Account Activity for Enrique Rodriguez

Printed on August 19, 2008

00024014	**03/26/2008**	**Robert C Gutierrez MD Govind Koka**	**11**	**$300.00**	**$0.00**	**$0.00**	**$300.00**	
99213	03/26/2008	lorrie	OFFICE/OP VISIT, EST PT, 2 KEY COMPONENTS: EXPAND PROB HX; EXPAND PROB EXAM;MED DECISION LOW COMPLEX --- 727.03	$300.00	$0.00	$0.00	$300.00	
	04/01/2008	lorrie	Ins 1.1(1): Jonathan Weber Aty					Closed
-misc-	**08/19/2008**	**Robert C Gutierrez MD**		**$41.40**	**$0.00**	**$0.00**	**$41.40**	
RecCopy	08/19/2008	lorrie	Copy Medical Records ---	$41.40	$0.00	$0.00	$41.40	

	Charges	Payments	Adj	Balance
Totals:	**$3,362.40**	**$10.20**	**$0.00**	**$3,352.20**

	0-30:	31-60	61-90	91-120	121+	Balance	Total Balance	Pending Insurance
Patient:	**$41.40**	**$0.00**	**$0.00**	**$0.00**	**$3,310.80**	**$3,352.20**	**$3,352.20**	
Insurance:	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**		**$0.00**

Notes

Date	User	Miscellaneous Notes
08/19/2008	Mrs. Lorretto E Owen	Records released to Prodox
12/04/2007	Mrs. Lorretto E Owen	Released printed records to Morgan Law Firm with Subpoena
10/23/2007	Mrs. Lorretto E Owen	records released to Benson
10/10/2006	Mrs. Lorretto E Owen	Records Release to benson, Bertoldo

Date	User	Statement Notes
07/31/2008	Lorretto Owen	Included in Batch Run Statement Generated: 07/31/2008 03:01:26 PM on Machine: CPS Statement Printed: 07/31/2008 03:03:53 PM Report Date Range: 01/01/2006 thru 07/31/2008 Total Balance Due By Patient: $3,310.80
01/29/2008	Lorretto Owen	Included in Batch Run Statement Generated: 01/29/2008 12:43:27 PM on Machine: CPS Statement Printed: 01/29/2008 12:45:35 PM Report Date Range: 01/01/2006 thru 01/31/2008 Total Balance Due By Patient: $3,010.80
12/10/2007	Lorretto Owen	Included in Batch Run Statement Generated: 12/10/2007 05:51:12 PM on Machine: CPS Statement Printed: 12/10/2007 05:52:16 PM Report Date Range: 01/01/2006 thru 12/31/2007 Total Balance Due By Patient: $3,010.80
11/06/2007	Lorretto Owen	Included in Batch Run Statement Generated: 11/06/2007 07:48:20 AM on Machine: CPS Statement Printed: 11/06/2007 07:51:40 AM Report Date Range: 01/01/2006 thru 11/30/2007 Total Balance Due By Patient: $3,010.80

16331

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

BENSON BERTOLDO BAKER AN
7408 WEST SAHARA AVE

LAS VEGAS NV 89117

PICA

PICA

CARRIER

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ ENRIQUE J

3. PATIENT'S BIRTH DATE MM DD YY SEX: X M F

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

5. PATIENT'S ADDRESS (No., Street)

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

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

CITY STATE

8. PATIENT STATUS: Single Married Other X

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

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: X 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? YES X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: STEVE BAKER

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 10/8/2008

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

PATIENT AND INSURED INFORMATION

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 PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

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. 569 3

2. 564 00

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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	04 07 08 04 07 08	11		99214		1 2	239 00 1			NPI	1588646830
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 203502995 SSN EIN X

26. PATIENT'S ACCOUNT NO.: 16331P140575

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

28. TOTAL CHARGE $ 239 00

29. AMOUNT PAID $

30. BALANCE DUE $ 239 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.)

CRAIG JORGENSON MD

SIGNED DATE 10/8/2008

32. SERVICE FACILITY LOCATION INFORMATION

ADV URGENT CARE - PRIMARY
9975 S EASTERN AVE 110
LAS VEGAS NV 891830010

a. 1457382863 b.

33. BILLING PROVIDER INFO & PH # 702-361-2273

ADVANCED URGENT CARE
PO BOX 530010
HENDERSON NV 890530010

a. 1457382863 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

6655

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

BENSON BERTOLDO BAKER AN
7408 WEST SAHARA AVE

LAS VEGAS NV 89117

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ ENRIQUE J

3. PATIENT'S BIRTH DATE MM DD YY: 07 15 1963 SEX [X] M [ ] F

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

5. PATIENT'S ADDRESS (No., Street)

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

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

CITY | STATE: CA

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

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 [X] 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? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: STEVE BAKER

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 4/17/2009

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 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 PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

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. V01 89
2.
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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	04 02 08	04 02 08	11		99211		1	54 00	1		NPI	1588646830
2	04 02 08	04 02 08	11		36415		1	10 00	1		NPI	1588646830
3	04 02 08	04 02 08	11		99000		1	10 00	1		NPI	1588646830
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: 203502995 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 6655P140575

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

28. TOTAL CHARGE: $ 74 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 74 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.)

CRAIG JORGENSON MD

SIGNED DATE 4/17/2009

32. SERVICE FACILITY LOCATION INFORMATION

ADV URGENT CARE - PRIMARY
9975 S EASTERN AVE 110
LAS VEGAS NV 891830010

a. 1457382863 b.

33. BILLING PROVIDER INFO & PH # (702) 361-2273

JORGENSON AND KOKA LLP
PO BOX 530010
HENDERSON NV 890530010

a. 1457382863 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

75206

CANYON MEDICAL BILLING
7435 S. EASTERN AVE.
STE. A5-273
LAS VEGAS NV 89123

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ ENRIQUE J

3. PATIENT'S BIRTH DATE SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

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

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

CITY STATE

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

CITY /E STATE

ZIP CODE TELEPHONE (Include Area Code)

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 SEX M [X] 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? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: CANYON MEDICAL BILLING

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 3/17/2008

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 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 PROVIDER OR OTHER SOURCE 17a. 17b. NPI

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

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. 719 46 3. 2. 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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	03 13 08	03 13 08	11		99243	25	1	283 00	1		NPI	1033269147
2	03 13 08	03 13 08	11		20610		1	251 00	1		NPI	1033269147
3	N400009028003 03 13 08	03 13 08	11		J1030		1	30 00	1		NPI	1033269147
4	N400409427602 03 13 08	03 13 08	11		J2001		1	24 00	2		NPI	1033269147
5	N400074161050 03 13 08	03 13 08	11		J3490		1	24 00	2		NPI	1033269147
6	03 13 08	03 13 08	11		73562		1	88 00	1		NPI	1033269147

25. FEDERAL TAX I.D. NUMBER SSN EIN [X]: 880454760

26. PATIENT'S ACCOUNT NO.: 75206P56094

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

28. TOTAL CHARGE $ 700 00

29. AMOUNT PAID $

30. BALANCE DUE $ 700 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.)
MICHAEL J CROVETTI DO
SIGNED 3/17/2008 DATE

32. SERVICE FACILITY LOCATION INFORMATION
BONE AND JOINT INSTITUTE
880 SEVEN HILLS DR STE 140
HENDERSON NV 89052
a. 1487788873 b.

33. BILLING PROVIDER INFO & PH # 702 990 2290
BONE AND JOINT INSTI
880 SEVEN HILLS DR STE 140
HENDERSON NV 89052
a. 1487788873 b.

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

CENTER FOR DISEASES & SURGERY OF THE SPINE
600 S. RANCHO DR. STE 107
LAS VEGAS NV 89106-4806
702-878-9396

Printed 13:45:37 24 JUL 2008
By: 892 THALGOTT.MB JJF

TaxID#: 88-0340195

ENRIQUE "HENRY" RODRIGUEZ (57217)

###.	Date....	Code....	Description..	DrFcl..	Dx....	Original	Batch....	Ref....
	647596.1*57217		ENRIQUE "HENRY" RODRIGUEZ			*Private*		
1	02/21/06	99205	OV NEW LEVEL	31.16	722.0	400.00	022106OFF	647596.
			Balance:			400.00		
Primary: 0.00	Secondary: 0.00		Personal: 0.00			Adjustments: 0.00		
	607568.1*57217		ENRIQUE "HENRY" RODRIGUEZ			*Private*		
2	03/07/06	95903	NCV MOTOR W/F	38.16	782.0	602.00	031006NER	607568.
			Balance:			602.00		
Primary: 0.00	Secondary: 0.00		Personal: 0.00			Adjustments: 0.00		
	607568.2*57217		ENRIQUE "HENRY" RODRIGUEZ			*Private*		
3	03/07/06	95904	NCV SENSORY	38.16	782.0	222.00	031006NER	607568.
			Balance:			222.00		
Primary: 0.00	Secondary: 0.00		Personal: 0.00			Adjustments: 0.00		
	607568.3*57217		ENRIQUE "HENRY" RODRIGUEZ			*Private*		
4	03/07/06	95926	SSEP LOWER LI	38.16	729.5	272.50	031006NER	607568.
			Balance:			272.50		
Primary: 0.00	Secondary: 0.00		Personal: 0.00			Adjustments: 0.00		
	607568.4*57217		ENRIQUE "HENRY" RODRIGUEZ			*Private*		
5	03/07/06	95927-59	DEP TRUNK OR	38.16	724.4	817.50	031006NER	607568.
			Balance:			817.50		
Primary: 0.00	Secondary: 0.00		Personal: 0.00			Adjustments: 0.00		
	607568.5*57217		ENRIQUE "HENRY" RODRIGUEZ			*Private*		
6	03/07/06	95934	H-REFLEX STUD	38.16	724.4	240.50	031006NER	607568.
			Balance:			240.50		
Primary: 0.00	Secondary: 0.00		Personal: 0.00			Adjustments: 0.00		
	649027.1*57217		ENRIQUE "HENRY" RODRIGUEZ			*Private*		
7	04/06/06	99213	OV OLD LEVEL	31.16	722.0	145.00	040606OFF	649027.
			Balance:			145.00		
Primary: 0.00	Secondary: 0.00		Personal: 0.00			Adjustments: 0.00		
	649849.1*57217		ENRIQUE "HENRY" RODRIGUEZ			*Private*		
8	04/27/06	99213	OV OLD LEVEL	31.16	722.0	145.00	042706OFF	649849.
			Balance:			145.00		

```
###. Date.... Code.... Description.. DrFcl.. Dx.... Original Batch.... Ref....
Primary: 0.00    Secondary: 0.00    Personal: 0.00    Adjustments: 0.00
-----------------------------------------------------------------------------
     651408.1*57217 ENRIQUE "HENRY" RODRIGUEZ      *Private*
9    06/08/06 99214    OV OLD LEVEL  31.16   722.0    220.00 060806OFF 651408.
                       Balance:                       220.00

Primary: 0.00    Secondary: 0.00    Personal: 0.00    Adjustments: 0.00
-----------------------------------------------------------------------------
     653985.1*57217 ENRIQUE "HENRY" RODRIGUEZ      *Private*
10   08/24/06 99213    OV OLD LEVEL  31.16   722.0    145.00 082406OFF 653985.
                       Balance:                       145.00

Primary: 0.00    Secondary: 0.00    Personal: 0.00    Adjustments: 0.00
-----------------------------------------------------------------------------
     656814.1*57217 ENRIQUE "HENRY" RODRIGUEZ      *Private*
11   11/09/06 99214    OV OLD LEVEL  31.16   722.0    220.00 110906OFF 656814.
                       Balance:                       220.00

Primary: 0.00    Secondary: 0.00    Personal: 0.00    Adjustments: 0.00
-----------------------------------------------------------------------------
     658990.1*57217 ENRIQUE "HENRY" RODRIGUEZ      *Private*
12   01/18/07 99213    OV OLD LEVEL  31.16   722.0    145.00 011807OFF 658990.
                       Balance:                       145.00

Primary: 0.00    Secondary: 0.00    Personal: 0.00    Adjustments: 0.00
-----------------------------------------------------------------------------
     662212.1*57217 ENRIQUE "HENRY" RODRIGUEZ      *Private*
13   04/12/07 99213    OV OLD LEVEL  31.16   722.0    145.00 041207OF 662212.
                       Balance:                       145.00

Primary: 0.00    Secondary: 0.00    Personal: 0.00    Adjustments: 0.00
-----------------------------------------------------------------------------
     665587.1*57217 ENRIQUE "HENRY" RODRIGUEZ      *Private*
14   08/30/07 99213    OV OLD LEVEL  31.16   722.0    145.00 083007OFF 665587.
                       Balance:                       145.00

Primary: 0.00    Secondary: 0.00    Personal: 0.00    Adjustments: 0.00
-----------------------------------------------------------------------------
     658633.1*57217 ENRIQUE "HENRY" RODRIGUEZ      *Closed*
15   01/07/08 S9982    COPY MEDICAL  31.16   722.0    197.40 010408MAI 658633.
16   01/07/08 15       MORAN ATTY CH 31.16           -197.40 010408MAI 658633.
                       Balance:                         0.00

Primary: 0.00    Secondary: 0.00    Personal: -197.40 Adjustments: 0.00
-----------------------------------------------------------------------------
     668990.1*57217 ENRIQUE "HENRY" RODRIGUEZ      *Private*
17   01/19/08 99213    OV OLD LEVEL  31.16   722.0    145.00 011908OFF 668990.
                       Balance:                       145.00

Primary: 0.00    Secondary: 0.00    Personal: 0.00    Adjustments: 0.00
-----------------------------------------------------------------------------
     660735.1*57217 ENRIQUE "HENRY" RODRIGUEZ      *Closed*
18   02/20/08 S9982    COPY MEDICAL  31.16   722.0     46.20 022008MAI 660735.
19   02/20/08 1        54598 BBBC PE 31.16            -46.20 022008MAI 660735.
                       Balance:                         0.00

Primary: 0.00    Secondary: 0.00    Personal: -46.20  Adjustments: 0.00
-----------------------------------------------------------------------------
```

```
###. Date.... Code.... Description.. DrFcl.. Dx.... Original Batch.... Ref....
     671329.1*57217 ENRIQUE "HENRY" RODRIGUEZ      *Private*
20   05/13/08 99213    OV OLD LEVEL  31.16   722.0    145.00 0513080FF 671329.
                       Balance:                         145.00

Primary: 0.00    Secondary: 0.00    Personal: 0.00    Adjustments: 0.00
-------------------------------------------------------------------------------

    TOTAL : 4154.50
```

