
AN MRI STUDY OF THE BRAIN MAY BE OF BENEFIT FOR FURTHER EVALUATION OF THIS PATIENT.

NIA CODE: P

/READ BY/ GEORGE M KOSCO
/Released By/ GEORGE M KOSCO

10/19/00 0958
LLW

pt notified
10-19-00

Complete

Quest Diagnostics

CLINICAL LABORATORY REPORT

875 GREENTREE ROAD
4 PARKWAY CENTER
PITTSBURGH, PA 15220-3610

Quest Diagnostics Incorporated - Medical Directors

Patient Name	Client Services Helpline	Billing Helpline	Date Collected	Time Collected
KING, FLORENCE I	(412) 920-7700	(412) 920-7800	03/12/2001	10:08

Patient Phone Number: 814 894-5410

Patient ID/Social Security Number: K-0083

Referring Physician: HENRY DELATORRE, M

49371 87-54-345
DELA TORRE MEDICAL CLINIC
231 HIGHLAND STREET
SYKESVILLE, PA 15865

Date Received	Date of Report
03/12/2001	03/13/2001

Sex	Age	ID Number
F	59	B0013900867

Specimen Number	Accession Number
B0013900867	RT290706Q

TEST PROCEDURE		TEST RESULT		UNITS	REFERENCE RANGE
AST		16		U/L	@@@ 5-35 P
UREA NITROGEN		21		MG/DL	@@@ 8-25 P
LIPID PANEL					
CHOLESTEROL, TOTAL		256	H	MG/DL	120-199 P
HDL CHOLESTEROL	=A=	28	L	MG/DL	35-59 P
CHOLESTEROL/HDL RATIO	=B=	9.14	H		@@@1.00-5.50 P
LDL CHOL, CALCULATED	=C=			MG/DL	P
TRIGLYCERIDES		409	H	MG/DL	40-199 P

= FOOTNOTES =

A= A HDL CONCENTRATION LESS THAN 35 MG/DL CONSTITUTES A CHD RISK FACTOR. A CONCENTRATION EQUAL TO OR GREATER THAN 60 MG/DL CONSTITUTES A NEGATIVE RISK FACTOR.

B= THE RANGE FOR CHOLESTEROL/HDL CHOLESTEROL REPRESENTS THE 75TH PERCENTILE FOR THE SPECIFIED AGE AND GENDER OF THIS PATIENT. THE HIGHER THE VALUE, THE HIGHER THE RISK FOR CHD.

C= LDL CHOLESTEROL CANNOT BE CALCULATED WHEN THE TRIGLYCERIDE CONCENTRATION EXCEEDS 400 MG/DL. A DIRECT MEASUREMENT OF LDL CHOLESTEROL MAY BE ORDERED ON THIS SPECIMEN, AT AN ADDITIONAL CHARGE. PLEASE CONTACT THE LABORATORY WITHIN ONE DAY TO ADD THIS TEST.

low sweets
exercise
Repeat 4 mths.

Attempts 3/13/01 4:5[illegible]
BUSY
BUSY @ 5:[illegible]

TEST PROCEDURE	TEST RESULT		UNITS	REFERENCE RANGE
ALT	16		U/L	@@@ 5-40 P
CREATININE	0.6		MG/DL	@@@ 0.5-1.1 P
TSH	6.80	H	UU/ML	@@@0.40-5.50 P

~~Repeat 4 mths~~

REFERENCE RANGES PROVIDED BY QUEST DIAGNOSTICS PERFORMING SITES
ARE ADULT/NON-SEX SPECIFIC UNLESS
@ = AGE RELATED, @@ = SEX RELATED, @@@ = AGE & SEX RELATED PRINTED

PERFORMING SITE CODE BREAKDOWN

CODE	PERFORMING SITE	ADDRESS
P	QUEST DIAGNOSTICS	875 GREENTREE RD., PGH. PA

Synthroid .1
Xenical TID

Synthroid to .125

KING, FLORENCE I FASTING: YES *CONSOLIDATED FINAL REPORT* 5
DELA TORRE MEDICAL CLINIC *NOTE: SOME OR ALL RESULTS WERE PREVIOUSLY REPORTED

Pt-notified

Quest Diagnostics

CLINICAL LABORATORY REPORT

875 G[illegible]ENTREE ROAD
4 PARKWAY CENTER
PITTSBURGH, PA 15220-3610

Quest Diagnostics Incorporated - Medical Directors

Patient Name: KING, FLORENCE I

Client Service Helpline: (412) 920-7700 | (412) 920-7800 | Date Collected: 11/14/2000 | Time Collected: 10:26

49371 09-54-099
DELA TORRE MEDICAL CLINIC
231 HIGHLAND STREET
SYKESVILLE, PA 15865

Patient Phone Number: 814 894-5410

Patient ID/Social Security Number: K-0083

Referring Physician: HENRY DELATORRE, M

Date Received: 11/15/2000 | Date of Report: 11/15/2000

Sex: F | Age: 59 | ID Number: B0013900820

Specimen Number: B0013900820 | Accession Number: AT713308P

TEST PROCEDURE		TEST RESULT		UNITS	REFERENCE RANGE
COMP METABOLIC PANEL					
SODIUM		141		MMOL/L	@@@ 136-145 P
POTASSIUM		4.5		MMOL/L	@@@ 3.5-5.2 P
CHLORIDE		107		MMOL/L	@@@ 99-109 P
CARBON DIOXIDE		25.9		MMOL/L	@@@21.3-30.5 P
CALCIUM		9.2		MG/DL	@@@ 8.5-10.3 P
ALKALINE PHOSPHATASE		76		U/L	@@@ 30-130 P
AST		19		U/L	@@@ 5-35 P
ALT		18		U/L	@@@ 5-40 P
BILIRUBIN, TOTAL		0.4		MG/DL	@@@ 0.2-1.1 P
GLUCOSE		90		MG/DL	65-109 P
UREA NITROGEN		16		MG/DL	@@@ 8-25 P
CREATININE		0.8		MG/DL	@@@ 0.5-1.1 P
BUN/CREATININE RATIO		20.0			@@@ 9.0-28.0 P
PROTEIN, TOTAL		6.7		GM/DL	@@@ 6.3-8.2 P
ALBUMIN		3.9		GM/DL	@@@ 3.7-4.7 P
GLOBULIN, CALCULATED		2.8		GM/DL	@@@ 2.2-3.8 P
A/G RATIO		1.4			@@@ 1.0-1.8 P
ST		19		U/L	@@@ 5-35 P
LIPID PANEL					
CHOLESTEROL		244	H	MG/DL	120-199 P
HDL CHOLESTEROL	=A=	28	L	MG/DL	35-59 P
CHOLESTEROL/HDL RATIO	=B=	8.71	H		@@@1.00-5.50 P
LDL CHOL, CALCULATED		144	H	MG/DL	75-129 P
TRIGLYCERIDES		358	H	MG/DL	40-199 P

FOOTNOTES =

A= A HDL CONCENTRATION LESS THAN 35 MG/DL CONSTITUTES A CHD RISK FACTOR. A CONCENTRATION EQUAL TO OR GREATER THAN 60 MG/DL CONSTITUTES A NEGATIVE RISK FACTOR.

B= THE RANGE FOR CHOLESTEROL/HDL CHOLESTEROL REPRESENTS THE 75TH PERCENTILE FOR THE SPECIFIED AGE AND GENDER OF THIS PATIENT. THE HIGHER THE VALUE, THE HIGHER THE RISK FOR CHD.

TEST PROCEDURE	TEST RESULT	UNITS	REFERENCE RANGE
CBC W/ DIFF & PLT			
WBC	5.7	X1000	@@@ 3.9-11.2 P
RBC	4.42	XMILLION	@@@ 3.8-5.2 P

PAGE 1: CONTINUED ON PAGE: 2

Pt. Notified 11-16-00

CLINICAL LABORATORY REPORT

Quest Diagnostics

875 G. ENTREE ROAD
4 PARKWAY CENTER
PITTSBURGH, PA 15220-3610

Patient Name	Client Account Number	Client Phone Number	Date Collected
KING, FLORENCE I	(412) 920-7700	(412) 920-7800	11/14/2000 10:26

49371 09-54-099
DELA TORRE MEDICAL CLINIC
231 HIGHLAND STREET
SYKESVILLE, PA 15865

Patient Phone Number	Date Received	Date of Report
814 894-5410	11/15/2000	11/15/2000

Patient ID/Social Security Number	Sex	Age	ID Number
K-0083	F	59	0013900820

Ordering Physician	Specimen Number	Accession Number
HENRY DELATORRE, M	0013900820	AT713308P

TEST PROCEDURE	TEST RESULT	UNITS	REFERENCE RANGE	
HEMOGLOBIN	13.8	G/DL	@@@11.6-15.5	P
HEMATOCRIT	41.1	%	@@@34.0-46.0	P
MCV	92.9	FL	@@@80.0-98.0	P
MCH	31.3	PG	@@@27.0-34.0	P
MCHC	33.7	%	32.0-36.0	P
TOTAL NEUTROPHILS, %	58	%	38-80	P
BANDS, %	0	%	0-10	P
TOTAL LYMPHOCYTES, %	34	%	15-49	P
MONOCYTES, %	5	%	0-13	P
EOSINOPHILS, %	2	%	0-8	P
BASOPHILS, %	1	%	0-2	P
ATYPICAL LYMPHOCYTES, %	0	%	0-5	P
METAMYELOCYTES, %	0	%		P
MYELOCYTES, %	0	%		P
PROMYELOCYTES, %	0	%		P
WBC DIFF SAMPLE	10	X10		P
RBC	NORMAL			P
PLATELET SUFFICIENCY	NORMAL			P
PLATELET COUNT	177000	/CU.MM	@@@ 150000-400000	P
RDW	12.6	%	@@@11.0-15.5	P
LT	18	U/L	@@@ 5-40	P
SH	8.11 H	UU/ML	@@@0.40-5.50	P

REFERENCE RANGES PROVIDED BY QUEST DIAGNOSTICS PERFORMING SITES
ARE ADULT/NON-SEX SPECIFIC UNLESS
@ = AGE RELATED, @@ = SEX RELATED, @@@ = AGE & SEX RELATED PRINTED

PERFORMING SITE CODE BREAKDOWN

CODE	PERFORMING SITE	ADDRESS
P	QUEST DIAGNOSTICS	875 GREENTREE RD., PGH. PA

pt-notified 11-16-00

Quest Diagnostics

CLINICAL LABORATORY REPORT

875 GREENTREE ROAD
4 PARKWAY CENTER
PITTSBURGH, PA 15220-3610

Quest Diagnostics Incorporated - Medical Directors:
Enrique [illegible], M.D. — Twinsburg, OH
Henry A. [illegible], M.D. — Columbus, OH
William B. Zeiler, M.D. — Pittsburgh, PA
Rafiqs Fazili, M.D. — Buffalo, NY
Quest Diagnostics Venture LLC
William B. Zeiler, M.D. — Medical Director
Trevor [illegible], M.D. — Chief Medical Officer

Field	Value
Patient Name	KING, FLORENCE I
Client Services Helpline	(412) 920-7700
Billing Helpline	(412) 920-7800
Date Collected	09/25/2000
Time Collected	11:44
Patient Phone Number	814 894-5410
Patient ID/Social Security Number	K-0083
Referring Physician	HENRY DELATORRE, M
Date Received	09/26/2000
Date of Report	09/26/2000
Sex	F
Age	58
ID Number	B0013900798
Specimen Number	B0013900798
Accession Number	AT529765H

49371 93-54-099
DELA TORRE MEDICAL CLINIC
231 HIGHLAND STREET
SYKESVILLE, PA 15865

TEST PROCEDURE	TEST RESULT	UNITS	REFERENCE RANGE
TSH	3.31	UU/ML	@@@0.40-5.50 P

REFERENCE RANGES PROVIDED BY QUEST DIAGNOSTICS PERFORMING SITES
ARE ADULT/NON-SEX SPECIFIC UNLESS
@ = AGE RELATED, @@ = SEX RELATED, @@@ = AGE & SEX RELATED PRINTED

PERFORMING SITE CODE BREAKDOWN

CODE	PERFORMING SITE	ADDRESS
P	QUEST DIAGNOSTICS	875 GREENTREE RD., PGH. PA

Notified by msg.
9-28-00

KING, FLORENCE I *CONSOLIDATED FINAL REPORT* 3
DELA TORRE MEDICAL CLINIC *NOTE: SOME OR ALL RESULTS WERE PREVIOUSLY REPORTED

Triple i / CliniForms

DATE | NOTES | NAME

MAR 15 2001 WT 174 BP 132/84 P 72 R 18
11:50AM Protocol checkup for Hypothyroidism, PAT, Hyperlipidemia
Review of labs
stopped Lipitor due to diarrhea J. Muth, CMA
Very tired, Dad - ? PE-CHF grandpa - MI
1/2 PPD Bil. PIP red finger swelling

03-15-01

Florence King

Patient is here for follow up of Hypothyroidism, PAT and Hyperlipidemia. Patient apparently stopped the Lipitor for her cholesterol due to diarrhea. Patient is being very tired with some things secondary to the Chronic Fatigue Syndrome which she had before. Patient's Dad had died of questionable PE and went into CHF. Grandfather with history of MI. Patient still smokes about 1/2 pack of cigarettes per day and strongly advised the patient to stop smoking. Patient is told of the dangers and problems with smoking. Patient also has swelling of the PIP joint of the second finger of both hands. Some mild limitation of motion. Advised the patient to just soak it for now. Will try the patient on Voltaren 75mg BID and start Plavix 75mg one tablet daily. Reviewed the patient's blood tests which showed high cholesterol of 256, HDL is low at 28, triglycerides were high at 409. TSH is slightly high at 6.8. Patient is advised to increase the Synthroid to 125 mcg for now. Patient is also taking Xenecal without any problems.
EXAM: Showed the patient to be in no distress. Color and hydration are fine. No thyromegaly. Lungs are clear. Heart is regular. Abdomen is soft and nontender. Extremities with no edema. Patient has the swelling of the PIP joint of both second fingers.
IMX: Chronic Fatigue Syndrome; Hyperlipidemia; Hypothyroidism; History of PAT; Osteoarthritis
PLAN: Drink lots of fluids. Advised the patient to exercise.
RTC: 1 month and PRN

Henry G. dela Torre, MD/lsm

APR 16 2001 WT 176 1/2 BP 130/86 P 76 R 16
2:53pm CC: f/up osteoarthritis, depression
dizziness - can't lay on (L) side
can't take Wellbutrin - couldn't concentrate [illegible]
- now ok
Similar prob 1 yr. ago. restarted 2 day ago

04-16-01

Florence King

Patient is here for follow up of Osteoarthritis and Depression. Also complaining of dizziness. Unable to lay on her left side. Severe dizzy spells. Rhomberg test is positive. Patient had similar problem a year ago and symptoms restarted two days ago. Patient is still depressed. Also having dry skin patch on the right leg. Patient also has high cholesterol problems, chronic anxiety as well as Hypothyroidism.
EXAM: Showed the patient to be slightly obese. Weight is 176 1/2 pounds. BP is good at 130/86. Pulse is 76. Resp. is 16. HEENT is unremarkable. Color and hydration are fine. Ears are unremarkable but rhomberg test is positive. Lungs are clear with decreased breath sounds. Heart is regular. Abdomen is soft and nontender. Extremities with no edema.
IMX: Labyrinthitis; Vertigo; Dry Skin Right Leg; Depression
PLAN: Patient will be referred to the Balance Disorder Clinic and to Physical Therapy. Meanwhile, will keep the patient on Prozac 20mg daily.
RTC: 2 weeks and PRN

Henry G. dela Torre, MD/lsm

DATE | NOTES | NAME

NOV 16 2000 W 173½ BP 156/80 P 72 R16 T
11:40 AM Protocol check up & Review of labs
still dizzy off & on

F Multy Comm.

11-16-00 Florence King 83

Patient is here protocol check up. Patient is feeling dizzy on and off which is moderately severe. Patient is taking Meclizine about 3-4 times a day but don't seem to be taking it on a regular basis. Patient denies any ear aches. No headache. No nausea, vomiting or diarrhea. No blurred vision. No chest pain.

EXAM: Showed the patient to be in no distress. Blood pressure is borderline at 156/80. Pulse is 72. Afebrile. Weight is 173 1/2 pounds which is slightly over the 171 3/4 pounds in October. Ears are clear. No inflammation of the tympanic membrane. No nasal congestion. Throat is not inflamed. Lungs are clear. Heart is regular. Abdomen is soft and nontender. Extremities with no edema. No neurologic deficits noted. Reviewed the patient's blood test which showed the chemistries are normal. Cholesterol however is high with total cholesterol of 244. HDL is low at 28. LDL is high at 144 with Triglycerides high at 358. CBC is unremarkable. Patient's TSH however is elevated at 8.11. Patient is complaining of being tired also. Rhomberg test is positive.

IMX: Labyrinthitis; Hypothyroidism; Hyperlipidemia

PLAN: At this point, will start the patient on EES 400mg one tablet QID. Also Synthroid is increased from .088 to 0.1mg one tablet daily. Start Lipitor 20mg at bedtime. Patient is advised on low fat diet, exercise and try to lose weight. Advised of the possible complications especially liver enzyme elevation. Patient is to have a liver test in one month. Will schedule the patient for Mammogram. Patient was given Flu Vaccine and Pneunovax due to history of chronic smoking.

RTC: Protocol

Henry G. dela Torre, MD/lsm

MESSAGE: URGENT ☐YES ☐NO

TELEPHONE RECORD
FORM # F2S REV (696)
TO REORDER CALL MEDICAL RECORDS SYSTEMS (800) 477-7374 OR IN ATLANTA (770) 396-4364

for Dr.	Caller	Relation to pt.	Physician's orders/Followup action
Pt. name Flo King	Pt. age	Date of message 11.16.00 / Time of Message AM PM	Xenical - ACTID
pt has Lipitor at home (you mentioned) Xenical which do you want Lipitor not working well			take 1 Bottle ac for 4:55 No Answer
Caller's phone # 894-5410	Call back at AM PM	Pharmacy Walmart	Pt. Chart # / Initials

TELEPHONE RECORD # 069755
Call Back? Yes ☐ No ☐
Chart Mod.? Yes ☐ No ☐
Followup Comp. AM PM
Initials

Triple i / CliniForms

DATE | NOTES

NAME

OCT 19 2000 WT 171 3/4 BP 150/84 P 64 R 16 T 98.2
11:25am cc: f/u on CT scan
(R) side neck hurts
coughing - phlegm tan colored
congested
plugged nose

10-19-00 Florence King

Patient is here for follow up of CT Scan. Right side of the neck apparently is still hurting her. Coughing and phlegm is slightly colored. Patient is congested in the chest and the nose. Patient smokes 1/2 pack of cigarettes per day. CT Scan of the Temporal Bones are unremarkable. MRI study of the brain was suggested so the patient will be scheduled for one if necessary. Physiologic functions are otherwise unremarkable. Patient denies any significant dizzy spell or headaches. Patient persists to have low back pain and also some discomfort in the ears.

EXAM: Ears look good. No tenderness of the mastoids. Lungs are clear with decreased breath sounds. Heart is regular. Abdomen is soft and nontender. Patient has some tenderness of the low back area. Rhomberg test is still positive although the dizziness itself is much improved.

IMX: LBS; Labyrinthitis

PLAN: Patient is to continue with Meclizine 25mg QID. Continue Voltaren since the patient don't seem to have side effects from it. Use a heating pad and avoid bending, twisting or sitting to long.

RTC: PRN and Protocol

Henry G. dela Torre, MD/lsm

TELEPHONE RECORD

MESSAGE: URGENT ☐ YES ☐ NO

for Dr.	Caller	Relation to pt.
Pt. name: Flo King	Pt. age / Date of message: 10/20/00	Time of Message AM PM

Message: pt has bad sore throat just seen yesterday was given Allegra-D but has diarrhea after taking it also would like antibiotic for

Physician's orders/Followup action: sore throat allergic to Sulfa & PCN. Minocin 100mg BID 10 days

Caller's phone # | Call back at AM PM | Pharmacy # | Pt. Chart # 185 | Initials

TELEPHONE RECORD # 090100

Call Back? Chart Mesg? Followup Comp. Initials

10/26/00 Still dizzy.
Dr MRI

Triple i / CliniForms

DATE | NOTES | NAME

SEP 07 2000 WT 165 3/4 BP 130/78 P 60 R 24
3:30
CC: swelling ® side neck, clicking in ® ear
pain shots from ear to neck into shoulder,
started 4 days ago. bruise to ® arm appeared
today.

Dr Wirths Thompson MA

9-7-00 Florence King - DOB: 10-14 -1941

Patient is here complaining of swelling on her right side of her neck and a clicking in her right ear. Further questioning patient she stated, that she had been doing alot of health cleaning for the last few days. There is also one bruise site on the right arm which is consistent with ecchymosis.

EXAM: Her B/P is 130/78. HEENT appears to be normal with her heart being regular rhythm without any murmur. Lungs are very clear. Her abdomen is soft and nontender. Positive bowel sounds. She does have some cervical motion restriction with moderate muscle spasm of the cervical area is noted.

IMX: 1. Probable Cervical Strain 2. Hypothyroidism 3. Ecchymosis on the Right Arm

PLAN: Which regards to Ecchymosis is concerned will observe at this time. Maybe treat with heating pad to the area. Will continue with Voltaren. I have suggested to the patient about muscle relaxer, but patient refused that option at this point because it makes her tired. Heating pad to the area will also help. Do alot of stretching and will follow-up with myself or Dr. delaTorre later in the month or PRN.

RTC: 1 month or prn.

Phuong T. Wirths, DO/mt

OCT 09 2000 WT 170 1/2 BP 140/80 P 62 R 18
11:30AM Complains of dizziness again
took Antivert in July and has been taking Antivert
since then w/o relief.

J Muth, CMA

10-09-00 Florence King K&S

Patient is here complaining of dizziness again. Took Antivert in July and has been taking Antivert again since then without relief. Patient also has some pain to the left supraclavicular shoulder area and also some right flank pain. Patient is taking the Antivert TID. Denies any significant cold symptoms. No nasal drainage. No fever or chills.

EXAM: Showed the patient to be in no distress. The rest of the physiologic functions are unremarkable. Weight is 170 1/2 pounds. BP is 140/80. Pulse is 62. Resp. is 18. HEENT is unremarkable. Ears are clear. Tympanic membranes are normal. No significant nasal congestion. Rhomberg test is positive. Throat is clear. Neck is supple. No thyromegaly. Lungs are clear. Heart is regular. No PVC's. No gallop. No murmur. Abdomen is soft and nontender. Extremities with no edema. No neurologic deficits. No mastoid tenderness. There is also some fullness and soft tissue swelling of the supraclavicular space both sides, a little bit more prominent on the left. No significant edema of the upper extremities but there is a prominence of the veins.

IMX: Left Supraclavicular Swelling; Rule Out Venous Thrombosis; Right Flank Pain; Vertigo

PLAN: Advised the patient to increase the Antivert to QID. Will schedule the patient for CT of the inner ears and the mastoids. Will start the patient on Maxzide 25mg one tablet daily.

RTC: 1 week

Henry G. delaTorre, MD/lsm

DuBOIS REGIONAL MEDICAL CENTER

Mon Apr 16 15:44:33 EDT 2001

Ancillary Departments

PATIENT

NAME AND ADDRESS	PREVIOUS NAME	REGISTRATION DATE	TIME	MED. REC. NO.	BILLING NO.
KING,FLORENCE I 253 WEST MAIN ST SYKESVILLE PA 15865	COUNTY 135 PA	04/16/01	15:44	303556	0110600704

AGE	BIRTH DATE	METHOD ARRIVAL	SEX	RACE	M.S.
59Y	10/14/41	2 WALK IN	F	1	D

P.T.	FIN.CL.	ADMIT BY
SER	MA	HW

TELEPHONE NO. (814)894-5410 S.S. NO. 184-32-4880

EMPLOYER, ADDRESS, OCCUPATION, PHONE
HOMEMAKER

HOMEMAKER

SYMPTOMS OR ACCIDENT - HOW, WHERE, WHEN — STAFF ALERT

PERSISTENT VERTIGO

PERSON TO NOTIFY IN CASE OF EMERGENCY — RELATIONSHIP

SONNIE,ROBYN SYKESVILLE PA(814)894-5537 K — DAUGHTER

RESP PARTY

NAME AND ADDRESS	TELEPHONE	REL	EMPLOYER NAME AND ADDRESS
KING,FLORENCE I SELF 253 WEST MAIN ST SYKESVILLE PA 15865	(814)894-5410 HOMEMAKER SOC.SEC.# 184-32-4880		HOMEMAKER

INS

INSURANCE COMPANY	PLAN	POLICY HOLDER	REL.	POLICY #	GROUP #
MA OUTPATIENT MEDICAL ASSISTANCE P	200012 20000	KING,FLORENCE;I KING,FLORENCE I	1	0019202555 0019202555	

ADMITTING PHYSICIAN	FAMILY PHYSICIAN	REFERRING PHYSICIAN
DELATORRE,HENRY G PRI	DELATORRE,HENRY G	

Smead
UPC 10320
No. 152L
HASTINGS, MN

MINIMUM RECYCLED CONTENT

8.13.

DRMC Physical Therapy
Prescription Form

(Please Mark Location)

X DRMC Physical Therapy at Medical Arts Building
Phone: 375-3372 Fax: 375-3049

___ DRMC Physical Therapy at The Force Clinic
Phone: 375-3372 Fax: 375-3049

___ DRMC Physical Therapy at Highland View Nursing Home in Brockway
Phone: 265-8792 Fax: 265-1899

___ DRMC Physical Therapy at The Reynoldsville Medical Center (ground floor)
Phone: 375-3372 Fax: 375-3049

Name: Florence King Date: 4-17-C

Diagnosis: Vertigo

Duration and Frequency of Treatment: _____

Comments: _____

- [x] Evaluate and treat
- [ ] Aquatic exercises
- [ ] Whirlpool
- [ ] Moist heat
- [ ] Phonophoresis
- [ ] Ultrasound
- [ ] Electric stimulation
- [ ] Iontophoresis
- [ ] Cyrotherapy
- [ ] Massage/Myofascial release
- [ ] Joint mobilization/ROM
- [ ] Wound care
- [ ] Active Assistive ROM
- [ ] Passive ROM
- [ ] Kincom/strength testing
- [ ] Functional Capacity Exam
- [ ] Cervical traction
- [ ] Lumbar traction
- [ ] Work Hardening
- [ ] Home exercise program
- [ ] Strengthening program
- [ ] Lifting tasks
- [ ] TNS
- [ ] Gait training
- [ ] Other _____

Additional instructions: Balance Center

Physician Signature: M. T. Thomas

TOTAL P.01

DuBois Regional
Medical Center

P.O. B ox 447
100 Hospital Avenue
DuBois, PA 15801-0447

Outpatient Therapy: (814) 375-3372
Fax: (814) 375-3049

Making the difference for life.

PHYSICAL THERAPY INITIAL EVALUATION

Patient:	Florence I. King	Date:	04/17/01
Diagnosis:	Vertigo		
Physician:	Henry G. Dela Torre, MD		
Primary Ins:	MA Outpatient		ID#0019202555

SUBJECTIVE:

HOW INJURY/EPISODE OCCURRED: Patient is a 59-year-old female who reports that her first episode of dizziness began last fall after she went on a fishing trip. Patient reports that she had dizziness off and on for approximately 3 months; it then resolved completely with the help of Antivert. She was without any dizziness until this past Saturday evening when she experienced a flare-up. She reports her dizziness is worse now with lying on her (L) side or in supine. Dizziness increases with head movements. She is taking Antivert currently with some relief. She denies any headache, nausea, or vomiting associated with this, denies any hearing loss or tinnitus. She does report that she has a hissing sensation in both of her ears. She states that she has some neck tension that makes her feel like it needs to crack. Patient denies any history of migraine. She did have a minor head trauma 3 years ago when a box of curlers fell on her head in a store. Patient had a MRI in the fall. It was negative for any significant findings.

PMH/MEDICATIONS: Medical history includes (L) Sciatica, OA, Thyroid difficulties, Fibromyalgia, Heart Palpations, and High Blood Pressure. Medications include Antivert, Xanax, Tenormin, Synthroid, Zorco, and Voltaren.

WORK TITLE/DESCRIPTION: Patient has been disabled since 1987.

PHYSICAL DEMAND CHARACTERISTICS OF WORK: Patient does live alone and takes care of all of her own household activities. She enjoys fishing and spending time in the outdoors.

OBJECTIVE:

FUNCTIONAL STATUS AT ADMISSION: Patient is currently experiencing an overall decrease in functional ability secondary to severe dizziness.

FUNCTIONAL STATUS PRIOR TO INJURY: Prior to last fall when her first episode of dizziness began, patient had a full activity level.

PAIN: Patient denies any pain. She does report that her dizziness ranges from a 2/10 to a 10/10.

AROM/PROM: AROM of the cervical spine is WNL's throughout. Patient does experience increased dizziness with (L) rotation and (L) side bending.

STRENGTH: Bilateral shoulder strength is 4/5, (L) elbow strength 4/5, bilateral hip strength is 3+/5, (L) knee flexion 3+/5, (R) knee flexion 4/5, bilateral knee extension 5/5, (L) ankle dorsiflexion 4-/5 otherwise ankle is 4/5 to 4+/5 throughout.

SPECIAL TESTS: 5 times sit to stand test was 10.59 seconds without any loss of balance but with an increase in dizziness. Romberg eyes opened was 30 seconds, eyes closed was 30 seconds with increase in sway. Standing on two pillows Romberg eyes closed 7.81 seconds with loss of balance to the (L). Tandem Romberg eyes opened was 30 seconds, eyes closed 30 seconds. (R) knee unilateral stance was 10.16 seconds (L) unilateral stance was 12.84 seconds. Activity Specific Balance Confidence Scale was a 22.5% out of 100%. Dynamic gait index was 18/24. Dizziness Handicap Inventory was 54 total points. Patient with a positive (L) Halpike, positive (R) Halpike and a negative horizontal roll test.

BALANCE: See special test section above.

OBSERVATION: Patient was very apprehensive about lying supine and rolling secondary to severe dizziness.

SENSATION/DTR'S: Intact and symmetrical.

GAIT: Patient presents with an unsteady gait pattern with veering bilateral directions. She is able to ascend and descend 12 stairs with one handrail independently; however she experienced significant dizziness upon descending the stairs.

TONE/PALPATION: Patient with increased tension in the (L) upper trap region with tenderness to palpation in this area.

TREATMENT: Treatment was initiated this date educating patient regarding anatomical structures involved was well as the pathology of BPPV. Completed the canalith repositioning maneuver x 2. Patient was given post positioning instructions including avoiding quick head movements, bending over, looking up, and lying supine for the next 24-48 hours.

GOALS:
1. Decrease subjective complaints of dizziness to a 2/10 at worst to improve patient's functional abilities.
2. Increase ABC scale to 60% or greater.
3. Decrease dizziness handicap inventory by 20 points or greater.
4. Increase Romberg with eyes closed standing on two pillows to 30 seconds as indicator of vestibular functioning.
5. Patient will be independent in a H.E.P. to minimize symptoms of vertigo.

FUNCTIONAL OUTCOMES: Patient to return to full prior activity level with decreased complaints of dizziness.

PATIENT/FAMILY PARTICIPATION IN PLAN: Patient and her sister understand the goals and agree to participate with the program.

UNDERSTANDING OF EXERCISE PROGRAM: N/A. Patient does understand the post positioning instructions and agrees to comply with these.

PATIENT EXPECTATIONS: Patient hopes to experience an overall decrease in dizziness and increase in functional abilities.