JOHN S THALGOTT MD-00004

870 S RANCHO DR
LAS VEGAS, NV 89106-3831
(702)870-2090

118487

75-1890731 071408 071408

RODRIGUEZ, ENRIQUE J

RODRIGUEZ, ENRIQUE J

REV CD	DESCRIPTION	HCPCS/RATE/HIPPS CODE	SERV DATE	SERV UNITS	TOTAL CHARGES	NON-COVERED CHARGES
490	Ambulatory Surgical Care	63650	071408	1	6,680.00	
490	Ambulatory Surgical Care	6365059	071408	1	6,680.00	
490	Ambulatory Surgical Care	6365059	071408	1	6,680.00	
270	Med/Surg Supplies - General	C1778	071408	1	4,170.00	
270	Med/Surg Supplies - General	C1778	071408	1	4,170.00	
270	Med/Surg Supplies - General	C1778	071408	1	4,170.00	
0001	PAGE 1 OF 1	CREATION DATE	072308	TOTALS	32,550.00	0.00

PAYER NAME: MISCELLANEOUS INSURANCE
HEALTH PLAN ID: 75-1890731
Y Y
PRIOR PAYMENTS
TOTAL AMOUNT DUE
INS NO: 1467415513
OR OTHER PRV ID: 75-1890731

INSURED'S NAME: RODRIGUEZ, ENRIQUE J
PATIENT RELATIONSHIP TO INSURED: 18
INSURANCE GROUP NO.

TREATMENT AUTHORIZATION CODES
DOCUMENTATION CONTROL NUMBER
EMPLOYER NAME: DISABLED

72210 7220
9

ATTENDING: NPI 1760447999 QUAL 1G G46280
LAST SCHIFINI FIRST JOSEPH
OPERATING: NPI 1760447999 QUAL 1G G46280
LAST SCHIFINI FIRST JOSEPH
OTHER: NPI QUAL
LAST FIRST
OTHER: NPI QUAL
LAST FIRST

REMARKS: CANYON MEDICAL BILLING
7435 SOUTH EASTERN AVENUE
SUITE A5-273
LAS VEGAS, NV 89123

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 Printed on Recycled Paper NUBC 10/2000 THE INSTRUCTIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

LV Surgery Center 0000001

LAS DEC. 5.2007 4:04PM L SURGERY CENTER NO.857 P.14/17

870 S RANCHO DR
LAS VEGAS, NV 89106-3831
(702)870-2090

118487 831

890731 113007 113007

PATIENT NAME: RODRIGUEZ, ENRIQUE J

10 BIRTHDATE: 3 11 SEX: M

RODRIGUEZ, ENRIQUE J

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	46 SERV DATE	47 SERV UNITS	48 TOTAL CHARGES	49 NON-COVERED CHARGES
490	Ambulatory Surgical Care	64520LT	113007	1	1,972.00	
0001	PAGE 1 OF 1	CREATION DATE 120407	TOTALS		1,972.00	0.00

50 PAYER NAME: MISCELLANEOUS INSURANCE
51 HEALTH PLAN ID: 75-1890731
53 EST AMOUNT DUE: 532.44
55 NPI: 1467415813
57 OTHER PRV ID: 75-1890731

60 INSURED'S NAME: RODRIGUEZ, ENRIQUE J
61 INSURED'S UNIQUE ID: 18
63 GROUP NAME:
64 INSURANCE GROUP NO:

67 TREATMENT AUTHORIZATION CODES:
68 PATIENT CONTROL NUMBER:
69 EMPLOYER NAME: DISABLED

39722 7244 7220
9

76 ATTENDING NPI 1760447999 QUAL 1G G46280
LAST SCHIFINI FIRST JOSEPH
77 OPERATING NPI 1760447999 QUAL 1G G46280
LAST SCHIFINI FIRST JOSEPH
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS CANYON MEDICAL BILLING
7435 SOUTH EASTERN AVENUE
SUITE A5-273
LAS VEGAS, NV 89123

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

Printed on Recycled Paper

LV Surgery Center 0000002

Canyon Medical Billing

8170 S. Eastern Ave Ste 4-273
Las Vegas, NV 89123

Invoice

Date	Invoice #
07/15/2008	2343
Terms	
Due Upon Settlement	

Bill To:

Enrique Rodriguez
C/O Benson Bertoldo & Baker
7408 W Sahara Ave
Las Vegas, NV 89117

Patient Name:	Enrique Rodriguez
Claim #	Social Security #
lien	

Decription	Amount
Rodriguez, Enrique ambu surg 63650/6365059/6365059/c1778/c1778/c1778/ Las Vegas Surgery Center 7.14.08	$32,550.00
Canyon Medical Billing, LLC has purchased the accounts receivable/lien from Las Vegas Surgery Center.	

Attorney:	
Procedure Date:	07/14/08
Diagnosis 1	722.10
Diagnosis 2	722.0
CPT Code	63650/6365059/6365059/c1778/c

Canyon Medical Billing, LLC has purchased the accounts receivable/lien from Las Vegas Surgery Center.

Total: $32,550.00

Please Make Checks payable to Canyon Medical Billing, Inc.
Taxpayer ID #16-1648699

LV Surgery Center 0000003

Canyon Medical Billing

8170 S. Eastern Ave Ste 4-273
Las Vegas, NV 89123

Invoice

Date	Invoice #
12/01/2007	1651
Terms	
Due on receipt	

Bill To:

Enrique Rodriguez
C/O Benson Bertoldo & Baker
7408 W Sahara Ave
Las Vegas, NV 89117

Patient Name:	Enrique Rodriguez

Claim #	Social Security #
lien	

Decription	Amount
Rodriguez, Enrique ambul surg care 64520LT LVSC 11.30.07	$1,972.00
Canyon Medical Billing, LLC has purchased the accounts receivable/lien from Las Vegas Surgery Center.	

Attorney:	
Procedure Date:	11/30/2007
Diagnosis 1	337.22
Diagnosis 2	724.4
CPT Code	64520LT

Canyon Medical Billing, LLC has purchased the accounts receivable/lien from Las Vegas Surgery Center.

Total: $1,972.00

Please Make Checks payable to Canyon Medical Billing, Inc.
Taxpayer ID #16-1648699

LV Surgery Center 0000004

Joseph J. Schifini, MD

Patient Ledger

Sorted By: Case Number

Entry	Date	POS	Description	Case	Procedure	Document	Provider	Amount
RODEN000	**Enrique J Rodriguez**							
	Last Payment:		0.00 On:					
203228	11/26/2007	11		35449		0711260000	JJSMD	1500.00
203514	11/30/2007	24		35453		0712030000	JJSMD	600.00
203515	11/30/2007	24		35453		0712030000	JJSMD	150.00
203516	11/30/2007	24		35453		0712030000	JJSMD	75.00
204129	12/6/2007	11		35453		0712060000	JJSMD	150.00
206476	1/10/2008	11		35453		0801100000	JJSMD	150.00
220976	7/1/2008	11		35453		0807020000	JJSMD	150.00
221847	7/14/2008	24		38179		0807140000	JJSMD	1950.00
221848	7/14/2008	24		38179		0807140000	JJSMD	1950.00
221849	7/14/2008	24		38179		0807140000	JJSMD	1950.00
221850	7/14/2008	24		38179		0807140000	JJSMD	150.00
221851	7/14/2008	24		38179		0807140000	JJSMD	75.00
221852	7/14/2008	24		38179		0807140000	JJSMD	150.00
							Patient Total	$9,000.00

Cal.Hand Surg & Orthop Spec Med Clinic, inc
P O Box 515110

FED. Tax. 54724131

Los Angeles CA, 900515110
(818) 700-1250

To: Law offices of Jonathon Weber
7408 W. Sahara Ave

Las Vegas NV, 89117
7022282600

Medical Record #: 0703070017

Patient **Rodriguez, Enrique**
SSN:
Date Of Injury: 11/22/2004

Adjuster:

Claim Number(s):

Employer: Jonathan Weber

WCAB #:

Diagnosis 1) 337.22 3)
2) 4)

1) 337.22

DOS	Description	Code	DX	Charge	Unit	Payment	Adj	Balance
07/17/2008	OFFICE OR OTHER OUTPATIENT VISIT FO	99214	1	134.36	1.0	0.00	0.00	134.36
07/17/2008	REPORT PREPARATION	99080	1	80.00	2.0	0.00	0.00	80.00

TOTAL CHARGE	214.36
TOTAL PAYMENT	0.00
TOTAL ADJUSTMENT	0.00
BALANCE NOW DUE	214.36

Cal. Hand 0000001

Cal Hand Surg & Orthop Spec Med Clinic, Inc
P O Box 515110

FED. Tax: 54724131

Los Angeles CA, 900515110
(818) 700-1250

To: Law offices of Jonathon Weber
7408 W. Sahara Ave

Las Vegas NV, 89117
7022282600

Medical Record #: 0703070017

Patient **Rodriguez, Enrique**
SSN:
Date Of Injury: 11/22/2004

Adjuster:

Claim Number(s):

Employer:

WCAB #:

Diagnosis 1) 337.22 3)
2) 4)

1) 337.22

DOS	Description	Code	DX	Charge	Unit	Payment	Adj	Balance
04/23/2008	OFFICE OR OTHER OUTPATIENT VISIT FO	99214	1	134.36	1.0	0.00	0.00	134.36
04/23/2008	REPORT PREPARATION	99080	1	80.00	2.0	0.00	0.00	80.00

TOTAL CHARGE	214.36
TOTAL PAYMENT	0.00
TOTAL ADJUSTMENT	0.00
BALANCE NOW DUE	214.36

Cal. Hand 0000002

Cal Hand Surg & Orthop Spec Med C. . , inc
P O Box 515110

FED. Ta 54724131

Los Angeles CA, 900515110
(818) 700-1250

To: Law offices of Jonathon Weber
7408 W. Sahara Ave

Las Vegas NV, 89117
7022282600

Medical Record #: 0703070017

Patient **Rodriguez, Enrique**
SSN:
Date Of Injury: 11/22/2004

Adjuster:

Claim Number(s):

Employer:

WCAB #:

Diagnosis 1) 337.22 3)
2) 4)

1) 337.22

DOS	Description	Code	DX	Charge	Unit	Payment	Adj	Balance
01/09/2008	OFFICE OR OTHER OUTPATIENT VISIT FO	99214	1	134.36	1.0	0.00	0.00	134.36

TOTAL CHARGE	134.36
TOTAL PAYMENT	0.00
TOTAL ADJUSTMENT	0.00
BALANCE NOW DUE	134.36

Cal. Hand 0000003

Cal Hand Surg & Orthop Spec Med Clinic, Inc
P O Box 515110

FED. Tax: 954724131

Los Angeles CA, 900515110
(818) 700-1250

To: Law offices of Jonathon Weber
7408 W. Sahara Ave

Las Vegas NV, 89117
7022282600

Medical Record #: 0703070017

Patient **Rodriguez, Enrique**
SSN:
Date Of Injury: 11/22/2004

Adjuster:

Claim Number(s):

Employer:

WCAB #:

Diagnosis 1) 337.22 3)
2) 4)

1) 337.22

DOS	Description	Code	DX	Charge	Unit	Payment	Adj	Balance
05/03/2007	OFFICE OR OTHER OUTPATIENT VISIT FO	99214	1	134.36	1.0	0.00	0.00	134.36
05/03/2007	SUPPLEMENTAL REPORT	99080	1	80.00	2.0	0.00	0.00	80.00

TOTAL CHARGE	214.36
TOTAL PAYMENT	0.00
TOTAL ADJUSTMENT	0.00
BALANCE NOW DUE	214.36

Cal. Hand 0000004

Cal Hand Surg & Orthop Spec Med Clinic, Inc
P O Box 515110

FED. Tax: . 4724131

Los Angeles CA, 900515110
(818) 700-1250

To: Law offices of Jonathon Weber
7408 W. Sahara Ave

Las Vegas NV, 89117
7022282600

Medical Record #: 0703070017

Patient **Rodriguez, Enrique**
SSN:
Date Of Injury: 11/22/2004

Adjuster:

Claim Number(s):

Employer:

WCAB #:

Diagnosis 1) 337.22 3)
2) 4)

1) 337.22

DOS	Description	Code	DX	Charge	Unit	Payment	Adj	Balance
04/18/2007	LUMBAR OR THORACIC (PARAVERTEBRAL	64520-LT	1	300.00	1.0	0.00	0.00	300.00
04/18/2007	FLUOROSCOPY UP TO ONE HOUR	76000-26	1	70.00	1.0	0.00	0.00	70.00

TOTAL CHARGE	370.00
TOTAL PAYMENT	0.00
TOTAL ADJUSTMENT	0.00
BALANCE NOW DUE	370.00

Cal. Hand 0000005

Cal Hand Surg & Orthop Spec Med Clinic, Inc
P O Box 515110

FED. Tax: 954724131

Los Angeles CA, 900515110
(818) 700-1250

To: Law offices of Jonathon Weber
7408 W. Sahara Ave

Las Vegas NV, 89117
7022282600

Medical Record #: 0703070017

Patient **Rodriguez. Enrique**
SSN:
Date Of Injury: 11/22/2004

Adjuster:

Claim Number(s):

Employer:

WCAB #:

Diagnosis 1) 337.22 3)
2) 4)

1) 337.22

DOS	Description	Code	DX	Charge	Unit	Payment	Adj	Balance
04/05/2007	OFFICE OR OTHER OUTPATIENT VISIT FO	99214	1	134.36	1.0	0.00	0.00	134.36
04/05/2007	SUPPLEMENTAL REPORT	99080	1	150.00	1.0	0.00	0.00	150.00

TOTAL CHARGE	284.36
TOTAL PAYMENT	0.00
TOTAL ADJUSTMENT	0.00
BALANCE NOW DUE	284.36

Cal. Hand 0000006

Cal Hand Surg & Orthop Spec Med Clinic, Inc
P O Box 515110

FED. Tax: . . 4724131

Los Angeles CA, 900515110
(818) 700-1250

To: Jonathan Weber, Esq
2029 Century Park E Ste 2100

Los Angeles CA, 90067
3102267570

Medical Record #: 0703070017

Patient **Rodriguez, Enrique**
SSN:
Date Of Injury: 11/22/2004

Adjuster:

Claim Number(s):

Employer:

WCAB #:

Diagnosis 1) 337.22 3)
2) 727.04 4)

1) 337.22 2) 727.04

DOS	Description	Code	DX	Charge	Unit	Payment	Adj	Balance
03/14/2007	LUMBAR OR THORACIC (PARAVERTEBRAL	64520-LT	1	300.00	1.0	0.00	0.00	300.00
03/14/2007	INJECTION(S); TENDON SHEATH, LIGAME	20550-51-LT	2	80.00	1.0	0.00	0.00	80.00
03/14/2007	FLUOROSCOPY UP TO ONE HOUR	76000-26	1	70.00	1.0	0.00	0.00	70.00

TOTAL CHARGE	450.00
TOTAL PAYMENT	0.00
TOTAL ADJUSTMENT	0.00
BALANCE NOW DUE	450.00

Cal. Hand 0000007

Account 0703070017 01
Episode Rodriguez, Enrique

Charge Number	DOS	CPT	Charges	Payments
Company	COHS			
Insurance	PI	Jonathan Weber, Esq		
0018182800-000	03/07/07	99245P-CONSULT COMPLEX	600.00	0.00
0018182800-000	03/07/07	PI99080-PI REPORT	350.00	0.00
0018182800-000.	03/07/07	95851-RANGE OF MOTION MEASUREMENTS AND REPORT (SEPARATE PROCEDURI	70.11	0.00
0018426100-000	03/14/07	64520-LUMBAR OR THORACIC (PARAVERTEBRAL SYMPATHETIC)	300.00 — DUP	0.00
0018426100-000	03/14/07	20550-INJECTION(S); TENDON SHEATH, LIGAMENT	80.00 — "	0.00
0018426100-000.	03/14/07	76000-FLUOROSCOPY UP TO ONE HOUR	70.00 — "	0.00
		Jonathan Weber, Esq	1,470.11	0.00
		COHS	1,470.11	0.00
		P.I.-neck,Rt upper extrm,back,Lt lower extrm	1,470.11	0.00
			1,470.11	0.00

Apr. 19. 2007 11:10AM GR MEDICAL MGMT No. 9728 P. 2/14

Cal. Hand 0000008

Balance
600.00
350.00
70.11
300.00
80.00
70.00
1,470.11
1,470.11
1,470.11
1,470.11

Cal. Hand 0000009

MEDICAL ASSOCIATES SOUTHERN NV
P.O. Box 778195
HENDERSON, NV 89077-8195
(702)492-7208

Statement Date	Page
3/16/2010	1

Enrique J. Rodriguez

Chart Number
RODEN000

DATE	PROCEDURE	UNITS	DESCRIPTION	CASE NUMBER	AMOUNT
Patient: Enrique J. Rodriguez Case Description: LN- Jonathan Weber			DX 1: 723.1 DX 2: 847.0	DX 3: 784.0	DX 4: 724.1
1/26/2006	99204	1	New Patient Comprehensive	1876	300.00
2/1/2006	99214	1	Office Visit Detailed	1876	165.00
2/20/2006	99214	1	Office Visit Detailed	1876	165.00
3/6/2006	99214	1	Office Visit Detailed	1876	165.00
3/6/2006	73110	1	X-Ray Wrist Complete	1876	110.00
3/22/2006	99214	1	Office Visit Detailed	1876	165.00
4/3/2006	99214	1	Office Visit Detailed	1876	165.00
4/26/2006	99214	1	Office Visit Detailed	1876	165.00
5/10/2006	99214	1	Office Visit Detailed	1876	165.00
5/22/2006	99214	1	Office Visit Detailed	1876	165.00
5/31/2006	99214	1	Office Visit Detailed	1876	165.00
5/31/2006	99080	1	Special Reports Form	1876	60.00
6/22/2006	99214	1	Office Visit Detailed	1876	165.00
6/30/2006	99214	1	Office Visit Detailed	1876	165.00
7/17/2006	99214	1	Office Visit Detailed	1876	165.00
8/16/2006	99214	1	Office Visit Detailed	1876	165.00
10/23/2007	PC000	88	Medical Records PC Charge	1876	52.80
2/25/2008	BEN	1	Benicorp payment for medical records	1876	-52.80
7/29/2008	RECBILL	1	Records and Bill	1876	0.00
6/29/2009	STATUS	1	STATUS	1876	0.00

Total Charges	Total Payments	Total Adjustments	Balance Due
$2667.80	-$52.80	$0.00	**2,615.00**

Koka 0000157

Primary Care Consultants
P.O. Box 778195
Henderson, NV 89077-8195
(702)492-7208

Statement Date	Page
3/16/2010	1

Enrique J. Rodriquez

Chart Number
RODEN000

DATE	PROCEDURE	UNITS	DESCRIPTION	CASE NUMBER	AMOUNT
Patient: Enrique J. Rodriquez Case Description: MVA/LN/John Weber/MASN			DX 1: 847.1 DX 2: 847.2 DX 3: 840.8 DX 4: E812.9		
10/25/2006	99211	1	SUTURE REMOVAL	159	45.00
11/9/2006	99214	1	OFFICE VISIT DETAILED	159	230.00
11/30/2006	99214	1	OFFICE VISIT DETAILED	159	230.00
2/9/2007	99214	1	OFFICE VISIT DETAILED	159	239.00
3/20/2007	99214	1	OFFICE VISIT DETAILED	159	239.00
5/10/2007	99214	1	OFFICE VISIT DETAILED	159	239.00
6/11/2007	99214	1	OFFICE VISIT DETAILED	159	239.00
10/12/2007	99214	1	OFFICE VISIT DETAILED	159	239.00
10/23/2007	PC	17	Medical Records Photo Copy Char	159	10.20
11/5/2007	99214	1	OFFICE VISIT DETAILED	159	239.00
12/3/2007	99214	1	OFFICE VISIT DETAILED	159	239.00
1/4/2008	99214	1	OFFICE VISIT DETAILED	159	239.00
2/25/2008	COPYFEES	1	Photocopy Fees	159	-10.20
1/21/2008	99214	1	OFFICE VISIT DETAILED	159	239.00
4/9/2008	99214	1	OFFICE VISIT DETAILED	159	239.00
4/9/2008	85025	1	CBC W/DIFF	159	16.60
7/21/2008	STAT	1	Status	159	0.00
6/13/2008	99214	1	OFFICE VISIT DETAILED	159	239.00
7/23/2008	99214	1	OFFICE VISIT DETAILED	159	239.00
7/29/2008	PC	89	Medical Records Photo Copy Char	159	53.40

Total Charges	Total Payments	Total Adjustments	Balance Due
Continued	Continued	Continued	**Continued**

Koka 0000158

Primary Care Consultants
P.O. Box 778195
Henderson, NV 89077-8195
(702)492-7208

Statement Date	Page
3/16/2010	2

Enrique J. Rodriquez

Chart Number
RODEN000

DATE	PROCEDURE	UNITS	DESCRIPTION	CASE NUMBER	AMOUNT
7/29/2008	RECBILLS	1	Records & Bills	159	0.00
8/8/2008	COPYFEES	1	Photocopy Fees	159	-53.40
8/20/2008	99214	1	OFFICE VISIT DETAILED	159	239.00
9/17/2008	99214	1	OFFICE VISIT DETAILED	159	239.00
10/1/2008	99214	1	OFFICE VISIT DETAILED	159	239.00
10/22/2008	99214	1	OFFICE VISIT DETAILED	159	239.00
11/19/2008	99214	1	OFFICE VISIT DETAILED	159	239.00
12/17/2008	99214	1	OFFICE VISIT DETAILED	159	239.00
2/2/2009	99214	1	OFFICE VISIT DETAILED	159	200.00
3/2/2009	99214	1	OFFICE VISIT DETAILED	159	200.00
3/30/2009	99214	1	OFFICE VISIT DETAILED	159	200.00
5/6/2009	99214	1	OFFICE VISIT DETAILED	159	200.00
6/15/2009	99214	1	OFFICE VISIT DETAILED	159	225.00
7/20/2009	99214	1	OFFICE VISIT DETAILED	159	225.00
8/7/2009	BALCON	1	Balance Confirmation	159	0.00
11/4/2009	99214	1	OFFICE VISIT DETAILED	159	225.00
12/16/2009	99214	1	OFFICE VISIT DETAILED	159	225.00
12/17/2009	99244	1	CONSULTATION INITIAL	159	560.43
12/17/2009	82055	1	Breathalyzer	159	30.00
12/17/2009	80101	1	UDS (5)	159	40.00
1/13/2010	99214	1	OFFICE VISIT DETAILED	159	225.00
3/3/2010	99214	1	OFFICE VISIT DETAILED	159	239.00

Total Charges	Total Payments	Total Adjustments	Balance Due
$7681.63	-$63.60	$0.00	**7,618.03**

Koka 0000159

MATT SMITH PHYSICAL THERAPY
848 N RAINBOW BLVD 357

LAS VEGAS, NV 89107-1103
702 804 0026

[CQFMAIN] Inquiry
Date 08/13/2009
Time 7:21a
User eek001
Page 1

Patient #: 18843
Bill To #: 18843
DOB:
Age: 46 Sex: M
SSN:
H/Ph #:
W/Ph #:

Patient Name: ENRIQUE J RODRIQUEZ
Resp Party: ENRIQUE J RODRIQUEZ
Dr #: 15 LORI M SKOPHAMMER PT
RDr #: 37 JOHN S THALGOTT MD
Patient Type: 40 LIENS/LITIGATION
Bill Cycle: 4 SAA-ZZZ
Credit Status: 28
Date Registered: 02/22/2006

S7

Patient E-mail:
Responsible Party E-mail:

Balances

0 - 30:	.00
31 - 60:	.00
61 - 90:	.00
91 - 120:	.00
121 - 150:	.00
151+ :	29,330.00
Total Balance:	29,330.00
- Pending:	.00
= Patient Balance:	29,330.00

Responsible Party Address:

Patient Address:

Last Transactions:

Charge:	06/14/2007	130.00
Personal:	05/23/2008	154.80
Insurance:	00/00/0000	.00

Location: 2 RANCHO OFFICE
Diagnosis: 847.0 SPRAIN OF NECK
Billing History: 06/30/2008 05/31/2008
04/30/2008 03/31/2008

Current Coverages

** No Current Insurance found **

Archived Coverages

** No Archived Insurance found **

Collection Information

** No Collection Information found **

Alert Notes

Posted	Type	Description	Receipt#	Status	Dr#
02/22/2006	8000001	RX 2-21-06 3X4 DX 847.0	000421876	U	7

Billing Notes

Posted	Time	Initials	Description
08/01/2008	2:10p	DRL	THIS PT HAS TWO ACCOUNTS FOR LIEN BALANCE 18843 &
08/01/2008	2:11p	DRL	23591. PLEASE CHECK BOTH BALANCES!!!!!!!!!!!!!!!