ASSESSMENT:

Patient is a 59-year-old female who presents with clinical signs and symptoms of BPPV as well as vertigo that is interfering with her daily activities. Patient will benefit from continued physical therapy.

PLAN:

Patient will be seen 1-2 times a week for an estimated duration of 4 weeks for vestibular rehab including re-positioning maneuvers, ROM activities, balance activities, and patient and family education.

Thank you for this referral. If you have any questions please feel free to contact me.

Holly M Tkacik, PT

Holly M Tkacik, PT

HMT/am

Daily Progress Note

Patient Name King, Florence

4/17/01 3:00→4:00.

Initial evaluation completed. Evaluation time 50 min, tx time 10 minutes. See chart for complete report.

Holly McKeachie, PT.

(2)

4/19/01 3:30→4:00

S: "I Feel really good since the last time, only very minimal dizziness now." Pt c/o Neck "Stiffness". "I've been afraid of moving because I don't want to get dizzy."

O: AROM C-spine All planes x10 ∃ any ↑ in sxs. Manual stretching (B) upper traps + levator mms c pt seated (10 min) STM to (B) upper traps + Manual distraction C-spine c pt supine (5 min). Re-assessed Hallpike maneuver: Both (L) and (R) Hallpike -ve. Pt instructed in + completed Brandt-Daroff exercises x 5 (B), added these to HEP along c self-stretch upper traps + levators + AROM C-spine. (15 min).

A: Significant ↓ in dizziness, Neck discomfort relieved c tx.

P: Continue, Reassess symptoms Next visit, Review HEP.

Holly McKeachie, PT.

King Florence

(3)

4/24/01 1:35 → 2:00.

S: "I'm feeling great, No dizziness at all." "I even went fishing without any trouble." Dizziness currently 9/10.

O: Pt completed HEP c good technique (I).
ABC scale 86.875%, DHI 28 total, DGI 22/24.
Romberg EC standing on 2 pillows >30 seconds, No LOB.
5x sit → stand 8.13 sec c LOB. AROM C-spine WNL all planes, No dizziness c any. Improved gait stability, improved cadence. (20 min).

A: All Goals met.

P: Pt wishes to DC to HEP at this time. Pt instructed to continue c HEP daily to minimize episodes of vertigo. ——— Holly McKeever, PT.

DuBois Regional Medical Center
P.O. Box 447
DuBois, Pennsylvania 15801-0447

Making the difference for life.

PHYSICAL THERAPY DISCHARGE SUMMARY

Patient Name: Florence King **Referral Date:** 4/17/01

Physician: Dr. Delatorre **Discharge Date:** 4/24/01

Diagnosis: Vertigo **Number of Visits:** 3

Treatment Program: Vestibular rehab including positional manuevers & pt & family education.

Level of Progress at Discharge: Dizziness 0/10 with all functional activity. Returned to full activity level. 5 Time sit → stand 8.13 seconds ∅ LOB. standing ∅ pillows EC Romberg >30sec No LOB. Activities Specific Balance Confidence Scale 86.875% /100%. Dynamic Gait index 22/24. Dizziness Handicap Inventory 28. (-) Hallpike (B). No difficulty ↑ supine or rolling. Gait much improved ↓ veering one direction or the other. No dizziness ↑ stairs. (E) ↑ HEP.

Initial Findings: Dizziness Rating 2 → 10/10. Experiencing ↓ed functional abilities 2° dizziness ↑ head movements. 5 Times sit → stand 10.59 sec. standing on 2 pillows Romberg EC 7.81 sec ↑ LOB (L). Activities Specific Balance Confidence scale 22.5% /100%. Dynamic Gait index 18/24 Dizziness Handicap Inventory 54. (+) Hallpike (L) and (R). Extremely apprehensive about supine lying & Rolling. Veering (B) directions ↑ gait, dizziness ↑ & stairs.

Goals/Functional Outcomes Not Achieved at Discharge and Why: All Goals met.

Home Exercise Program and Education: Edu Re: pathology of BPPV. Instructed in Brandt-Daroff exercises to minimize Recurrence of Vertigo and Neck ROM & stretching.

Employment Status at Discharge: Disabled.

Comments: Pt doing very well, ∅ Sxs. Good compliance ↑ HEP.

Plan: DC to (E) HEP.

Yolanda Meek, PTA — Therapist Name

4/26/01 — Date

DUBOIS REGIONAL MEDICAL CENTER **MEDICAL RECORDS** Seen in ER past 48 hrs? N Sun Jul 16 22:12:52 EDT 2000

PATIENT

NAME AND ADDRESS
KING,FLORENCE I
253 WEST MAIN ST
SYKESVILLE PA 15865
COUNTY 035 PA
TELEPHONE NO. (814)894-5410 S.S. NO. 184-32-4880

REGISTRATION DATE	TIME	ORG UNR	MED. REC. NO.	BILLING NO.
07/16/00	22:12		308556	0019800262

AGE	BIRTH DATE	METHOD ARRIVAL	SEX	RACE	M.S.
58Y	10/14/41	2 WALK IN	F	1	D

RELIGION	P.T.	FIN.CL.	ADMIT BY
SYKESVILLE UNITMETHODIST	ER	MA	HW

EMPLOYER, ADDRESS, OCCUPATION, PHONE
HOMEMAKER
HOMEMAKER

ICD-9-CM/CPT4 CODES

PT/PT REPRESENTATIVE STATES SYMPTOMS OR ACCIDENT - HOW, WHERE, WHEN
DIZZINESS

STAFF ALERT

PERSON TO NOTIFY IN CASE OF EMERGENCY
SONNIE,ROBYN SYKESVILLE PA(814)894-5537 K
RELATIONSHIP DAUGHTER

RESP PARTY

NAME AND ADDRESS
KING,FLORENCE I SELF
253 WEST MAIN ST
SYKESVILLE PA 15865

TELEPHONE (814)894-5410
HOMEMAKER
SOC.SEC.#
184-32-4880

REL

EMPLOYER NAME AND ADDRESS
HOMEMAKER

INS

INSURANCE COMPANY	PLAN	POLICY HOLDER	REL	POLICY #	GROUP #
MA OUTPATIENT	200012	KING,FLORENCE;I	1	0019202555	JDT

E.R. PHYSICIAN	FAMILY PHYSICIAN	REFERRING PHYSICIAN
PALMER,GEORGE JR	DELATORRE,HENRY G	DELATORRE,HENRY G

AUTHORIZATION FOR EMERGENCY, OUTPATIENT, OR SHORT PROCEDURES UNIT TREATMENT

I, _____ (or Sherie _____

for Florence _____), voluntarily authorize and consent to diagnostic procedures,

examinations, and/or medical care as prescribed by, or deemed necessary in the judgement of Dr. Palmer _____ for

X Emergency Treatment ____ Outpatient Services ____ Short Procedures Unit Services.

I understand that this consent does not include operations or any non-routine procedures or treatment, and that the risks and alternatives for such procedures or treatment, which a reasonable patient would consider significant to a decision whether or not to undergo such treatment or procedures, will be explained to me by my treating physician or another physician designated by him.

I certify that no guarantees have been made to me as to the results of treatments or examinations in the Medical Center.

This form has been explained to me and I certify that I understand its contents.

NOTE: This report is strictly Confidential and is for the information only of the person to whom it is addressed. No responsibility can be accepted if it is made available to any other person, INCLUDING THE PATIENT.

_____ / _____ / _____
Signature of Patient Relationship Date/Time

_____
Witness

Patient is unable to consent for the following reason: Condition

Sherri L Kin _____ / Daughter _____ / 7/16/00 22:12
Signature of Patient Representative Relationship Date/Time

Heather Whitaker _____ / _____
Witness Witness

RELEASE FROM RESPONSIBILITY FOR DISCHARGE

am leaving (or taking _____ from) the DuBois Regional Medical Center against the advice of my physician. I have been informed of the risks involved in this decision. I hereby release the DuBois Regional Medical Center, its staff, and my physician from all responsibility for any ill effects which may result from this action.

_____ / _____ / _____
Signature of Patient Relationship Date/Time

_____ _____
Witness Witness

DuBois Regional Medical Center - Emergency Department
100 Hospital Ave.
DuBois, PA 15801
(814)371-2200

Patient: Florence King, 303556
Date: 07/17/2000 Time: 01:28

Discharge Instructions

Learning Needs Identified: Illness, Medication, Follow-up Care
Primary Language: English
Barriers Identified: None
Intervention for Barriers to Learning: None
Teaching Methods Used: Printed patient instruction, Verbal Instruction

IMPORTANT: We examined and treated you today on an emergency basis only. This was not a substitute for, or an effort to provide, complete medical care. In most cases, you must let your doctor check you again. Tell your doctor about any new or lasting problems. We cannot recognize and treat all injuries or illnesses in one Emergency Department visit. If you had special tests, such as EKG's or X-rays, we will review them again within 24 hours. We will call you if there are any new suggestions. After you leave, you should **follow the instructions below.**

You were treated today by GEORGE JR PALMER, MD.

THIS INFORMATION IS ABOUT YOUR FOLLOW UP CARE
Call as soon as possible to make an appointment in 2 days to see HENRY G DELATORRE, MD. You can reach HENRY G DELATORRE at (814)894-2448, 231 EAST HIGHLAND, SYKESVILLE, PA, 15865. If you have any problems before this appointment, call the office.

SPECIAL INFORMATION
NO STRENOUS ACTIVITY STOP CIGARETTE SMOKING

THIS INFORMATION IS ABOUT YOUR DIAGNOSIS
LABYRINTHITIS.
Your inner ear is inflamed. This could be caused by a virus, bacteria, allergies, certain medicines or a head injury. The inner ear controls your balance and is involved with hearing. This is why you feel extremely dizzy. Some people lose all hearing in the affected ear. While these symptoms are scary, they are only temporary. The severe dizziness should pass in a few days to a week. You may feel slightly dizzy for several weeks.

Follow these instructions:
- Rest in bed.
- Do not drink alcohol, drive or operate machinery when you are dizzy.
- Sit or stand up **slowly.**
- Avoid sudden head movements.
- Hold onto the wall or handrail when walking or using the stairs.

Call your doctor if you have:
- increased stomach upset or vomiting.
- a severe headache.
- continued severe dizziness lasting more than 10 days.
- any new or severe symptoms.

THIS INFORMATION IS ABOUT YOUR MEDICINE
MECLIZINE (Antivert).

Take this medicine in the following dose: 25 mg by mouth 4 times a day for dizziness.

This medicine treats dizziness and an upset stomach that comes from motion sickness or other medical problems. Side effects may include: sleepiness, blurred vision, dry mouth or headache. Allergy would show up as: **rash or itching, wheezing or shortness of breath.**

Follow these instructions:
- Use gum, hard candy, or ice chips for a dry mouth.
- Store this medicine away from heat, moisture or direct light.
- If you miss a dose, take it as soon as possible. If it is almost time for your next dose, skip the missed dose. Do not double the doses.
- Do not drink alcohol, drive or operate machinery while taking this medicine.

Call your doctor if you have:
- any sign of allergy.
- any new or severe symptoms.

YOU ARE THE MOST IMPORTANT FACTOR IN YOUR RECOVERY. Follow the above instructions carefully. Take your medicines as prescribed. Most important, see a doctor again as discussed. If you have problems that we have not discussed, **call or visit your doctor right away.** If you cannot reach your doctor, return to the Emergency Department.

"I have received this information and my questions have been answered. I have discussed any challenges I see with this plan with the nurse or physician."

X Florence L King
Florence King or Responsible Person

Florence King or Responsible Person has received this information and tells me that all questions have been answered.

Ruth Ann Smith, RN
DuBois Regional Medical Center Staff Signature Date: 07/17/2000 Time: 01:28

You may receive a survey in about a week from DuBois Regional Medical Center regarding this Emergency Department visit. Please complete the survey, as we are interested in hearing your feedback ! Thank You!

DuBois Regional Medical Center — Making the difference for life

EMERGENCY DEPARTMENT RECORD

303556 0019800262
KING,FLORENCE I 07/16/00
184-32-4880 F 58Y 10/14/41
PALMER,GEORGE JR
DELATORRE,HENRY G

Time: 2211 ☐ Emergent ☒ Urgent ☐ Nonurgent

CONDITION ON ARRIVAL: ☐ Poor ☐ Fair ☒ Satisfactory ☐ DOA

CHIEF COMPLAINT: Dizziness s/sx started Sat 530 am. ? GN/V/D. GAA. Hx Vertigo

VITAL SIGNS	Temp	Pulse	Resp	BP	O_2 Sat	WT
	98	61	18	172/90		

ALLERGIES: Darvocet, Darvon, PCN.

CURRENT MEDS: ☐ See attached list
Tenormin
Xanax
Synthroid

IMMUNIZATIONS: ☒ DNA ☐ UP TO DATE LAST TT/TD: ____

VISUAL ACUITY ☒ DNA | OD | OS | OU | ☐ CORRECTED ☐ UNCORRECTED

PT. PREGNANT? ☒ DNA ☐ YES ☐ NO ☐ UNSURE ☐ HYSTERECTOMY ☐ TUBAL LIGATION
LMP ____

TRIAGE TO ☐ Registration ☐ Room ____ Triage Nurse: [signature]

Primary Nurse: [signature]

CHECK THE REQ...

☒ CBC	☐ Cardiac enzymes	☐ UA	☐ C&S
☒ Lytes	☐ CKMB	☐ UC	☐ Wet Mount
☐ BUN	☐ CPK, Trip, Myo	☐ RSS	☐ RSV
☐ Creatinine	☐ Troponin I	☐ Throat C&S	☐ Triage Drug Screen
☐ Blood Sugar	☐ Digoxin level	☐ Blood C&S	☐ Coma Panel
☐ Amylase	☐ Cholesterol	☐ Type and Screen	☐
☐ PT/PTT	☐ Monospot	☐ Type and Cross	☐
☒ Basic Met Prof.	☐ Pregnancy	☐ Type and Cross	☐
☐ Hepatic Prof.	☐ ETOH	☐ Chlamydia	☐
☐ Compre profile	☐ Magnesium	☐ GC	☐

EKG / CARDIO:
☒ EKG: Provisional Reading:
☐ Repeat
☐ ABG ☐ on O_2 ☐ on Room Air
☐ Proventil ____ ☐ Repeat ☐ Repeat
☐ Proventil ____ Atrovent ____ ☐ Repeat ☐ Repeat
☐ Vaponephrine ____ ☐ Repeat ☐ Repeat
☐ Other ____ ☐ Repeat ☐ Repeat
☐ Peak Flows ☐

X-RAY / SPECIAL:
☐ Chest ☐ Portable Chest ☐ Port Lat C Spine ☐ C Spine ☐ LS Spine ☐ ABD Series
☐ CT ☐ Enhanced ☐ Unenhanced

PHYSICIAN REPORT

Dictated ✓

EXAM TIME: 2211

Rx Antivert 25 mg po Q.I.D. # 20

DX ORDERS

Dx Labyrinthitis, AROTF.

Antivert 25 mg po [illegible]

DISPOSITION OF PATIENT AND PATIENT INSTRUCTIONS

Condition On Discharge: ☒ Satisfactory ☐ Fair ☐ Poor Time: 130A WITH: ☐ self ☒ family ☐ other

☐ Admitted Room No: ☐ Physician Notified/Time: ☒ Sent Home ☐ Return to work ☐ Deceased ☐ Transferred

NOTIFIED: ☐ Relative ☐ Police ☐ Coroner ☐ Poison Center

For follow-up care please see: ☐ Personal physician ☐ Occupational medicine ☐ ER if worse or not improving

FOLLOW INSTRUCTIONS ON ☐ HEAD INJURY ☐ CULTURE ☐ STREP SCREEN ☐ LAB TEST ☐ X-RAY/EKG'S ☐ SPRAINS, STRAINS AND CONTUSIONS ☐ NOSEBLEEDS ☐ U.R.I. ☐ WOUND CARE AND BURN CARE ☐ GASTROENTERITIS AND/OR ABDOMINAL PAIN ☐ ALLERGY INJ. ☐ URINARY INFECTIONS ☐ CARE OF CHILD AND FEVER ☐ ANIMAL BITES ☐ CASTS ☐ EYE CARE ☐ TETANUS INJECTION ☐ MEDICATION ALERT ☐ MEDICATION USE

OTHER INSTRUCTION: No strenuous activity. Fluids - [illegible]. Take medication as directed.

☐ No Work or School Date: ____
☐ No Physical Education ☐ Until Released by Physician
☐ Light Work Only

Method of Validating Knowledge: ☒ Verbalization ☐ Return Demo ☐ Other: ____

PATIENT/ RESPONSIBLE PARTY [signature] NURSE'S SIGNATURE PHYSICIAN'S SIGNATURE

I hereby acknowledge receipt of these instructions, have read them and understand them. I further understand that I have had emergency treatment and that I may be released before all of my medical conditions/test results are known or treated. I will arrange for follow-up care. DuBois Regional Medical Center-DuBois, PA 15801

303556 00,19800262 07/16/00
KING,FLORENCE I
184-32-4880 F 58Y 10/14/41
PALMER,GEORGE JR
DELATORRE,HENRY G

DuBois Regional Medical Center 47

EMERGENCY PHYSICIAN RECORD

Dizziness (5)

TIME SEEN: 2300 ROOM: 10 __ EMS Arrival
HISTORIAN: __patient __spouse __paramedics
__HX/__EXAM LIMITED BY:

HPI

chief complaint: (dizziness) weakness near-syncope vertigo *(person / room)*

started: Sunday May 5 3pm.

time course:
(sudden) / gradual onset
__still present __better
__gone now
lasted:
__*constant*
__*intermittent episodes lasting*
__*worse/persistent since* Sunday

quality:
__spinning / falling / movement
(off-balance)
__light-headedness
__sense of confusion
__fainted / blacked out
__felt like might pass out
__generally weak (all over)

severity:
maximum-
mild (moderate) severe

when seen in ED-
gone almost gone
mild (moderate) severe

worsened by:
nothing
(changing position)
(movement of head)
standing position

(Similar symptoms previously) 2 to 3 years ago

__Recently seen/treated by doctor
Was seen Sat
Dr Delatorre

ROS

NEURO
__headache / head injury
__double vision
__sensory/motor loss
__difficulty walking

VESTIBULAR
__hearing loss
(ringing/roaring in ear)
__ear-pain
__nausea/vomiting
__sweating

CVS, BLOOD LOSS
__racing/irregular heart beat
__chest pain
__black/bloody stools
__heavy periods / abnml bldg

CONST
__fever
subjective / to ____ °F
__chills

ENT-CHEST
__sore throat
(cough)
__trouble breathing

GI & GU
__abdominal / pelvic pain
__diarrhea
__missed / irregular periods

SKIN & LYMPH & MS
__skin rash / swelling
(joint pain) Knees
☑ all systems neg. except as marked

PAST HISTORY __negative
__stroke
(inner ear problems)
__peptic ulcer
__GI bleeding
__diabetes *insulin / oral / diet*
__other problems Types 1 min
(high blood pressure)
(elevated cholesterol)
(heart disease)
rhythm problems: atrial fib.
CAD angina CHF MI
post MI

Surgeries:
__cardiac bypass
__pacemaker
__cholecystectomy
__appendectomy
(hysterectomy) 1983
__tonsillectomy

Medications __none (see nurses note
__ASA __ibuprofen __acetaminophen

Allergies __NKDA
(see nurses note

SOCIAL HX (smoker) drugs
alcohol *(recent / heavy / occasional)*
FAMILY HX __stroke __migraines __CAD
mother MI
Dad osteoarthritis

☑ Nursing Assessment Reviewed. ☑ BP, HR, RR, Temp reviewed.

303556 0019800262 07/16/00
KING,FLORENCE I
184-32-4880 F 58Y 10/14/41
PALMER,GEORGE JR
DELATORRE,HENRY G

PHYSICAL EXAM

✓ Alert __Anxious __IV __Hyperventilating

Distress- __NAD __mild __moderate __severe

HEENT
✓ nml ENT inspectn
✓ pharynx nml
✓ TM's nml

__pharyngeal erythema / tonsillar exudate
__TM erythema/dullness
__scleral icterus / pale conjunctivae

NECK
✓ supple

__thyromegaly
__carotid bruit(R / L)

RESPIRATORY
✓ no resp. distress
✓ breath sounds nml

__resp. distress
__rales / rhonchi / wheezing

CVS
✓ regular rate, rhythm
✓ heart sounds nml

__tachycardia / bradycardia
__irregularly irregular rhythm
__gallop (S3 / S4)
__murmur grade ___ /6 sys / dias
__decreased pulse(s)

ABDOMEN
✓ non-tender
✓ no organomegaly

__tenderness
__organomegaly / mass

RECTAL
__heme-neg stool

__heme positive stool

SKIN
✓ color nml, no rash
✓ warm, dry

__cyanosis / diaphoresis / pallor
__skin rash

EXTREMITIES
✓ non tender
✓ normal ROM
✓ no pedal edema

__pedal edema

NEURO/PSYCH

higher functions
__nml orientation
__mood/affect nml

__slow responsiveness
__depressed affect
__disoriented
to: time *place* *person*

cranial nerves-
__normal as tested
__pupils equal, round, and reactive to light
✓ EOM's intact
✓ no nystagmus

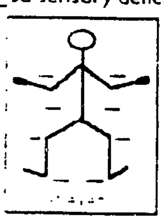
__facial droop (R / L)
__hearing deficit (R / L)
__tongue deviation (to R / L)
__dysarthria
__nystagmus
fast component to: left right
__unequal pupils
R pupil ___*mm* *L pupil* ___*mm*
__EOM palsy
__papilledema (fundiscopic)

cerebellar-
__normal as tested

__abnormal Romberg test
__abnormal finger-nose-finger
__abnormal gait

sensorimotor
__no motor deficit
__no sensory deficit

__weakness
hemiparesis / hemiplegia (R / L)
__*pronator drift* (*RUE / LUE*)
__altered light-touch sensation
__abnormal pin-prick sensation



LABS, XRAYS, and PROGRESS

EKG MONITOR STRIP __NSR __abnml

EKG __NML ☐ Interp. by me. ☑ Reviewed by me Rate 58
__*NSR* __*nml intervals* __*nml axis* __*nml QRS* __*nml ST/T*

[illegible handwriting]

not / changed from:

CXR ☐ Interp. by me ☐ Reviewed by me ☐ Discsd w/radiologist
__*nml/NAD* __*no infiltrates* __*nml heart size* __*nml mediastinm*

not / changed from:

CBC *normal except*		**Chemistries** *normal except*	
WBC	segs	Gluc 93	K 4.8
Hgb	bands	BUN 21	Cl 104
Hct	lymphs	Creat 1.8	CO2 24.7
Platelets	monos	Na 142	Anion Gap
	eos		serum preg pos / neg

[illegible handwriting]

Head CT __nml

Postural Vitals __nml __abnormal:

Time 0101 __unchanged (improved) (re-examined)

[illegible handwriting]

[illegible handwriting]

[illegible handwriting] 0110.

__Discussed with Dr.
will see patient in: office / ED / hospital
✓ CRIT CARE- *30-74 min* *75-104 min* 20 *min*
__Counseled patient / family regarding:
(lab results) (diagnosis) need for follow-up
__Prior records ordered
(Rx given) __Admit orders written
__Additional history from: *family caretaker paramedics*

CLINICAL IMPRESSION:

(Dizziness)/Vertigo - *acute*
Syncope/ Near Syncope
(Generalized Weakness)
(Difficulty Walking)
Hyperventilation
Pregnancy

Acute GI Bleed/ Hypovolemia
Cerebrovascular Accident
Cardiac Dysrhythmia
Transient Ischemic Attack
(Labyrinthitis)- *acute diffuse toxic*
Vestibular Neuronitis- acute

DISPOSITION- ☑ home ☐ admitted ☐ transferred
CONDITION- ☐ unchanged ☑ (improved) ☑ stable

MD/DO

Dizzy-47

DeSoto Regional Medical Center

Emergency Department Record 7 of 7

303556 0019800262 07/16/00
KING,FLORENCE I
184-32-4880 F 58Y 10/14/41
PALMER,GEORGE JR
DELATORRE,HENRY G

ACCUCHEK	HEMOCCULT
Time: _____	Time: _____
Results: _____ Initials: _____	Results: _____ Initials: _____

Time	IV Fluid/cc/Medication Added	Rate	Size/Site	Amount Infused	Time D/C	Initials

Time	Medication/Dose	Route	Site	#/Dispensed by Physician	Time/Effect Code	Initials
1200p	Antivert 25mg	po				EA
1330a	Antivert 25 mg	po		#1/Pacer		RD

Code: R = Relief P = Partial Relief N = No relief O = No adverse effect # = Pain Scale

Time	Intervention	Type/Site	Comments	Initials
	Wound Care:			
	Cleansed			
	Steri Strips			
	Dressing			
	Musculoskeletal			
	Splint			
	Ace			
	Immobilizer			
	Sling			
	Crutches/Walker			
	Immobilizations Removed			
	GI			
	NG/Lavage			
	Enema			
	GU			
	Catheter			
	Other:			

RD

DuBois Regional Medical Center — Emergency Department Record — Page 2 of 7

TIME: 2230

303556 0019800262 07/16/00
KING,FLORENCE I
184-32-4880 F 58Y 10/14/41
PALMER,GEORGE JR
DELATORRE,HENRY G

Mode of Arrival	Arrived with	Self Care
☐ Ambulance ☐ W.C.	☐ Self ☐ Police	☒ Independent
☒ Ambulatory ☐ Carried	☐ Parent ☐ Friend	☐ Total Assist
Gait ☐ Steady	☐ Spouse ☐ Delegate	☐ Partial Assist
☐ Unsteady	☒ Family ☐ _____	☐ Child

Safety Measures
☒ Siderails up ☒ Family at bedside
☒ Call Bell ☐ Security present

Environmental
Lives with: ☐ Self ☐ Spouse
☒ Family ☐ Other _____
Language barrier ☐
Translator _____

Psychosocial
Overall appearance: ☒ Normal ☐ Frail ☐ Obese
Mood/affect: ☒ Alert ☐ Anxious ☐ Crying
☒ Cooperative ☐ Blunted/flat ☐ Lethargic
☐ Age appropriate ☐ Combative ☐ Confused
☐ Unresponsive ☐ Uncooperative
Ideations: _____

Trauma/Accidents ☒ DNA
☐ Driver ☐ Passenger ☐ Front ☐ Back
☐ Seat Belt on ☐ Air bag deployed
Type: ☐ Car ☐ Truck ☐ Motorcycle
☐ Bicycle ☐ _____
Impact: ☐ Front ☐ Back
☐ Rollover ☐ Side
☐ Helmet ☐ Protective Clothing
Time of incident: _____
Extrication needed ☐ Yes ☐ No
☐ Fall (_____feet) ☐ GSW
☐ Assault ☐ Other _____

Prehospital Care / Treatment ☒ DNA
☐ LSB ☐ CID ☐ Stiff collar
☐ IV of _____#_____at _____in_____
☐ IV of _____#_____at _____in_____
☐ Accuchek _____
☐ Meds: _____
☐ Splints _____ ☐ _____
O_2 ☐ NC ☐ Simple ☐ Non-Rebreather
Airway: ☐ Oral ☐ Nasopharyngeal
☐ ETT _____ ☐ EOA

PMH: ☐ DNA
☐ NONE ☐ Unable to obtain
☐ CHF
☐ MI **Surgeries:**
☐ Cardiac Cath ☐ Angioplasty
☐ Hypertension ☐ CABG
☐ Diabetes ☐ Hysterectomy
☐ Asthma/COPD ☐ Appendectomy
☐ Seizures ☐ _____
☐ Cancer ☐ _____
☐ Stroke
☐ Dementia
☐ Mental Illness
☐ Ulcers
☐ GI Bleed
☐ Renal Disease
☐ thyroid-hyper
☐ _____

Alcohol use: _____
Tobacco use: _____
Caffine use: _____

Airway
☒ Clear/Patent
☐ Adjuncts _____

Breathing
☒ Normal ☐ Dyspneic ☐ Grunting
☐ Stridor ☐ Nasal flaring ☐ Retractions
☐ Accessory muscles ☐ Absent
☐ Other _____
Cough: ☐ Non productive ☐ Productive
Breath Sounds:
☐ Not assessed / DNA

Right	Left
☐ Clear	☒
☐ Rales/crackles	☐
☐ Rhonchi/Coarse	☐
☐ Wheeze	☐
☐ Diminished	☐
☐ Absent	☐
☐ Tracheal Deviation	☐
☐ JVD	☐

Oxygen: _____LPM _____Time
☐ NC ☐ Simple face ☐ Nonrebreather
☐ Tube ☐ Humidified ☐ Ventilator
Pulse Oximeter on at _____%

Circulation
Color: ☒ Normal ☐ Pale
☐ Mottled ☐ Cyanotic
☐ Ashen ☐ Jaundice
☐ Sallow ☐ _____
Condition: ☒ Warm ☒ Dry
☐ Cool ☐ Moist
☐ Hot ☐ Cold

Pulses:	Right	Left	☐ DNA
Radial	☐	☐	
Normal	☒	☒	
Thready	☐	☐	
Bounding	☐	☐	
Absent	☐	☐	
Pedal	☐	☐	
Normal	☐	☐	
Thready	☐	☐	
Bounding	☐	☐	
Absent	☐	☐	

Capillary refill: <2 sec seconds
Bleeding controlled ☐ Yes ☐ No

Cardio Pulmonary ☒ DNA
Chest pain ☐ Yes ☐ No
Location: _____
Radiation: _____
Onset/Duration: _____
Pain Scale (0-10) _____
Character: _____
☐ Dyspnea
☐ Syncope
☐ Diaphoresis

Dinemapp on: ☒

CARDIAC MONITOR ☒
Rhythm NSR
Pacemaker ☐ Yes ☐ No

Neurological ☐ DNA
Patient Status
Loss of Consciousness ☐ Yes ☒ No
☐ Witnessed Duration _____
☐ Unwitnessed ☐ Incontinence
☐ Nausea ☐ Headache
☐ Vomiting ☐ Post ictal
☐ Visual disturbance Denies Denies
☒ Appropriate verbal responses
☒ Appropriate motor responses
☐ (-) Vertigo

Pupils
☒ Equal
☐ Unequal _____
☒ Reactive
☐ Non reactive _____
☐ Dilated & Fixed
☒ EOMI
☐ Other (-) nystagmus

Extremity movement
Hand grasps
☒ Equal
☐ Unequal _____
☒ Strong
☐ Weak
Leg movement
☒ Equal
☐ Unequal _____
☒ Strong
☐ Weak

Signature: _____ MD

Dallas Regional Medical Center | Emergency Department Record | 3 of 7

303556 0019800262 07/16/00
KING,FLORENCE I
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PALMER,GEORGE JR
DELATORRE,HENRY G

MISCELLANEOUS

☒ DNA

Musculoskeletal Injury/Wounds

☐ DNA

Mechanism of Injury/Description: _____

Injured at: ☐ Work ☐ Home ☐ Other

☐ See body diagram _____

EENT

☒ DNA

EYES	OD	OS
Red	☐	☐
Tearing	☐	☐
Matted	☐	☐
Burning/pain	☐	☐
Itching	☐	☐
Blurred vision	☐	☐
Loss of vision	☐	☐
Flashing light	☐	☐
Floaters	☐	☐
Foreign body	☐	☐

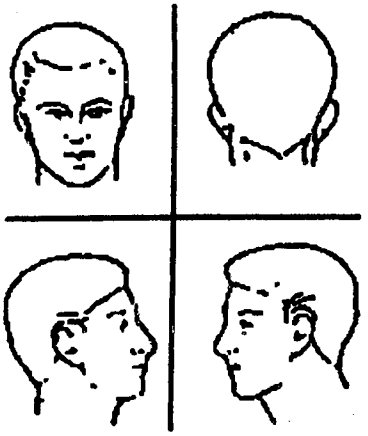
EARS	AD	AS
Pain	☐	☐
Drainage	☐	☐
Decreased Hearing	☐	☐

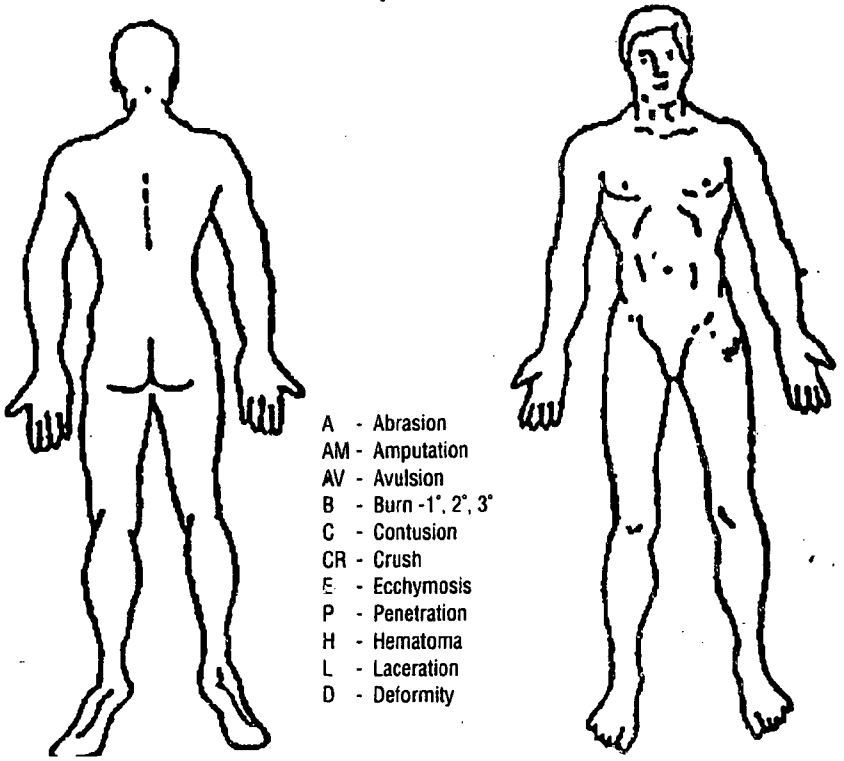
Other: _____

NOSE/THROAT
- ☐ Epistaxis
- ☐ Rhinorrhea
- ☐ Sore throat
- ☐ Dysphagia

Other: _____

DESCRIPTION: _____





A - Abrasion
AM - Amputation
AV - Avulsion
B - Burn -1°, 2°, 3°
C - Contusion
CR - Crush
E - Ecchymosis
P - Penetration
H - Hematoma
L - Laceration
D - Deformity

GI/GU/GYN

☐ DNA

Abdomen:
- ☒ Soft
- ☐ Distended
- ☐ Guarding
- ☐ Rigid

Tenderness:
- ☒ none
- ☐ LUQ
- ☐ RUQ
- ☐ LLQ
- ☐ RLQ
- ☐ Epigastric

Bowel Sounds:
- ☒ Present
- ☐ Diminished
- ☐ Hyperative
- ☐ None

Last BM _____

GI:
- ☐ Nausea
- ☐ Dry heaves
- ☐ Vomiting _____
- ☐ Diarrhea _____
- ☐ Rectal Bleed _____

GU:
- ☒ Voids without difficulty
- ☐ Flank pain R L
- ☐ Dysuria
- ☐ Urgency
- ☐ Hematuria
- ☐ Frequency
- ☐ Foley
- ☐ Other _____

GYN:

Fetal tones _____
- ☐ Vaginal bleeding
- ☐ Vaginal discharge
- ☐ History of ectopic

Para _____ Gravida _____ Ab _____

Description: _____

DuBois Regional Medical Center
Making the difference for life.