On-Bill Notes

** No On-bill notes found **

Collection Notes

** No Collection notes found **

Insurance Notes

** No Insurance notes found **

Valley Rehab. 0000007

PLEASE REMIT TO:
RANCHO PHYSICAL THERAPY, INC.
P.O. BOX 870
MURRIETA, CA 92564
(951) 696-9353
FED TAX ID # 33-0493339

SERVICES RENDERED AT:
RANCHO PHYSICAL THERAPY, INC.
630 E. LATHAM AVENUE
HEMET, CA 92543

STATEMENT DATE: 11/13/2009
PATIENT: ENRIQUE RODRIGUEZ
INJURED: 11/22/2004
PHYSICIAN: NORK MD, JOHN G

BENSON, BERTOLDO, BAKER, AA
7408 WEST SAHARA AVENUE
LAS VEGAS NV 89117

EMPLOYER: SELF

ACCT N20022 AL N2 DIAGNOSIS: PAIN IN JOINT INVOLVING LOWER LEG
STIFFNESS OF JOINT, NOT ELSEWHERE CLASSIFIED, INVOLVING LOWE
OTHER JOINT DERANGEMENT, NOT ELSEWHERE CLASSIFIED
SPRAIN OF OTHER SPECIFIED SITES OF KNEE AND LEG

DATE	DESCRIPTION		CHARGES	INSURANCE PAID	ADJUSTS	PATIENT PAID
	BALANCE FORWARD	0.00				
12/08/04	PHYSICAL THERAPY EVALUATION 1 UNIT		120.00			
12/08/04	THERAPEUTIC EXERCISE 1 UNIT		45.00			
12/08/04	ELECTRICAL STIMULATION 1 UNIT		25.00			
12/08/04	HOT PACK/COLD PACK		25.00			
12/08/04	ELECTRODES		8.00			
12/10/04	POOL THERAPY 3 UNITS		210.00			
12/10/04	WHIRLPOOL 1 UNIT		30.00			
12/10/04	ELECTRICAL STIMULATION 1 UNIT		25.00			
12/10/04	HOT PACK/COLD PACK		25.00			
12/13/04	POOL THERAPY 3 UNITS		210.00			
12/13/04	97140- MANUAL THERAPY 1 UNIT		45.00			
12/13/04	WHIRLPOOL 1 UNIT		30.00			
12/13/04	ELECTRICAL STIMULATION 1 UNIT		25.00			
12/15/04	POOL THERAPY 3 UNITS		210.00			
12/15/04	97140- MANUAL THERAPY 1 UNIT		45.00			
12/15/04	WHIRLPOOL 1 UNIT		30.00			
12/15/04	ELECTRICAL STIMULATION 1 UNIT		25.00			
12/17/04	POOL THERAPY 3 UNITS		210.00			
12/17/04	97140- MANUAL THERAPY 1 UNIT		45.00			
12/17/04	WHIRLPOOL 1 UNIT		30.00			
12/17/04	ELECTRICAL STIMULATION 1 UNIT		25.00			
12/20/04	POOL THERAPY 3 UNITS		210.00			
12/20/04	97140- MANUAL THERAPY 1 UNIT		45.00			
12/20/04	WHIRLPOOL 1 UNIT		30.00			
12/22/04	POOL THERAPY 4 UNITS		280.00			
12/22/04	97140- MANUAL THERAPY 1 UNIT		45.00			
12/22/04	ELECTRICAL STIMULATION 1 UNIT		25.00			
12/23/04	POOL THERAPY 4 UNITS		280.00			

CONTINUED ON NEXT PAGE

PLEASE REMIT TO:
RANCHO PHYSICAL THERAPY, INC.
P.O. BOX 870
MURRIETA, CA 92564
(951) 696-9353
FED TAX ID # 33-0493339

SERVICES RENDERED AT:
RANCHO PHYSICAL THERAPY, INC.
630 E. LATHAM AVENUE
HEMET, CA 92543

BENSON, BERTOLDO, BAKER, AA
7408 WEST SAHARA AVENUE
LAS VEGAS NV 89117

STATEMENT DATE: 11/13/2009
PATIENT: ENRIQUE RODRIGUEZ
INJURED: 11/22/2004
PHYSICIAN: NORK MD, JOHN G

EMPLOYER: SELF

ACCT N20022 'AL N2 DIAGNOSIS: PAIN IN JOINT INVOLVING LOWER LEG
STIFFNESS OF JOINT, NOT ELSEWHERE CLASSIFIED, INVOLVING LOWE
OTHER JOINT DERANGEMENT, NOT ELSEWHERE CLASSIFIED
SPRAIN OF OTHER SPECIFIED SITES OF KNEE AND LEG

DATE	DESCRIPTION	CHARGES	INSURANCE PAID	ADJUSTS	PATIENT PAID
	BALANCE FORWARD 2358.00				
12/23/04	ELECTRICAL STIMULATION 1 UNIT	25.00			
12/23/04	HOT PACK/COLD PACK	25.00			
01/03/05	THERAPEUTIC EXERCISE 2 UNITS	90.00			
01/03/05	MANUAL THERAPY 1 UNIT	45.00			
01/03/05	ELECTRICAL STIMULATION 1 UNIT	25.00			
01/03/05	HOT PACK/COLD PACK	25.00			
01/05/05	POOL THERAPY 4 UNITS	280.00			
01/05/05	WHIRLPOOL 1 UNIT	30.00			
01/07/05	P.T. RE-EVALUATION	45.00			
01/07/05	POOL THERAPY 4 UNITS	280.00			
01/07/05	MANUAL THERAPY 1 UNIT	45.00			
01/07/05	WHIRLPOOL 1 UNIT	30.00			
01/07/05	HOT PACK/COLD PACK	25.00			
01/10/05	POOL THERAPY 4 UNITS	280.00			
01/10/05	THERAPEUTIC EXERCISE 2 UNITS	90.00			
01/10/05	MANUAL THERAPY 1 UNIT	45.00			
01/10/05	ELECTRICAL STIMULATION 1 UNIT	25.00			
01/10/05	HOT PACK/COLD PACK	25.00			
01/12/05	CORY JONES, billed 2408.00 for 12/08-12/23/4				
01/12/05	POOL THERAPY 4 UNITS	280.00			
01/12/05	THERAPEUTIC EXERCISE 2 UNITS	90.00			
01/12/05	MANUAL THERAPY 1 UNIT	45.00			
01/12/05	ELECTRICAL STIMULATION 1 UNIT	25.00			
01/12/05	HOT PACK/COLD PACK	25.00			
01/13/05	CORY JONES, AA Billed 2,408.00 for 12/08-01/12/				
01/13/05	CORY JONES, billed 920.00 for 01/03-01/07/5				
01/13/05	POOL THERAPY 4 UNITS	280.00			
01/13/05	THERAPEUTIC EXERCISE 2 UNITS	90.00			

CONTINUED ON NEXT PAGE

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MURRIETA, CA 92564
(951) 696-9353
FED TAX ID # 33-0493339

SERVICES RENDERED AT:
RANCHO PHYSICAL THERAPY, INC.
630 E. LATHAM AVENUE
HEMET, CA 92543

STATEMENT DATE: 11/13/2009
PATIENT: ENRIQUE RODRIGUEZ
INJURED: 11/22/2004
PHYSICIAN: NORK MD, JOHN G

EMPLOYER: SELF

BENSON, BERTOLDO, BAKER, AA
7408 WEST SAHARA AVENUE
LAS VEGAS NV 89117

ACCT N20022 AL N2 DIAGNOSIS: PAIN IN JOINT INVOLVING LOWER LEG
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OTHER JOINT DERANGEMENT, NOT ELSEWHERE CLASSIFIED
SPRAIN OF OTHER SPECIFIED SITES OF KNEE AND LEG

DATE	DESCRIPTION	CHARGES	INSURANCE PAID	ADJUSTS	PATIENT PAID
	BALANCE FORWARD 4628.00				
01/13/05	WHIRLPOOL 1 UNIT	30.00			
01/13/05	ELECTRICAL STIMULATION 1 UNIT	25.00			
01/13/05	HOT PACK/COLD PACK	25.00			
01/17/05	POOL THERAPY 4 UNITS	280.00			
01/17/05	THERAPEUTIC EXERCISE 2 UNITS	90.00			
01/17/05	MANUAL THERAPY 1 UNIT	45.00			
01/17/05	ELECTRICAL STIMULATION 1 UNIT	25.00			
01/17/05	HOT PACK/COLD PACK	25.00			
01/20/05	NO SHOW APPT FEE	25.00			
01/21/05	CORY JONES, billed 1380.00 for 01/10-01/13/5				
01/21/05	POOL THERAPY 4 UNITS	280.00			
01/21/05	THERAPEUTIC EXERCISE 2 UNITS	90.00			
01/21/05	MANUAL THERAPY 1 UNIT	45.00			
01/21/05	WHIRLPOOL 1 UNIT	30.00			
01/21/05	ELECTRICAL STIMULATION 1 UNIT	25.00			
01/24/05	POOL THERAPY 4 UNITS	280.00			
01/24/05	THERAPEUTIC EXERCISE 1 UNIT	45.00			
01/24/05	WHIRLPOOL 1 UNIT	30.00			
01/24/05	ELECTRICAL STIMULATION 1 UNIT	25.00			
01/24/05	HOT PACK/COLD PACK	25.00			
01/27/05	POOL THERAPY 4 UNITS	280.00			
01/27/05	THERAPEUTIC EXERCISE 1 UNIT	45.00			
01/27/05	ELECTRICAL STIMULATION 1 UNIT	25.00			
01/27/05	HOT PACK/COLD PACK	25.00			
01/31/05	CORY JONES, billed 935.00 for 01/17-01/21/5				
01/31/05	POOL THERAPY 3 UNITS	210.00			
01/31/05	MANUAL THERAPY 1 UNIT	45.00			
01/31/05	WHIRLPOOL 1 UNIT	30.00			

CONTINUED ON NEXT PAGE

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HEMET, CA 92543

BENSON, BERTOLDO, BAKER, AA
7408 WEST SAHARA AVENUE
LAS VEGAS NV 89117

STATEMENT DATE: 11/13/2009
PATIENT: ENRIQUE RODRIGUEZ
INJURED: 11/22/2004
PHYSICIAN: NORK MD, JOHN G

EMPLOYER: SELF

ACCT N20022 AL N2 DIAGNOSIS: PAIN IN JOINT INVOLVING LOWER LEG
STIFFNESS OF JOINT, NOT ELSEWHERE CLASSIFIED, INVOLVING LOWE
OTHER JOINT DERANGEMENT, NOT ELSEWHERE CLASSIFIED
SPRAIN OF OTHER SPECIFIED SITES OF KNEE AND LEG

DATE	DESCRIPTION	CHARGES	INSURANCE PAID	ADJUSTS	PATIENT PAID
	BALANCE FORWARD 6733.00				
01/31/05	ELECTRICAL STIMULATION 1 UNIT	25.00			
01/31/05	HOT PACK/COLD PACK	25.00			
02/03/05	CORY JONES, billed 780.00 for 01/24-01/27/5				
02/07/05	CORY JONES, billed 335.00 for 01/31-01/31/5				
02/18/05	CORY JONES, AA Billed 6,783.00 for 12/08-02/07/				
02/18/05	ENRIQUE RODRIG Billed 6,783.00 for 12/08-02/18/				
02/18/05	CORY JONES, AA Billed 6,783.00 for 12/08-02/18/				
03/14/05	CORY JONES, AA Billed 6,783.00 for 12/08-02/18/				
03/14/05	ENRIQUE RODRIG Billed 6,783.00 for 12/08-03/14/				
04/14/05	CORY JONES, AA Billed 6,783.00 for 12/08-03/14/				
04/14/05	CORY JONES, AA Billed 6,783.00 for 12/08-04/14/				
04/14/05	CORY JONES, AA Billed 6,783.00 for 12/08-04/14/				
05/19/05	CORY JONES, AA Billed 6,783.00 for 12/08-04/14/				
05/19/05	ENRIQUE RODRIG Billed 6,783.00 for 12/08-05/19/				
06/14/05	CORY JONES, AA Billed 6,783.00 for 12/08-05/19/				
07/05/05	CORY JONES, AA Billed 6,783.00 for 12/08-06/14/				
07/05/05	CORY JONES, AA Billed 6,783.00 for 12/08-07/05/				
07/20/05	CORY JONES, AA Billed 6,783.00 for 12/08-07/05/				
08/10/05	BENSON, BERTOL Billed 6,783.00 for 12/08-07/20/				
08/15/05	BENSON, BERTOL Billed 6,783.00 for 12/08-08/10/				
09/15/05	BENSON, BERTOL Billed 6,783.00 for 12/08-08/15/				
09/16/05	ENRIQUE RODRIG Billed 6,783.00 for 12/08-09/15/				
09/16/05	ENRIQUE RODRIG Billed 6,783.00 for 12/08-09/16/				
09/26/05	BENSON, BERTOL Billed 6,783.00 for 12/08-09/16/				
10/17/05	BENSON, BERTOL Billed 6,783.00 for 12/08-09/26/				
10/17/05	ENRIQUE RODRIG Billed 6,783.00 for 12/08-10/17/				
10/24/05	POOL THERAPY 3 UNITS	210.00			
10/24/05	MANUAL THERAPY 1 UNIT	45.00			

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630 E. LATHAM AVENUE
HEMET, CA 92543