Emergency Department Record

303556 0019800262 07/16/00
KING,FLORENCE I
184-32-4880 F 58Y 10/14/41
PALMER,GEORGE JR
DELATORRE,HENRY G

PATIENT PROBLEM LIST

Patient needs identified as: (Number to Prioritize) (Minimum of 1 need to be identified)

___ Knowledge deficit:	___ Alteration in body temperature:
✓ Alteration in Comfort: vertigo	___ Individual ineffective coping:
___ Alteration in fluid volume:	___ Risk of infection
___ Alteration in Oxygenation:	___ Impaired tissue integrity:
___ Decreased Cardiac Output:	___ Other:

(See Chart and nurses notes for interventions and response.)

SCREENING CRITERIA **Patient Home Phone Number/Room #:** ___

Suspected Abuse: Adult/Child: [X] No Identified Needs [ ] Unusual/suspicious marks (i.e. burns, bruises, welts, lacerations, punctures) [ ] Sexual abuse [ ] Domestic Violence: Patient verbalizes need for assistance. **FOLLOW DRMC POLICY (PR-1, PR-1.2, PR-1.3),**	**Initial visit: date:** **Time:** **Signature:** **Follow-up:** [ ] None [ ] See Progress Note
Discharge Planning: [X] No Identified Needs [ ] Additional supportative services needed upon d/c (med. equip., Home Health). [ ] INITIAL Placement assistance needed before discharge. [ ] Financial assistance required to follow treatment. [ ] Patient has an Advanced Directive but did not bring in a copy, follow up needed.	**Initial visit: date:** **Time:** **Signature:** **Follow-up:** [ ] None [ ] See Progress Note
Pastoral Care: [X] No Identified Needs [ ] Terminal Illness; [ ] Recent Loss of Significant Other; [ ] Request for Pastoral Care **If any of the above are indicated, PLEASE FAX THIS FORM TO THE SOCIAL WORK/PASTORAL CARE AREA #3488**	**Initial visit: date:** **Time:** **Signature:** **Follow-up:** [ ] None [ ] See Progress Note

TIME	NOTES	INITIALS
2220	Onset of vertigo c room spinning last p.m @ 5³⁰ p.m ⊖ headache. ⊖ N/V/D ⊖ no known injury	EA
12⁵⁰	Resting comfortably OOB to B.R c assistance	EA

Signature: ___ Initials: EA Signature: ___ Initials: ___

DUBOIS REGIONAL MEDICAL CENTER
100 Hospital Ave, DuBois, PA 15801
Mon Jul 17, 2000 09:32 am
Outpatient Summary Report

Pat Name: KING,FLORENCE I Page: 1
Unit #/Acct #: 000303556/D0019800262
Loc: ER 07/17/00
Phys-Service: PALMER,GEORGE JR - *EMERGENCY ROOM

****

In: 07/16/00 2329
Out: 07/16/00 2357
Coll Time: 07/16/00 2325
Order Phys: PALMER,GEORGE JR

BASIC METABOLIC PANEL.

Spec: Blood
Techs: V10718 T01752
[D0019800262/1204317]

*STAT*STAT*STAT*

Result Name	Result	Normal Range
Glucose(mg/dl):	93	70-110
BUN(mg/dl):	21 H	7-18
Creatinine, Serum(mg/dl):	0.8	0.6-1.3
Calcium(mg/dl):	9.1	8.5-10.4
Sodium(mEq/L):	142	140-148
Potassium(mEq/L):	4.8	3.6-5.2
Chloride(mEq/L):	104	96-108
Total Co2(mEq/L):	24.7	21-32
Anion Gap:	13.3	0-17
Order Comment:	ROOM 10	

In: 07/16/00 2329
Out: 07/16/00 2348
Coll Time: 07/16/00 2325
Order Phys: PALMER,GEORGE JR

CBC & DIFF

Spec: Blood
Techs: V10718 T01752
[D0019800262/1204317]

*STAT*STAT*STAT*

Result Name	Result	Normal Range
WBC(X(10)3 ul):	10.16	4.5-11.0
RBC(x10 6/ul):	5.04	4.1-5.1
Hgb(gm/dl):	15.3	12-16
Hct(%):	44.8	36-46
MCV(fl):	88.9	82.6-96.0
MCH(pg):	30.3	28.1-31.7
MCHC(g/dl):	34.0	32.7-35.1
Plt(X(10)3 ul):	195	150-380
RDW-CV(%):	13.1	11.8-14.2
MPV(fl):	8.2 L	8.4-10.8
Neutrophil -(X(10)3 ul):	7.14	2.0-7.5
Lymphocyte -(X(10)3 ul):	2.30	1.0-3.5
Atypical Lymphs -(X(10)3 ul):	0.08	
Monocyte -(X(10)3 ul):	0.43	0.0-0.8
Eosinophil -(X(10)3 ul):	0.16	0.0-0.7
Basophil -(X(10)3 ul):	0.05	0.0-0.1
Neutrophil %(%):	70.3	52.0-78.0
Lymphocyte %(%):	22.6	15.0-42.0

(Continued on next page)

DUBOIS REGIONAL MEDICAL CENTER
100 Hospital Ave, DuBois, PA 15801
Mon Jul 17, 2000 09:32 am
Outpatient Summary Report

Pat Name: KING,FLORENCE I Page: 2
Unit #/Acct #: 000303556/D0019800262
Loc: ER 07/17/00
Phys-Service: PALMER,GEORGE JR - *EMERGENCY ROOM

****

In: 07/16/00 2329
Out: 07/16/00 2348
Coll Time: 07/16/00 2325
Order Phys: PALMER,GEORGE JR

| CBC & DIFF |

Spec: Blood
Techs: V10718 T01752
[D0019800262/1204317]

*STAT*STAT*STAT*

Result Name	Result	Normal Range
(Continued from previous page)		
Atypical Lymphs(%):	0.8	
Monocyte %(%):	4.2	0.0-8.0
Eosinophil %(%):	1.6	0.0-5.0
Basophil %(%):	0.5	0.0-2.0
Manual Diff:	Not Indicated	
Order Comment:	ROOM 10	

End of Report - 07/17/00 09:32am

DUBOIS REGIONAL MEDICAL CENTER

303556 0019800262 07/16/00
DC KING,FLORENCE I
184-32-4880 F 58Y 10/14/41
PALMER,GEORGE JR
AD DELATORRE,HENRY G

☐ EAST ☐ WEST

ABG ANALYSIS	RESULTS	NORMAL RANGE
pH	7.42	7.37-7.43
pCO_2	36	37-43 mmHg
pO_2	74	90-105 mmHg
HCO_3	23	22-26 meq/L
B.E.	-1	-3 - +3
O_2 SAT. CALCULATED	——	> 95.0%
CO_2	24	21-30 mM/L
CO-OXIMETRY ANALYSIS	**RESULTS**	**NORMAL RANGE**
THb	14.9	
% O_2Hb	91.5	> 95%
% COHb	4.4	< 2.0%
% MeTHb	0.3	< 1.0%
VOL % O_2	19.0	14-24 VOL %

☐ INPAT. ☐ OUTPAT. ☐ ER ☑ STAT ☐ ROUTINE ☐ PRE-OP.

RR 18 ☐ LABORED ☐ NON LABORED ☐ REG. ☐ IRREG.

PT. TEMP. _____ CORR ☐ UNCORR ☑

FIO_2 Rm Air

NOTES:
(+) Allens
(R) Rad
pressure dressing applied

DATE	TIME SAMPLE DRAWN	TECH.
7/16/00	2330	KB
DATE	TIME REPORT RETURNED	TECH.
7/16/00	2335	KB

CHART COPY

PULMONARY

DUBOIS REGIONAL MEDICAL CENTER-DUBOIS, PA.

REMOVE SLOWLY TO EXPOSE ADHESIVE
RETIRER LENTEMENT POUR EXPOSER L'ADHESIF
TAPE GROUP USA

REMOVE STRIP OF TAPE
AND ATTACH SECOND REPORT

303556

07/16/2000 23:33:27
58 years Female

KING, FLORENCE

Dußois Regional Medical Cente
Dept: ~~GP~~ ER

Oper: KB

Doctor DeLATORR

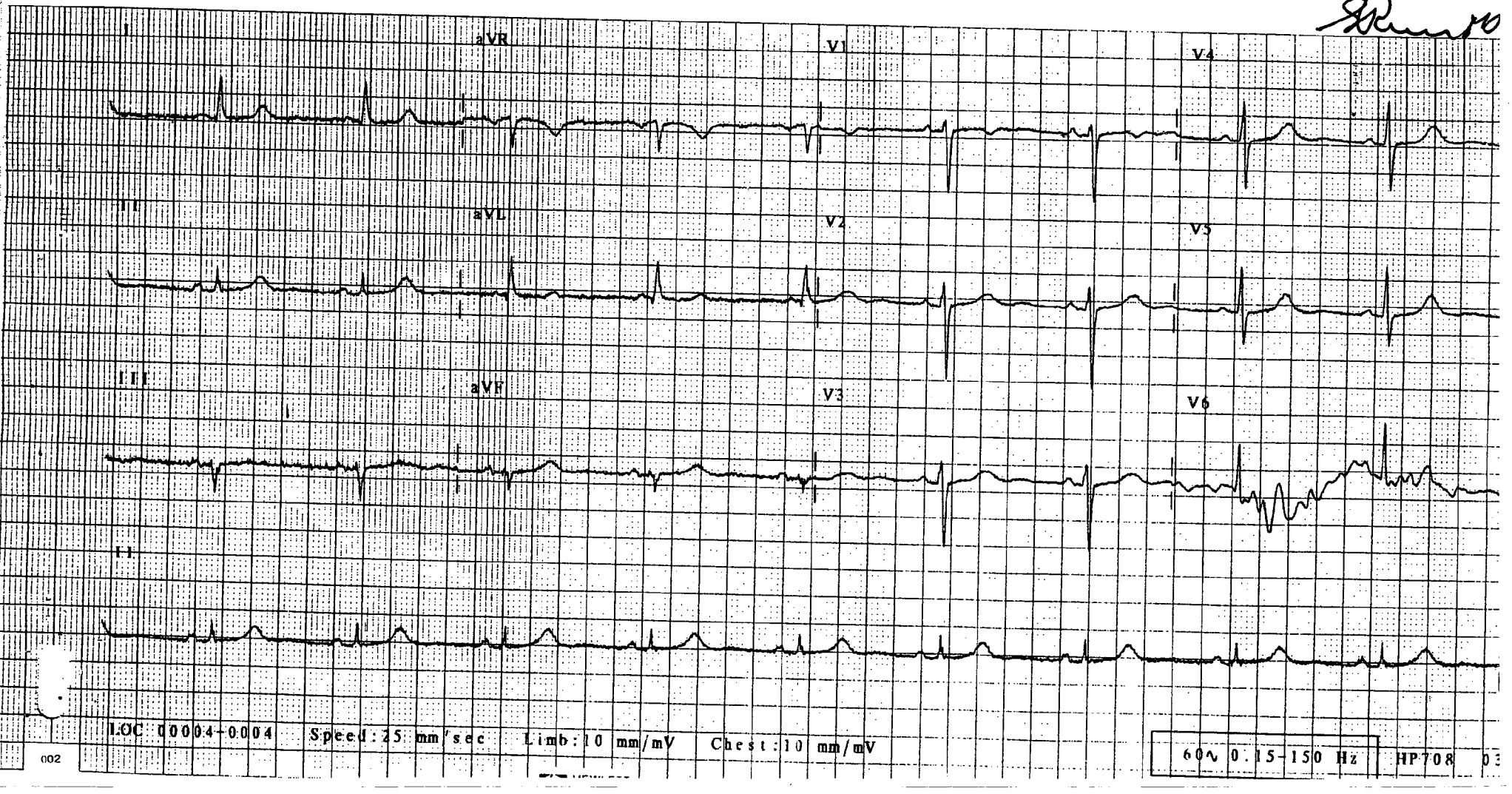
Rate	58
PR	155
QRSD	85
QT	421
QTc	413

--AXIS--

P	52
QRS	-4
T	50

. Normal sinus rhythm, rate 58

- NORMAL ECG -



DUBOIS REGIONAL MEDICAL CENTER — MEDICAL RECORDS

Seen in ER past 48 hrs? ☐ — Wed Dec 15 02:25:14 EST 1999

PATIENT

NAME AND ADDRESS
KING,FLORENCE I
~~130~~ 253 WEST MAIN STREET
SYKESVILLE PA 15865
COUNTY 035 PA
TELEPHONE NO. (814)894-5410 S.S. NO. 184-32-4880

REGISTRATION DATE	TIME	ORG DNR	MED. REC. NO.	BILLING NO.
12/15/99	~~00:00~~ 1125		303556	9934800357

AGE	BIRTH DATE	METHOD ARRIVAL	SEX	RACE	M.S.
58Y	10/14/41	2 WALK IN	F	1	D

RELIGION	P.T.	FIN.CL.	ADMIT BY
SYKESVILLE UNITMETHODIST	OSE	MA	

EMPLOYER, ADDRESS, OCCUPATION, PHONE
HOMEMAKER
HOMEMAKER

ICD-9-CM/CPT4 CODES
V62.10
45.23

PT/PT REPRESENTATIVE STATES SYMPTOMS OR ACCIDENT - HOW, WHERE, WHEN
COLONOSCOPY

STAFF ALERT
45378

PERSON TO NOTIFY IN CASE OF EMERGENCY
SONNIE,ROBYN SYKESVILLE PA(814)894-5537 K — RELATIONSHIP: DAUGHTER

RESP. PARTY

NAME AND ADDRESS
KING,FLORENCE I SELF
130 WEST MAIN STREET
SYKESVILLE PA 15865

TELEPHONE (814)894-5410
HOMEMAKER
SOC.SEC.#
184-32-4880

REL

EMPLOYER NAME AND ADDRESS
HOMEMAKER

INS

INSURANCE COMPANY	PLAN	POLICY HOLDER	REL	POLICY #	GROUP #
MA OUTPATIENT SURGER	200015	KING,FLORENCE;I	1	0019202555	
MEDICAL ASSISTANCE P	20000	KING,FLORENCE I		0019202555	

NURSING

E.R. PHYSICIAN: DELATORRE,HENRY G
FAMILY PHYSICIAN: DELATORRE,HENRY G
REFERRING PHYSICIAN:

CONDITION ON ARRIVAL: ☒ SATISFACTORY ☐ FAIR ☐ POOR ☐ DOA
PT PREGNANT: ☐ YES ☒ NO ☐ DNA
LAST TT:
LMP:

ALLERGIES: Penicillin, Sulfa
CURRENT MEDS: Neomycin 0.5% Oint, Lotrisone Cream, Lopressor 100mg, Nystatin 100,000 U/gm Cream, Ophthalmic 0.5% Drop, Ativan 2.5mg IM, 2-4mg PO/IV
WT: 165 lbs

REASON FOR ADMISSION / CHIEF COMPLAINT / ASSESSMENT
Triage Status: ☐ Emergent ☐ Urgent ☒ Non-urgent

Pt States She had Screening Exam, Took Prep
for Onset 1 month
Pt on Lopressor
Pt Allergic to Penicillin
Other Legends
and Epilepsy
12/14/99

VITAL SIGNS

TIME	1125am		
TEMP.	98.2		
PULSE	52		
RESP.	18		
B.P.	170/84		

LAB: No path
X-RAY:

HISTORY EXAM

PHYSICIAN'S REPORT — NURSE'S SIGNATURE: Joanne Kuehler

EXAM TIME: 1125 am to 1155 am

NOTE: This report is ~~strictly Confidential~~ and is for the information ~~only~~ of the person to whom it is addressed. ~~No responsibility~~ can be accepted if it is ~~made available to any~~ other person, INCLUDING THE PATIENT.

See H & P

DX

Hx of Rectal Carcinoma

☐ O_2 ☐ EKG ☐ ABG ☒ PULSE OXIMETER ☒ B/P MONITOR ☒ CARDIAC MONITOR ☒ SEE FLOW SHEET

MEDICATIONS / I.V.'S / NOTES

TREATMENT

Please do Proctosigmoidoscopy

DISPOSITION: ☐ ADMITTED ROOM NO. ☒ SENT HOME ☐ RETURN TO WORK ☐ DECEASED ☐ TRANSFERRED

CONDITION ON DISCHARGE: ☒ SATIS ☐ FAIR ☐ POOR TIME: 70

INSTRUCTIONS

F.D. NOTIFIED TIME:
CONSULTING PHYSICIAN TIME:
☐ F.D. REQUEST ☐ PATIENT REQUEST ☐ ON CALL
☐ CORONER NOTIFIED ☐ POLICE TIME:
FOLLOW-UP CARE: ☐ FAMILY PHYS. ☐ XPRESS CARE ☐ ER PHYSICIAN

FOLLOW INSTRUCTIONS ON PATIENT'S INSTRUCTION COPY FOR: ☐ HEAD INJURY ☐ CULTURES ☐ STREP SCREEN ☐ DIAGNOSTIC TEST ☐ LAB TESTS ☐ X-RAY/EKG's ☐ SPRAIN/STRAIN/CONTUSION ☐ NOSEBLEEDS ☐ U.R.I. ☐ EYE CARE ☐ WOUND AND BURN CARE ☐ GASTROENTERITIS AND/OR ABDOMINAL PAIN ☐ ALLERGY INJ. ☐ URINARY INFECTIONS ☐ CARE OF CHILD AND FEVER ☐ ANIMAL BITES ☐ CASTS

OTHER INSTRUCTIONS: See attached
Metamucil daily. Bland diet

☐ TETANUS INJECTION ☒ MEDICATION ALERT ☒ MEDICATION USE

Method of Validating Knowledge: ☒ Verbalization ☐ Return Demonstration ☐ Other:

PATIENT / WITNESS / PHYSICIAN

DUBOIS REGIONAL MEDICAL CENTER — MEDICAL RECORDS

Seen in ER past 48 hrs? ☐ — Wed Dec 15 11:44:03 EST 1999

PATIENT

NAME AND ADDRESS
KING,FLORENCE I
130 WEST MAIN STREET
SYKESVILLE PA 15865
COUNTY 035 PA
TELEPHONE NO. (814)894-5410 S.S. NO. 184-32-4880

REGISTRATION DATE	TIME	ORG DNR	MED. REC. NO.	BILLING NO.
12/15/99	00:00		303556	9934800357

AGE	BIRTH DATE	METHOD ARRIVAL	SEX	RACE	M.S.
58Y	10/14/41	2 WALK IN	F	1	D

RELIGION: SYKESVILLE UNITMETHODIST | P.T.: OSE | FIN.CL.: MA | ADMIT BY:

EMPLOYER, ADDRESS, OCCUPATION, PHONE
HOMEMAKER
HOMEMAKER

ICD-9-CM/CPT4 CODES:

PT/PT REPRESENTATIVE STATES SYMPTOMS OR ACCIDENT - HOW, WHERE, WHEN
PROCTOSIGMOIDOSCOPY

STAFF ALERT:

PERSON TO NOTIFY IN CASE OF EMERGENCY
SONNIE,ROBYN SYKESVILLE PA(814)894-5537 K — RELATIONSHIP: DAUGHTER

RESP. PARTY

NAME AND ADDRESS
KING,FLORENCE I SELF
130 WEST MAIN STREET
SYKESVILLE PA 15865

TELEPHONE (814)894-5410
HOMEMAKER
SOC.SEC.#
184-32-4880

REL:

EMPLOYER NAME AND ADDRESS
HOMEMAKER

INS

INSURANCE COMPANY	PLAN	POLICY HOLDER	REL	POLICY #	GROUP #
MA OUTPATIENT SURGER	200015	KING,FLORENCE;I	1	0019202555	
MEDICAL ASSISTANCE P	20000	KING,FLORENCE I		0019202555	

NURSING

E.R. PHYSICIAN: DELATORRE,HENRY G
FAMILY PHYSICIAN: DELATORRE,HENRY G
REFERRING PHYSICIAN:

CONDITION ON ARRIVAL: ☒ SATISFACTORY ☐ FAIR ☐ POOR ☐ DOA
PT PREGNANT: ☐ YES ☒ NO ☐ DNA

ALLERGIES: See attached sheet

REASON FOR ADMISSION / CHIEF COMPLAINT / ASSESSMENT
Triage Status: ☐ Emergent ☐ Urgent ☒ Non-urgent

LAST TT:
LMP:

CURRENT MEDS: See attached sheet

See attached sheet - Pt refuses colonoscopy but agreed to have proctosigmoidoscopy by Dr Delatorre

Sally Franklin

WT.:

VITAL SIGNS

TIME				
TEMP.				
PULSE				
RESP.				
B.P.				

HISTORY EXAM

PHYSICIAN'S REPORT — NURSE'S SIGNATURE

EXAM TIME:

LAB:

X-RAY:

DX

☐ O_2 ☐ EKG ☐ ABG ☐ PULSE OXIMETER
☐ B/P MONITOR ☐ CARDIAC MONITOR ☒ SEE FLOW SHEET

MEDICATIONS / IV'S / NOTES:

TREATMENT

DISPOSITION ☐ ADMITTED ROOM NO. ☐ SENT HOME ☐ RETURN TO WORK ☐ DECEASED ☐ TRANSFERRED

CONDITION ON DISCHARGE ☐ SATIS ☐ FAIR ☐ POOR TIME:

INSTRUCTIONS

F.D. NOTIFIED TIME:
CONSULTING PHYSICIAN TIME:
☐ F.D. REQUEST ☐ PATIENT REQUEST ☐ ON CALL
☐ CORONER NOTIFIED ☐ POLICE TIME:
FOLLOW-UP CARE ☐ FAMILY PHYS. ☐ XPRESS CARE ☐ ER PHYSICIAN

FOLLOW INSTRUCTIONS ON PATIENT'S INSTRUCTION COPY FOR
☐ HEAD INJURY ☐ CULTURES ☐ STREP SCREEN ☐ DIAGNOSTIC TEST ☐ LAB TESTS ☐ X-RAY/EKG's ☐ SPRAIN/STRAIN/CONTUSION ☐ NOSEBLEEDS ☐ U.R.I. ☐ EYE CARE
☐ WOUND AND BURN CARE ☐ GASTROENTERITIS AND/OR ABDOMINAL PAIN ☐ ALLERGY INJ. ☐ URINARY INFECTIONS ☐ CARE OF CHILD AND FEVER ☐ ANIMAL BITES ☐ CASTS

OTHER INSTRUCTIONS

☐ TETANUS INJECTION
☐ MEDICATION ALERT
☐ MEDICATION USE

Method of Validating Knowledge: ☐ Verbalization ☐ Return Demonstration ☐ Other: _____

PATIENT/ NURSE/ PHYSICIAN

AUTHORIZATION FOR EMERGENCY, OUTPATIENT, OR SHORT PROCEDURES UNIT TREATMENT

I, Alorence King (or _____
for _____), voluntarily authorize and consent
to diagnostic procedures, examinations, and/or medical care as prescribed by, or deemed necessary
in the judgement of Dr. Delatorre for

- ☐ Emergency Treatment
- ☐ Outpatient Services
- ☒ Short Procedures Unit Services

I understand that this consent does not include operations or any non-routine procedures or treatment, and that the risks and alternatives for such procedures or treatment, which a reasonable patient would consider significant to a decision whether or not to undergo such treatment or procedures, will be explained to me by my treating physician or another physician designated by him.

I certify that no guarantees have been made to me as to the results of treatments or examinations in the Medical Center.

This form has been explained to me and I certify that I understand its contents.

X Alorence King | Self | 12/15/99 11AM
Signature of Patient | Relationship | Date/Time

Witness

Patient is unable to consent for the following reason: _____

_____

_____ | _____ | _____
Signature of Patient Representative | Relationship | Date/Time

_____
Witness

RELEASE FROM RESPONSIBILITY FOR DISCHARGE DATE _____ TIME _____ A.M. P.M.

I am leaving (or taking _____ from) the DuBois Regional Medical Center against the advice of my physician. I have been informed of the risks involved in this decision. I hereby release the DuBois Regional Medical Center, its staff, and my physician from all responsibility for any ill effects which may result from this action.

WITNESS _____ _____
Signature of Patient/Patient Representative

_____ _____
Relationship

DISCHARGE INSTRUCTION FOR GI LAB

DUBOIS REGIONAL MEDICAL CENTER
DUBOIS, PENNA.

303556 58Y OSE
KING, FLORENCE I
DELATORRE, HENRY G
10/14/41 F 12/15/99
184-32-4880 9934800357

YOU ARE URGED TO FOLLOW CAREFULLY THE FOLLOWING INSTRUCTIONS:

Avoid fried greasy spicy foods

☒ **PROCTOSIGMOIDOSCOPY**

1. You will need to expel air from rectum to allow bowel return to normal size.
2. You may eat Bland diet diet.
3. Observe for rectal bleeding, severe abdominal pain, fever - - If these symptoms occur, notify physician or go to Emergency Department.
4. Follow physician instructions.

Take Metamucil OR citrucel one tablespoon daily in water OR juice.

☐ **ESOPHAGEAL DILATATION**

1. You may drink and eat one (1) hour after procedure is completed.
2. Observe for excessive expectoration of blood or difficulty swallowing - - If these symptoms occur, notify physician or go to Emergency Department.
3. If sore throat develops, gargle frequently with warm salt water.
4. Follow physician instructions.

☐ **GASTROSCOPY**

1. You will be drowsy today; rest; no driving for 24 hours.
2. You may drink and eat one (1) hour after procedure is completed.
3. If sore throat develops, gargle frequently with warm salt water.
4. If difficulty in swallowing occurs, notify physician or go to Emergency Department.
5. There may be mild tenderness at the intravenous site for a few days; apply warm, moist compresses.

☐ **COLONOSCOPY**

1. You will be drowsy today; rest; no driving for 24 hours.
2. You will need to expel air from rectum to encourage bowel to return to normal size; you may have gas for 1 to 2 days - - a heating pad or a hot tub bath may relieve gas discomfort.
3. You may resume normal diet.
4. Observe for excessive rectal bleeding, severe abdominal pain, fever - - If these symptoms occur, notify your physician or go to Emergency Department.
5. There may be mild tenderness at intravenous site for a few days; apply warm, moist compresses.
6. Follow physician instructions.

☐ **COLONOSCOPY WITH POLYPECTOMY**

1. Follow colonoscopy instructions.
2. Allowed _____ diet.
3. Expect a small amount of rectal bleeding. If excessive bleeding occurs, notify physician or go to Emergency Department.

☐ I CERTIFY THAT I HAVE RECEIVED A COPY OF DR. _____ INSTRUCTIONS FOR _____	I CERTIFY THAT I HAVE RECEIVED AND UNDERSTAND THESE INSTRUCTIONS FOR MY FOLLOW-UP CARE. PATIENTS SIGNATURE Florence King	PHYSICIAN'S SIGNATURE

HW-043
H:\SHARING\NURSFORM\MDH&PEXM.PM5

DuBois Regional Medical Center

Making the difference for life.

MEDICAL HISTORY AND PHYSICAL EXAMINATION FOR OUTPATIENT SURGERY

303556 58Y OSE
KING, FLORENCE I
DELATORRE, HENRY G
10/14/41 F 12/15/99
[illegible]-32-4880 9934800357

CHIEF COMPLAINT _____

HISTORY OF PRESENT ILLNESS Patient noted some blood ? either vagina or rectum but patient is s/p hysterectomy. Vaginal area dry @ the office showed no blood. No chronic bleeding. Patient, however, reports colonoscopy but convinced the patient as per hx

ALLERGIES _____ CHILDHOOD DISEASES _____

MEDICATIONS Hx of chronic anxiety, depression, hypothyroidism → hx of chronic allergies hypo

OPERATIONS _____

ACCIDENTS/INJURIES _____ PREGNANCIES _____

SOCIAL HISTORY: ____ SINGLE ____ MARRIED ____ WIDOWED ✓ DIVORCED

TOBACCO: ____ YEARS ____ PACK(S) PER DAY ALCOHOL: _____

REVIEW OF SYSTEMS: GENERAL Nervous G/I no nausea - ? rectal

HEENT no sore throat G/U vs. vaginal bleeding

PULMONARY no significant cough MUSCULOSKELETAL chronic joint pain

C/V no chest pain GYN s/p hysterectomy

PHYSICAL EXAMINATION: MENTAL STATUS conscious coherent B/P 170/84 TEMP 98.2

GENERAL obese HEENT no drainage NECK supple

HEART RRR LUNGS clear BS

ABDOMEN soft, non-tender

BREAST — GENITAL /PELVIC s/p hyst. no lesions

RECTAL no hemorrhoids SKIN warm - entire body

EXTREMITIES/BACK symm. no deformities

NEUROLOGICAL no sensory deficit HEIGHT ____ WEIGHT ____

IMPRESSION Rectal Bleeding

DATE 12/15/99 PHYSICIAN SIGNATURE _____

3/85
Reviewed 11/91, 9/92, 3/93 SAG

OPERATIVE REPORT **DATE:** 12/15/1999
DUBOIS REGIONAL MEDICAL CENTER
DUBOIS, PENNSYLVANIA

10/14/1941
NAME: KING, FLORENCE I 9934800357 - 000303556 OP

SURGEON: H.G. DelaTorre, M.D. ASSISTANT:

PREOPERATIVE DIAGNOSIS: Rectal bleeding.

POSTOPERATIVE DIAGNOSIS: Sigmoid diverticulosis.

NAME OF OPERATION: ?? flexible Rectosigmoidoscopy

FINDINGS: No significant hemorrhoids noted, no features noted. Patient had pelvic examination and also Pap test done recently. We showed the patient status post hysterectomy with no associated bleeding.

PROCEDURE: The procedure was explained to the patient right before starting the procedure. Patient was initially scheduled for colonoscopy but the patient backed out and was afraid of being given some sedatives or IV medications. I explained to the patient then that at least we will do a flexible sigmoidoscopy to take a look at the lower part of the colon. Patient agreed for the procedure. Patient was then placed on the table in the left lateral decubitus position and then an Olympus flexible sigmoidoscope was used. Rectal examination was done first before inserting the scope. The scope was inserted without difficulty up to the splenic flexure. No significant pathology was noted, except a few scattered big diverticulosis in the sigmoid colon. No active bleeding was seen from the diverticulosis, but cannot rule out bleeding more than a week ago. The patient tolerated the procedure very well and most of the air was removed also.

D: 12/15/1999 12:01 P
T: 12/18/1999 9:11 P HGT/der
DOCUMENT NO: 116162
Job/Tape ID: 002377

H.G. DelaTorre, M.D.

cc: H.G. DelaTorre, M.D.

Chart Copy

HS-024 King
H:\SHARING\NURSFORM\CNSSEDAT.PM5

DUBOIS REGIONAL MEDICAL CENTER
DUBOIS, PENNSYLVANIA

CONSENT FOR SEDATION
AND SPECIAL PROCEDURES

303556 58Y OSE
KING,FLORENCE I
DELATORRE,HENRY G
10/14/41 F 12/15/99
194-32-4880 9934800357

1. I authorize the performance upon Florence King of the following operation or procedure (Colonoscopy possible biopsy) (pt refused) proctosigmoidoscopy possible biopsy to be performed under the direction of Dr. Delatorre. He is authorized to utilize in the performance of the procedure, the service of such assistant(s) a he may designate.

2. If conditions arise during the course of the procedure or while I am sedated, which makes it medically advisable to extend the procedure, or to undertake procedure different from those set forth above, I authorize Dr. Delatorre or the physician authorized by him, to perform the procedures as are advisable in his/her judgment for my health and safety.

3. I consent to the administration of such sedatives as may be considered necessary or advisable by the physicians responsible for this service.

4. For the purpose of advancing medical education, I consent to the taking of photographs provided my identity is not revealed by the pictures or the descriptive text accompanying them.

5. I acknowledge that the nature, purpose, and results of such procedure and possible alternative methods of treatment have been explained to me by Dr. Delatorre. I have also been informed that there are risks such as perforation of the esophagus, stomach or colon, which may result in hospitalization and further treatment. Bleeding may occur at site of biopsy or polyp removal. Other risks may include but are not limited to drug reactions and complications from unrelated diseases. I acknowledge that no guarantees have been made to me concerning the results of the procedure. I acknowledge that I have all the information I desire, and all of my questions have been answered to my satisfaction.

Joanne [signature] | X Florence King | 12/15/99 1115 AM
(Witness) | (Signature of Patient) | (Date-Time)

The patient described herein is (a minor) (unable to give his/her consent), and I am giving consent of his behalf. I further warrant and represent that I have full and legal authority to give this permission.

Signature of person giving consent | (Relationship to Patient) | (Date-Time)

I have explained the nature and purpose of the above procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been explained. No guarantee or assurance has been given as to the result that may be obtained.

Cross out any paragraphs which do not apply.

(Signature of Physician)

Reviewed: 7/90, 9/95

OGRESS REPORT

CASTEEL CHIROPRACTIC CENTER
10 NORTH MAIN STREET
DUBOIS, PA 15801
814-371-8686

Case # 3303 X-rays

CLAIMS MANAGEMENT INC

Name Florence King Ins. PI - WAL-MART

Address 130 W MAIN ST SYKESVILLE PA Phone (home) 814-894-5410

Employment Phone (work)

Address Age 56 Sex F Ref. by

DATE OF INJURY FEB 28 1999 CLAIM # 99518770

DATE MO	DD	YR	ADJUSTMENT AND REMARKS	NEW	EST.	Total Fee	*PT/In* Paid	Adj.	Bal.
			Consultation	90620					
			Brief Exam	99201	99212				
MAR	1	1999	Intermediate Exam	99202	99213	50			
			Comprehensive Exam	99203	99214				
			CC (+)- ROM (+) SD (+) RL (+) ADSONS +- RL						
			SH +- (+) LAS +- RLB BRAG +-						
			ELY +- THOM +- GOLD +- LS PINWHEEL						
			DERF +- PI AS RC LC						
			Reflexes L/R BI Tri Rad Pat Ach						
			TTF / ROM √ R LaTcerv bending						
			Muscle Testing Pain upon extension						
MAR	1	1999	Radiology √ (R) cerv rotation						
			72010 FS A-P Lat	72072 Cervico Thoracic A-P Lat		75			
			72040 Cerv A-P Lat	72100 Lumb Pelvic A-P Lat					
			72052 Davis Series	72110 4 V Lumbo Pelvic					
			72070 Thoracic A-P Lat	70328 Open Mouth					
			X-ray Findings C6 PRI-L T, PR ASRP						
			Radiology Treatment Plan						
			Subluxation Level √S C6 Cervicalgia Cephalgia						
MAR	1	1999	ADJUSTMENT Neck Pain (R) side 10			30			
			S						
			O C6 PRI-L cc ASRP RB T, PR/SA						
			A FO						
			P 3-3 11:30						
MAR	8	1999	S Neck Pain (R) side 10			50			
			O C6 PRI-L cc ASRP RB T, PR/SA				(R) AI	(R) AC	
			A FO						
			P Wed 3/10 11:30						

CASTEEL CHIROPRACTIC CENTER
10 NORTH MAIN STREET
DUBOIS, PA. 15801
814-371-8686

Case # 3323 X-rays

CLAIMS MANAGEMENT INC

Name Florence King Ins. PI Wel Matt

Address 130 W MAIN ST SYKESVILLE PA Phone (home) 814-894-5410

Employment Phone (work)

Address Age 56 Sex F Ref. by

DATE OF INJURY FEB 28 1999 CLAIM # 99518770

DATE MO	DD	YR	ADJUSTMENT AND REMARKS	Total Fee	*PT/In* Paid	Adj.	Bal.
			PATIENT PREVIOUS BALANCE				
MAR	12	1999	S Dizzy LBP	30			
			O L5PL PI(L) C5(R) C2(L)				
			A F/				
			P 1wk 3/15 11:30				
MAR	15	999	S Dizzy LB Pain	30			
			O L5PL PI(L) C5(R) C2(L) C6 PRT-L	T1PL			
			A FO				
			P ~~1wk~~ 3-17 3/22 11:30				
MAR	26	1999	S Dizzy LB Pain neck pain "(L) sho	30			
			O L5PL PI(L) C5(R) C2(L) C6 PRT-L	T1PL	T2PR		
			A FO				
			P 1wk 3/29 11:30				
MAR	29	1999	S Dizzy neck Pain	30			
			O C2 ESL McB ASRP L5PL PI(L) T1	PL T2PR	C6PRT-L		
			A FO				
			P 4-2 3/31 11:30				
MAR	31	1999	S neck Pain Pain B/w shos	30			
			O C2 ES(L) ASRP L5PL PI(L) T1PL	T2PR	C6PRT-L		
			A FO				
			P 4-5 11:30				
APR	2	1999	S Neck pain Pain B/w shos LBP into hips	30			
			O C2 ESL ASRP L5PL PI(L) T1PL	T2PR	C6PRT-L		
			A FO SARpain PT(R)				
			P 4-5 11:30				
APR	5	1999	S neck pain	30			
			O C2 ESL ASRP L5PL PI OT1PL	T2PR	C6PRT-L		
			A FO				
			P 4-7 11:30				

CHIROPRACTIC CENTER
H MAIN STREET
S, PA. 15801
-371-8686

Case # 3323 X-rays

Name Florence King Ins. PI - WAL-MART

Address 2534 W. MAIN ST. Sykesville PA Phone (home) 814-894-6410

Employment Phone (work)

Address Age 56 Sex F Ref. by

DATE OF INJURY Feb 28 1999 CLAIM # 99518770

DATE MO	DD	YR	ADJUSTMENT AND REMARKS	Total Fee	*PT/In* Paid	Adj.	Bal.
			Patient Previous Balance				
APR	23	1999	S neck pain HA L/sided ®side	30			
			O C_2 ESL ASRP L5 PL PI© T1PL	T_2 PR	C_6 PRI-L		
			A F©				
			P 1wk 4/28 11:30 4/5. Fri	>>			
MAY	26	1999	S Very sore Today (L) T4/5 R.I Pain	30			
			O C_2 ESL ASRP L5PL PI© T1PL	T_2 PR	C_6 PRI-L		
			A F© T4/5 RHL				
			P 1wk 6/2 11:30 - 6-7 11:30				
JUN	7	1999	S Neck, slo CB	30			
			O C_2 ESL ASRP L5PL PI© T1PL	T2R	C6PRIL		
			A				
			P F. 2w 6/21 11:30				
JUN	11	1999	S neck, slo	30		1	
			O C_2 ESL ASRP L5PL PI© T1PL	T_2 PR	C_6 PRI-L		
			A F				
			P 2wk 6-21 11:30				
JUN	30	1999	S Neck, slo	30T			
			O C_2 ESL ASRP L5PL PI© T1PL T2PR C6PRI-L				
			A F				
			P 2w 7-9 11:30				
JUL	14	1999	S Upper neck Swollen Swollen glands	30T			
			O C3® C5BL PI© T1PL T2PR				
			A F				
			P 2w 7-28 11:30				
JUL	28	1999	S Upper neck	30			
			O C3® C5 BL (cc) PI© C6 PRI-L (cc)				
			A F				
			P 2wk 8/10 11:30 ©				

CASTEEL CHIROPRACTIC CENTER
10 NORTH MAIN STREET
DUBOIS, PA. 15801
814-371-8686

Case # 3323 X-rays _____

Name Florence King Ins. PI - CLAIMS MANAGEMENT INC

Address 253 W. MAIN ST. SYKESVILLE PA. Phone (home) 814-894-5410

Employment _____ Phone (work) _____

Address _____ Age 56 Sex F Ref. by _____

DATE OF INJURY 02-28-99 CLAIM # 995187 70

DATE MO	DD	YR	ADJUSTMENT AND REMARKS	Total Fee	*PT/In* Paid	Adj.	Bal.
			Patient Previous Balance				
AUG	16	1999	S General achiness	30			
			O C3 (R) C5 BL CC PI (L) C6 PRI-L (C) T2 PR(SA)				
			A F				
			P 2wk 8/20 11:30				
AUG	20	1999	S Hurts all over	30			
			O PI (L) C5 BL C6 PRI-L (MRE)				
			A F				
			P ~~2wk~~ FU 8/27 11:30				
AUG	27	999	S Still sore	30			
			O PI (L) C5 BL C6 PRI-L				
			A F				
			P 1½W 9/8 11:30				
SEP	1	1999	S HA for 2 days	30			
			O C5 BL C3 (R) (CC) PI (L)				
			A F				
			P FU 9/8 11:30				
SEP	23	999	S Pain in Neck	30			
			O C5 (L) 3 (R) PI (L)				
			A Imp				
			P 2W				
OCT	22	1999	S Pain in Neck (R)	30			
			O C5 (L) C1 (R) PI (L)				
			A Imp				
			P 2W				
OCT	29	1999	S S6 (R) Neck, Hip pain, Urinary incont	30			
			O C5 (L) C1 (R) PI (L) L5 PR				
			A Imp				
			P Pend				

CASTEEL CHIROPRACTIC CENTER
10 NORTH MAIN STREET
DUBOIS, PA. 15801
814-371-8686

Case # 3323 DX:

LEVEL

Name Florence King

Ins. PI

Address

Phone (home)

Employment

Phone (work)

Age Sex Ref. by

Address

DATE OF INJURY

CLAIM #

DATE MO	DD	YR	ADJUSTMENT AND REMARKS	Total Fee	*PT/In* Paid	Adj.	Bal.
			PATIENT PREVIOUS BALANCE				
NOV	4	1999	S [illegible]	30			
			O 15PL [illegible] C5 [illegible]				
			A [illegible]				
			P 1w				
NOV	12	1999	S Pain in neck & b/w blades	30			
			O C5(L) C1(R)(cc) L5 PL (P/P)				
			A F				
			P 1w				

CASTEEL CHIROPRACTIC CENTER
10 NORTH MAIN STREET
DUBOIS, PA 15801
814-371-8686

Case # 3323 DX: _____

LEVEL _____

PROGRESS REPORT

Name Florence King Ins. MA

Address _____ Phone (home) _____

Employment _____ Phone (work) _____

Address _____ Age _____ Sex _____ Ref. by _____

DATE OF INJURY CLAIM #

DATE MO	DD	YR	ADJUSTMENT AND REMARKS	Total Fee	*PT/In* Paid	Adj.	Bal.
			Consultation 99241 NEW EST.				
			W.C. N.F. P.I. 2nd 99212				
			Intermediate Exam 99202 99213				
			Brief Exam 99211				
			CC +- RLM SD +- RL ADSONS +- RL				
			SH +- LAS +- RLB BRAG +-				
			ELY +- THOM +- GOLD +- LS PINWHEEL				
			DERF +- PI AS RC LC				
			Reflexes L/R Bi Tri Rad Pat Ach				
			TTF / ROM				
			Muscle Testing				
			Radiology				
			72010 FS A-P Lat 72072 Cervico Thoracic A-P Lat				
			72040 Cerv A-P Lat 72100 Lumb Pelvic A-P Lat				
			72052 Davis Series 72110 4 V Lumbo Pelvic				
			72070 Thoracic A-P Lat 70328 Open Mouth				
			X-ray Findings				
			Radiology Treatment Plan				
			Subluxation Level				
NOV	16	1999	98940 Adjustment	30	0		1
			S Neck, UB				
			O: C5(L) C1(R) PI(L) L5PL				
			A				
			P				
DEC	2	1999	S Ringing in Ears, Neck stiff	30	1		1
			O C1(R) PI(L) L5PL				
			A				
			P				

CASTEEL CHIROPRACTIC CENTER
10 NORTH MAIN STREET
DUBOIS, PA 15801
814-371-8686

Case # 3303 X-rays

CLAIMS MANAGEMENT INC

OGRESS REPORT

Name Florence King

Ins. PI - WAL-MART

Address 130 W MAIN ST SYKESVILLE PA

Phone (home) 814-894-5410

Employment

Phone (work) 5.00 / VISIT

Address

Age 56 Sex F Ref. by

DATE OF INJURY FEB 28 1999

CLAIM # 99518770

DATE MO	DD	YR	ADJUSTMENT AND REMARKS	Total Fee	*PT/In* Paid	Adj.	Bal.
			Consultation 90620 NEW EST.				
			Brief Exam 99201 99212				
MAR	1	1999	Intermediate Exam 99202 99213	50		50	
			Comprehensive Exam 99203 99214				
			CC +- RLM SD +- RL ADSONS +- RL				
			SH +- LAS +- RLB BRAG +-				
			ELY +- THOM +- GOLD +- LS PINWHEEL				
			DERF +- PI AS RC LC				
			Reflexes L/R Bi Tri Rad Pat Ach				
			TTF / ROM √ R Lateral bending				
			Muscle Testing Pain upon extension				
MAR	1	1999	Radiology √ (R) cervical rotation				
			72010 FS A-P Lat 72072 Cervico Thoracic A-P Lat	25		75	
			72040 Cerv A-P Lat 72100 Lumb Pelvic A-P Lat				
			72052 Davis Series 72110 4 V Lumbo Pelvic				
			72070 Thoracic A-P Lat 70328 Open Mouth				
			X-ray Findings C6 PRI L T1 PR ASRP				
			Radiology Treatment Plan				
			Subluxation Level L/S C6 Cervicalgia Cephalgia				
MAR	1	1999	ADJUSTMENT Neck Pain (R) side 1°	30		25	5
			S C6 PRI L cc ASRP RS T1 PR/SA				
			O				
			A FC				
			P 3-5 11:30				
MAR	9		S Neck Pain (R) side 10	50		45	10
			O C6 PRI L cc ASRP RS T1 PR/SA		(R) AI	(R) AC	
			A FC				
			P wed 3/10 11:30				

CASTEEL CHIROPRACTIC CENTER
10 NORTH MAIN STREET
DUBOIS, PA. 15801
814-371-8686

Case # 3323 X-rays

CLAIMS MANAGEMENT INC

Name Florence King Ins. PI ~~Wel Mart~~

Address 130 W MAIN ST SYKESVILLE PA Phone (home) 814-894-5410

Employment Phone (work) 5.00/ VISIT

Address Age 56 Sex F Ref. by

DATE OF INJURY FEB 28 1999 CLAIM # 99518770

DATE MO	DD	YR	ADJUSTMENT AND REMARKS	Total Fee	*PT/In* Paid	Adj.	Bal.
			PATIENT PREVIOUS BALANCE				
MAR	12	1999	S Dizzy LB Pain	30		25	15
			O Lip PRI C5 Ⓡ C2 Ⓛ				
			A F-				
			P 1 wk 3/15 11:30				
MAR	15	1999	S Dizzy LB Pain	30		25	20
			O L5 PL PI Ⓛ C5 Ⓡ C2 Ⓛ C6 PRI-L	T1 PL			
			A F Ⓒ				
			P ~~1 wk~~ 3-17 3/22 11:30				
MAR	26	1999	S Dizzy LB Pain neck pain Ⓛ sho	30		25	25
			O L5 PL PI Ⓛ C5 Ⓡ C2 Ⓛ C6 PRI-L	T1 PL	T2 PR		
			A F Ⓒ				
			P 1wk 3/29 11:30				
MAR	29	1999	S Dizzy neck Pain	30		25	30
			O C2 ESL mcB ASRP L5 PL PI Ⓒ T1 PL T2 PR			C6 PRI-L	
			A F Ⓒ				
			P 4-2 3/31 11:30				
MAR	31	1999	S neck Pain Pain B/w shos	30		25	35
			O C2 ES Ⓛ ASRP L5 PL PI Ⓛ T1 PL	T2 PR	C6 PRI-L		
			A F Ⓒ				
			P 4-5 11:30				
APR	2	1999	S neck pain Pain B/w shos LBP into hips	30		25	40
			O C2 ESL ASRP L5 PL PI Ⓛ T1 PL	T2 PR	C6 PRI-L		
			A F Ⓒ SARp.11 PI Ⓡ				
			P 4-5 11:30				
APR	5	1999	S neck pain	30		25	45
			O C2 ESL ASRP L5 PL PI Ⓛ T1 PL	T2 PR	C6 PRI-L		
			A F Ⓒ				
			P 4-7 11:30				

CHIROPRACTIC CENTER
TH MAIN STREET
S, PA. 15801
-371-8686

Case # 3323 X-rays

Name Florence King Ins.

Address 2534 W. MAIN ST. SYKESVILLE PA Phone (home) 5.00/ 121SIT

Employment Phone (work)

Address Age 56 Sex F Ref. by

DATE OF INJURY Feb 2x 1999 CLAIM # 995187770

DATE MO	DD	YR	ADJUSTMENT AND REMARKS	Total Fee	*PT/In* Paid	Adj.	Bal.
	-		Patient Previous Balance				
APR	23	1999	S neck pain HA s/w shoi (R) side	30		25	50
			O C_2 ESL ASRP L_5 PL PI(C) T_1 PL	T_2 PR	C_6 PRI-L		
			A F(C)				
			P 1wk 4/28 11:30 4/5. Fri				
MAY	26	1999	S Very sore today (L) T4/5 R.I Pain	30		25	55
			O C_2 ESL ASRP L_5 PL PI(C) T_1 PL	T_2 PR	C_6 PRI-L		
			A F(C) T4/5 RHL)				
			P 1wk 6/2 11:30 - 6-7 11:30				
JUN	7	1999	S Neck, slo C3	30		25	60
			O C_2 ESL ASRP L_5 PL PI(C) T_1 PL	T_2 PR	C_6 PRI-L		
			A F.				
			P 2w 6/21 11:30				
JUN	11	1999	S neck, slo	30		25	65
			O C_2 ESL ASRP L_5 PL PI(C) T_1 PL	T_2 PR	C_6 PRI-L		
			A F				
			P 2wk 6-21 11:30				
JUN	30	1999	S Neck, slo	30		25	70
			O C_2 ESL ASRP L_5 PL PI(C) T_1 PL	T_2 PR	C_6 PRI-L		
			A F				
			P 2w 7-9 11:30				
MA JUL	14	1999	S (C) upper neck swollen Swollen glands	30			71
			O C3(C) C_5 PL PI(C) T1R TEN				
			A F				
			P 2w 7-28 11:30				
JUL	28	1999	S Upper neck	30			72
			O C3(R) C5 BL (cc) PI(C) C6 PRI-L (cc)				
			A F				
			P 2wk 8/10 11:30 (C)				
			X				

CASTEEL CHIROPRACTIC CENTER
10 NORTH MAIN STREET
DUBOIS, PA. 15801
814-371-8686

Case # 3323 X-rays

Name Florence King Ins. IN

Address 253 W. MAIN ST. Sykesville PA. Phone (home) 814-894-5410

Employment Phone (work)

Address Age 56 Sex F Ref. by

DATE OF INJURY 02-28-99 CLAIM # 995187A

DATE MO	DD	YR		ADJUSTMENT AND REMARKS	Total Fee	*PT/In* Paid	Adj.	Bal.
				Patient Previous Balance				
AUG	16	1999	S	General achiness	30			73
			O	C3 (R) C5 BL (C) PI (L) C6 PRI-L (C) T2 PR(SA)				
			A	F				
			P	2wk 8/20 11:30				
AUG	20	1999	S	Hurts all over	30			74
			O	PI (L) C5 BL C6 PRI-L (MRE)				
			A	F				
			P	~~2wk~~ Fri 8/27 11:30				
AUG	27	999	S	Still sore	30			75
			O	PI (L) C5 BL C6 PRI-L				
			A	F				
			P	1½ W 9/8 11:30				
SEP	1	1999	S	HA for 2 days	30			1
			O	C5 BL C3 (R) (cc) PI (L)				
			A	F				
			P	Fri 9/8 11:30				
SEP	23	999	S	Pain in Neck	30		05	2
			O	C5 (L) 3 (R) PI (L)				
			A	for				
			P	1W				
OCT	22	1999	S	Pain in Neck (R)	30			3
			O	C5 (L) C1 (R) PI (L)				
			A	for				
			P	1W				
OCT	29	1999	S	S6 (L) Neck, Hip pain, Urinary incontinence	30			4
			O	C5 (L) C1 (R) PI (L) 15#				
			A	for				
			P	Rest				

CASTEEL CHIROPRACTIC CENTER
10 NORTH MAIN STREET
DUBOIS, PA. 15801
814-371-8686

Case # 3323 DX: ______

LEVEL ______

Name Florence King | Ins. PI

Address ______ | Phone (home) ______

Employment ______ | Phone (work) ______

Address ______ | Age ______ Sex ______ Ref. by ______

DATE OF INJURY | CLAIM #

DATE MO	DD	YR	ADJUSTMENT AND REMARKS	Total Fee	*PT/In* Paid	Adj.	Bal.
			PATIENT PREVIOUS BALANCE				
NOV	4	1999	S [illegible]	30			5
			O L5 PL [illegible] C5 [illegible]				
			A [illegible]				
			P Iw				
NOV	12	1999	S Pain in neck ē b/w blades	30			6
			O C5 Ⓛ C1 Ⓡ (cc) L5 PL (r/p)				
			A F				
			P Iw				

INITIAL REPORT

TO: CLAIMS MANAGEMENT INC CLAIM # 99518770

PATIENT FLORENCE KING

EMPLOYER N/A DATE OF INJURY/ONSET 02-28-1999

1. Incident of Injury HOT CURLERS BOX FELL ON HEAD IN FRONTAL REGION WEIGHT OF BOX WAS 8 TO 10 LBS. INCIDENT OCCURRED AT DUBOIS WAL-MART STOR
2. Patient's Complaints NECK PAIN & HEADACHES
3. Objective Findings (Examination) TTP' c-6 © Sup c-6 © ⊕CC n ⊕Shr Rf. © ⊕Soto Hall; ↓ @ Ant cervical Flexion Pain upon extension ↓ @ cervical rotation
4. X-Ray Analysis Summary AP and LAT Cervico-Dorsal X-rays revealed the following!
5. Diagnosis — ICDA # 839.06 VERTEBRAL SUBLUXATION OF CERVICAL SPINE C-6 CERVICALGIA 723.1 784.0 CEPHALGIA
6. Alternate Summary (Comments)
7. Disability Data
8. Examination Forms Attached? ☐ Yes ☐ No
9. Additional Evaluations Attached? ☐ Yes ☐ No
10. Accident Report Attached? ☐ Yes ☐ No

Doctor's Signature

04/02/99
Date

Completed by

CASTEEL CHIROPRACTIC CNTR

100 Main St.
DuBois, PA 15801

Name Florence King

Date Feb 12, 1999

OUCH! OUCH! OUCH!

Have you had an accident or an injury since your last Adjustment? Yes ✓ No ___

If so, please describe the injury and how it happened. ALSO GIVE DATE

I was getting out of my car slip + fall Landing on (R) side hit (R) knee (R) wrist (L) Arm hit concrete curb also Twisting in LB area

Did it happen at work? Yes ___ No X

Was it an automobile accident? Yes ___ No X

Where is your pain? Please describe the location. (Low back, leg pain, neck pain.)
Type of pain. (Sharp, dull, numbness, burning, etc.)

(R) Arm (R) hip Pain is servere sharp burning Type

Please fill out and give to our Receptionist.

Florence King
Signature

PERSONAL INJURY QUESTIONNAIRE

Name Florence Kina Phone (814) 894-5410

Address 130 W Main ST City Ex Kesuille State PA Zip 15865

Age 56 Birthdate 10-14-41 Sex F S/S # 184-32-4880

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy # _____ Agent's Name _____

Name on Policy (If other than self) _____ Policy # _____

Responsible Party's Name _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Policy # _____

ATTORNEY

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? ( ) Yes ( ) No Name(s) _____

NATURE OF ACCIDENT:

1. Date of Accident 2-28-1999 Time of Day 12:45
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? _____ Were you wearing seat belts? _____
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
5. What direction was other vehicle headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Approximate speed of your car _____ mph Other car _____ mph
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
9. Were police notified? ( ) Yes ( ) No (FS-1016) Box > sft on shelf
10. In your own words, please describe accident: Hot Curler Box Fell on My (Front) Head at DuBois Wal-Mart on 2-28-99 Tyler

11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes (X) No If yes, please describe in detail:

12. Please describe how you felt:
    a. DURING the accident: Headache, Pain in my head + neck
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: Headache + Neck Pain Stiffness in neck dizziness Shoulder Pain
    d. THE NEXT DAY: Same

13. What are your PRESENT complaints and symptoms? Headache, Pain & stiffness in neck & shoulder

14. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes (X) No If yes, please describe:

15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No If yes, please describe:

16. Have you ever been involved in an accident before? ( ) Yes (X) No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received.

17. Where were you taken after the accident? Home

18. Have you been treated by another doctor since the accident? ( ) Yes (X) No If yes, please list doctor's name and address:

What type of treatment did you receive?

19. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☒ Headache	☐ Irritablity	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☒ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☒ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems Too Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arms	☐ Lights Bother Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ _____

Symptoms Other Than Above

21. Have you lost time from work as a result of this accident? ( ) Yes (X) No If yes, please complete this question.

a. Last Day Worked:

b. Type of Employment:

c. Present Salary:

d. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compensation you are receiving:

22. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No If yes, please describe, in detail:

23. Other pertinent information:

3-1-99
DATE

Florence King
PATIENT'S SIGNATURE

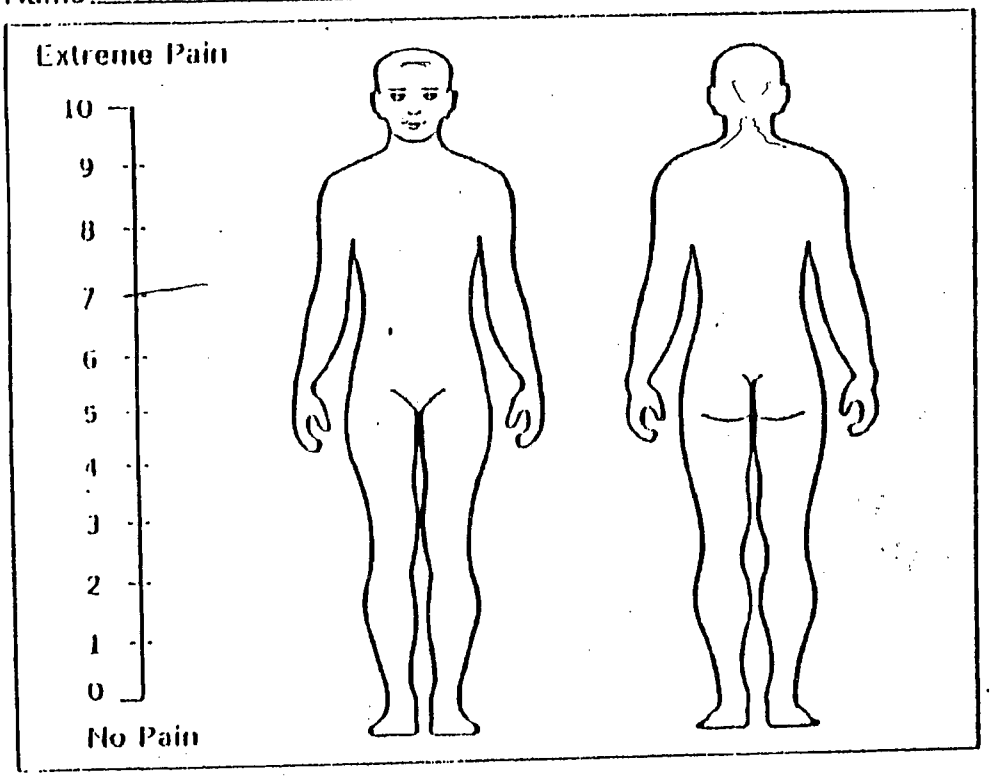
BILL TO: CLAIMS MANAGEMENT INC.
P.O. BOX 8083
BENTONVILLE AR 72712-8083

CLAIM #
99518770
EMP
Q0678 ADJ
JENNIFER BROW

1-800-527-0566

PAIN ASSESSMENT

Name Florence King Date 3-1-99



Please indicate the areas of your pain on the figures above. Then mark the severity of your pain on the scale of 0-10.