BENSON, BERTOLDO, BAKER, AA
7408 WEST SAHARA AVENUE
LAS VEGAS NV 89117

STATEMENT DATE: 11/13/2009
PATIENT: ENRIQUE RODRIGUEZ
INJURED: 11/22/2004
PHYSICIAN: NORK MD, JOHN G

EMPLOYER: SELF

ACCT N20022 AL N2 DIAGNOSIS: PAIN IN JOINT INVOLVING LOWER LEG
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OTHER JOINT DERANGEMENT, NOT ELSEWHERE CLASSIFIED
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DATE	DESCRIPTION	CHARGES	INSURANCE PAID	ADJUSTS	PATIENT PAID
	BALANCE FORWARD 7038.00				
10/24/05	WHIRLPOOL 1 UNIT	30.00			
10/24/05	ELECTRICAL STIMULATION 1 UNIT	25.00			
10/26/05	POOL THERAPY 3 UNITS	210.00			
10/26/05	MANUAL THERAPY 1 UNIT	45.00			
10/26/05	WHIRLPOOL 1 UNIT	30.00			
10/26/05	ELECTRICAL STIMULATION 1 UNIT	25.00			
10/26/05	HOT PACK/COLD PACK	25.00			
10/27/05	POOL THERAPY 3 UNITS	210.00			
10/27/05	MANUAL THERAPY 1 UNIT	45.00			
10/27/05	WHIRLPOOL 1 UNIT	30.00			
10/27/05	ELECTRICAL STIMULATION 1 UNIT	25.00			
10/27/05	HOT PACK/COLD PACK	25.00			
11/03/05	POOL THERAPY 2 UNITS	140.00			
11/03/05	MANUAL THERAPY 1 UNIT	45.00			
11/03/05	THERAPEUTIC EXERCISE 1 UNIT	45.00			
11/03/05	NEUROMUSCULAR RE-EDUCATION 1 UNIT	45.00			
11/03/05	ELECTRICAL STIMULATION 1 UNIT	25.00			
11/03/05	HOT PACK/COLD PACK	25.00			
11/04/05	P.T. RE-EVALUATION	45.00			
11/04/05	POOL THERAPY 2 UNITS	140.00			
11/04/05	MANUAL THERAPY 1 UNIT	45.00			
11/04/05	THERAPEUTIC EXERCISE 1 UNIT	45.00			
11/04/05	NEUROMUSCULAR RE-EDUCATION 1 UNIT	45.00			
11/04/05	WHIRLPOOL 1 UNIT	30.00			
11/04/05	ELECTRICAL STIMULATION 1 UNIT	25.00			
11/04/05	HOT PACK/COLD PACK	25.00			
11/14/05	BENSON, BERTOL Billed 8,488.00 for 12/08-11/04/				
11/14/05	ENRIQUE RODRIG Billed 8,488.00 for 12/08-11/14/				

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MURRIETA, CA 92564
(951) 696-9353
FED TAX ID # 33-0493339

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630 E. LATHAM AVENUE
HEMET, CA 92543

BENSON, BERTOLDO, BAKER, AA
7408 WEST SAHARA AVENUE
LAS VEGAS NV 89117

STATEMENT DATE: 11/13/2009
PATIENT: ENRIQUE RODRIGUEZ
INJURED: 11/22/2004
PHYSICIAN: NORK MD, JOHN G

EMPLOYER: SELF

ACCT N20022 AL N2 DIAGNOSIS: PAIN IN JOINT INVOLVING LOWER LEG
STIFFNESS OF JOINT, NOT ELSEWHERE CLASSIFIED, INVOLVING LOWE
OTHER JOINT DERANGEMENT, NOT ELSEWHERE CLASSIFIED
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DATE	DESCRIPTION	CHARGES	INSURANCE PAID	ADJUSTS	PATIENT PAID
	BALANCE FORWARD 8488.00				
11/14/05	ENRIQUE RODRIG Billed 8,488.00 for 12/08-11/14/				
12/01/05	POOL THERAPY 3 UNITS	210.00			
12/01/05	MANUAL THERAPY 1 UNIT	45.00			
12/01/05	THERAPEUTIC EXERCISE 1 UNIT	45.00			
12/01/05	ULTRASOUND 1 UNIT	30.00			
12/01/05	WHIRLPOOL 1 UNIT	30.00			
12/01/05	ELECTRICAL STIMULATION 1 UNIT	25.00			
12/01/05	HOT PACK/COLD PACK	25.00			
12/02/05	POOL THERAPY 3 UNITS	210.00			
12/02/05	WHIRLPOOL 1 UNIT	30.00			
12/02/05	ELECTRICAL STIMULATION 1 UNIT	25.00			
12/02/05	HOT PACK/COLD PACK	25.00			
12/05/05	POOL THERAPY 3 UNITS	210.00			
12/05/05	WHIRLPOOL 1 UNIT	30.00			
12/05/05	ELECTRICAL STIMULATION 1 UNIT	25.00			
12/05/05	HOT PACK/COLD PACK	25.00			
12/06/05	BENSON, BERTOL Billed 8,488.00 for 12/08-11/14/				
12/06/05	POOL THERAPY 3 UNITS	210.00			
12/06/05	WHIRLPOOL 1 UNIT	30.00			
12/06/05	ELECTRICAL STIMULATION 1 UNIT	25.00			
12/06/05	HOT PACK/COLD PACK	25.00			
12/07/05	BENSON, BERTOL Billed 8,488.00 for 12/08-12/06/				
12/07/05	P.T. RE-EVALUATION	45.00			
12/07/05	POOL THERAPY 3 UNITS	210.00			
12/07/05	WHIRLPOOL 1 UNIT	30.00			
12/07/05	ELECTRICAL STIMULATION 1 UNIT	25.00			
12/07/05	HOT PACK/COLD PACK	25.00			
12/12/05	NO SHOW FEE	25.00			

CONTINUED ON NEXT PAGE

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7408 WEST SAHARA AVENUE
LAS VEGAS NV 89117

STATEMENT DATE: 11/13/2009
PATIENT: ENRIQUE RODRIGUEZ
INJURED: 11/22/2004
PHYSICIAN: NORK MD, JOHN G

EMPLOYER: SELF

ACCT N20022 AL N2 DIAGNOSIS: PAIN IN JOINT INVOLVING LOWER LEG
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OTHER JOINT DERANGEMENT, NOT ELSEWHERE CLASSIFIED
SPRAIN OF OTHER SPECIFIED SITES OF KNEE AND LEG

DATE	DESCRIPTION	CHARGES	INSURANCE PAID	ADJUSTS	PATIENT PAID
	BALANCE FORWARD 10128.00				
12/15/05	BENSON, BERTOL Billed 10,103.00 for 12/08-12/07/				
01/17/06	BENSON, BERTOL Billed 10,128.00 for 12/08-12/15/				
01/17/06	ENRIQUE RODRIG Billed 10,128.00 for 12/08-01/17/				
02/16/06	BENSON, BERTOL Billed 10,128.00 for 12/08-01/17/				
02/16/06	ENRIQUE RODRIG Billed 10,128.00 for 12/08-02/16/				
03/04/06	BENSON, BERT billed 3320.00 for 10/24-12/07/5				
03/16/06	BENSON, BERTOL Billed 10,128.00 for 12/08-03/04/				
03/16/06	BENSON, BERTOL Billed 10,128.00 for 12/08-03/16/				
03/16/06	ENRIQUE RODRIG Billed 10,128.00 for 12/08-03/16/				
03/18/06	BENSON, BERTOL Billed 10,128.00 for 12/08-03/16/				
03/20/06	ENRIQUE RODRIG Billed 10,128.00 for 12/08-03/18/				
03/29/06	BENSON, BERTOL Billed 10,128.00 for 12/08-03/20/				
04/17/06	BENSON, BERTOL Billed 10,128.00 for 12/08-03/29/				
04/17/06	ENRIQUE RODRIG Billed 10,128.00 for 12/08-04/17/				
08/31/06	BENSON, BERTOL Billed 10,128.00 for 12/08-04/17/				
02/27/07	BENSON, BERTOL Billed 10,128.00 for 12/08-08/31/				
04/24/07	BENSON, BERTOL Billed 10,128.00 for 12/08-02/27/				
06/18/07	BENSON, BERTOL Billed 10,128.00 for 12/08-12/12/				
06/19/07	BENSON, BERTOL Billed 10,128.00 for 12/08-06/18/				
10/22/07	BENSON, BERTOL Billed 10,128.00 for 12/08-06/19/				
10/23/07	BENSON, BERTOL Billed 10,128.00 for 12/08-10/22/				
11/15/07	BENSON, BERTOL Billed 10,128.00 for 12/08-10/23/				
11/21/07	BENSON, BERTOL Billed 10,128.00 for 12/08-11/15/				
04/21/08	BENSON, BERTOL Billed 10,128.00 for 12/08-11/21/				
04/21/08	BENSON, BERTOL Billed 10,128.00 for 12/08-04/21/				
08/21/08	BENSON, BERTOL Billed 10,128.00 for 12/08-04/21/				
09/12/08	BENSON, BERTOL Billed 10,128.00 for 12/08-08/21/				
10/20/08	BENSON, BERTOL Billed 10,128.00 for 12/08-09/12/				

CONTINUED ON NEXT PAGE

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STATEMENT DATE: 11/13/2009
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INJURED: 11/22/2004
PHYSICIAN: NORK MD, JOHN G

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ACCT N20022 AL N2 DIAGNOSIS: PAIN IN JOINT INVOLVING LOWER LEG
STIFFNESS OF JOINT, NOT ELSEWHERE CLASSIFIED, INVOLVING LOWE
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SPRAIN OF OTHER SPECIFIED SITES OF KNEE AND LEG

DATE	DESCRIPTION	CHARGES	INSURANCE PAID	ADJUSTS	PATIENT PAID
	BALANCE FORWARD 10128.00				
03/19/09	BENSON, BERTOL Billed 10,128.00 for 12/08-10/20/				
04/29/09	BENSON, BERTOL Billed 10,128.00 for 12/08-03/19/				
04/29/09	BENSON, BERTOL Billed 10,128.00 for 12/08-04/29/				
06/29/09	BENSON, BERTOL Billed 10,128.00 for 12/08-04/29/				
06/29/09	BENSON, BERTOL Billed 10,128.00 for 12/08-06/29/				
11/12/09	BENSON, BERTOL Billed 10,128.00 for 12/08-06/29/				
	TOTALS	10128.00	0.00	0.00	0.00
			PLEASE PAY		10128.00

THIS BALANCE REFLECTS YOUR CHARGES AS OF THE DATE OF THIS STATEMENT. ALL CHARGES ARE YOUR RESPONSIBILITY AND ARE DUE UPON SETTLEMENT OF YOUR LAW SUIT. BILLING QUESTIONS? CALL 951-696-9353

Rancho PT 0000146

Patient History - Summary

CENTENNIAL MEDICAL GROUP

By Date of Service
Date ranges 09/17/2008 to 09/17/2008
All Providers
Show last billed date
Open Items Only

Chart #:	3860	**Home Phone:**	
Patient Name:	RODRIGUEZ,ENRIQUE	**Office Phone:**	
Address:	F	**Resp. Party:**	RODRIGUEZ,ENRIQUE
City, State, Zip:		**Resp. Acct#**	43236

U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	72141		Y	Y	9/17/2008	120	84419	$2,500.00	$0.00	$0.00	$2,500.00	$2,500.00	BENS1	11/25/2008	43236
	72146		Y	Y	9/17/2008	120	84419	$2,500.00	$0.00	$0.00	$2,500.00	$2,500.00	BENS1	11/25/2008	43236
	72148		Y	Y	9/17/2008	120	84419	$2,500.00	$0.00	$0.00	$2,500.00	$2,500.00	BENS1	11/25/2008	43236
Grand Total:								**$7,500.00**	**$0.00**	**$0.00**	**$7,500.00**	**$7,500.00**			

* U = Unapplied * I = Bill Insurance * B = Insurance Billed

Generated 12/19/2008 3:20:49 PM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

ATTY BENSON & BERTOLDO
MEDICAL CLAIMS
7408 W. SAHARA AVE
LAS VEGAS NV 89117

CARRIER

PICA ☐ PICA ☐

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ ENRIQUE J

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

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

5. PATIENT'S ADDRESS (No., Street)

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

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

CITY | STATE

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐; Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

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

a. INSURED'S DATE OF BIRTH 3 SEX: M [X] 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: DISABLED

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ 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.

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 ON FILE DATE 09/16/08

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 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 PROVIDER OR OTHER SOURCE: JOSEPH J SCHIFINI

17a. G G46280

17b. NPI

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 .00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by Line)

1. 722.10 HERNIATED DISK
2. 723.1 CERVICALGIA
3. 722.52 DEGENERATI
4. 724.2 LUMBAGO

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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1				CONSULTATION COMPREHENSIV						1G	H84814
09/02/08		11		99245		1234	570 00	1		NPI	1437148442
2				X-RAY L-SPINE 5 VIEW						1G	H84814
09/02/08		11		72110		1234	215 00	1		NPI	1437148442
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 880218251 ☐ [P]

26. PATIENT'S ACCOUNT NO.: 69721

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

28. TOTAL CHARGE $ 785.00

29. AMOUNT PAID $ 0.00

30. BALANCE DUE $ 785.00

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.)