Describe any changes in your condition or any new concerns:

Head Ache, Pain in neck, Dizzy ~~Pain~~
Didn't Know my selve for About 2 minutes

X Patient Signature Florence King

#20440 — Medical Arts Press 1-800-328-2179

CALLED
7-21-99
7-26-99
8-26-99
CALLED
OUT OFF
OFFICE
UNTIL
8-31-99

How - Box FALL on my Head at Wal-Mart (HOT Rollers Box)

When Feb 28- 1999 12:45 AM

Where WAL-MART

Deb - Cashier

Manager

CASE HISTORY RECORD

DATE 9-9-92 CASE NO. 3323

SOC. SEC.# 184-32-4880

INSTRUCTIONS: PLEASE PRINT BIRTHDATE: 10-14-41

NAME King (LAST) Florence (FIRST) I (INITIAL) 50 (AGE)

ADDRESS Rd #1 (NO.) Box 82 (STREET) DuBois (CITY) PA. (STATE) 15801 (ZIP)

MALE ____ FEMALE ✓ NUMBER OF CHILDREN 5

MARRIED ____ SINGLE ____ OTHER Divorced

EMPLOYED Yes FULL-TIME STUDENT ____ PART-TIME STUDENT ____

TELEPHONE ~~371-9852~~ (DuBois 7) OCCUPATION Bartender

BUSINESS PHONE 371-9852 WHERE EMPLOYED Sport Spot

SPOUSE'S NAME ____ WHERE EMPLOYED ____

PARENT'S NAME ____ WHERE EMPLOYED ____

PREVIOUS: CHIROPRACTIC DR. Dr Tardi, Sacter MEDICAL DR. ____ OTHER DR. ____

DATE ILLNESS BEGAN OR ACCIDENT OCCURRED: (Circle which applies) Years

IF ACCIDENT, WHERE AND HOW DID IT OCCUR? ____

WAS IT AN ON-THE-JOB ACCIDENT? ____ WAS IT REPORTED? ____ TO WHOM? ____

IF AUTO ACCIDENT, WHICH STATE DID IT HAPPEN IN? ____ WAS IT REPORTED? ____

•••IMPORTANT•••

Please list below three or more main complaints you have in order of their importance. Also, the length of time you have had them.

1. Rgt Hip/Legs Numb HOW LONG? Last 3 wks
2. ____ HOW LONG? ____
3. ____ HOW LONG? ____
4. ____ HOW LONG? ____
5. ____ HOW LONG? ____

LIST ANY SURGERY YOU HAVE HAD AND THE YEAR IT WAS DONE Hysterectomy 1982.

INJURIES (Car wrecks, falls, etc.) ____

FAMILY HISTORY (Please list any family illness such as tuberculosis, diabetes, cancer, arthritis, high blood pressure, etc.):

patient taking Tegretol, Maxzide, Xmax - nerve pills. heart palpitation

FEMALE HISTORY: DATE OF LAST MENSTRUAL CYCLE None

REGULAR ____ IRREGULAR ____ BIRTH CONTROL PILLS YES ____ NO ____

DO YOU HAVE CRAMPING? ____ ARE YOU PREGNANT AT THIS TIME? ____

Continued on Back

DO YOU HAVE ANY TROUBLE WITH ANY OF THE FOLLOWING:

	YES	NO		YES	NO
1. HEADACHES	✓		11. DIGESTION	✓	
2. EAR		✓	12. CONSTIPATION		✓
3. SINUS		✓	13. URINATION		✓
4. EYE (vision)	✓		14. LOWER BACK	✓	
5. NECK	✓		15. LEG PAINS/NUMBNESS	✓	
6. SHOULDER		✓	16. JOINT SWELLING	✓	
7. CHEST PAINS		✓	17. GENERAL WEAKNESS	✓	
8. SHORTNESS OF BREATH		✓	18. TENSION	✓	
9. BLOOD PRESSURE	✓	✓	19. NERVOUSNESS	✓	
10. ARMS (wrist, elbows, hands)	✓		20. MENSTRUAL TROUBLES		✓

INSURED INFORMATION

INSURED'S NAME _____ (LAST / FIRST / INITIAL)

INSURED'S ADDRESS _____ (NO. / STREET / CITY / STATE / ZIP)

INSURED'S: SOC. SEC. NO. _____ PHONE NO. _____

BIRTHDATE _____ SEX: F _____ M _____

EMPLOYER'S NAME OR SCHOOL NAME _____

NAME OF INSURANCE COMPANY _____

INSURANCE COMPANY ADDRESS _____

POLICY # _____

GROUP # _____

PLAN NAME _____

IS THERE ANOTHER HEALTH BENEFIT PLAN? YES _____ NO ✓

IF YES, INSURED'S NAME _____ (LAST / FIRST / INITIAL)

INSURED'S ADDRESS _____ (NO. / STREET / CITY / STATE / ZIP)

INSURED'S: SOC. SEC. NO. _____ PHONE NO. _____

BIRTHDATE _____ SEX: F _____ M _____

EMPLOYER'S NAME OR SCHOOL NAME _____

NAME OF INSURANCE COMPANY _____

INSURANCE COMPANY ADDRESS _____

POLICY # _____

GROUP # _____

PLAN NAME _____

****FOR MEDICARE PATIENTS ONLY**** IF YOU HAVE INSURANCE OTHER THAN MEDICARE, IS YOUR INSURANCE:

PRIMARY TO MEDICARE? _____ MEDIGAP (YOU PAY FOR MEDICARE SUPPLEMENT)? _____

EMPLOYER SUPPLEMENT (PAST OR PRESENT EMPLOYER PAYS FOR SUPPLEMENT)? _____

MEDICAID (MEDICAL ASSISTANCE)? _____ IF YES, WHAT STATE? _____

REFERRED BY: ☑ FRIEND ☐ RELATIVE ☐ RADIO ☐ NEWSPAPER ☑ PHONE BOOK

In order for us to properly determine who will receive a chiropractic adjustment for referring you to our office, please write their full name on the following line: _____

NOTICE TO OUR NEW PATIENTS: YOU ARE RESPONSIBLE FOR ALL FEES NOT COVERED BY YOUR INSURANCE COMPANY, UNLESS OTHER ARRANGEMENTS ARE MADE WITH THE DOCTOR.

SIGNED: Florence King

DATED: 9-9-92

UPDATE

NAME Florence King DATE 7-6-94

CURRENT ADDRESS RD #1 Box 82

CITY DuBois STATE PA ZIP 15801

TELEPHONE (HOME) 583-7838 (WORK) 371-3780

CURRENT MARITAL STATUS: MARRIED _____ SINGLE _____ OTHER Divorce

NUMBER OF CHILDREN 3 CURRENT EMPLOYER Moose Lodge

CURRENT INSURANCE COVERAGE _____

IF OTHER THAN PATIENT: INSURED"S NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE # _____ BIRTHDATE _____ CURRENT EMPLOYER _____

In order for us to best serve you, we must, naturally, have all available information regarding your present health. To bring our original case history up to date would you please provide us with the following information;

PLEASE PRINT:

1. MY SYMPTOMS ARE Ears Blocking Pain in Right Shoulder ~~&~~ Lower Back Pain
2. RECENT FALLS No
3. RECENT SURGERIES No
4. RECENT ACCIDENTS No
5. LAST PHYSICAL 1994 Feb.
6. LAST ADJUSTMENT 9-1-93
7. SINCE I LAST SAW YOU, I HAVE BEEN SEEN BY DR. _____

   FOR _____
8. PATIENT COMMENTS: _____

PATIENT SIGNATURE Florence King

UPDATE

8-16-93

NAME Florence Mae King DATE ~~583-7838~~

CURRENT ADDRESS RD #1 Box 82

CITY DuBois STATE PA ZIP 15801

TELEPHONE (HOME) 583-7838 (WORK) 371-9852

CURRENT MARITAL STATUS: MARRIED _____ SINGLE _____ OTHER Divorced

NUMBER OF CHILDREN _____ CURRENT EMPLOYER Sports Spot

CURRENT INSURANCE COVERAGE _____

IF OTHER THAN PATIENT: INSURED"S NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE # _____ BIRTHDATE _____ CURRENT EMPLOYER _____

In order for us to best serve you, we must, naturally, have all available information regarding your present health. To bring our original case history up to date would you please provide us with the following information;

PLEASE PRING:

1. MY SYMPTOMS ARE Numbness Right Leg & Hip & Pain
2. RECENT FALLS no
3. RECENT SURGERIES no
4. RECENT ACCIDENTS no
5. LAST PHYSICAL _____
6. LAST ADJUSTMENT 12-92.
7. SINCE I LAST SAW YOU, I HAVE BEEN SEEN BY DR. _____

   FOR _____
8. PATIENT COMMENTS: _____

PATIENT SIGNATURE Florence King

CASTEEL CHIROPRACTIC CNTR

100 Main St.
DuBois, PA 15801

Name Florence Long

Date JUN 16 1995

OUCH! OUCH! OUCH!

Have you had an accident or an injury since your last Adjustment? Yes ____ No ✓

If so, please describe the injury and how it happened. ALSO GIVE DATE

Did it happen at work? Yes ____ No —

Was it an automobile accident? Yes ____ No —

Where is your pain? Please describe the location. (Low back, leg pain, neck pain.)
Type of pain. (Sharp, dull, numbness, burning, etc.)

Right Hip - Leg Numb. (LOT OF PAIN)

Please fill out and give to our Receptionist.

Flo King

Signature

INITIAL REPORT

TO: CLAIMS MANAGEMENT INC CLAIM # 99518770

PATIENT FLORENCE KING

EMPLOYER N/A DATE OF INJURY/ONSET 02-28-1999

1. Incident of Injury HOT CURLERS BOX FELL ON HEAD IN FRONTAL REGION WEIGHT OF BOX WAS 8 TO 10 LBS. INCIDENT OCCURRED AT DUBOIS WAL-MART STORE
2. Patient's Complaints NECK PAIN & HEADACHES
3. Objective Findings (Examination) TTP c-6 ① Sup c-6 ② ④CC m ④Sh. Rt ① ③Soto Hall; ↓ @ lat cervical flexion Pain upon extension ↓ @ cervical rotation
4. X-Ray Analysis Summary A-P and LAT Cervico-Dorsal X-rays revealed the following:
5. Diagnosis — ICDA # 839.06 VERTEBRAL SUBLUXATION OF CERVICAL SPINE C-6 CERVICALGIA 723.1 784.0 CEPHALGIA
6. Alternate Summary (Comments)
7. Disability Data
8. Examination Forms Attached? ☐ Yes ☐ No
9. Additional Evaluations Attached? ☐ Yes ☐ No
10. Accident Report Attached? ☐ Yes ☐ No

Doctor's Signature

04/02/99
Date

Completed by

A108
Reorder H.J. Ross Co. (714) 539-2130

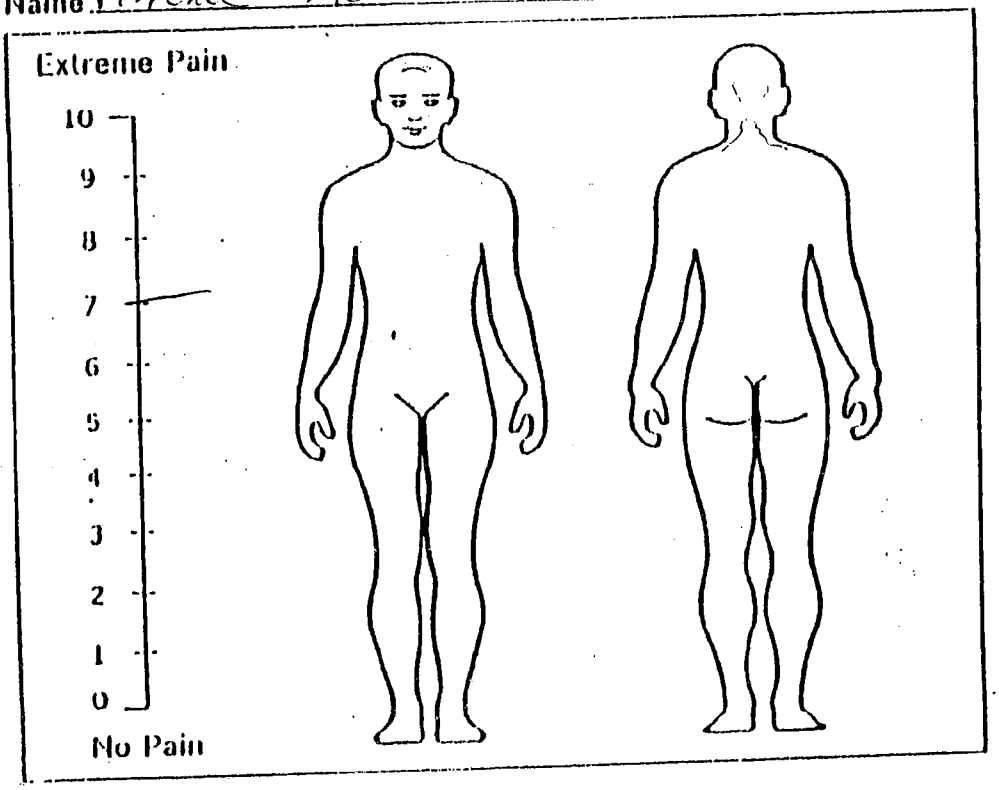
BILL TO: CLAIMS MANAGEMENT INC.
P.O. BOX 8083
BENTONVILLE AR 72712-8083

CLAIM #
995187 70
EXT
80678 ADJ
JENNIFER BROW

-800-527-0566

PAIN ASSESSMENT

Name Florence King Date 3-1-99



Please indicate the areas of your pain on the figures above. Then mark the severity of your pain on the scale of 0-10.

Describe any changes in your condition or any new concerns:

Headache, Pain in neck, Dizzy [redacted]
Didn't Know my name for About 2 minutes

X Patient Signature Florence King

#20440 — Medical Arts Press 1-800-328-2179

CALLED
7-2199
7-26-99
8-26-99
CALLED
OUT OF
OFFICE
UNTIL
8-31-99

Naw - Box FALL on my head at Wal-Mart (Hot Rollers Box)

When Feb 28 1999 12:45 AM

Where WAL-MART.

Debi Cashier

PERSONAL INJURY QUESTIONNAIRE

Name Florence King Phone (814) 834-3410

Address 130 W. MAIN ST City DuBois State PA Zip 15801

Age 56 Birthdate 10-14-41 Sex F S/S # 154-32-4880

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy # _____ Agent's Name _____

Name on Policy (if other than self) _____ Policy # _____

Responsible Party's Name _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Policy # _____

ATTORNEY

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? ( ) Yes ( ) No Name(s) _____

NATURE OF ACCIDENT:

1. Date of Accident 2-28-1999 Time of Day 12:45
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? _____ Were you wearing seat belts? _____
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
5. What direction was other vehicle headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Approximate speed of your car _____ mph Other car _____ mph
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
9. Were police notified? ( ) Yes ( ) No
10. In your own words, please describe accident: HOT CURLER BOX FELL ON MY (Lights) HEAD AT DuBois WAL-MART ON 2-28-99

11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes (X) No If yes, please describe in detail:

12. Please describe how you felt:
    a. DURING the accident: ~~Headache~~, Pain in my Head & Neck
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: Head Ache & Neck Pain Stiffness in Neck Shoulder Pain
    d. THE NEXT DAY: SAME

13. What are your PRESENT complaints ... symptoms? Headache, Pain & Stiffness in Neck + Shoulder.

14. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes (←) No If yes, please describe:

15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No If yes, please describe:

16. Have you ever been involved in an accident before? ( ) Yes (←) No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received.

17. Where were you taken after the accident? Home

18. Have you been treated by another doctor since the accident? ( ) Yes (X) No If yes, please list doctor's name and address:

What type of treatment did you receive?

19. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☒ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☒ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☒ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems Too Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arms	☐ Lights Bother Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ _____

Symptoms Other Than Above

21. Have you lost time from work as a result of this accident? ( ) Yes (X) No If yes, please complete this question.

a. Last Day Worked:

b. Type of Employment:

c. Present Salary:

d. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compensation you are receiving:

22. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No If yes, please describe, in detail:

23. Other pertinent information:

3-1-99
DATE

Florence King
PATIENT'S SIGNATURE

CLAIMS MANAGEMENT
P.O. BOX 806
[illegible]

02/03/1999

Florence King
130 S. Main St
Sykesville, PA 15865

RE: Florence King
FILE #: 99518770 - CLAIM #
DATE OF LOSS: 02/[illegible]/1999
STORE #:1769

Dear Ms. King :

Claims Management, Inc., is the claims handler for Wal-Mart Stores, Inc., and its self-insurance carriers regarding customer incidents.

I am very sorry to hear of your incident which occurred at Wal-Mart/Sam's Club and was reported to us by the store. I have been unable to reach you by telephone.

If you have experienced problems arising from this incident, please let me know by calling (800) 527-0566 extension 20671.

Wal Mart values you as a customer and hopes you will continue to shop at your local Wal-Mart/Sam's Club.

Sincerely,

B.J. Parrish
Case Manager
General Liability Division

Claims Management, Inc.
(dba)
Claims Management, Inc. of Arkansas
Arkansas Claims Management, Inc.

INDIANA OPEN MRI

119 Professional Center, Suite 305 ◆ Indiana, Pennsylvania 15701 Toll Free 888-270-9222 (412) 349-3110
Fax (412) 349-3119

FLORENCE I. KING
SS # 184-32-4880
Dr. John Markley
January 29, 1998
Patient # 05700

MRI OF THE LUMBAR SPINE

HISTORY: Left leg coldness and numbness, lateral aspect. Occasional low back pain.

TECHNIQUE: Images were performed in the sagittal and axial planes. The axial images were angled through each disc space from L2-3 through L5-S1. Routine pulse sequences were used.

FINDINGS: Comparison is made with a CT scan of the lumbosacral spine of October 9, 1997.

There is some desiccation of L4-5 and L5-S1 and to a lesser extent L3-4.

There is slight retro-listhesis of L5 posterior relative to S1.

A disc herniation is noted on the left at L5-S1. There is left sided neuroforaminal narrowing at this level. There is lesser right sided neuroforaminal narrowing noted at this level. There is some degree of bilateral neuroforaminal narrowing of L4-5.

A disc bulge is noted at L4-5 and L3-4. The disc bulge that is noted at L3-4 is best visualized on the axial images. This is slightly more prominent on the left.

Ligamentum flavum and facet hypertrophy is noted from L2-3 through L5-S1. Mild central canal narrowing is noted at L2-3. Mild central canal narrowing is noted at L3-4. Mild central canal narrowing is noted at L4-5.

IMPRESSION: CENTRAL CANAL AND NEUROFORAMINAL NARROWING AS NOTED. A DISC HERNIATION IS NOTED ON THE LEFT AT L5-S1. THIS IMPINGES UPON THE EXITING L5 NERVE ROOT AT THIS LEVEL. DISC BULGING AS NOTED. THERE ARE NO FOCAL ABNORMALITIES OF THE CAUDA EQUINA OR CONUS MEDULLARIS.

Thank you for giving us the opportunity to examine your patient.

Christopher N. Hobbie, MD

CH\gca

CASTEEL CHIROPRACTIC CNTR

100 Main St.
DuBois, PA 15801

Name Florence King

Date Feb 12, 1999

OUCH! OUCH! OUCH!

Have you had an accident or an injury since your last Adjustment? Yes ✓ No ___

If so, please describe the injury and how it happened. ALSO GIVE DATE

I was getting out of my car slip & fall Landing on (R) side hit (R) knee (R) wrist (L) Arm hit concrete curb also Twisting in LB area

Did it happen at work? Yes ___ No X

Was it an automobile accident? Yes ___ No X

Where is your pain? Please describe the location. (Low back, leg pain, neck pain.)
Type of pain. (Sharp, dull, numbness, burning, etc.)

(R) Arm (R) hip Pain is servere sharp burning Type

Please fill out and give to our Receptionist.

Florence King

Signature

CLAIMS MANAGEMENT, INC.
P.O. BOX 8083
BENTONVILLE, AR 72712-8083

03/03/1999

Florence King
130 W. Main St
Sykesville, PA 15865

RE: Florence King
FILE #: 99518770 - CLAIM #
DATE OF LOSS: 02/28/1999
STORE #:1769

Dear Ms. King :

Claims Management, Inc., is the claims handler for Wal-Mart Stores, Inc., and their insurance carrier, regarding customer incidents.

I am very sorry to hear of your incident which occurred at Wal-Mart/Sam's Club and was reported to us by the store. I have been unable to reach you by telephone.

If you have experienced problems arising from this incident, please let me know by calling (800) 527-0566 extension 20671.

Wal-Mart values you as a customer and hopes you will continue to shop at your local Wal-Mart/Sam's Club.

Sincerely,

B.J. Parrish
Case Manager
General Liability Division

Claims Management, Inc.
(dba)
Claims Management, Inc. of Arkansas
Arkansas Claims Management, Inc.

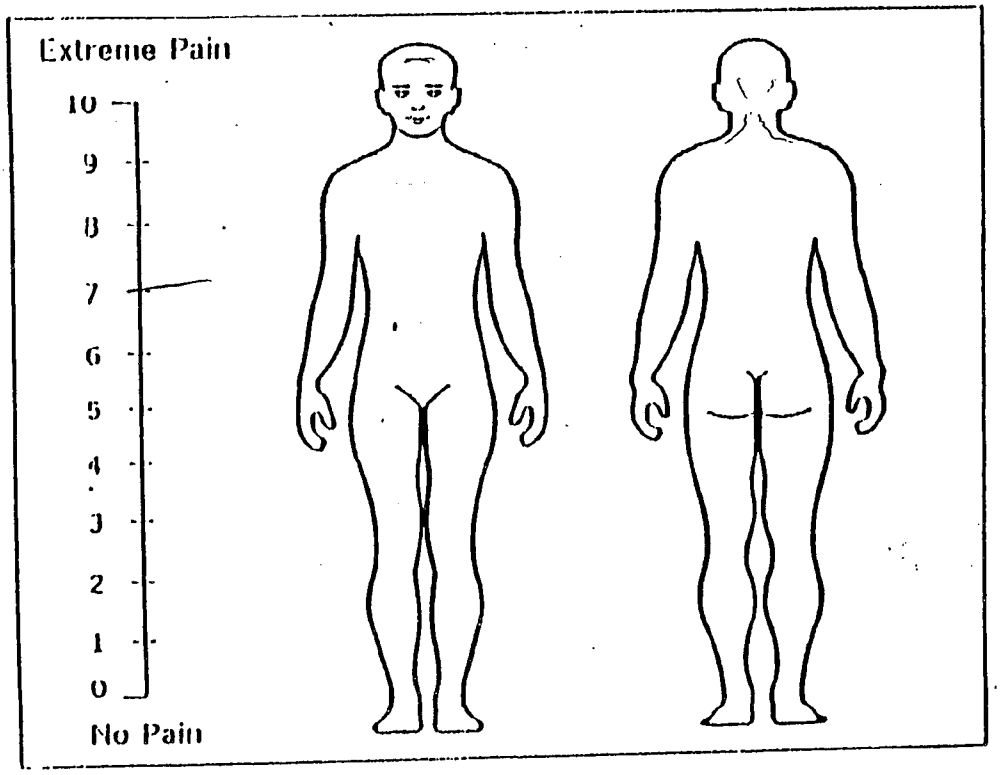
BILL TO: CLAIMS MANAGEMENT INC.
P.O. BOX 8083
BENTONVILLE AR 72712-8083

CLAIM # 9951870 EXT 80678 ADJ JENNIFER BROWN

1-800-527-0566

PAIN ASSESSMENT

Name Florence King Date 3-1-99



Please indicate the areas of your pain on the figures above. Then mark the severity of your pain on the scale of 0-10.

Describe any changes in your condition or any new concerns:

Head Ache, Pain in neck, Dizzy ~~Pain~~

Didn't Know my selve For About 2 minutes

X Patient Signature Florence King

#20440 — Medical Arts Press 1-800-328-2179

CALLED 7-27-99 7-26-99 8-26-99 CALLED OUT OF Office UNTIL 8-31-99

Now - Box FALL on my Head at Wal-Mart (Hot Rollers Box)

When Feb 28-1999 12:45 AM

Where WAL-MART

Deb - Cashier

Manager

PERSONAL INJURY QUESTIONNAIRE

Name Florence King Phone (814) 894-5410

Address 130 W Main ST City Sykesville State PA Zip 15865

Age 56 Birthdate 10-14-41 Sex F S/S # 184-32-4880

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy # _____ Agent's Name _____

Name on Policy (If other than self) _____ Policy # _____

Responsible Party's Name _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Policy # _____

ATTORNEY

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? ( ) Yes ( ) No Name(s) _____

NATURE OF ACCIDENT:

1. Date of Accident 2-28-1999 Time of Day 12:45
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? _____ Were you wearing seat belts? _____
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
5. What direction was other vehicle headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Approximate speed of your car _____ mph Other car _____ mph
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
9. Were police notified? ( ) Yes ( ) No
10. In your own words, please describe accident: Hot Curler Box Fell on My (Frontal region) Head at DuBois Wal-Mart on 2-28-99 (8-10lb) Box set up on shelf

11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes (X) No If yes, please describe in detail:

12. Please describe how you felt:
    a. DURING the accident: ~~Headache~~, Pain in my Head & Neck
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: Head Ache & Neck Pain (Shoulder Pain) Stiffness in Neck dizziness
    d. THE NEXT DAY: Same

13. What are your PRESENT complaints and symptoms? Headache, Pain & stiffness in neck + Shoulder.

14. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes (X) No If yes, please describe:

15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No If yes, please describe:

16. Have you ever been involved in an accident before? ( ) Yes (X) No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received.

17. Where were you taken after the accident? Home

18. Have you been treated by another doctor since the accident? ( ) Yes (X) No If yes, please list doctor's name and address:

What type of treatment did you receive?

19. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☑ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☑ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☑ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems Too Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arms	☐ Lights Bother Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ _____

Symptoms Other Than Above

21. Have you lost time from work as a result of this accident? ( ) Yes (X) No If yes, please complete this question.

a. Last Day Worked:

b. Type of Employment:

c. Present Salary:

d. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compensation you are receiving:

22. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No If yes, please describe, in detail;

23. Other pertinent information:

3-1-99
DATE

Florence King
PATIENT'S SIGNATURE

INITIAL REPORT

TO: CLAIMS MANAGEMENT INC CLAIM # 99518770

PATIENT FLORENCE KING

EMPLOYER N/A DATE OF INJURY/ONSET 02-28-1999

1. Incident of Injury HOT CURLERS BOX FELL ON HEAD IN FRONTAL REGION WEIGHT OF BOX WAS 8 TO 10 LBS. INCIDENT OCCURRED AT DUBOIS WAL-MART STC

2. Patient's Complaints NECK PAIN & HEADACHES

3. Objective Findings (Examination) TTP's C-6 (L) Fup C-6 (L) (+) CC m (+) Sho Dep. (L) (-) Soto Hall; ↓ (R) lat cervical flexion pain upon extension ↓ (R) cervical rotation

4. X-Ray Analysis Summary A-P and LAT Cervico-Dorsal X-rays revealed the following!

5. Diagnosis — ICDA # 839.06 VERTEBRAL SUBLUXATION OF CERVICAL SPINE C-6 CERVICALGIA 723.1 784.0 CEPHALGIA

6. Alternate Summary (Comments)

7. Disability Data

8. Examination Forms Attached? ☐ Yes ☐ No

9. Additional Evaluations Attached? ☐ Yes ☐ No

10. Accident Report Attached? ☐ Yes ☐ No

[signature]
Doctor's Signature

04/02/99
Date

Completed by [signature]

A106
Reorder H.J. Ross Co. (714) 539-2130

Ex "C"

Dela Torre Medical Ci
231 E Highland Street

Sykesville,PA 15865
814-894-2448

ACCOUNT	AMOUNT DUE	CLOSE DATE	PAGE
kingfl-00	0.00	06/25/01	01

TO: Florence I King
130 W Main St

Sykesville,PA 15865

PREVIOUS BALANCE--> 0.00

DATE	DR.	PATIENT	PROC	DESCRIPTION	DIAG	AMOUNT
03/16/99	hgd	Florenc	99214	Office Visit Detailed	714.0	70.00
03/16/99				Payment-Thank You		1.00-
05/04/99				Adj:Medicaid Write Medicaid		69.00-
03/16/99	hgd	Florenc	93000	Ekg	786.59	47.50
05/04/99				Plan Payment:08367 Medicaid		39.50-
05/04/99				Adj:Medicaid Write Medicaid		8.00-
04/13/99	hgd	Florenc	99213	Office Visit Expanded	724.2	45.00
04/13/99				Payment-Thank You		1.00-
06/01/99				Plan Payment:01190 Medicaid		19.00-
06/01/99				Adj:Medicaid Write Medicaid		25.00-
06/09/99	phu	Florenc	99212	Office Visit Focused	466.0	30.00
06/09/99				Payment-Thank You		1.00-
10/22/99				Plan Payment:unkno Medicaid		19.00-
10/22/99				Adj:Medicaid Write Medicaid		10.00-
06/15/99	phu	Florenc	99212	Office Visit Focused	466.0	30.00
10/22/99				Plan Payment:unkno Medicaid		19.00-
10/22/99				Adj:Medicaid Write Medicaid		11.00-
07/20/99	phu	Florenc	99212	Office Visit Focused	462	30.00
12/23/99				Plan Payment:09225 Medicaid		0.00
02/14/00				Plan Payment:09307 Medicaid		19.00-
02/14/00				Adj:Medicaid Write Medicaid		11.00-
11/05/99	hgd	Florenc	99214	Gyn Exam Established Patient	616.10	60.00
11/05/99				Payment-Thank You		1.00-
12/23/99				Plan Payment:09225 Medicaid		19.00-

CONT'D

ACCOUNT NO	CURRENT	31-60	61-90	91-120	OVER 120

Dela Torre Medical Ci
231 E Highland Street

Sykesville,PA 15865
814-894-2448

ACCOUNT	AMOUNT DUE	CLOSE DATE	PAGE
kingfl-00	0.00	06/25/01	02

TO: Florence I King
130 W Main St

Sykesville,PA 15865

DATE	DR.	PATIENT	PROC	DESCRIPTION	DIAG	AMOUNT
12/23/99				Adj:Medicaid Write Medicaid		40.00-
12/15/99	hgd	Florenc	45330	Sigmoid Flex	569.3	150.00
02/14/00				Plan Payment:09289 Medicaid		61.50-
02/14/00				Adj:Medicaid Write Medicaid		88.50-
12/20/99	hgd	Florenc	99212	Office Visit Focused	487.1	30.00
12/20/99				Payment-Thank You		1.00-
02/14/00				Plan Payment:09289 Medicaid		19.00-
02/14/00				Adj:Medicaid Write Medicaid		10.00-
01/17/00	hgd	Florenc	99213	Office Visit Expanded	465.9	50.00
01/17/00				Payment-Thank You		1.00-
03/03/00				Plan Payment:08389 Medicaid		19.00-
03/03/00				Adj:Medicaid Write Medicaid		30.00-
02/09/00	phu	Florenc	99213	Office Visit Expanded	401.9	50.00
03/31/00				Plan Payment:07803 Medicaid		19.00-
03/31/00				Adj:Medicaid Write Medicaid		31.00-
03/27/00	hgd	Florenc	99213	Office Visit Expanded	401.9	50.00
05/26/00				Plan Payment:08508 Medicaid		19.00-
05/26/00				Adj:Medicaid Write Medicaid		31.00-
03/27/00	hgd	Florenc	93000	Ekg	401.9	47.50
05/26/00				Plan Payment:08508 Medicaid		20.50-
05/26/00				Adj:Medicaid Write Medicaid		27.00-
04/25/00	phu	Florenc	99212	Office Visit Focused	922.9	40.00
06/05/00				Plan Payment:08860 Medicaid		19.00-
06/05/00				Adj:Medicaid Write Medicaid		21.00-

CONT'D

ACCOUNT NO	CURRENT	31-60	61-90	91-120	OVER 120

Dela Torre Medical Ci
231 E Highland Street

Sykesville,PA 15865
814-894-2448

ACCOUNT	AMOUNT DUE	CLOSE DATE	PAGE
kingfl-00	0.00	06/25/01	03

TO: Florence I King
130 W Main St

Sykesville,PA 15865

DATE	DR.	PATIENT	PROC	DESCRIPTION	DIAG	AMOUNT
04/25/00	phu	Florenc	90702	Dt	922.9	16.00
06/05/00				Adj:Medicaid Write Medicaid		16.00-
06/26/00	hgd	Florenc	99213	Office Visit Expanded	729.1	50.00
09/05/00				Plan Payment:01884 Medicaid		50.00-
06/26/00	hgd	Florenc	94010	Spirometry	786.09	66.00
09/05/00				Plan Payment:01884 Medicaid		2.00-
09/05/00				Adj:Medicaid Write Medicaid		64.00-
07/03/00	hgd	Florenc	99214	Office Visit Detailed	729.1	75.00
07/03/00				Payment-Thank You		1.00-
11/28/00				Plan Payment:03473 Medicaid		0.00
12/05/00				Plan Payment:09126 Medicaid		0.00
01/19/01				Plan Payment:09802 Medicaid		0.00
01/19/01				Adj:Medicaid Write Medicaid		74.00-
07/18/00	phu	Florenc	99213	Office Visit Expanded	386.30	50.00
09/05/00				Plan Payment:01887 Medicaid		19.00-
09/05/00				Adj:Medicaid Write Medicaid		31.00-
09/07/00	phu	Florenc	99213	Office Visit Expanded	723.9	50.00
10/20/00				Plan Payment:03424 Medicaid		19.00-
10/20/00				Adj:Medicaid Write Medicaid		31.00-
10/09/00	hgd	Florenc	99213	Office Visit Expanded	780.4	50.00
10/09/00				Payment-Thank You		1.00-
11/28/00				Plan Payment:03473 Medicaid		19.00-
11/28/00				Adj:Medicaid Write Medicaid		30.00-
10/19/00	hgd	Florenc	99213	Office Visit Expanded	724.2	50.00

CONT'D

ACCOUNT NO	CURRENT	31-60	61-90	91-120	OVER 120

Dela Torre Medical Cl
231 E Highland Street

Sykesville,PA 15865
814-894-2448

ACCOUNT	AMOUNT DUE	CLOSE DATE	PAGE
kingfl-00	0.00	06/25/01	04

TO: Florence I King
130 W Main St

Sykesville,PA 15865

DATE	DR.	PATIENT	PROC	DESCRIPTION	DIAG	AMOUNT
10/19/00				Payment-Thank You		1.00-
12/05/00				Plan Payment:09126 Medicaid		19.00-
12/05/00				Adj:Medicaid Write Medicaid		30.00-
11/16/00	hgd	Florenc	99214	Office Visit Detailed	272.4	75.00
11/16/00				Payment-Thank You		1.00-
01/08/01				Plan Payment:09779 Medicaid		19.00-
01/08/01				Adj:Medicaid Write Medicaid		55.00-
03/15/01	hgd	Florenc	99214	Office Visit Detailed	715.09	75.00
03/15/01				Payment-Thank You		1.00-
05/07/01				Plan Payment:09965 Medicaid		19.00-
05/07/01				Adj:Medicaid Write Medicaid		55.00-
04/16/01	hgd	Florenc	99213	Office Visit Expanded	386.30	55.00
04/16/01				Payment-Thank You		1.00-
06/07/01				Plan Payment:03682 Medicaid		19.00-
06/07/01				Adj:Medicaid Write Medicaid		35.00-
				*** PENDING AT CARRIER ***		
03/12/01	hgd	Florenc	g0001	Venipucture Specimen And Coll	272.4	4.00
04/16/01				Adj:Medicaid Write Medicaid		4.00-

PAY THIS AMOUNT --> 0.00

ACCOUNT NO	CURRENT	31-60	61-90	91-120	OVER 120

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER
[ ] (Medicare #) [X] (Medicaid #) [ ] (Sponsor's SSN) [ ] (VA File #) [ ] (SSN or ID) [ ] (SSN) [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 0019202555

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): King Florence I

3. PATIENT'S BIRTH DATE MM DD YY: 10 14 1941 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 253 W Main Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Sykesville STATE: PA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 15865 TELEPHONE (Include Area Code): (814) 894-5410

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 10 14 1941 SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
Signature Exception 062501
SIGNED _____ DATE _____

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

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: John Markley MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 722.10 Lumbar Disc Herniati 3. 729.5 Limb Pain
2. 724.2 Lumbar Spine Pain 4. 782.0 Numbness, P

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
01 29 98		01	54	72148	00	1 2	680 00	1				311 00
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 25-1732853

26. PATIENT'S ACCOUNT NO.: kingfl033956

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ 680 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
C Hobbie MD
SIGNED DATE 062501

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
Indiana MRI
Indiana, PA 15701

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Advanced Imaging Associates
P O Box 450
New Stanton PA 15672
PIN# 1604197 /01 GRP# 1496090 /08

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500,

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID [X] (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 0019202555

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): King Florence I

3. PATIENT'S BIRTH DATE MM DD YY: 10 14 1941 | SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 253 W Main Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Sykesville | STATE: PA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY | STATE

ZIP CODE: 15865 | TELEPHONE (Include Area Code): (814) 894-5410

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 10 14 1941 | SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signature Exception 062501

SIGNED _____ DATE _____

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

SIGNED _____

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Henry Delatorre MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 780.4 Vertigo
2. 784.0 Headache
3. ____
4. ____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2	11 07 00		01	54	70553 00	1 2	1400 00	1				338 00
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 25-1732853 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: kingf1057306

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ 1400 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

B Mariano MD

SIGNED DATE 062501

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Indiana MRI
Indiana, PA 15701

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # (724) 925-2830

Advanced Imaging Associates
P O Box 450
New Stanton PA 15672

PIN# 0921037 /13 GRP# 1496090 /08

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90) FORM RRB-1500.

ALL CHARGES/PAYMENTS

ITEMIZED STATEMENT

CLAIM:

DATE: 05/16/2001

IRS#: 251542351

PATIENT: FLORENCE I. KING 100667
253 W MAIN STREET
SYKESVILLE PA 15865
SS#184-32-4880 POL#0019202555
DATE/INJ: GRP#

EMPLOYER:

TO: MEDICAL ASSISTANCE
PO BOX 8297
HARRISBURG PA 17105

CASTEEL CHIROPRACTIC CENTER
10 N MAIN ST-814/371-8686
DUBOIS PA 15801
814/371-8686 Fax:814/371-8618

DIAGNOSIS:
839.02 VERTEBRAL SUBLUXATION OF CERVICAL SPINE C2

723.1 NECK PAIN/CERVICALGIA

FC: MEDICAID
DATE OF LAST BILL: 05/01/2001 PR# 422127J9D ID# 422127J9D

DATE	CPT	DESCRIPTION	*	POS	TOS	#	AMOUNT
12/02/1999	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
12/28/1999	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
01/19/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
01/26/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
02/02/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
02/08/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
02/18/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
03/02/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
04/26/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
05/02/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
05/03/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
05/15/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
05/22/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
07/07/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
07/15/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
07/16/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
07/30/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
09/11/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
09/27/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
10/25/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
11/13/2000	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
01/19/2001	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
01/26/2001	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
02/02/2001	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
02/16/2001	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
02/26/2001	W9960	BRIEF OFFICE VISIT	*	01	60	1	30.00
03/16/2001	W9960	BRIEF OFFICE VISIT		01	60	1	30.00
		CONTINUED					

SUBTOTAL: 810.00

ALL CHARGES/PAYMENTS

I T E M I Z E D S T A T E M E N T

CLAIM:

DATE: 05/16/2001

IRS#: 251542351

PATIENT: FLORENCE I. KING 100667
253 W MAIN STREET
SYKESVILLE PA 15865
SS#184-32-4880 POL#0019202555
DATE/INJ: GRP#

EMPLOYER:

TO: MEDICAL ASSISTANCE
PO BOX 8297
HARRISBURG PA 17105

CASTEEL CHIROPRACTIC CENTER
10 N MAIN ST-814/371-8686
DUBOIS PA 15801
814/371-8686 Fax:814/371-8618

DIAGNOSIS:
839.02 VERTEBRAL SUBLUXATION OF CERVICAL SPINE C2

723.1 NECK PAIN/CERVICALGIA

FC: MEDICAID
DATE OF LAST BILL: 05/01/2001 PR# 422127J9D ID# 422127J9D

DATE	CPT	DESCRIPTION	*	POS	TOS	#	AMOUNT
03/21/2001	W9960	BRIEF OFFICE VISIT		01	60	1	30.00
04/16/2001	W9960	BRIEF OFFICE VISIT		01	60	1	30.00
04/23/2001	W9960	BRIEF OFFICE VISIT		01	60	1	30.00
12/02/1999	PAYMENT	PA CASH					-1.00
12/28/1999	PAYMENT	PA CASH					-1.00
01/11/2000	PAYMENT	IN 98940G 11/04/99	#102567				-12.00
01/11/2000	ADJUST	IA XFER TO PATIENT	#102567				-1.00
01/11/2000	DEBIT	DE XFER FR INSUR	#102567				1.00
01/11/2000	ADJUST	IA FORGIVE	#102567				-17.00
01/11/2000	PAYMENT	IN 98940G 11/16/99	#102567				-12.00
01/11/2000	ADJUST	IA XFER TO PATIENT	#102567				-1.00
01/11/2000	DEBIT	DE XFER FR INSUR	#102567				1.00
01/11/2000	ADJUST	IA FORGIVE	#102567				-17.00
01/12/2000	PAYMENT	IN 98940G 11/12/99	#102568				-12.00
01/12/2000	ADJUST	IA XFER TO PATIENT	#102568				-1.00
01/12/2000	DEBIT	DE XFER FR INSUR	#102568				1.00
01/12/2000	ADJUST	IA FORGIVE	#102568				-17.00
01/17/2000	PAYMENT	IN 98940G 09/01/99	#101690				-12.00
01/17/2000	ADJUST	IA XFER TO PATIENT	#101690				-1.00
01/17/2000	DEBIT	DE XFER FR INSUR	#101690				1.00
01/17/2000	ADJUST	IA FORGIVE	#101690				-17.00
01/17/2000	PAYMENT	IN 98940G 09/23/99	#101691				-12.00
01/17/2000	ADJUST	IA XFER TO PATIENT	#101691				-1.00
01/17/2000	DEBIT	DE XFER FR INSUR	#101691				1.00
01/17/2000	ADJUST	IA FORGIVE	#101691				-17.00
01/17/2000	PAYMENT	IN 98940G 10/22/99	#101691				-12.00
		CONTINUED					
			SUBTOTAL:				741.00

ALL CHARGES/PAYMENTS

I T E M I Z E D S T A T E M E N T

CLAIM:

DATE: 05/16/2001

IRS#: 251542351

PATIENT: FLORENCE I. KING 100667
253 W MAIN STREET
SYKESVILLE PA 15865
SS#184-32-4880 POL#0019202555
DATE/INJ: GRP#

EMPLOYER:

TO: MEDICAL ASSISTANCE
PO BOX 8297
HARRISBURG PA 17105

CASTEEL CHIROPRACTIC CENTER
10 N MAIN ST-814/371-8686
DUBOIS PA 15801
814/371-8686 Fax:814/371-8618

DIAGNOSIS:
839.02 VERTEBRAL SUBLUXATION OF CERVICAL SPINE C2

723.1 NECK PAIN/CERVICALGIA

FC: MEDICAID
DATE OF LAST BILL: 05/01/2001 PR# 422127J9D ID# 422127J9D

DATE	CPT	DESCRIPTION	* POS TOS #	AMOUNT
01/17/2000	ADJUST	IA XFER TO PATIENT	#101691	-1.00
01/17/2000	DEBIT	DE XFER FR INSUR	#101691	1.00
01/17/2000	ADJUST	IA FORGIVE	#101691	-17.00
01/17/2000	PAYMENT	IN 98940G 10/29/99	#101691	-12.00
01/17/2000	ADJUST	IA XFER TO PATIENT	#101691	-1.00
01/17/2000	DEBIT	DE XFER FR INSUR	#101691	1.00
01/17/2000	ADJUST	IA FORGIVE	#101691	-17.00
01/19/2000	PAYMENT	PA CASH		-1.00
01/26/2000	PAYMENT	PA CASH		-6.00
02/02/2000	PAYMENT	PA CASH		-1.00
02/08/2000	PAYMENT	IN W9960 12/02/99	#102978	-12.00
02/08/2000	ADJUST	IA XFER TO PATIENT	#102978	-1.00
02/08/2000	DEBIT	DE XFER FR INSUR	#102978	1.00
02/08/2000	ADJUST	IA FORGIVE	#102978	-17.00
02/08/2000	PAYMENT	IN W9960 12/28/99	#102978	-12.00
02/08/2000	ADJUST	IA XFER TO PATIENT	#102978	-1.00
02/08/2000	DEBIT	DE XFER FR INSUR	#102978	1.00
02/08/2000	ADJUST	IA FORGIVE	#102978	-17.00
02/08/2000	PAYMENT	PA CASH		-1.00
02/18/2000	PAYMENT	PA		-1.00
03/02/2000	PAYMENT	PA CASH		-1.00
03/06/2000	PAYMENT	IN W9960 01/19/00	#104236	-12.00
03/06/2000	ADJUST	IA FORGIVE	#104236	-18.00
03/06/2000	PAYMENT	IN W9960 01/26/00	#104236	-12.00
03/06/2000	ADJUST	IA XFER TO PATIENT	#104236	-1.00
03/06/2000	DEBIT	DE XFER FR INSUR	#104236	1.00
03/06/2000	ADJUST	IA FORGIVE	#104236	-17.00
		CONTINUED		
			SUBTOTAL:	567.00

ALL CHARGES/PAYMENTS

I T E M I Z E D S T A T E M E N T

CLAIM:

DATE: 05/16/2001

IRS#: 251542351

PATIENT: FLORENCE I. KING 100667
253 W MAIN STREET
SYKESVILLE PA 15865
SS#184-32-4880 POL#0019202555
DATE/INJ: GRP#

EMPLOYER:

TO: MEDICAL ASSISTANCE
PO BOX 8297
HARRISBURG PA 17105

CASTEEL CHIROPRACTIC CENTER
10 N MAIN ST-814/371-8686
DUBOIS PA 15801
814/371-8686 Fax:814/371-8618

DIAGNOSIS:
839.02 VERTEBRAL SUBLUXATION OF CERVICAL SPINE C2

723.1 NECK PAIN/CERVICALGIA

FC: MEDICAID
DATE OF LAST BILL: 05/01/2001 PR# 422127J9D ID# 422127J9D

DATE	CPT	DESCRIPTION	* POS TOS #	AMOUNT
04/12/2000	PAYMENT	IN W9960 02/02/00	#104580	-12.00
04/12/2000	ADJUST	IA XFER TO PATIENT	#104580	-1.00
04/12/2000	DEBIT	DE XFER FR INSUR	#104580	1.00
04/12/2000	ADJUST	IA FORGIVE	#104580	-17.00
04/12/2000	PAYMENT	IN W9960 02/18/00	#104580	-12.00
04/12/2000	ADJUST	IA XFER TO PATIENT	#104580	-1.00
04/12/2000	DEBIT	DE XFER FR INSUR	#104580	1.00
04/12/2000	ADJUST	IA FORGIVE	#104580	-17.00
04/12/2000	PAYMENT	IN W9960 02/08/00	#104581	-12.00
04/12/2000	ADJUST	IA XFER TO PATIENT	#104581	-1.00
04/12/2000	DEBIT	DE XFER FR INSUR	#104581	1.00
04/12/2000	ADJUST	IA FORGIVE	#104581	-17.00
05/02/2000	PAYMENT	PA CASH		-2.00
05/03/2000	PAYMENT	PA CASH		-1.00
05/16/2000	PAYMENT	IN W9960 03/02/00	#105386	-12.00
05/16/2000	ADJUST	IA XFER TO PATIENT	#105386	-1.00
05/16/2000	DEBIT	DE XFER FR INSUR	#105386	1.00
05/16/2000	ADJUST	IA FORGIVE	#105386	-17.00
06/09/2000	PAYMENT	IN W9960 04/26/00	#106094	-12.00
06/09/2000	ADJUST	IA XFER TO PATIENT	#106094	-1.00
06/09/2000	DEBIT	DE XFER FR INSUR	#106094	1.00
06/09/2000	ADJUST	IA FORGIVE	#106094	-17.00
07/07/2000	PAYMENT	PA CASH		-4.00
07/15/2000	PAYMENT	PA CASH		-1.00
07/16/2000	PAYMENT	PA CASH		-1.00
07/17/2000	PAYMENT	IN W9960 05/03/00	#106950	-12.00
07/17/2000	ADJUST	IA XFER TO PATIENT	#106950	-1.00
		CONTINUED		
			SUBTOTAL:	400.00

ALL CHARGES/PAYMENTS

I T E M I Z E D S T A T E M E N T

CLAIM:

DATE: 05/16/2001

IRS#: 251542351

PATIENT: FLORENCE I. KING 100667
253 W MAIN STREET
SYKESVILLE PA 15865
SS#184-32-4880 POL#0019202555
DATE/INJ: GRP#

EMPLOYER:

TO: MEDICAL ASSISTANCE
PO BOX 8297
HARRISBURG PA 17105

CASTEEL CHIROPRACTIC CENTER
10 N MAIN ST-814/371-8686
DUBOIS PA 15801
814/371-8686 Fax:814/371-8618

DIAGNOSIS:
839.02 VERTEBRAL SUBLUXATION OF CERVICAL SPINE C2

723.1 NECK PAIN/CERVICALGIA

FC: MEDICAID
DATE OF LAST BILL: 05/01/2001 PR# 422127J9D ID# 422127J9D

DATE	CPT	DESCRIPTION	* POS TOS #	AMOUNT
07/17/2000	DEBIT	DE XFER FR INSUR	#106950	1.00
07/17/2000	ADJUST	IA FORGIVE	#106950	-17.00
07/17/2000	PAYMENT	IN W9960 05/15/00	#106950	-12.00
07/17/2000	ADJUST	IA XFER TO PATIENT	#106950	-1.00
07/17/2000	DEBIT	DE XFER FR INSUR	#106950	1.00
07/17/2000	ADJUST	IA FORGIVE	#106950	-17.00
07/17/2000	PAYMENT	IN W9960 05/22/00	#106950	-12.00
07/17/2000	ADJUST	IA XFER TO PATIENT	#106950	-1.00
07/17/2000	DEBIT	DE XFER FR INSUR	#106950	1.00
07/17/2000	ADJUST	IA FORGIVE	#106950	-17.00
07/17/2000	PAYMENT	IN W9960 05/02/00	#106949	-12.00
07/17/2000	ADJUST	IA XFER TO PATIENT	#106949	-1.00
07/17/2000	DEBIT	DE XFER FR INSUR	#106949	1.00
07/17/2000	ADJUST	IA FORGIVE	#106949	-17.00
09/11/2000	PAYMENT	IN W9960 07/30/00	#108366	-12.00
09/11/2000	ADJUST	IA XFER TO PATIENT	#108366	-1.00
09/11/2000	DEBIT	DE XFER FR INSUR	#108366	1.00
09/11/2000	ADJUST	IA FORGIVE	#108366	-17.00
09/11/2000	PAYMENT	IN W9960 07/15/00	#108365	-12.00
09/11/2000	ADJUST	IA XFER TO PATIENT	#108365	-1.00
09/11/2000	DEBIT	DE XFER FR INSUR	#108365	1.00
09/11/2000	ADJUST	IA FORGIVE	#108365	-17.00
09/11/2000	PAYMENT	IN W9960 07/16/00	#108365	-12.00
09/11/2000	ADJUST	IA XFER TO PATIENT	#108365	-1.00
09/11/2000	DEBIT	DE XFER FR INSUR	#108365	1.00
09/11/2000	ADJUST	IA FORGIVE	#108365	-17.00
09/11/2000	PAYMENT	PA CASH		-1.00

CONTINUED

SUBTOTAL: 209.00

ALL CHARGES/PAYMENTS

I T E M I Z E D S T A T E M E N T

CLAIM:

DATE: 05/16/2001

IRS#: 251542351

PATIENT: FLORENCE I. KING 100667
253 W MAIN STREET
SYKESVILLE PA 15865
SS#184-32-4880 POL#0019202555
DATE/INJ: GRP#

EMPLOYER:

TO: MEDICAL ASSISTANCE
PO BOX 8297
HARRISBURG PA 17105

CASTEEL CHIROPRACTIC CENTER
10 N MAIN ST-814/371-8686
DUBOIS PA 15801
814/371-8686 Fax:814/371-8618

DIAGNOSIS:
839.02 VERTEBRAL SUBLUXATION OF CERVICAL SPINE C2

723.1 NECK PAIN/CERVICALGIA

FC: MEDICAID
DATE OF LAST BILL: 05/01/2001 PR# 422127J9D ID# 422127J9D

DATE	CPT	DESCRIPTION	*	POS	TOS	#	AMOUNT
09/13/2000	PAYMENT	IN W9960 07/07/00				#108364	-12.00
09/13/2000	ADJUST	IA XFER TO PATIENT				#108364	-1.00
09/13/2000	DEBIT	DE XFER FR INSUR				#108364	1.00
09/13/2000	ADJUST	IA FORGIVE				#108364	-17.00
10/25/2000	PAYMENT	PA CASH					-1.00
11/13/2000	PAYMENT	PA CASH					-3.00
11/16/2000	PAYMENT	IN W9960 09/11/00				#110217	-12.00
11/16/2000	ADJUST	IA XFER TO PATIENT				#110217	-1.00
11/16/2000	DEBIT	DE XFER FR INSUR				#110217	1.00
11/16/2000	ADJUST	IA FORGIVE				#110217	-17.00
11/16/2000	PAYMENT	IN W9960 09/27/00				#110217	-12.00
11/16/2000	ADJUST	IA XFER TO PATIENT				#110217	-1.00
11/16/2000	DEBIT	DE XFER FR INSUR				#110217	1.00
11/16/2000	ADJUST	IA FORGIVE				#110217	-17.00
12/15/2000	PAYMENT	IN W9960 10/25/00				#110836	-12.00
12/15/2000	ADJUST	IA XFER TO PATIENT				#110836	-1.00
12/15/2000	DEBIT	DE XFER FR INSUR				#110836	1.00
12/15/2000	ADJUST	IA FORGIVE				#110836	-17.00
01/15/2001	PAYMENT	IN W9960 11/13/00				#111299	-12.00
01/15/2001	ADJUST	IA XFER TO PATIENT				#111299	-1.00
01/15/2001	DEBIT	DE XFER FR INSUR				#111299	1.00
01/15/2001	ADJUST	IA FORGIVE				#111299	-17.00
01/19/2001	PAYMENT	PA CASH					-1.00
01/26/2001	PAYMENT	PA CASH					-1.00
02/16/2001	PAYMENT	PA CASH					-1.00
02/26/2001	PAYMENT	PA CASH					-1.00
03/20/2001	PAYMENT	IN W9960 01/19/01				#113107	-12.00
		CONTINUED					
					SUBTOTAL:		44.00

ALL CHARGES/PAYMENTS

I T E M I Z E D S T A T E M E N T

CLAIM:

DATE: 05/16/2001

IRS#: 251542351

PATIENT: FLORENCE I. KING 100667
253 W MAIN STREET
SYKESVILLE PA 15865
SS#184-32-4880 POL#0019202555
DATE/INJ: GRP#

EMPLOYER:

TO: MEDICAL ASSISTANCE
PO BOX 8297
HARRISBURG PA 17105

CASTEEL CHIROPRACTIC CENTER
10 N MAIN ST-814/371-8686
DUBOIS PA 15801
814/371-8686 Fax:814/371-8618

DIAGNOSIS:
839.02 VERTEBRAL SUBLUXATION OF CERVICAL SPINE C2

723.1 NECK PAIN/CERVICALGIA

FC: MEDICAID
DATE OF LAST BILL: 05/01/2001 PR# 422127J9D ID# 422127J9D

DATE	CPT	DESCRIPTION	* POS TOS #	AMOUNT
03/20/2001	ADJUST	IA XFER TO PATIENT	#113107	-1.00
03/20/2001	DEBIT	DE XFER FR INSUR	#113107	1.00
03/20/2001	ADJUST	IA FORGIVE	#113107	-17.00
03/20/2001	PAYMENT	IN W9960 01/26/01	#113107	-12.00
03/20/2001	ADJUST	IA XFER TO PATIENT	#113107	-1.00
03/20/2001	DEBIT	DE XFER FR INSUR	#113107	1.00
03/20/2001	ADJUST	IA FORGIVE	#113107	-17.00
03/21/2001	PAYMENT	PA CASH		-1.00
04/16/2001	PAYMENT	IN W9960 02/02/01	#113323	-12.00
04/16/2001	ADJUST	IA FORGIVE	#113323	-18.00
04/16/2001	PAYMENT	IN W9960 02/16/01	#113323	-12.00
04/16/2001	ADJUST	IA XFER TO PATIENT	#113323	-1.00
04/16/2001	DEBIT	DE XFER FR INSUR	#113323	1.00
04/16/2001	ADJUST	IA FORGIVE	#113323	-17.00
04/16/2001	PAYMENT	IN W9960 02/26/01	#113323	-12.00
04/16/2001	ADJUST	IA XFER TO PATIENT	#113323	-1.00
04/16/2001	DEBIT	DE XFER FR INSUR	#113323	1.00
04/16/2001	ADJUST	IA FORGIVE	#113323	-17.00
04/16/2001	PAYMENT	PA CASH		-1.00

PROVIDER: SCOTT CASTEEL DC
SS# 160565186

TOTAL: $ -92.00
BALANCE 05/16/2001: $ 118.00

 PA/PK/CC/IN=Csh/Check/CC/Ins. paymnt; CR/DE=Credit/Debit; IA=Ins adj; *=Ins Pd

APPROVED OMB-0938-0008

WALMART STORE
ROUTE 255
DUBOIS
PA
15801

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER
( ) (Medicare#) ( ) (Medicaid #) ( ) (Sponsor's SSN) ( ) (VA File #) ( ) (SSN or ID) ( ) (SSN) (X) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
KING, FLORENCE I.

3. PATIENT'S BIRTH DATE MM DD YY: 10 14 41 SEX M ( ) F (X)

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
KING, FLORENCE I.

5. PATIENT'S ADDRESS (No., Street)
130 WEST MAIN ST

6. PATIENT RELATIONSHIP TO INSURED
Self (X) Spouse ( ) Child ( ) Other ( )

7. INSURED'S ADDRESS (No., Street)
130 WEST MAIN ST

CITY: SYKESVILLE | STATE: PA

8. PATIENT STATUS
Single ( ) Married ( ) Other (X)

CITY: SYKESVILLE | STATE: PA

ZIP CODE: 15865 | TELEPHONE (Include Area Code): (814)-894-5400

Employed (X) Full-Time Student ( ) Part-Time Student ( )

ZIP CODE: 15865 | TELEPHONE (INCLUDE AREA CODE): (814)-894-5400

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ( ) YES (X) NO

a. INSURED'S DATE OF BIRTH MM DD YY: 10 14 41 SEX M ( ) F (X)

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ( ) F ( )

b. AUTO ACCIDENT? ( ) YES (X) NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME
MOUSE LODGE

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? (X) YES ( ) NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ( ) YES (X) NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY 02 28 99 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ( ) YES ( ) NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 839.06
2. 723.1
3. 784.0
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 03 01 99		11		99202		1,2,3,	$80.00	1				
2 03 01 99		11		72072		1,2,3,	$75.00	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ( ) EIN (X): 25-1542351

26. PATIENT'S ACCOUNT NO.: 3323

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) (X) YES ( ) NO

28. TOTAL CHARGE: $ 155.00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 155.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

TYSON L. DIXON, D.C.
SIGNED 9770510J9D DATE 04/01/99

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE
LAUREL CHIROPRACTIC CTR
10 NORTH MAIN STREET
DUBOIS, PA
PHONE 814-371-8
PIN# GRP# GA655686

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 9/89) PLEASE PRINT OR TYPE

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

APPROVED OMB-0938-0008

CLAIMS MANAGEMENT, INC
P O BOX 8083

BENTONVILLE, AR
72712-8083

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER X
(Medicare#) | (Medicaid #) | (Sponsor's SSN) | (VA File #) | (SSN or ID) | (SSN) | (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): CL# 99518770

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): KING, FLORENCE I.

3. PATIENT'S BIRTH DATE: MM 10 DD 14 YY 41 SEX: M ___ F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): KING, FLORENCE I.

5. PATIENT'S ADDRESS (No., Street): 130 WEST MAIN ST

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse ___ Child ___ Other ___

7. INSURED'S ADDRESS (No., Street): 130 WEST MAIN ST

CITY: SYKESVILLE | STATE: PA

8. PATIENT STATUS: Single ___ Married ___ Other X
Employed X Full-Time Student ___ Part-Time Student ___

CITY: SYKESVILLE | STATE: PA

ZIP CODE: 15865 | TELEPHONE (Include Area Code): (814)-894-5400

ZIP CODE: 15865 | TELEPHONE (INCLUDE AREA CODE): (814)-894-5400

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ___ NO X

a. INSURED'S DATE OF BIRTH: MM 10 DD 14 YY 41 SEX: M ___ F X

b. OTHER INSURED'S DATE OF BIRTH: MM DD YY SEX: M ___ F ___

b. AUTO ACCIDENT? YES ___ NO X PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME: MOOSE LODGE

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES X NO ___

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ___ NO X *If yes,* return to and complete Item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE:

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM 03 DD 28 YY 99 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ___ NO ___ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 839.06
2. 723.1
3. 784.0
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FO LOCAL USE
1 03 08 99		11		99202		1,2,3,	$50.00	1				
2 03 12 99		11		98940		1,2,3,	$30.00	1				
3 03 15 99		11		98940		1,2,3,	$30.00	1				
4 03 26 99		11		98940		1,2,3,	$30.00	1				
5 03 29 99		11		98940		1,2,3,	$30.00	1				
6 03 31 99		11		98940		1,2,3,	$30.00	1				

25. FEDERAL TAX I.D. NUMBER: 25-1542351 SSN ___ EIN X

26. PATIENT'S ACCOUNT NO.: 3323

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO ___

28. TOTAL CHARGE: $ 200.00

29. AMOUNT PAID: $

30. BALANCE DU: $ 200.

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SCOTT B. CASTEEL, D.C
422127J9D 04/01/99
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
10 NORTH MAIN STREET
DUBOIS, PA
814-37

PIN# GRP# CA655686

PLEASE PRINT OR TYPE

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88

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

APPROVED OMB-0938-0008

CLAIMS MANAGEMENT, INC
P O BOX 8083

BENTONVILLE, AR
72712-8083

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
(Medicare#)	(Medicaid #)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	X (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): CL# 99518770

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): KING, FLORENCE I.