SIGNED 09 16 2008 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH #
GREGORY ELKANICH MD
2680 CRIMSON CANYON DRIVE
LAS VEGAS NV 89128-9995

1841229762 1G H84814

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

ATTY BENSON & BERTOLDO
MEDICAL CLAIMS
7408 W. SAHARA AVE
LAS VEGAS NV 89117

CARRIER

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ ENRIQUE J

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

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

5. PATIENT'S ADDRESS (No., Street)

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

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

CITY STATE

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

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous): YES NO

b. AUTO ACCIDENT? YES NO PLACE (State)

c. OTHER ACCIDENT? YES NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

b. EMPLOYER'S NAME OR SCHOOL NAME: DISABLED

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] 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 ON FILE DATE 10/01/08

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 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 PROVIDER OR OTHER SOURCE

17a. G

17b. NPI

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. 722.0 DISPLACEMENT,
2. 723.0 CERVICAL SPINA
3. 722.10 HERNIATED
4. 723.1 CERVICALGI

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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	09/30/08	11		ESTABLISHED PATIENT DETAI 99214		1234	240 00	1		1G NPI	H84814 1437148442
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: 880218251 [P]

26. PATIENT'S ACCOUNT NO.: 69721

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

28. TOTAL CHARGE: $ 240.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 240.00

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.)

SIGNED 10 01 2008 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. 1841229762 b. 1G H84814

33. BILLING PROVIDER INFO & PH # MICHAEL ELKANICH MD
2680 CRIMSON CANYON DRIVE
LAS VEGAS NV 89128-9995

NUCC Instruction Manual available at: www.nucc.org
Mfd. by Medical Arts Press
Call toll-free: 1-800-328-2179

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#14710 - Medical Arts Press
Use with Envelope #14145 (gummed) or #14146 (self-seal)

Walgreens

Report date/time: 11/28/2008 01:07 P

Confidential Patient Information
Prescription Profile
01/16/2007 through 11/28/2008

Patient Info: ENRIQUE RODRIGUEZ
[redacted]

Store Info: 8350 S RIVER PKWY
TEMPE, AZ 85284
()-

Patient Phone: [redacted]
Date of Birth:
Gender: M

Prescription Number	Medication	NDC	RPh	Prescriber	Ins. Plan(s) Claim Ref#(s)	Date of Service	Quantity	
1038957-04854	CYCLOBENZAPRINE 10MG TABLETS	59746-0177-10	TBM	KOKA, G.	IEHP / A0087326718241	11/27/08	30.000	0.00
	Your insurance saved you $14.99							

Total Fillings: 1 Subtotal: 30.000 0.00

Total Scripts: 243 Total Price: 282.98

Using generics saved you a total of	0.00
Using more generics could have saved you a total of	0.00
Your insurance saved you a total of	25138.86
Your cash quantity discount saved you a total of	0.00

The Manager and Staff at Walgreens
Thank You For Your Patronage
For your convenience, this information is available online at www.walgreens.com.
Ask our pharmacy staff for more information.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

WEBER JONATHON ESQ PI
7408 W SAHARA AVE
LAS VEGAS NV 89117

PICA

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

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ ENRI[redacted]

3. PATIENT'S BIRTHDATE MM DD YY [redacted] SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

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

CITY: [redacted] STATE: [redacted]

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

CITY: STATE:

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

ZIP CODE: TELEPHONE (Include Area Code): [redacted]

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

c. EMPLOYER'S NAME OR SCHOOL NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO

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

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

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER:

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

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. INSURANCE PLAN NAME OR PROGRAM NAME:

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 ON FILE 04 02 2009
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): 11 22 2004

15. IF PATIENT HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY: N/A

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: KOKA GOVIND

17a. H51767

17b. NPI 1942322466

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

19. RESERVED FOR LOCAL USE: 013

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1,2,3 or 4 to item 24E by Line)
1. 8470
2. 3540
3. 8409
4. 8472

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 SERV	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
				FOLLOW UP							
02032009	02032009	11		99214		1234	275 00	1		NPI	1346324092
				SPECIAL REPORT CHARG							
02032009	02032009	11		99080		1234	150 00	3		NPI	1346324092
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: 770637238 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 1958

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

28. TOTAL CHARGE $ 425 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 425 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.
SHAH MD RUSSEL J
04 02 09
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
CHARLESTON OFFI
2628 W CHARLESTON AVE
LAS VEGAS NV 89102
a. b.

33. BILLING PROVIDER INFO & PH # (702)6440500
RUSSEL J SHAH MD LTD
10624 S EASTERN AVE A425
HENDERSON NV 89052
a. 1346324092 b.

Shah 0000001

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

WEBER JONATHON ESQ PI
7408 W SAHARA AVE
LAS VEGAS NV 89117

PICA

PICA

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

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ ENRIQUE J

3. PATIENT'S BIRTHDATE MM DD YY: [redacted] SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

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

CITY: [redacted] STATE: [redacted]

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

CITY: STATE:

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

ZIP CODE: TELEPHONE (Include Area Code): [redacted]

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:

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 ON FILE 12 22 2008
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 11 22 2004 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY: N/A

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: KOKA GOVIND
17a. H54767
17b. NPI 1942322466

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

19. RESERVED FOR LOCAL USE: 013

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1,2,3 or 4 to item 24E by Line)
1. 8470
2. 3540
3. 7244
4. 8409

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 SERV	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
				FOLLOW UP							
10272008	10272008	11		99213		1234	250 00	1		NPI	1346324092
				SPECIAL REPORT CHARG							
10272008	10272008	11		99080		1234	150 00	3		NPI	1346324092
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: 770637238 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 1958

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

28. TOTAL CHARGE: $ 400 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 400 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.)
SHAH MD RUSSEL J
12 22 08
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
CHARLESTON OFFI
2628 W CHARLESTON AVE
LAS VEGAS NV 89102
a. b.

33. BILLING PROVIDER INFO & PH # (702)6440500
RUSSEL J SHAH MD LTD
10624 S EASTERN AVE A425
HENDERSON NV 89052
a. 1346324092 b.

Shah 0000002

1500

HEALTH INSUI.ANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

WEBER JONATHON ESQ PI
7408 W SAHARA AVE
LAS VEGAS NV 89117

PICA

PICA

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

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ ENRIQUE J

3. PATIENT'S BIRTHDATE MM DD YY [redacted] SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

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

CITY: [redacted] STATE: [redacted]

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

CITY: STATE:

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

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

ZIP CODE: TELEPHONE (Include Area Code): [redacted]

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): [X] YES [ ] 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 PLACE (State): [X] YES [ ] NO

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 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 08 19 2008
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 11 22 2004 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: KOKA GOVIND

17a. H51767
17b. NPI 1942322466

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

19. RESERVED FOR LOCAL USE: 013

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1,2,3 or 4 to item 24E by Line)
1. 8470
2. 3540
3. 7244
4. 71946

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 SERV	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
				FOLLOW UP							
07222008	07222008	11		99213		1234	250 00	1		NPI	1346324092
				SPECIAL REPORT CHARG							
07222008	07222008	11		99080		1234	150 00	3		NPI	1346324092
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 770637238 [ ] [X]

26. PATIENT'S ACCOUNT NO.: 1958

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

28. TOTAL CHARGE $ 400 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 400 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.)
SHAH MD RUSSEL J
08 19 08
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
CHARLESTON OFFI
2628 W CHARLESTON AVE
LAS VEGAS NV 89102
a. b.

33. BILLING PROVIDER INFO & PH # (702)6440500
RUSSEL J SHAH MD LTD
10624 S EASTERN AVE A425
HENDERSON NV 89052
a. 1346324092 b.

Shah 0000003

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

WEBER JONATHON ESQ PI
7408 W SAHARA AVE
LAS VEGAS NV 89117

PICA

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

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ ENRIQUE J

3. PATIENT'S BIRTHDATE MM DD YY: [redacted] SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

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

CITY: [redacted] STATE: CA

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

CITY: STATE:

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

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

ZIP CODE: TELEPHONE (Include Area Code): [redacted]

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) [X] YES [ ] 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 PLACE (State) [X] YES [ ] NO

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 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 05 28 2008
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: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY: 11 22 2004

15. IF PATIENT HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY: N/A

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: KOKA DO GOVIND

17a. H51767

17b. NPI

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

19. RESERVED FOR LOCAL USE: 013

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)
1. 8470
2. 7234
3. 8472
4. 72402

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 SERV	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
				FOLLOW UP							
05192008	05192008	11		99214		12345	275 00	1		NPI	1346324092
				SPECIAL REPORT CHARG							
05192008	05192008	11		99080		12345	200 00	4		NPI	1346324092
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: 770637238 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 1958

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

28. TOTAL CHARGE $ 475 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 475 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.)
SHAH MD RUSSEL J
05 28 08
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
CHARLESTON OFFI
2628 W CHARLESTON AVE
LAS VEGAS NV 89102
a. b.

33. BILLING PROVIDER INFO & PH # (702)6440500
RUSSEL J SHAH MD LTD
10624 S EASTERN AVE A425
HENDERSON NV 89052
a. 1346324092 b.

Shah 0000004

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

WEBER JONATHON ESQ PI
7408 W SAHARA AVE
LAS VEGAS NV 89117

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) [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ ENRIQUE J

3. PATIENT'S BIRTHDATE MM DD YY [redacted] SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

7. INSURED'S ADDRESS (No, Street)

CITY: [redacted] STATE: [redacted]

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

CITY STATE

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

ZIP CODE TELEPHONE (Include Area Code) [redacted]

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) [X] YES [ ] 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 PLACE (State) [X] YES [ ] NO

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 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 02192008
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 11222004 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

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

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: KOKA DO GOVIND

17a. I.D. NUMBER OF REFERRING PHYSICIAN: H5176

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

19. RESERVED FOR LOCAL USE: 013

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 8470
2. 7234
3. 8472
4. 72402

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 SERV	C TYPE OF SERV	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
02052008	02052008	11	01	99213		1234	250 00	1				10954
02052008	02052008	11	04	FOLLOW UP 99080		1234	150 00	3				10954
				SPECIAL REPORT		CHARG						

25. FEDERAL TAX I.D. NUMBER: 770637238 SS [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 1958

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

28. TOTAL CHARGE $ 400 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 400 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.)
SHAH MD RUSSEL J
02192008
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
CHARLESTON OFFI
2628 W CHARLESTON AVE
LAS VEGAS NV 89102

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE
RUSSEL J SHAH MD PLLC
10624 S EASTERN AVE A425
HENDERSON NV 89052
7026440500
PIN# GRP# 10954

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008 FORM NO. 511B 94

PLEASE PRINT OR TYPE

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

Shah 0000005

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

WEBER JONATHON ESQ PI
7408 W SAHARA AVE
LAS VEGAS NV 89117

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): [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ ENRIQUE J

3. PATIENT'S BIRTHDATE MM DD YY: [redacted] SEX M [x] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

7. INSURED'S ADDRESS (No, Street)

CITY: [redacted] STATE: [redacted]

8. PATIENT STATUS: Single [x] Married [ ] Other [ ]; Employee [x] Full-Time Student [ ] Part-Time Student [ ]

CITY STATE

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

ZIP CODE TELEPHONE (Include Area Code): [redacted]

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): [x] YES [ ] 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 PLACE (State): [x] YES [ ] NO

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 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: 11092007

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 11222004 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY: N/A

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: KOKA DO GOVIND

17a. I.D. NUMBER OF REFERRING PHYSICIAN: H51767

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

19. RESERVED FOR LOCAL USE: 013

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 8470 3. 8472
2. 7234 4. 72402

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 SERV	C TYPE OF SERV	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
09042007	09042007	11	04	99080		1234	150 00	3				10954
10012007	10012007	11	07	SPECIAL REPORT 99371		CHARG 1234	125 00	1				10954
10012007	10012007	11	04	TELEPHONE CALL 99080		1234	50 00	1				10954
				SPECIAL REPORT		CHARG						

25. FEDERAL TAX I.D. NUMBER: 770637238 SS [ ] EIN [x]

26. PATIENT'S ACCOUNT NO.: 1958

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

28. TOTAL CHARGE: $ 325 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 325 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.)
SHAH MD RUSSEL J
SIGNED DATE 11092007

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
CHARLESTON OFFI
2628 W CHARLESTON AVE
LAS VEGAS NV 89102

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE
RUSSEL J SHAH MD LTD
10624 S EASTERN AVE A425
HENDERSON NV 89052
7026440500
PIN# GRP# 10954

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008 FORM NO. 511B 04

PLEASE PRINT OR TYPE

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

Shah 0000006

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

WEBER JONATHON ESQ PI
7408 W SAHARA AVE
LAS VEGAS NV 89117

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): [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ ENRIQUE J

3. PATIENT'S BIRTHDATE MM DD YY: [redacted] SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

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

CITY: [redacted] STATE: [redacted]

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

CITY: STATE:

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

ZIP CODE: TELEPHONE (Include Area Code): [redacted]

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): [X] YES [ ] 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: [X] YES [ ] NO 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 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: 11092007

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 11222004 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY: N/A

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: KOKA DO GOVIND

17a. I.D. NUMBER OF REFERRING PHYSICIAN: H51767

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

19. RESERVED FOR LOCAL USE: 013

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 8470
2. 7234
3. 8472
4. 72402

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 SERV	C TYPE OF SERV	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
08072007	08072007	11	01	99213		1234	250 00	1				10954
08072007	08072007	11	04	FOLLOW UP 99080		1234	150 00	3				10954
08282007	08282007	11	02	SPECIAL REPORT CHARG 95864		1234	4800 00	1				10954
08282007	08282007	11	02	EMG FOUR EXTREMITIES 99070		1234	50 00	1				10954
09042007	09042007	11	01	EMG NEEDLE SPLY CHRG 99214		1234	275 00	1				10954
				FOLLOW UP								

25. FEDERAL TAX I.D. NUMBER: 770637238 SS [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 1958

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

28. TOTAL CHARGE: $ 5525 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 5525 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.)
SHAH MD RUSSEL J
SIGNED: 11092007 DATE:

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
CHARLESTON OFFI
2628 W CHARLESTON AVE
LAS VEGAS NV 89102

33. PHYSICIAN'S OR SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE
RUSSEL J SHAH MD LTD
10624 S EASTERN AVE A425
HENDERSON NV 89052
7026440500
PIN#: GRP# 10954

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008 FORM NO. 511B 04

PLEASE PRINT OR TYPE

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

Shah 0000007

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

WEBER JONATHON ESQ PI
7408 W SAHARA AVE
LAS VEGAS NV 89117

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): [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ ENRIQUE J

3. PATIENT'S BIRTHDATE MM DD YY: [redacted] SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

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

CITY: [redacted] STATE: [redacted]

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

CITY: STATE:

ZIP CODE: [redacted] TELEPHONE (Include Area Code): ([redacted]

ZIP CODE: TELEPHONE (Include Area Code): [redacted]

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) [X] YES [ ] 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? [X] YES [ ] NO 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 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.
SIGNED: SIGNATURE ON FILE DATE: 12062007

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 11222004 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY: N/A

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: KOKA DO GOVIND

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 151767

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

19. RESERVED FOR LOCAL USE: 013

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 8470 3. 8472
2. 7234 4. 72402

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

23. PRIOR AUTHORIZATION NUMBER:

24A. DATE(S) OF SERVICE FROM MM DD YY	TO MM DD YY	B. PLACE OF SERV.	C. TYPE OF SERV.	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
08082007	08082007	11	03	95950 AMBULATORY EEG		1234	1500 00	1				10954
08092007	08092007	11	03	95950 AMBULATORY EEG		1234	1500 00	1				10954

25. FEDERAL TAX I.D. NUMBER: 770637238 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 1958

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

28. TOTAL CHARGE: $ 3000 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 3000 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.)
SHAH MD RUSSEL J
SIGNED: 12062007 DATE:

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
LONG BEACH OFFI
2777 PACIFIC AVE
LONG BEACH CA 90806

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE
RUSSEL J SHAH MD LTD
10624 S EASTERN AVE A425
HENDERSON NV 89052
7026440500
PIN# GRP# 10954

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) APPROVED OMB-0938-0008 FORM NO. 5115 04

PLEASE PRINT OR TYPE

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

Shah 0000008

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

WEBER JONATHON ESQ PI
7408 W SAHARA AVE
LAS VEGAS NV 89117

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): [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ ENRIQUE J

3. PATIENT'S BIRTHDATE MM DD YY: [redacted] SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

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

CITY: [redacted] STATE: [redacted]

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

CITY: STATE:

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

ZIP CODE: TELEPHONE (Include Area Code): [redacted]

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

c. EMPLOYER'S NAME OR SCHOOL NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10. IS PATIENT'S CONDITION RELATED TO:

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

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

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

10d. RESERVED FOR LOCAL USE:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

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

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. INSURANCE PLAN NAME OR PROGRAM NAME:

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

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SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY 11222004 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY: N/A

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: KOKA DO GOVIND

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1351767

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

19. RESERVED FOR LOCAL USE: 013

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 8470
2. 7234
3. 8472
4. 72402

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 SERV	C TYPE OF SERV	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
08082007	08082007	11	02	95900		1234	300 00	2				10954
08082007	08082007	11	02	MOTOR NERVE W/C 95903		F WA 1234	2000 00	8				10954
08082007	08082007	11	02	MOTOR NERVE W/F 95904		WAVE 1234	2100 00	14				10954
08082007	08082007	11	02	SENSORY NERVE CONDUC 95934		1234	800 00	2				10954
				H WAVE REFLEXES								

25. FEDERAL TAX I.D. NUMBER: 770637238 SS [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 1958

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

28. TOTAL CHARGE: $ 5200 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 5200 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.)
SHAH MD RUSSEL J
SIGNED DATE 12062007

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
LONG BEACH OFFI
2777 PACIFIC AVE
LONG BEACH CA 90806

33. PHYSICIAN'S OR SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE
RUSSEL J SHAH MD LTD
10624 S EASTERN AVE A425
HENDERSON NV 89052
7026440500
PIN# GRP# 10954

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008 FORM NO. 5118 04

PLEASE PRINT OR TYPE

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

Shah 0000009

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

WEBER JONATHON ESQ PI
7408 W SAHARA AVE
LAS VEGAS NV 89117

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): [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ ENRIQUE J

3. PATIENT'S BIRTHDATE MM DD YY: [redacted] SEX M [x] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

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

CITY: [redacted] STATE: [redacted]

8. PATIENT STATUS: Single [x] Married [ ] Other [ ]; Employee [x] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: [redacted] TELEPHONE (Include Area Code): ([redacted])

ZIP CODE: TELEPHONE (Include Area Code): [redacted]

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

c. EMPLOYER'S NAME OR SCHOOL NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10. IS PATIENT'S CONDITION RELATED TO:

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

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

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

10d. RESERVED FOR LOCAL USE:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

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

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. INSURANCE PLAN NAME OR PROGRAM NAME:

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.
SIGNED: SIGNATURE ON FILE DATE: 11092007

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 11222004 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY: N/A

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: KOKA DO GOVIND

17a. I.D. NUMBER OF REFERRING PHYSICIAN: H51787

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

19. RESERVED FOR LOCAL USE: 013

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 8470
2. 7234
3. 8472
4. 72402

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 SERV.	C TYPE OF SERV.	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
11292006	11292006	11	04	99080		1234	200:00	4				10954
				SPECIAL REPORT		CHARG						

25. FEDERAL TAX I.D. NUMBER: 770637238 SS [ ] EIN [x]

26. PATIENT'S ACCOUNT NO.: 1958

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

28. TOTAL CHARGE: $ 200:00

29. AMOUNT PAID: $ 0:00

30. BALANCE DUE: $ 200:00

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.)
SHAH MD RUSSEL J
SIGNED: 11092007 DATE:

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
HENDERSON OFFIC
2465 HORIZON RIDGE PKWY120
HENDERSON NV 89052

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE
RUSSEL J SHAH MD LTD
10624 S EASTERN AVE A425
HENDERSON NV 89052
7026440500
PIN# GRP# 10954

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008 FORM NO. 511B 04

PLEASE PRINT OR TYPE

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

Shah 0000010

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

WEBER JONATHON ESQ PI
7408 W SAHARA AVE
LAS VEGAS NV 89117

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): [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ ENRIQUE J

3. PATIENT'S BIRTHDATE MM DD YY: [redacted] SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

7. INSURED'S ADDRESS (No, Street)

CITY: [redacted] STATE: [redacted]

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

CITY STATE

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

ZIP CODE TELEPHONE (Include Area Code): [redacted]

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

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

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

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

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

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.
SIGNED: SIGNATURE ON FILE DATE: 11092007

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 11222004 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY: N/A

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: KOKA DO GOVIND

17a. I.D. NUMBER OF REFERRING PHYSICIAN: H51767

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

19. RESERVED FOR LOCAL USE: 013

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 8470
2. 7234
3. 8472
4. 72402

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 SERV	C TYPE OF SERV	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
08092006	08092006	11	02	95903		1234	2000 00	8				10954
08092006	08092006	11	02	MOTOR NERVE W/F 95934		WAVE 1234	800 00	2				10954
08182006	08182006	11	01	H WAVE REFLEXES 99213		1234	250 00	1				10954
08182006	08182006	11	04	FOLLOW UP 99080		1234	150 00	3				10954
11292006	11292006	11	01	SPECIAL REPORT 99214		CHARG 1234	275 00	1				10954
				FOLLOW UP								

25. FEDERAL TAX I.D. NUMBER: 770637238 SS [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 1958

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

28. TOTAL CHARGE: $ 3475 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 3475 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.)
SHAH MD RUSSEL J
SIGNED DATE 11092007

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
HENDERSON OFFIC
2465 HORIZON RIDGE PKWY120
HENDERSON NV 89052

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE
RUSSEL J SHAH MD PHD
10624 S EASTERN AVE A425
HENDERSON NV 89052
7026440500
PIN# GRP# 10954

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008 FORM NO. 511B 04

PLEASE PRINT OR TYPE

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

Shah 0000011

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

WEBER JONATHON ESQ PI
7408 W SAHARA AVE
LAS VEGAS NV 89117

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)

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3. PATIENT'S BIRTHDATE MM DD YY: [redacted] SEX M [x] F [ ]

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5. PATIENT'S ADDRESS (No., Street): [redacted]

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

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

CITY: [redacted] STATE: [redacted]

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

Employee [x] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

ZIP CODE: TELEPHONE (Include Area Code): [redacted]

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

c. EMPLOYER'S NAME OR SCHOOL NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10. IS PATIENT'S CONDITION RELATED TO:

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

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

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

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER:

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

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. INSURANCE PLAN NAME OR PROGRAM NAME:

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

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17a. I.D. NUMBER OF REFERRING PHYSICIAN: H51757

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

19. RESERVED FOR LOCAL USE: 013

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 8470
2. 7234
3. 8472
4. 72402

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 SERV	C TYPE OF SERV	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
08092006	08092006	11	01	99214		12345	275 00	1				10954
08092006	08092006	11	04	FOLLOW UP 99080		12345	250 00	5				10954
				SPECIAL REPORT		CHARG						

25. FEDERAL TAX I.D. NUMBER: 770637238 SS [ ] EIN [x]

26. PATIENT'S ACCOUNT NO.: 1958

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

28. TOTAL CHARGE: $ 525 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 525 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.)
SHAH MD RUSSEL J
11092007
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
NORTH LAS VEGAS
4454 N DECATUR BLVD
NORTH LAS VEGAS NV 89130

33. PHYSICIAN OR SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE
RUSSEL J SHAH MD LTD
10624 S EASTERN AVE A425
HENDERSON NV 89052
7026440500
PIN# GRP# 10954

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008 FORM NO. 5118 04

PLEASE PRINT OR TYPE

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

Shah 0000012

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

WEBER JONATHON ESQ PI
7408 W SAHARA AVE
LAS VEGAS NV 89117

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): [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ ENRIQUE J

3. PATIENT'S BIRTHDATE MM DD YY: [redacted] SEX M (X) F ( )

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

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

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

CITY: [redacted] STATE: [redacted]

8. PATIENT STATUS: Single (X) Married ( ) Other ( ); Employee (X) Full-Time Student ( ) Part-Time Student ( )

CITY: STATE:

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

ZIP CODE: TELEPHONE (Include Area Code): [redacted]

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

c. EMPLOYER'S NAME OR SCHOOL NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10. IS PATIENT'S CONDITION RELATED TO:

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

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

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

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER:

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

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. INSURANCE PLAN NAME OR PROGRAM NAME:

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.
SIGNED: SIGNATURE ON FILE DATE: 11092007

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 11222004 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY: N/A

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: KOKA DO GOVIND

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 11517

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

19. RESERVED FOR LOCAL USE: 013

20. OUTSIDE LAB? ( ) YES (X) NO $ CHARGES: NO PURCH. SVC.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 8470
2. 7234
3. 8472
4. 72402

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 SERV	C TYPE OF SERV	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
07112006	07112006	11	01	99245		1234	650 00	1				10954
07112006	07112006	11	04	CONSULTATION 99080		1234	300 00	6				10954
08092006	08092006	11	02	SPECIAL REPORT CHARG 95864		1234	4800 00	1				10954
08092006	08092006	11	02	EMG FOUR EXTREMITIES 99070		1234	50 00	1				10954
08092006	08092006	11	02	EMG NEEDLE SPLY CHRG 95904		1234	1350 00	9				10954
				SENSORY NERVE CONDUC								

25. FEDERAL TAX I.D. NUMBER: 770637238 SSN ( ) EIN (X)

26. PATIENT'S ACCOUNT NO.: 1958

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

28. TOTAL CHARGE: $ 7150 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 7150 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.)
SHAH MD RUSSEL J
11092007
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
HENDERSON OFFIC
2465 HORIZON RIDGE PKWY120
HENDERSON NV 89052

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE
RUSSEL J SHAH MD LTD
10624 S EASTERN AVE A425
HENDERSON NV 89052
7026440500
PIN# GRP# 10954

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008 FORM NO. 511B 04

PLEASE PRINT OR TYPE

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

Shah 0000013

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

WEBER JONATHON ESQ PI
7408 W SAHARA AVE
LAS VEGAS NV 89117

PICA

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

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ ENRIQUE J

3. PATIENT'S BIRTHDATE MM DD YY [redacted] SEX [X] M [ ] F

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

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

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

CITY: [redacted] STATE: [redacted]

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

CITY: STATE: NV

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

ZIP CODE: TELEPHONE (Include Area Code): [redacted]

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 PLACE (State) [ ] YES [X] NO

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 [ ] 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 12 07 2009
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: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 11 22 2004

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: KOKA GOVIND

17a. H51767
17b. NPI 1942322466

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

19. RESERVED FOR LOCAL USE: 013

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1,2,3 or 4 to item 24E by Line)
1. 7244
2. 8470
3. 8409
4. 8449

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 SERV	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
				FOLLOW UP							
11042009	11042009	11		99214		1234	275 00	1		NPI	1346324092
				SPECIAL REPORT CHARG							
11042009	11042009	11		99080		1234	150 00	3		NPI	1346324092
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 770637238 [ ] [X]

26. PATIENT'S ACCOUNT NO.: 1958

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

28. TOTAL CHARGE $ 425 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 425 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.)
SHAH MD RUSSEL J
12 07 09
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
CHARLESTON OFFI
2628 W CHARLESTON BLVD
LAS VEGAS NV 89102
a. b.