3. PATIENT'S BIRTH DATE: 10 14 41 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): KING, FLORENCE I.

5. PATIENT'S ADDRESS (No., Street): 130 WEST MAIN ST

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 130 WEST MAIN ST

CITY: SYKESVILLE STATE: PA

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]

CITY: SYKESVILLE STATE: PA

ZIP CODE: 15865 TELEPHONE (Include Area Code): (814)-894-5400

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 15865 TELEPHONE (INCLUDE AREA CODE): (814)-894-5400

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH: 10 14 41 SEX: M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH: MM DD YY SEX: M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME: MOOSE LODGE

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? [X] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY 02 28 99 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 839.06
2. 723.1
3. 784.0
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 04 02 99		11		98940		1,2,3,	$30.00	1				
2 04 05 99		11		98940		1,2,3,	$30.00	1				
3 04 23 99		11		98940		1,2,3,	$30.00	1				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 25-1542351 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 3323

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE: $ 90.00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 90.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SCOTT B. CASTEEL, D.C

SIGNED 422127J9D DATE 05/03/99

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE PHONE #

CASTEEL CHIROPRACTIC CTR
10 NORTH MAIN STREET
DUBOIS, PA

814-371-80

PIN# GRP# CA655686

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

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

APPROVED OMB-0938-0008

CLAIMS MANAGEMENT, INC
P O BOX 8083

BENTONVILLE, AR
72712-8083

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER X
(Medicare#) | (Medicaid #) | (Sponsor's SSN) | (VA File #) | (SSN or ID) | (SSN) | (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): CL# 99518770

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): KING, FLORENCE I.

3. PATIENT'S BIRTH DATE: MM 10 DD 14 YY 41 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): KING, FLORENCE I.

5. PATIENT'S ADDRESS (No., Street): 253 W MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 253 W MAIN STREET

CITY: SYKESVILLE STATE: PA

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: SYKESVILLE STATE: PA

ZIP CODE: 15865 TELEPHONE (Include Area Code): (814)894-5410

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 15865 TELEPHONE (INCLUDE AREA CODE): (814)894-5410

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM 10 DD 14 YY 41 SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [X] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM 05 DD 26 YY 99 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 839.06
2. 723.1
3. 784.0
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 05 26 99	11		98940		1,2,3,	$30.00	1				
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 25-1542351

26. PATIENT'S ACCOUNT NO.: 3323

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 30.00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 30.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SCOTT B. CASTEEL, D.C
422127J9D 06/01/99
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
10 NORTH MAIN STREET
DUBOIS, PA
814-371-8(

PIN# GRP# CA655686

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

CLAIMS MANAGEMENT, INC
P O BOX 8083

BENTONVILLE, AR
72712-8083

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): CL# 99518770

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): KING, FLORENCE I.

3. PATIENT'S BIRTH DATE MM DD YY: 10 14 41 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): KING, FLORENCE I.

5. PATIENT'S ADDRESS (No., Street): 253 W MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 253 W MAIN STREET

CITY: SYKESVILLE STATE: PA

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: SYKESVILLE STATE: PA

ZIP CODE: 15865 TELEPHONE (Include Area Code): (814)-894-5410

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 15865 TELEPHONE (INCLUDE AREA CODE): (814)-894-5410

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 10 14 41 SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [X] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE:

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY: 02 28 99 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 839.06
2. 723.1
3. 784.0
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 06 07 99		11		98940		1,2,3,	$30.00	1				
2 06 11 99		11		98940		1,2,3,	$30.00	1				
3 06 30 99		11		98940		1,2,3,	$30.00	1				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 25-1542351

26. PATIENT'S ACCOUNT NO.: 3323

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 90.00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 90.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SCOTT B. CASTEEL, D.C

SIGNED 422127J9D DATE 07/01/99

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

CASTEEL CHIROPRACTIC CTR
10 NORTH MAIN STREET
DUBOIS, PA

814-371-8

PIN# GRP# CA655686

790-0120 (12/90) (OCR) 2 pt.

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

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

APPROVED OMB-0938-0008

CLAIMS MANAGEMENT, INC
P O BOX 8083

BENTONVILLE, AR
72712-8083

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
(Medicare#)	(Medicaid #)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	X (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): CL# 99518770

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
KING, FLORENCE I.	10 04 41 — M [ ] F [X]	KING, FLORENCE I.
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
253 W MAIN STREET	Self [X] Spouse [ ] Child [ ] Other [ ]	253 W MAIN STREET
CITY: SYKESVILLE — STATE: PA	8. PATIENT STATUS: Single [X] Married [ ] Other [ ]	CITY: SYKESVILLE — STATE: PA
ZIP CODE: 15865 — TELEPHONE (Include Area Code): (814)-894-5410	Employed [X] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE: 15865 — TELEPHONE (INCLUDE AREA CODE): (814)-894-5410
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH / SEX: 10 04 41 — M [ ] F [X]
b. OTHER INSURED'S DATE OF BIRTH / SEX: MM DD YY — M [ ] F [ ]	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? [X] YES [ ] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE — DATE:

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO MM DD YY
07 28 99		
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? [ ] YES [ ] NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 839.06
2. 723.1
3. 784.0
4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07 14 99		11		98940		1,2,3,	$30.00	1				
2 07 28 99		11		98940		1,2,3,	$30.00	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
25-1542351	[ ]	[X]	3323	[X] YES [ ] NO	$ 60.00	$	$ 60.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SCOTT B. CASTEEL, D.C
422127J9D — 08/02/99
SIGNED — DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

CASTEEL CHIROPRACTIC CLINIC
10 NORTH MAIN STREET
DUBOIS, PA
814-371-8

PIN# — GRP# CA655686

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) — PLEASE PRINT OR TYPE — FORM HCFA-1500 (12-90) — FORM OWCP-1500 — FORM RRB-1500

APPROVED OMB-0938-0008

CLAIMS MANAGEMENT, INC
P O BOX 8083

BENTONVILLE, AR
72712-8083

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
(Medicare#)	(Medicaid #)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	X (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): CL# 99518770

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
KING, FLORENCE I.	MM 10 DD 14 YY 41 M [ ] F [X]	KING, FLORENCE I.
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
253 W MAIN STREET	Self [X] Spouse [ ] Child [ ] Other [ ]	253 W MAIN STREET
CITY: SYKESVILLE — STATE: PA	8. PATIENT STATUS: Single [X] Married [ ] Other [ ]	CITY: SYKESVILLE — STATE: PA
ZIP CODE: 15865 — TELEPHONE (Include Area Code): (814)-894-5410	Employed [X] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE: 15865 — TELEPHONE (INCLUDE AREA CODE): (814)-894-5410
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH / SEX: MM 10 DD 14 YY 41 M [ ] F [X]
b. OTHER INSURED'S DATE OF BIRTH / SEX: MM DD YY M [ ] F [ ]	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State) [ ]	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? [X] YES [ ] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM 02 DD 28 YY 99 (ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP))	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 839.06 2. 723.1 3. 784.0 4.		22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 08 16 99		11		98940		1,2,3,	$30.00	1				
2 08 20 99		11		98940		1,2,3,	$30.00	1				
3 08 27 99		11		98940		1,2,3,	$30.00	1				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
25-1542351	[ ]	[X]	3323	[X] YES [ ] NO	$ 90.00	$	$ 90.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE
SCOTT B. CASTEEL, D.C 422127J9D 09/01/99 SIGNED DATE		CASTEEL CHIROPRACTIC CTR 10 NORTH MAIN STREET DUBOIS, PA 814-371-6 PIN# CA655686 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

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

APPROVED OMB-0938-0008

CLAIMS MANAGEMENT INC
P O BOX 8083
BENTONVILLE AK 72712

HEALTH INSURANCE CLAIM FORM

XXX PICA — PICA XXX

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
(Medicare#)	(Medicaid #)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	X (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 99518770

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): KING FLORENCE I

3. PATIENT'S BIRTH DATE MM DD YY: 10 14 1941 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 253 W MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: SYKESVILLE — STATE: PA

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY — STATE

ZIP CODE: 15865 — TELEPHONE (Include Area Code): (814) 894-5410

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? PLACE (State): YES [ ] NO [X]

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [X] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: CLAIMS MANAGEMENT INC

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNATURE ON FILE — 11 01 1999
SIGNED _____ DATE _____

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

14. DATE OF CURRENT: MM DD YY 02 28 1999 — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) INJURY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 839.06 3. ____
2. 723.1 4. ____

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 09011999		11	01	98940		1 2	30 00	001				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 251542351 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 100667-101690

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ 30 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 30 0

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SCOTT CASTEEL DC
SIGNED 11 01 DATE 1999

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
SAME

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
CASTEEL CHIROPRACTIC CENTER
10 N MAIN ST-814/371-8686
DUBOIS PA 15801
PIN# 22127J9D GRP# 655686

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) — *PLEASE PRINT OR TYPE* — FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

APPROVED OMB-0938-0008

CLAIMS MANAGEMENT INC
P O BOX 8083
BENTONVILLE AK 72712

HEALTH INSURANCE CLAIM FORM

XXX PICA — PICA

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER — [ ] (Medicare#) [ ] (Medicaid #) [ ] (Sponsor's SSN) [ ] (VA File #) [ ] (SSN or ID) [ ] (SSN) [X] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 99518770

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): KING FLORENCE I

3. PATIENT'S BIRTH DATE MM DD YY: 10 14 1941 — SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 253 W MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: SYKESVILLE — STATE: PA

8. PATIENT STATUS: Single [X] Married [ ] Other [ ] — Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: — STATE:

ZIP CODE: 15865 — TELEPHONE (Include Area Code): (814) 894-5410

ZIP CODE: — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? [X] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: CLAIMS MANAGEMENT INC

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNATURE ON FILE — DATE 11 01 1999
SIGNED _____ DATE _____

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

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 02 28 1999 INJURY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [X] NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 839.06
2. V723.1
3.
4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 09 23 99		11	01	98940		1 2	30 00	001				
2 10 21 99		11		98940		1 2	30 00	001				
3 10 29 99		11		98940		1 2	30 00	001				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 251542351 — SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 100667-101691

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO

28. TOTAL CHARGE: $ 90 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 90

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
STEVEN SORBERA DC
SIGNED 11 0 DATE 1999

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
SAME

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
CASTEEL CHIROPRACTIC CENTER
10 N MAIN ST-814/371-8686
DUBOIS PA 15801
PIN# 375685J9D — GRP# 655686

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) — *PLEASE PRINT OR TYPE* — FORM HCFA-1500 (12-90) — FORM OWCP-1500 — FORM RRB-1500

APPROVED OMB-0938-0008

XXX PICA

HEALTH INSURANCE CLAIM FORM

PICA X

1. MEDICARE ( ) (Medicare#) | MEDICAID ( ) (Medicaid #) | CHAMPUS ( ) (Sponsor's SSN) | CHAMPVA ( ) (VA File #) | GROUP HEALTH PLAN ( ) (SSN or ID) | FECA BLK LUNG ( ) (SSN) | OTHER ( ) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 0019202555

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): KING FLORENCE I

3. PATIENT'S BIRTH DATE (MM DD YY): 10 14 1941 SEX: M ( ) F (X)

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 253 W MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self (X) Spouse ( ) Child ( ) Other ( )

7. INSURED'S ADDRESS (No., Street):

CITY: SYKESVILLE STATE: PA

8. PATIENT STATUS: Single (X) Married ( ) Other ( )

CITY: STATE:

ZIP CODE: 15865 TELEPHONE (Include Area Code): (814) 894-5410

Employed ( ) Full-Time Student ( ) Part-Time Student ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ( ) NO (X)

a. INSURED'S DATE OF BIRTH (MM DD YY): SEX M ( ) F ( )

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY): SEX M ( ) F ( )

b. AUTO ACCIDENT? YES ( ) NO (X) PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME: MOOSE LODGE

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES (X) NO ( )

c. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICAL ASSISTANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ( ) NO (X) *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNATURE EXCEPTION 12 01 1999

SIGNED _____ DATE _____

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

SIGNATURE EXCEPTION

SIGNED _____

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (MM DD YY): 02 28 1999

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE (MM DD YY): 02 28 1999

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE:

17a. I.D. NUMBER OF REFERRING PHYSICIAN:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM TO

19. RESERVED FOR LOCAL USE:

20. OUTSIDE LAB? YES ( ) NO ( ) $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 839.06
2. 723.1
3. .
4. .

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11041999		11		98940	GA	1 2	30 00	001	0			
2 11161999		11		98940	GA	1 2	30 00	001	0			
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 251542351 SSN ( ) EIN (X)

26. PATIENT'S ACCOUNT NO.: 100667-102567

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ( ) NO ( )

28. TOTAL CHARGE: $ 60 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

STEVEN SORBERA DC

SIGNED 12 01 DATE 1999

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

SAME

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

CASTEEL CHIROPRACTIC CENTER
10 N MAIN ST-814/371-8686
DUBOIS PA 15801

PIN# 01705860/02 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

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

APPROVED OMB-0938-0008

XXX PICA

HEALTH INSURANCE CLAIM FORM

PICA XX

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 0019202555

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): KING FLORENCE I

3. PATIENT'S BIRTH DATE MM DD YY: 10 14 1941 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 253 W MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: SYKESVILLE STATE: PA

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 15865 TELEPHONE (Include Area Code): (814) 894-5410

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [X]

b. EMPLOYER'S NAME OR SCHOOL NAME: MOOSE LODGE

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [X] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICAL ASSISTANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNATURE EXCEPTION SIGNED _____ 12 01 1999 DATE

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

SIGNATURE EXCEPTION SIGNED _____

14. DATE OF CURRENT: MM DD YY 02 28 1999 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY: 02 28 1999

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 839.06
2. 723.1
3. ____
4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 21 99	11		98940	GA	1 2	30 00	001	0			
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 251542351

26. PATIENT'S ACCOUNT NO.: 100667-102568

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ 30 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SCOTT CASTEEL DC

SIGNED 12 01 DATE 1999

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

SAME

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

CASTEEL CHIROPRACTIC CENTER
10 N MAIN ST-814/371-8686
DUBOIS PA 15801

PIN# 1060068/02 GRP#

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88

PLEASE PRINT OR TYPE

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

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
(Medicare#)	X (Medicaid #)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	(ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 001920255S

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): KING FLORENCE I

3. PATIENT'S BIRTH DATE: 10 14 1941 SEX: M ___ F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 253 W MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse ___ Child ___ Other ___

7. INSURED'S ADDRESS (No., Street):

CITY: SYKESVILLE STATE: PA

8. PATIENT STATUS: Single X Married ___ Other ___

CITY: STATE:

ZIP CODE: 15865 TELEPHONE (Include Area Code): (814) 894-5410

Employed ___ Full-Time Student ___ Part-Time Student ___

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ___ NO X

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ___ F ___

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ___ F ___

b. AUTO ACCIDENT? YES ___ NO X PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME: MOOSE LODGE

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES X NO ___

c. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICAL ASSISTANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ___ NO X *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNATURE EXCEPTION 01 01 2000

SIGNED _____ DATE _____

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

SIGNATURE EXCEPTION

SIGNED _____

14. DATE OF CURRENT: MM DD YY 02 28 1999 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 02 28 1999

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM ___ TO ___

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM ___ TO ___

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ___ NO ___ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 839.06
2. 723.1
3. ___
4. ___

22. MEDICAID RESUBMISSION CODE ___ ORIGINAL REF. NO. ___

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 12 02 1999		01	60	W9960		1 2	30 00	001	0			
2 12 31 1999		01	60	W9960		1 2	30 00	001	0			
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 251542351 SSN ___ EIN X

26. PATIENT'S ACCOUNT NO.: 100667 102278

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ___ NO ___

28. TOTAL CHARGE: $ 60 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

STEVEN SORBERA DC

SIGNED 01 0 DATE 2000

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

SAME

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

CASTEEL CHIROPRACTIC CENTER
10 N MAIN ST-814/371-8686
DUBOIS PA 15801

PIN# 01705860/02 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

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

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF FINANCIAL OPERATIONS
TPL SECTION CASUALTY UNIT
PO BOX 8486
HARRISBURG, PA 17105-8486

July 19, 2001

WOOMER & FRIDAY LLP
CYNTHIA M PORTA ESQ
3220 WEST LIBERTY AVE STE 200
PITTSBURGH PA 15216

Re: FLORENCE KING
CIS #: 001920255
Incident Date: 2/27/1999

Dear Ms. Porta:

Enclosed please find the itemized bills you have requested from the provider.

If you have any further questions, please contact me. Thank you for your cooperation in this matter.

Sincerely,

Jessica L. Bupp

Jessica L. Bupp
TPL Program Investigator
717-772-6617
717-772-6553 FAX

Enclosure

DuBois Regional Medical Center

P.O. Box 447 - DuBois, PA 15801-0447
(814) 375-4200
FEDERAL I.D. NO. 25-1490707

DETAIL STATEMENT

TYPE OF BILL	DATE OF BILL	PAGE NO.
D1-ER	07/21/00	1

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
FLORENCE I KING	00198-00262	F	59Y	07/16/00	07/17/00	

INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER	PAYMENT AMOUNT
200012 MA OUTPATIENT		0019202555	

GUARANTOR NAME AND ADDRESS
FLORENCE I KING
253 WEST MAIN ST
SYKESVILLE PA 15865

☐ MasterCard ☐ VISA ☐ DISCOVER

CARD NO. _____
EXPIRATION DATE _____
SIGNATURE _____

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE

DATE	ITEM NO.	DESCRIPTION	CLM CODE	ORDER NO	QTY	UNIT PRICE	TOTAL CHARGES
07/16/00	58846	MECLIZINE HCL 25MG,TABLET	250	1	2	1.00	2.00
		TOTAL PHARMACY					2.00
07/16/00	95312	SLIPPERS LARGE	270	8	1	3.00	3.00
		TOTAL SUPPLIES					3.00
07/16/00	22498	SPECIMEN COLLECTION - CHRG ONLY	300	3	1	5.00	5.00
07/16/00	24047	CBC & DIFF	305	1	1	42.00	42.00
07/16/00	68519	02 SATURATION DIRECT MEASURE	300	5	1	21.00	21.00
07/16/00	68917	ARTERIAL BLOOD GASES	300	4	1	96.00	96.00
		TOTAL LABORATORY					164.00
07/16/00	23008	CALCIUM SERUM	301		1	22.00	22.00
07/16/00	23089	BASIC METABOLIC PANEL	301	1	1	66.00	66.00
		TOTAL chemistry lab					88.00
07/16/00	16078	EMERGENCY VISIT	450	10	1	0.00	0.00
07/16/00	16213	EMERGENCY DEPARTMENT VISIT L4	450	9	1	350.00	350.00
		TOTAL EMERGENCY ROOM					350.00
07/16/00	34900	EKG TRACING ONLY WO INT&RPT	730	6	1	68.00	68.00
		TOTAL EKG					68.00
07/16/00	518	PC ECG REESE INT&RPT	730	7	1	26.00	26.00
		TOTAL Professional fee--general					26.00
		TOTAL CHARGES					701.00
09/11/00	I1075	960 MEDICAL ASSISTANCE OUTPATIEN	T				-22.00
10/30/00	I1075	496 MEDICAL ASSISTANCE OUTPATIEN	T				-679.00
		TOTAL PAYMENTS/ADJUSTMENTS					-701.00

PATIENT NUMBER
00198-00262

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY

TOTAL AMOUNT DUE	0.00

PAYMENTS may be taken to the East or West registration areas or to the Business Office located at 207 Hospital Avenue.

PLEASE RETAIN FOR YOUR RECORDS

DuBois Regional Medical Center

P.O. Box 447 - DuBois, PA 15801-0447
(814) 375-4200
FEDERAL I.D. NO. 25-1490707

DETAIL STATEMENT

TYPE OF BILL	DATE OF BILL	PAGE NO.
D1-OPW	10/21/00	1

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
FLORENCE I KING	00287-00489	F	59Y	10/17/00	10/17/00	

INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER	PAYMENT AMOUNT
200012 MA OUTPATIENT		0019202555	

GUARANTOR NAME AND ADDRESS
FLORENCE I KING
253 WEST MAIN ST
SYKESVILLE PA 15865

☐ MasterCard ☐ VISA ☐ DISCOVER

CARD NO. _____
EXPIRATION DATE _____
SIGNATURE _____

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE

DATE	ITEM NO.	DESCRIPTION	CLM CODE	ORDER NO.	QTY	UNIT PRICE	TOTAL CHARGES
10/17/00	72787	CT ORB/SELLA/POST FOSSA, NO CONT	350	1	1	503.00	503.00
10/17/00	72817	CT - EACH ADDITIONAL FILM	351	1	5	17.00	85.00
		TOTAL CT SCAN					588.00
		TOTAL CHARGES					588.00
04/30/01	I1075	136 MEDICAL ASSISTANCE OUTPATIEN	T				-587.00
05/17/01	A1710	000 SMALL BALANCE WRITE OFFS					-1.00
		TOTAL PAYMENTS/ADJUSTMENTS					-588.00

PATIENT NUMBER
00287-00489

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY

TOTAL AMOUNT DUE	0.00

PAYMENTS may be taken to the East or West registration areas or to the Business Office located at 207 Hospital Avenue.

PLEASE RETAIN FOR YOUR RECORDS

DuBois Regional Medical Center
P.O. Box 447 - DuBois, PA 15801-0447
(814) 375-4200
FEDERAL I.D. NO. 25-1490707

DETAIL STATEMENT

TYPE OF BILL	DATE OF BILL	PAGE NO.
D1-MAB	01/23/01	1

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
FLORENCE I KING	01014-00126	F	59Y	01/19/01	01/19/01	

INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER	PAYMENT AMOUNT
200012 MA OUTPATIENT		0019202555	

GUARANTOR NAME AND ADDRESS
FLORENCE I KING
253 WEST MAIN ST
SYKESVILLE PA 15865

☐ MasterCard ☐ VISA ☐ DISCOVER

CARD NO. _____
EXPIRATION DATE _____
SIGNATURE _____

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE

DATE	ITEM NO.	DESCRIPTION	CLM. CODE	ORDER NO.	QTY	UNIT PRICE	TOTAL CHARGES
01/19/01	48025	MAMMOGRAPHY SCREENING	403	1	1	106.00	106.00
		TOTAL Mammo Screening					106.00
		TOTAL CHARGES					106.00
01/23/01	P1145	3 PATIENT PAYMENT OUTPATIENT					-1.00
03/09/01	I1075	685 MEDICAL ASSISTANCE OUTPATIEN	T				-105.00
		TOTAL PAYMENTS/ADJUSTMENTS					-106.00

PATIENT NUMBER
01014-00126

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY

TOTAL AMOUNT DUE	0.00

PAYMENTS may be taken to the East or West registration areas or to the Business Office located at 207 Hospital Avenue.

PLEASE RETAIN FOR YOUR RECORDS

DuBois Regional Medical Center
P.O. Box 447 - DuBois, PA 15801-0447
(814) 375-4200
FEDERAL I.D. NO. 25-1490707

DETAIL STATEMENT

TYPE OF BILL	DATE OF BILL	PAGE NO.
D1-SER	05/04/01	1

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
FLORENCE I KING	01106-00704	F	59Y	04/16/01	04/30/01	

INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER	PAYMENT AMOUNT
200012 MA OUTPATIENT 200003 MEDICAL ASSISTANCE PR		0019202555 0019202555	

GUARANTOR NAME AND ADDRESS: FLORENCE I KING
253 WEST MAIN ST
SYKESVILLE PA 15865

☐ MasterCard ☐ VISA ☐ DISCOVER

CARD NO. _____
EXPIRATION DATE _____
SIGNATURE _____

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE

DATE	ITEM NO.	DESCRIPTION	CLM CODE	ORDER NO	QTY	UNIT PRICE	TOTAL CHARGES
04/19/01	70530	THERAPEUTIC EXERC STRENGTH/15 MI	420	2	2	50.00	100.00
04/24/01	70530	THERAPEUTIC EXERC STRENGTH/15 MI	420	3	1	50.00	50.00
		TOTAL PHYSICAL THERAPY					150.00
04/17/01	70021	EVALUATION EXTENDED	424	1	1	110.00	110.00
		TOTAL EVAL/RE-EVAL PT					110.00
		TOTAL CHARGES					260.00
06/21/01	I1075	591 MEDICAL ASSISTANCE OUTPATIEN	T				-254.00
		TOTAL PAYMENTS/ADJUSTMENTS					-254.00

PATIENT NUMBER	*PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.*	PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY	TOTAL AMOUNT DUE	6.00
01106-00704				

PAYMENTS may be taken to the East or West registration areas or to the Business Office located at 207 Hospital Avenue.

PLEASE RETAIN FOR YOUR RECORDS

FLORENCE I KING 99348-00357 F 59Y 12/15/99 12/15/99

200015 MA OUTPATIENT SURGERY 0019202555
200003 MEDICAL ASSISTANCE PP 0019202555

FLORENCE I KING
253 WEST MAIN ST
SYKESVILLE PA 15865

12/15/99	60082	LAVAGE,4000 ML	360	1	1	40.30	40.30
		TOTAL PHARMACY					40.30
12/15/99	95033	CRD SUCTION CANISTER	270	5	1	5.00	5.00
12/15/99	95070	SLIPPERS - MED	270	2	1	3.00	3.00
12/15/99	95882	TUBING SUCTION PN-59	270	6	1	3.00	3.00
12/15/99	96900	WHISTLE CLEANING BRUSH	270	3	1	18.00	18.00
12/15/99	96901	STERIS 20 STERILANT	270	4	1	20.00	20.00
		TOTAL SUPPLIES					49.00
12/15/99	15320	SIGMOIDOSCOPY (FLEXIBLE SCOPE)	360	1	1	890.00	890.00
		TOTAL OPERATING ROOM					890.00
		TOTAL CHARGES					979.30
02/15/00	I1080	583 MEDICAL ASSISTANCE OUTPT SPU					-197.00
02/07/00	A1380	738 MEDICAL ASSISTANCE- SPU					-779.30
02/16/00	A1710	000 SMALL BALANCE WRITE OFFS					-3.00
		TOTAL PAYMENTS/ADJUSTMENTS					-979.30

0.00

99348-00357

FLORENCE I KING 99332-00393 F 59Y 12/14/99 12/14/99

200012 MA OUTPATIENT 0019202555

FLORENCE I KING
253 WEST MAIN ST
SYKESVILLE PA 15865

12/14/99	48025	MAMMOGRAPHY SCREENING	401	1	1	101.00	101.00
		TOTAL RADIOLOGY					101.00
		TOTAL CHARGES					101.00
02/04/00	I1075	469 MEDICAL ASSISTANCE OUTPATIENT					-26.50
02/04/00	A1375	469 MEDICAL ASSISTANCE OUTPATIENT					-73.50
02/16/00	A1710	000 SMALL BALANCE WRITE OFFS					-1.00
		TOTAL PAYMENTS/ADJUSTMENTS					-101.00

0.00

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,

Plaintiff,

vs.

WAL-MART STORES, INC.,

Defendant.

CIVIL ACTION

No. 00-908-CD

NOTICE OF SERVICE OF NOTICE OF TELEPHONE DEPOSITIONS OF MELISSA KNOX, SUE DODGE AND ERIC YOUNT

Filed on behalf of Plaintiff:
FLORENCE KING

Counsel for Record for this Party:
Cynthia M. Porta, Esquire
Pa I.D. # 82111

WOOMER & FRIDAY, LLP
3220 West Liberty Avenue, Ste. 200
Pittsburgh, PA 15216
(412) 563-7980

JURY TRIAL DEMANDED

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,	CIVIL ACTION
Plaintiff,	No. 00-908-CD
vs.	
WAL-MART STORES, INC.,	
Defendant.	

NOTICE OF SERVICE

I hereby certify on July 2, 2002, that a true and correct copy of the ***Notice o Telephone Depositions of Melissa Knox, Sue Dodge and Eric Yount*** was served upon the following, by First Class U.S. mail, postage prepaid:

Patrick J. Doheny, Esquire
Gorr, Moser, Dell & Loughney
1300 Frick Building Pittsburgh, PA 15219

Respectfully Submitted,

Woomer & Friday, LLP

By: Cynthia M. Porta

Cynthia M. Porta, Esquire
PA I.D. # 82111
Counsel for Plaintiff

3220 West Liberty Avenue, Ste. 200
Pittsburgh, PA 15216
(412) 563-7980

OFFICE OF COURT ADMINISTRATOR

FORTY-SIXTH JUDICIAL DISTRICT OF PENNSYLVANIA

CLEARFIELD COUNTY COURTHOUSE
230 EAST MARKET STREET, SUITE 228
CLEARFIELD, PENNSYLVANIA 16830

DAVID S. MEHOLICK
COURT ADMINISTRATOR

PHONE: (814) 765-2641
FAX: 1-814-765-~~6089~~ 7649

MARCY KELLEY
DEPUTY COURT ADMINISTRATOR

March 1, 2001

Cynthia M. Porta, Esquire
Woomer & Friday, LLP
1701 McFarland Road
Pittsburgh, PA 15216

Patrick J. Doheny, Esquire
Gorr, Moser, Dell & Loughney
1300 Frick Building
Pittsburgh, PA 15219

FILED
MAR 12 2001
William A. Shaw
Prothonotary
Removed from Docket
6-24-02

RE: FLORENCE KING
vs.
WAL-MART STRORES, INC.
No. 00-908-CD

Dear Counsel:

The above case is scheduled for Arbitration Hearing to be held **Friday, May 25, 2001.** The following have been appointed to the Board of Arbitrators:

David S. Ammerman, Esquire
Barbara J. Hugney-Shope, Esquire
Gary A. Knaresboro, Esquire
Mark A. Falvo, Esquire
Frederick M. Neiswender, Esquire

If you wish to strike an Arbitrator, you must notify the undersigned within seven (7) days from the date of this letter the name you wish stricken from the list.

You will be notified at a later date the exact time of the Arbitration Hearing.

Very truly yours,

Marcy Kelley
Deputy Court Administrator

OFFICE OF COURT ADMINISTRATOR
FORTY-SIXTH JUDICIAL DISTRICT OF PENNSYLVANIA

CLEARFIELD COUNTY COURTHOUSE
230 EAST MARKET STREET, SUITE 228
CLEARFIELD, PENNSYLVANIA 16830

DAVID S. MEHOLICK
COURT ADMINISTRATOR

PHONE: (814) 765-2641
FAX: 1-814-765-~~6089~~ 7641

MARCY KELLEY
DEPUTY COURT ADMINISTRATOR

March 12, 2001

Cynthia M. Porta, Esquire
Woomer & Friday, LLP
1701 McFarland Road
Pittsburgh, PA 15216

Patrick J. Doheny, Esquire
Gorr, Moser, Dell & Loughney
1300 Frick Building
Pittsburgh, PA 15219

RE: FLORENCE KING
vs.
WAL-MART STRORES, INC.
No. 00-908-CD

Dear Counsel:

The above case is scheduled for Arbitration Hearing to be held **Friday, May 25, 2001 at 9:00 A.M.** The following have been appointed to the Board of Arbitrators:

David S. Ammerman, Esquire, Chairman
Barbara J. Hugney-Shope, Esquire
Gary A. Knaresboro, Esquire

Pursuant to Local Rule 1306A, you must submit your Pre-Trial Statement seven (7) days prior to the scheduled Arbitration. The original should be forwarded to the Court Administrator's Office and copies to opposing counsel and the Board of Arbitrators. For your convenience, a Pre-Trial (Arbitration) Memorandum Instruction Form is enclosed as well as a copy of said Local Rule of Court.

Very truly yours,
Marcy Kelley
Marcy Kelley
Deputy Court Administrator

cc: David S. Ammerman, Esquire
Barbara J. Hugney-Shope, Esquire
Gary A. Knaresboro, Esquire

OFFICE OF COURT ADMINISTRATOR

FORTY-SIXTH JUDICIAL DISTRICT OF PENNSYLVANIA

CLEARFIELD COUNTY COURTHOUSE
230 EAST MARKET STREET, SUITE 228
CLEARFIELD, PENNSYLVANIA 16830

DAVID S. MEHOLICK
COURT ADMINISTRATOR

PHONE: (814) 765-2641
FAX: 1-814-765-~~5889~~ 7649

MARCY KELLEY
DEPUTY COURT ADMINISTRATOR

June 1, 2001

Cynthia M. Porta, Esquire
Woomer & Friday, LLP
1701 McFarland Road
Pittsburgh, PA 15216

Patrick J. Doheny, Esquire
Gorr, Moser, Dell & Loughney
1300 Frick Building
Pittsburgh, PA 15219

RE: FLORENCE KING
vs.
WAL-MART STRORES, INC.
No. 00-908-CD

Dear Counsel:

The above case is scheduled for Arbitration Hearing to be held **Monday, August 13, 2001 at 1:00 P.M.** The following have been appointed to the Board of Arbitrators:

James A. Naddeo, Esquire,
Ronald L. Collins, Esquire
Theron G. Noble, Esquire
Christopher E. Mohney, Esquire
Paul Colavecchi, Esquire

If you wish to strike an Arbitrator, you must notify the undersigned within seven (7) days from the date of this letter the name you wish stricken from the list.

Very truly yours,

Marcy Kelley
Deputy Court Administrator

FILED
JUN 1 2001
William A. Shaw
Prothonotary

OFFICE OF COURT ADMINISTRATOR
FORTY-SIXTH JUDICIAL DISTRICT OF PENNSYLVANIA

CLEARFIELD COUNTY COURTHOUSE
230 EAST MARKET STREET, SUITE 228
CLEARFIELD, PENNSYLVANIA 16830

DAVID S. MEHOLICK
COURT ADMINISTRATOR

PHONE: (814) 765-2641
FAX: 1-814-765-~~8089~~ 7649

MARCY KELLEY
DEPUTY COURT ADMINISTRATOR

June 11, 2001

Cynthia M. Porta, Esquire
Woomer & Friday, LLP
1701 McFarland Road
Pittsburgh, PA 15216

Patrick J. Doheny, Esquire
Gorr, Moser, Dell & Loughney
1300 Frick Building
Pittsburgh, PA 15219

RE: FLORENCE KING
vs.
WAL-MART STRORES, INC.
No. 00-908-CD

Dear Counsel:

The above case is scheduled for Arbitration Hearing to be held **Monday, August 13, 2001 at 1:00 P.M.** The following have been appointed as Arbitrators:

James A. Naddeo, Esquire, Chairman
Ronald L. Collins, Esquire
Theron G. Noble, Esquire

Pursuant to Local Rule 1306A, you must submit your Pre-Trial Statement seven (7) days prior to the scheduled Arbitration. The original should be forwarded to the Court Administrator's Office and copies to opposing counsel and the Board of Arbitrators. For your convenience, a Pre-Trial (Arbitration) Memorandum Instruction Form is enclosed as well as a copy of said Local Rule of Court.

Very truly yours,

Marcy Kelley
Deputy Court Administrator

cc: James A. Naddeo, Esquire
Ronald L. Collins, Esquire
Theron G. Noble, Esquire

WAL.192

12

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,

Plaintiff,

vs.

WAL-MART STORES, INC.,

Defendant.

ARBITRATION DIVISION

No. 00-908-CD

JURY TRIAL DEMANDED

DEFENDANT'S NOTICE OF APPEAL FROM AWARD OF ARBITRATION

Filed on behalf of WAL-MART STORES, INC.,

Counsel of Record for this Party:

Patrick J. Loughney, Esq.
Pa. I.D. ##23163

Patrick J. Doheny, Esq.
Pa. I.D. #85547

GORR, MOSER, DELL & LOUGHNEY
Firm #753

1300 Frick Building
Pittsburgh, PA 15219

Phone: (412) 471-1180
Fax: (412) 471-9012

WAL.192

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,	ARBITRATION DIVISION
Plaintiff,	No. 00-908-CD
vs.	JURY TRIAL DEMANDED
WAL-MART STORES, INC.,	
Defendant.	

NOTICE OF APPEAL FROM AWARD OF ARBITRATION

TO: William A. Shaw, Prothonotary

Notice is given that Defendant Wal-Mart Stores, Inc. appeals from the award of arbitration entered in this case on August 13, 2001. A jury trial is demanded.

I hereby certify that the compensation of the arbitrators has been paid.

Respectfully submitted,

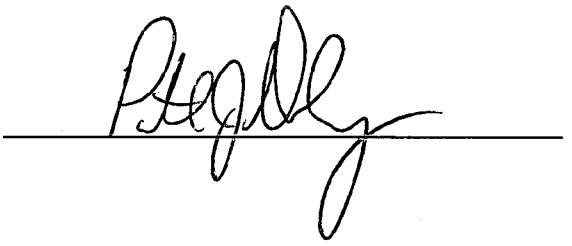
GORR, MOSER, DELL & LOUGHNEY

Patrick J. Doheny, Esquire
437 Grant Street
1300 Frick Building
Pittsburgh, PA 15219
Counsel for Wal-Mart Stores, Inc.

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of Defendant's Notice of Appeal from Award of Arbitration was served by U.S. Mail, postage prepaid, this 17th day of August, 2001, upon all counsel of record or parties as follows:

Cynthia M. Porta, Esquire
WOOMER & FRIDAY, LLP
1701 McFarland Road
Pittsburgh, PA 15216
Counsel for Plaintiff



FILED

AUG 2 0 2001

Mitchell A. Shaw
Prothonotary

Doherty

Pd $40.00

no cc

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING, Plaintiff, v. WAL-MART STORES, INC. Defendant.	ARBITRATION DIVISION No.: 00-908-CD **PRAECIPE FOR ARGUMENT** Filed on Behalf of Plaintiff: Florence King Counsel of Record for this Party: Cynthia M. Porta, Esquire PA I.D. #: 82111 WOOMER & FRIDAY, LLP 3220 West Liberty Ave., Suite 200 Pittsburgh, PA 15216 (412) 563-7980 **JURY TRIAL DEMANDED**

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,	)	ARBITRATION DIVISION
	)	
Plaintiff,	)	No.: 00-908-CD
	)	
v.	)	
	)	
WAL-MART STORES, INC.	)	
	)	
Defendant.	)	

PRAECIPE FOR ARGUMENT

TO THE COURT ADMINISTRATOR:

AND NOW comes Plaintiff, Florence King, by and through her attorneys, Woomer & Friday, LLP, and requests that oral argument be scheduled to occur regarding the Motion for Summary Judgment filed by Defendant, Wal-Mart Stores, Inc., on March 6, 2002.

Respectfully submitted,

Cynthia M. Porta

Cynthia M. Porta, Esquire
Attorney for Plaintiff
PA I.D. #: 82111

WOOMER & FRIDAY, LLP
3220 West Liberty Ave., Suite 200
Pittsburgh, PA 15216
(412) 563-7980

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,	)	ARBITRATION DIVISION
	)	
Plaintiff,	)	No.: 00-908-CD
	)	
v.	)	
	)	
WAL-MART STORES, INC.	)	
	)	
Defendant.	)	

CERTIFICATE OF SERVICE

I, Cynthia M. Porta, Esquire, hereby certify that on this 7th day of March, 2002, a true and correct copy of the foregoing *Praecipe for Argument* was served upon the following via first class United States Mail, postage pre-paid:

John A. Burgess, Esquire
Gorr, Moser, Dell & Loughney
1300 Frick Building
Pittsburgh, PA 15219

Respectfully submitted,

Cynthia M. Porta

Cynthia M. Porta, Esquire
Attorney for Plaintiff
PA I.D. #: 82111

WOOMER & FRIDAY, LLP
3220 West Liberty Ave., Suite 200
Pittsburgh, PA 15216
(412) 563-7980

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

CIVIL ACTION

FLORENCE KING	:	
-vs-	:	No. 00 – 908 – CD
WAL-MART STORES, INC.	:	

ORDER

NOW, this 20th day of June, 2002, following argument and briefs into Defendant's Motion for Summary Judgment, it is the ORDER of this Court that said matter be and is hereby continued for a period of 60 days to permit completion of discovery.

By the Court,

President Judge

FILED

JUN 20 2002

0/2:30/nas

William A. Shaw

Prothonotary

CERT TO DOUGENY + PORTA

I do hereby certify this to be a true and attested copy of the original statement filed in this case.

JUN 20 2002

Attest.

William A. Shaw

Prothonotary

00-908-CD

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,

Plaintiff,

vs.

WAL-MART STORES, INC.,

Defendant.

CIVIL DIVISION

Docket No. : 00-908-CD

NOTICE OF SERVICE OF PLAINTIFF'S SECOND SET OF INTERROGATORIES AND REQUEST FOR PRODUCTION OF DOCUMENTS DIRECTED TO DEFENDANT

Filed on behalf of Plaintiff
FLORENCE KING

Counsel of Record for this Party:
Cynthia M. Porta, Esquire
Pa I.D. # 82111

WOOMER & FRIDAY, LLP
3220 West Liberty Avenue, Ste. 200
Pittsburgh, PA 15216
(412) 563-7980

JURY TRIAL DEMANDED

00-908-CD

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING

Plaintiff,

vs.

WAL-MART STORES, INC.

Defendant.

CIVIL DIVISION

Docket No. : 00-908-CD

Code No.:

NOTICE OF SERVICE OF PLAINTIFF'S SECOND SET OF INTERROGATORIES AND REQUEST FOR PRODUCTION OF DOCUMENTS DIRECTED TO DEFENDANT

I hereby certify that on July 30, 2002 an original set of ***Plaintiff's Second Set of Interrogatories and Request for Production of Documents Directed to Defendant*** were served by first class U.S. mail, postage prepaid, upon Defendant's counsel, to-wit:

Patrick J. Doheny, Esquire
Gorr, Moser, Dell & Loughney
1300 Frick Building
Pittsburgh, PA 15219

Woomer & Friday, LLP

Cynthia M. Porta

Cynthia M. Porta, Esq.
Pa I.D. # 82111
Attorney for Plaintiff

Woomer & Friday, LLP
3220 West Liberty Avenue, Ste. 200
Pittsburgh, PA 15216
(412) 563-7980

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING, Plaintiff, v. WAL-MART STORES, INC. Defendant.	ARBITRATION DIVISION No.: 00-908-CD **MOTION TO CONTINUE DISCOVERY** Filed on Behalf of Plaintiff: Florence King Counsel of Record for this Party: Cynthia M. Porta, Esquire PA I.D. #: 82111 WOOMER & FRIDAY, LLP 3220 West Liberty Ave., Suite 200 Pittsburgh, PA 15216 (412) 563-7980 **JURY TRIAL DEMANDED**

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,	)	ARBITRATION DIVISION
	)	
Plaintiff,	)	No.: 00-908-CD
	)	
v.	)	
	)	
WAL-MART STORES, INC.	)	
	)	
Defendant.	)	

MOTION TO CONTINUE DISCOVERY

AND NOW comes Plaintiff, Florence King, by and through her attorneys, Woomer & Friday, LLP, and files the following Motion to Continue Discovery:

1. The instant matter was initiated by a Complaint in Civil Action filed on or about August 3, 2000, wherein Plaintiff alleges to have sustained injuries and damages as the result of the negligence of Defendant.

2. An arbitration hearing regarding the matter occurred on or about August 13, 2001.

3. Defendant filed a Notice of Appeal from the Award of the Arbitration on or about August 17, 2001.

4. On or about March 6, 2002, Defendant filed a Motion for Summary Judgment.

5. On or about June 20, 2002, this Honorable Court issued an Order continuing discovery for a period of sixty (60) days.

6. On or about July 22, 2002, the depositions of three (3) employees of Defendant were taken.

7. During these depositions, the witnesses identified various documents which are relevant to the instant matter, and which Plaintiff was unaware existed.

8. On or about July 30, 2002, Plaintiff forwarded a Second Set of Interrogatories and Request for Production of Documents to Defendant. Therein, Plaintiff seeks production of the documents identified in the July 22, 2002 depositions.

9. As discovery is currently scheduled to conclude on August 19, 2002, plaintiff respectfully requests that this Honorable Court extends discovery in this matter for an additional thirty (30) days.

10. The granting of this motion will not prejudice the Defendant.

11. This matter is not currently on any trial list.

WHEREFORE, Plaintiff respectfully requests that this Honorable Court continue the instant matter until September 18, 2002 for the completion of discovery.

Respectfully submitted,

Cynthia M. Porta

Cynthia M. Porta, Esquire
Attorney for Plaintiff
PA I.D. #: 82111

WOOMER & FRIDAY, LLP
3220 West Liberty Ave., Suite 200
Pittsburgh, PA 15216
(412) 563-7980

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,	)	ARBITRATION DIVISION
	)	
Plaintiff,	)	No.: 00-908-CD
	)	
v.	)	
	)	
WAL-MART STORES, INC.	)	
	)	
Defendant.	)	

ORDER

AND NOW, this 8TH day of August, 2002, it is hereby ORDERED that the Plaintiff's Motion to Continue Discovery is granted. This matter is hereby continued until September 18, 2002, for the completion of discovery.

By the Court,

President Judge

FILED

AUG 08 2002

01:23/2cc atty Porta

William A. Shaw

Prothonotary

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,	)	ARBITRATION DIVISION
	)	
Plaintiff,	)	No.: 00-908-CD
	)	
v.	)	
	)	
WAL-MART STORES, INC.	)	
	)	
Defendant.	)	

CERTIFICATE OF SERVICE

I, Cynthia M. Porta, Esquire, hereby certify that on this 31st day of July, 2002, a true and correct copy of the foregoing *Motion to Continue Discovery* was served upon the following via first class United States Mail, postage pre-paid:

John A. Burgess, Esquire
Gorr, Moser, Dell & Loughney
1300 Frick Building
Pittsburgh, PA 15219

Respectfully submitted,

Cynthia M. Porta

Cynthia M. Porta, Esquire
Attorney for Plaintiff
PA I.D. #: 82111

WOOMER & FRIDAY, LLP
3220 West Liberty Ave., Suite 200
Pittsburgh, PA 15216
(412) 563-7980

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING, Plaintiff, v. WAL-MART STORES, INC. Defendant.	ARBITRATION DIVISION No.: 00-908-CD **MOTION TO COMPEL** Filed on Behalf of Plaintiff: Florence King Counsel of Record for this Party: Cynthia M. Porta, Esquire PA I.D. #: 82111 WOOMER & FRIDAY, LLP 3220 West Liberty Ave., Suite 200 Pittsburgh, PA 15216 (412) 563-7980 **JURY TRIAL DEMANDED**

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,	)	ARBITRATION DIVISION
	)	
Plaintiff,	)	No.: 00-908-CD
	)	
v.	)	
	)	
WAL-MART STORES, INC.	)	
	)	
Defendant.	)	

MOTION TO COMPEL

AND NOW comes plaintiff, Florence King, by and through her attorneys, Woomer & Friday, LLP, and files the following Motion to Compel:

1. On or about July 30, 2002, plaintiff served Plaintiff's Second Set of Interrogatories and Request for Production of Documents Directed to Defendant. (See Copy of Notice of Service, attached hereto as Exhibit "A.")

2. To date, defendant has failed to provide any answer to these discovery requests.

3. Plaintiff has sought the information requested within these discovery requests in order to challenge the Motion for Summary Judgment filed by defendant in this case.

4. Defendant's failure to provide timely answers to the aforementioned discovery requests has seriously prejudiced plaintiff's defense of the Motion for Summary Judgment, and preparation of this matter for trial.

5. Accordingly, plaintiff requests that this Honorable Court direct defendant to provide appropriate answers to Plaintiff's Second Set of Interrogatories and Request For Production of Documents, without objection, within the next twenty (20) days.

WHEREFORE, plaintiff Florence King respectfully requests that this Honorable Court grant this Motion to Compel.

Respectfully submitted,

Cynthia M. Porta-Clark

Cynthia M. Porta-Clark, Esquire
Attorney for Plaintiff
PA I.D. #: 82111

WOOMER & FRIDAY, LLP
3220 West Liberty Ave., Suite 200
Pittsburgh, PA 15216
(412) 563-7980

00-908-CD

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,

Plaintiff,

vs.

WAL-MART STORES, INC.,

Defendant.

CIVIL DIVISION

Docket No. : 00-908-CD

NOTICE OF SERVICE OF PLAINTIFF'S SECOND SET OF INTERROGATORIES AND REQUEST FOR PRODUCTION OF DOCUMENTS DIRECTED TO DEFENDANT

Filed on behalf of Plaintiff
FLORENCE KING

Counsel of Record for this Party:
Cynthia M. Porta, Esquire
Pa I.D. # 82111

WOOMER & FRIDAY, LLP
3220 West Liberty Avenue, Ste. 200
Pittsburgh, PA 15216
(412) 563-7980

JURY TRIAL DEMANDED

Exhibit "A"

00-908-CD

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING

Plaintiff, CIVIL DIVISION

vs. Docket No. : 00-908-CD

WAL-MART STORES, INC. Code No.:

Defendant.

NOTICE OF SERVICE OF PLAINTIFF'S SECOND SET OF INTERROGATORIES AND REQUEST FOR PRODUCTION OF DOCUMENTS DIRECTED TO DEFENDANT

I hereby certify that on July 30, 2002 an original set of ***Plaintiff's Second Set of Interrogatories and Request for Production of Documents Directed to Defendant*** were served by first class U.S. mail, postage prepaid, upon Defendant's counsel, to-wit:

Patrick J. Doheny, Esquire
Gorr, Moser, Dell & Loughney
1300 Frick Building
Pittsburgh, PA 15219

Woomer & Friday, LLP

Cynthia M. Porta

Cynthia M. Porta, Esq.
Pa I.D. # 82111
Attorney for Plaintiff

Woomer & Friday, LLP
3220 West Liberty Avenue, Ste. 200
Pittsburgh, PA 15216
(412) 563-7980

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,	)	ARBITRATION DIVISION
	)	
Plaintiff,	)	No.: 00-908-CD
	)	
v.	)	
	)	
WAL-MART STORES, INC.	)	
	)	
Defendant.	)	

ORDER

AND NOW this 18th day of October, 2002, it is hereby ORDERED and DECREED that Plaintiff's Motion to Compel is granted. Defendant shall provide appropriate answers to Plaintiff's Second Set of Interrogatories and Request for Production of Documents, without objection, within the next twenty (20) days.

J.

FILED

OCT 18 2002

William A. Shaw
Prothonotary

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,	)	ARBITRATION DIVISION
	)	
Plaintiff,	)	No.: 00-908-CD
	)	
v.	)	
	)	
WAL-MART STORES, INC.	)	
	)	
Defendant.	)	

CERTIFICATE OF SERVICE

I, Cynthia M. Porta, Esquire, hereby certify that on this 10th day of October, 2002, a true and correct copy of the foregoing *Motion to Compel* was served upon the following via first class United States Mail, postage pre-paid:

John A. Burgess, Esquire
Gorr, Moser, Dell & Loughney
1300 Frick Building
Pittsburgh, PA 15219

Respectfully submitted,

Cynthia M. Porta-Clark

Cynthia M. Porta-Clark, Esquire
Attorney for Plaintiff
PA I.D. #: 82111

WOOMER & FRIDAY, LLP
3220 West Liberty Ave., Suite 200
Pittsburgh, PA 15216
(412) 563-7980

WAL.192

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,

Plaintiff,

vs.

WAL-MART STORES, INC.,

Defendant.

ARBITRATION DIVISION

No. 00-908-CD

JURY TRIAL DEMANDED

PRAECIPE TO SCHEDULE ARGUMENT

Filed on behalf of WAL-MART STORES, INC.,

Counsel of Record for this Party:

Patrick J. Loughney, Esq.
Pa. I.D. ##23163

Patrick J. Doheny, Esq.
Pa. I.D. #85547

DELL, MOSER, LANE & LOUGHNEY, L.L.C.
Firm #753

1300 Frick Building
Pittsburgh, PA 15219

Phone: (412) 471-1180
Fax: (412) 471-9012

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,	ARBITRATION DIVISION
Plaintiff,	No. 00-908-CD
vs.	JURY TRIAL DEMANDED
WAL-MART STORES, INC.,	
Defendant.	

PRAECIPE TO SCHEDULE ARGUMENT

TO: COURT ADMINISTRATOR:

Please schedule argument upon Wal-Mart Stores, Inc.'s Motion for Summary Judgment, which was previously filed in the above-captioned matter, for the next available argument date.

Respectfully submitted

Dell, Moser, Lane & Loughney, LLC

By: _____

Patrick J. Doheny, Esquire
PA I.D. #85547

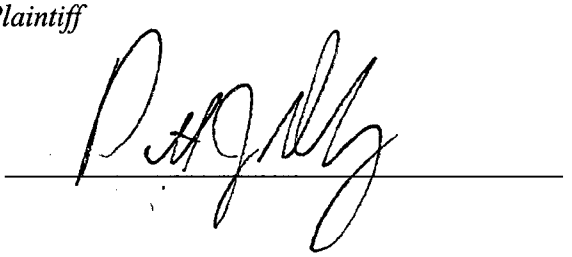
Dell, Moser, Lane & Loughney, LLC
1300 Frick Building
437 Grant Street
Pittsburgh, PA 15219

Phone: (412) 471-1180
Fax: (412) 471-9012

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of Wal-Mart's Praecipe to Schedule Argument was served by U.S. Mail, postage prepaid, this 28th day of October, 2002, upon all counsel of record or parties as follows:

Cynthia M. Porta, Esquire
WOOMER & FRIDAY, LLP
1701 McFarland Road
Pittsburgh, PA 15216
Counsel for Plaintiff



00-908-CD

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,

Plaintiff,

vs.

WAL-MART STORES, INC.,

Defendant.

CIVIL DIVISION

Docket No. : 00-908-CD

PRAECIPE TO SETTLE AND DISCONTINUE

Filed on behalf of Plaintiff
FLORENCE KING

Counsel of Record for this Party:
Cynthia M. Porta, Esquire
Pa I.D. # 82111

WOOMER & FRIDAY, LLP
3220 West Liberty Avenue, Ste. 200
Pittsburgh, PA 15216
(412) 563-7980

JURY TRIAL DEMANDED

00-908-CD

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,

Plaintiff,

vs.

WAL-MART STORES, INC.,

Defendants.

CIVIL DIVISION

Docket No. : 00-908-CD

Code No.:

PRAECIPE TO SETTLE AND DISCONTINUE

TO THE PROTHONOTARY:

Kindly mark the above-captioned case settled and discontinued.

Respectfully submitted November 18, 2002

Woomer & Friday, LLP

Cynthia M. Porta-Clark

Cynthia M. Porta-Clark, Esq.
Pa I.D. # 82111
Attorney for Plaintiff

Woomer & Friday, LLP
3220 West Liberty Avenue, Ste. 200
Pittsburgh, PA 15216
(412)563-7980

COPY

IN THE COURT OF COMMON PLEAS OF
CLEARFIELD COUNTY, PENNSYLVANIA

CIVIL DIVISION

Florence King

Vs. **No. 2000-00908-CD**
Wal-Mart Store, Inc.

CERTIFICATE OF DISCONTINUATION

Commonwealth of PA
County of Clearfield

I, William A. Shaw, Prothonotary of the Court of Common Pleas in and for the County and Commonwealth aforesaid do hereby certify that the above case was on November 21, 2002 marked:

Settled and Discontinued

Costs in the sum of $80.00 have been paid by Cynthia Porta. Costs in the sum of $20.00 have been paid by Brad D. Trust. Costs in the sum of $600.00 have been paid by Patrick J. Doheny. Record costs have been paid in full.

IN WITNESS WHEREOF, I have hereunto affixed my hand and seal of this Court at Clearfield, Clearfield County, Pennsylvania this 21st day of November A.D. 2002.

_____
William A. Shaw, Prothonotary

WAL.192

CP

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,

Plaintiff,

vs.

WAL-MART STORES, INC.,

Defendant.

ARBITRATION DIVISION

No. 00-908-CD

JURY TRIAL DEMANDED

MOTION FOR SUMMARY JUDGMENT

Filed on behalf of WAL-MART STORES, INC.,

Counsel of Record for this Party:

Patrick J. Loughney, Esq.
Pa. I.D. ##23163

Patrick J. Doheny, Esq.
Pa. I.D. #85547

GORR, MOSER, DELL & LOUGHNEY
Firm #753

1300 Frick Building
Pittsburgh, PA 15219

Phone: (412) 471-1180
Fax: (412) 471-9012

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

FLORENCE KING,	ARBITRATION DIVISION
Plaintiff,	No. 00-908-CD
vs.	JURY TRIAL DEMANDED
WAL-MART STORES, INC.,	
Defendant.	

MOTION FOR SUMMARY JUDGMENT

AND NOW, comes Defendant, Wal-Mart Stores, Inc. by and through its attorneys, Gorr, Moser, Dell & Loughney, LLC, and Patrick J. Doheny, Esquire and files the following Motion for Summary Judgment based upon lack of evidence of negligence.

1. On or about August 3rd, 2000, Plaintiff, Florence King, commence this action against Defendant, Wal-Mart Stores, Inc., to recover for personal injuries and damages sustained by Florence King.

2. Plaintiff alleges, among other things, that the hot curling set was negligently shelved causing injury to Plaintiff.

3. To establish liability, the Plaintiff must prove that the Defendant created the condition of which she complains, or that the Defendant knew of the damages or in the exercise of reasonable care should have known of the existence of the condition.

4. In Pennsylvania, the doctrine of *res ipsa loquitur* and the exclusive control doctrine do not apply in cases involving business invitees injured by falling merchandise in retail stores.

5. Florence King concedes that there is no evidence to suggest that Wal-Mart knew of the curling iron condition, caused it or should have know of the curling iron condition.

6. Florence King admits that, although she could reach it herself, she could not see behind the curling set that she was reaching for. See exhibits "A" through "E" attached to Wal-Mart Stores, Inc's Brief in Support of Motion For Summary Judgment.

7. No evidence exists in the record as to how long the hot curling set was in its condition prior to Florence King's alleged incident.

8. Under Pennsylvania Law, the Plaintiff is unable to present a prima facie case because she is unable to present any evidence that Defendant caused the allegedly dangerous condition or that Defendant either had actual or constructive notice of the condition.

9. No genuine issue of fact exist in this action as to the liability of Defendant, and, as such, Defendant is entitled to judgment as matter of law.

10. Wherefore, Defendant, Wal-Mart Stores, Inc., respectfully request that this Honorable Court enter Summary Judgment in its favor and against the Plaintiff Florence King.

Respectfully submitted,

GORR, MOSER, DELL & LOUGHNEY

Patrick J. Loughney, Esquire
PA I.D. No. 23163
Attorneys for the Defendant,
Wal-Mart Stores, Inc.

Gorr, Moser, Dell & Loughney
437 Grant Street
1300 Frick Building
Pittsburgh, PA 15219

Q. What is your date of birth?
A. 10-14-41.
Q. How old are you today?
A. Fifty-nine.
Q. Mrs. King, do you recall the events that occurred on February 28, 1999?
A. Yes, I do.
Q. What were you doing on that date?
A. Shopping at Wal-Mart.
Q. Which Wal-Mart store were you shopping at?
A. DuBois Mall, Sandy Plaza.
Q. Approximately at what time were you at the store?
A. It was in the evening.
Q. Do you know the time that it happened?
A. No, I don't.
Q. Did you sustain an injury while shopping at Wal-Mart on February 28, 1999?
A. Yes.
Q. Could you explain for the arbitration panel how you were injured on that date?
A. I reached up over my head to get hot curlers. When I did, the box that was in my hand was hooked onto another box that was open, which I did not know at the time, and it hit me on the head, above my hairline.

Q. You're showing that you reached above your head with both hands, is that correct?
A. Yes.
Q. Do you know how high you were reaching?
A. However high it was --
Q. Two feet above your height?
A. Probably a foot.
Q. How tall are you?
A. 5'2" and a half.
Q. Did you have the opportunity to remove the box of hot curlers that you had your hands on?
A. Yes, I did.
Q. At any time that you were attempting to remove that box, did you know that there were any other boxes attached to it?
A. No, I did not.
Q. Could you show us where on your body you were struck with the second box of hot curlers?
A. Right where my hairline starts, it hit me.
Q. Did it knock you to the ground?
A. No, I would --
Q. Did you feel pain anywhere in your body as a result of that accident, immediately after the accident?
A. No.
Q. What did you feel immediately after the

because you went to see a doctor, isn't that right?

A. It was a long time for me, I'm sorry.

Q. Now you don't recall doing that, right?

A. I don't recall it, but I must have done it.

Q. Now the day of incident, that was February 28, 1999, right?

A. Yes.

Q. Now I am kind of confused. You were in an aisle, you were looking at some hot curl irons, is that right?

A. Hot curlers.

Q. Now, while in the aisle, you said they were attached or connected in some way?

A. Yes, I did. I did not know this.

Q. You didn't know that? How were they attached?

A. The box was open. One box was open, that was behind the box that I picked up.

Q. Okay. It was opened? How do you mean it was opened? The flap was open?

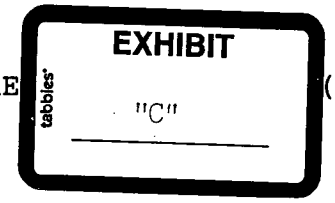
A. The whole thing was opened up, the flap.

Q. Were there cords running out of it?

A. No, there was not.

Q. Were the cords connected in any way?

A. No.



Q. Was a flap intertwined with a flap on the second box?

A. Yes.

Q. So both of them were opened?

A. No. It was just stuck inside the corner of the box that I was pulling out, and I didn't see it at the time that it was open.

Q. Were both of them open?

A. No, they were not.

Q. That is what I am trying to get at. How then was the one box attached to the other box mechanically? I don't see that.

A. The carton of the lid on the open box was stuck inside the carton that I was pulling down.

Q. Could you maybe draw a picture? I will give you a sheet of paper, just for reference sake.

(Witness doing as requested)

BY MR. DOHENY:

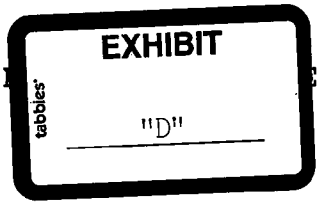
Q. This was a square box, is that correct?

A. Right.

Q. Now, was it on top of that box?

A. It was behind it.

Q. And so the front box you were pulling at was



was there. There was nobody with me.

Q. You were reaching up on the shelf, correct?

A. Yes, I was.

Q. Did you ask anyone for assistance to get it down?

A. No, because I could reach it.

Q. So, basically, your recollection is the only basis we have of how this happened?

A. That is right.

Q. When did you actually report this accident? The following day?

A. I thought I called when I got home. I told Sue, the cashier, what happened. She asked if I was okay. I said, no, I am not okay. She said, oh, I'm sorry. Oh well.

Q. Now, I'd like to show you a recorded statement you gave in this case. I'll give a copy to you and your attorney. I believe we have produced that. I will give a copy to the panel. I think I only have one copy. You can look at that.

You see the top of the statement, this was given July 29th, I believe that was 1999. Does that sound right? Does that date sound right to you, Ms. King?

A. I don't know.