33. BILLING PROVIDER INFO & PH # (702)6440500
RUSSEL J SHAH MD LTD
10624 S EASTERN AVE A425
HENDERSON NV 89052
a. 1346324092 b.

Shah 0000082

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

WEBER JONATHON ESQ PI
7408 W SAHARA AVE
LAS VEGAS NV 89117

PICA

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

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ ENRIQUE J

3. PATIENT'S BIRTHDATE MM DD YY: [redacted] SEX M [X] F

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

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

7. INSURED'S ADDRESS (No, Street)

CITY: [redacted] STATE: [redacted]

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

CITY STATE

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

ZIP CODE TELEPHONE (Include Area Code): [redacted]

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 PLACE (State) YES [X] NO

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 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 08 18 2010
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): 11 22 2004

15. IF PATIENT HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY: N/A

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: KOKA GOVIND

17a. H54767

17b. NPI 1942322466

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

19. RESERVED FOR LOCAL USE: 013

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1,2,3 or 4 to item 24E by Line)
1. 72402
2. 71946
3. 8470
4. V493

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 SERV	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
				FOLLOW UP							
08102010	08102010	11		99214		1234	275 00	1		NPI	1346324092
				SPECIAL REPORT CHARG							
08102010	08102010	11		99080		1234	100 00	2		NPI	1346324092
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: 770637238 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 1958

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

28. TOTAL CHARGE $ 375 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 375 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.)
SHAH MD RUSSEL J
08 18 10
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
CHARLESTON OFFI
2628 W CHARLESTON BLVD
LAS VEGAS NV 89102
a. b.

33. BILLING PROVIDER INFO & PH # (702)6440500
RUSSEL J SHAH MD LTD
10624 S EASTERN AVE A425
HENDERSON NV 89052
a. 1346324092 b.

R. Shah 0000086 Rodriguez

MAKE CHECKS PAYABLE TO:

CHYNOWETH, HILL AND LEAVITT
3831 W. CHARLESTON BLVD
LAS VEGAS, NV 89102

16466-3AN5

RETURN SERVICE REQUESTED

1212

LAST PMT:
AMOUNT: 0.00

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

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

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS

CARD NUMBER	SIGNATURE CODE
SIGNATURE	EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
05/31/2009	Continued	1855

PAGE: 1 of 12

SHOW AMOUNT PAID HERE $

500118A

STEVE BAKER ATTY.
7408 W.SAHARA AVE.
LAS VEGAS, NV 89117-2740

CHYNOWETH, HILL AND LEAVITT LLC
3831 W. CHARLESTON BLVD
LAS VEGAS, NV 89102-1859

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

STATEMENT

Date	Patient	Description	Charges	Pat. Pmt.	Adjust.	Balance
10/22/08	Rodriguez, Enrique	Initial Evaluation	95.00	0.00	0.00	95.00
10/22/08	Rodriguez, Enrique	Aqua Therapy	100.00	0.00	0.00	100.00
10/22/08	Rodriguez, Enrique	Manual Therapy Technique	45.00	0.00	0.00	45.00
10/22/08	Rodriguez, Enrique	Ultrasound	28.00	0.00	0.00	28.00
10/22/08	Rodriguez, Enrique	Electrical Stimulation	28.00	0.00	0.00	28.00
10/23/08	Rodriguez, Enrique	Aqua Therapy	100.00	0.00	0.00	100.00
10/23/08	Rodriguez, Enrique	Ultrasound	28.00	0.00	0.00	28.00
10/23/08	Rodriguez, Enrique	Electrical Stimulation	28.00	0.00	0.00	28.00
10/24/08	Rodriguez, Enrique	Aqua Therapy	100.00	0.00	0.00	100.00
10/24/08	Rodriguez, Enrique	Ultrasound	28.00	0.00	0.00	28.00
10/24/08	Rodriguez, Enrique	Electrodes	12.00	0.00	0.00	12.00
10/27/08	Rodriguez, Enrique	Aqua Therapy	100.00	0.00	0.00	100.00
10/27/08	Rodriguez, Enrique	Massage	35.00	0.00	0.00	35.00
10/27/08	Rodriguez, Enrique	Ultrasound	28.00	0.00	0.00	28.00
10/27/08	Rodriguez, Enrique	Electrical Stimulation	28.00	0.00	0.00	28.00

*** Balance is overdue. Contact us or be referred to a collection agency. ***

Current	30 Days	60 Days	90 Days	120 Days	Total Balance	Now Due
0.00	0.00	1,376.00	1,387.00	5,464.00	$ 8,227.00	Continued

Messages

Account Number
1855

Statement Date
05/31/2009

Make Checks Payable To:

CHYNOWETH, HILL AND LEAVITT LLC
3831 W. CHARLESTON BLVD
LAS VEGAS, NV 89102

Billing Questions
(877) 325-2776 144

16466-3AN5*TO310C2GG000140

KHPT 0000001

THOMAS VATER DO
7326 W Cheyenne Ave
LAS VEGAS NV 891296201

Bill To:

Enrique J Rodriguez
[redacted]

Amount Remitted:
Account Number: 4381
Statement Date: 11/10/2009
Patient's Balance Due: $330.00
Page: 1 of 1

Please Note: If a 'P' appears in this column, we have filed with your primary carrier. If a '2' appears, we have also filed with your secondary carrier. Our records show your insurance as follows:

Date	Provider	ICD9	Reference	Description of Services	Amount Charged	Payments	Insurance	Your Balance
10/13/08	TV		99204	OV-NEW LEV 4 (45 MIN)	300.00			0.00
10/13/08	TV		99243	OFFC CONSULT (40 MIN)	330.00			330.00
11/19/08				WRONG CHARGES MARKED CR A		300.00		

Account Balance	(Refer to "Due From Patient" For Amount to Pay)	Current Balance	Over 30	Over 60	Over 90	Over 120	Due From Patient
$330.00		$0.00	$0.00	$0.00	$0.00	$330.00	$330.00

Providers	Account Number	Name	Telephone for Questions
THOMAS VATER DO	4381	ENRIQUE J RODRIGUEZ	[redacted]
	Statement Date	Make check Payable To	
	11/10/2009	VATER SPINE	

Dr. Vater 0000010

LOUIS MORTILLARO, PH D
501 S RANCHO DRIVE STE F37
LAS VEGAS NV 89106-4828
702-256-1330

09-07-2010

JONATHAN WEBER, ESQ.
7408 W SAHARA AVE
LAS VEGAS NV 89117

Patient: RODRIGUEZ, ENRIQUE
Account #: 2483

Statement

Svc Date	Code	MD	Description	Charges	Credits	Insurance Status	Payable Now
08-31-05	96100	0	PSYCHOLOGICAL TESTING	750.00			750.00
09-01-05	90801	0	PSYCH. DIAGNOSTIC EXAM	252.00			252.00
09-26-05	90806	0	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
09-26-05	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
09-27-05	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
10-03-05	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
10-03-05	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
10-05-05	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
10-10-05	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
10-10-05	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
11-07-05	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
11-07-05	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
11-08-05	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
11-09-05	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
11-09-05	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
11-10-05	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
11-14-05	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
11-15-05	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
12-13-05	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
12-14-05	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
12-14-05	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
12-19-05	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
01-03-06	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
01-03-06	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
01-04-06	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
01-05-06	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
01-11-06	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
01-11-06	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
01-17-06	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
01-17-06	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
01-18-06	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
01-18-06	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
01-30-06	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
01-30-06	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
02-23-06	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
02-24-06	90901	0	BIOFEEDBACK TRAINING	135.00			135.00

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LOUIS MORTILLARO, PH D
501 S RANCHO DRIVE STE F37
LAS VEGAS NV 89106-4828
702-256-1330

09-07-2010

JONATHAN WEBER, ESQ.
7408 W SAHARA AVE
LAS VEGAS NV 89117

Patient: RODRIGUEZ, ENRIQUE
Account #: 2483

Statement

Svc Date	Code	MD	Description	Charges	Credits	Insurance Status	Payable Now
03-09-06	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
03-09-06	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
03-17-06	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
03-21-06	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
03-27-06	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
04-03-06	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
04-03-06	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
04-26-06	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
05-10-06	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
05-10-06	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
05-18-06	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
06-01-06	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
06-21-06	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
06-28-06	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
06-28-06	90901	0	BIOFEEDBACK TRAINING	135.00			135.00
07-27-06	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
07-27-06	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
08-07-06	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
08-10-06	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
08-10-06	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
08-14-06	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
08-17-06	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
08-17-06	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
08-18-06	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
08-24-06	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
08-24-06	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
09-11-06	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
09-11-06	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
09-26-06	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
09-26-06	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
10-12-06	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
10-12-06	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
10-25-06	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
10-25-06	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
11-08-06	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
11-08-06	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00

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LOUIS MORTILLARO, PH D
501 S RANCHO DRIVE STE F37
LAS VEGAS NV 89106-4828
702-256-1330

09-07-2010

JONATHAN WEBER, ESQ.
7408 W SAHARA AVE
LAS VEGAS NV 89117

Patient: RODRIGUEZ, ENRIQUE
Account #: 2483

Statement

Svc Date	Code	MD	Description	Charges	Credits	Insurance Status	Payable Now
11-22-06	99049	0	NO CALL NO SHOW	175.00			175.00
11-28-06	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
11-28-06	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
12-12-06	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
12-12-06	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
01-17-07	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
01-17-07	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
01-30-07	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
01-30-07	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
03-01-07	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
03-01-07	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
03-20-07	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
03-20-07	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
04-25-07	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
04-25-07	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
05-10-07	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
05-10-07	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
05-24-07	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
05-31-07	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
05-31-07	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
07-26-07	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
07-26-07	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
08-14-07	90806	36	INDIVIDUAL PSYCHOTHERAPY	175.00			175.00
08-14-07	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
09-25-07	90804	36	PSYCHOTHERAPY, 20-30 MINUTI	130.00			130.00
09-25-07	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
11-08-07	90806	36	INDIVIDUAL PSYCHOTHERAPY	200.00			200.00
11-08-07	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
12-03-07	99049	36	MISSED APPT	200.00			200.00
12-03-07	99049	JM	MISSED APPT	135.00			135.00
12-11-07	90806	36	INDIVIDUAL PSYCHOTHERAPY	200.00			200.00
12-11-07	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
12-17-07	99049	36	MISSED APPT	200.00			200.00
12-18-07	96101	0	PSYCH TESTING COMPLETE BY	900.00			900.00
12-19-07	90801	0	PSYCH. DIAGNOSTIC EXAM	300.00			300.00
12-19-07	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00

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LOUIS MORTILLARO, PH D
501 S RANCHO DRIVE STE F37
LAS VEGAS NV 89106-4828
702-256-1330

09-07-2010

JONATHAN WEBER, ESQ.
7408 W SAHARA AVE
LAS VEGAS NV 89117

Patient: RODRIGUEZ, ENRIQUE
Account #: 2483

Statement

Svc Date	Code	MD	Description	Charges	Credits	Insurance Status	Payable Now
01-24-08	90806	36	INDIVIDUAL PSYCHOTHERAPY	200.00			200.00
01-24-08	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
03-12-08	90806	36	INDIVIDUAL PSYCHOTHERAPY	200.00			200.00
03-12-08	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
03-31-08	90806	36	INDIVIDUAL PSYCHOTHERAPY	200.00			200.00
03-31-08	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
05-01-08	90806	36	INDIVIDUAL PSYCHOTHERAPY	200.00			200.00
05-01-08	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
06-11-08	90806	36	INDIVIDUAL PSYCHOTHERAPY	200.00			200.00
06-11-08	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
08-13-08	90806	36	INDIVIDUAL PSYCHOTHERAPY	200.00			200.00
08-13-08	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
09-18-08	90806	36	INDIVIDUAL PSYCHOTHERAPY	200.00			200.00
09-18-08	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
10-23-08	99049	36	MISSED APPT	200.00			200.00
10-23-08	99049	JM	MISSED APPT	135.00			135.00
10-28-08	90806	36	INDIVIDUAL PSYCHOTHERAPY	200.00			200.00
10-28-08	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
12-17-08	90806	36	INDIVIDUAL PSYCHOTHERAPY	200.00			200.00
12-17-08	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
02-05-09	90806	36	INDIVIDUAL PSYCHOTHERAPY	200.00			200.00
02-05-09	90901	JM	BIOFEEDBACK TRAINING	135.00			135.00
03-31-09	90806	36	INDIVIDUAL PSYCHOTHERAPY	200.00			200.00
05-06-09	90806	36	INDIVIDUAL PSYCHOTHERAPY	200.00			200.00
08-20-09	90806	36	INDIVIDUAL PSYCHOTHERAPY	200.00			200.00
11-05-09	90806	36	INDIVIDUAL PSYCHOTHERAPY	200.00			200.00
12-17-09	90806	36	INDIVIDUAL PSYCHOTHERAPY	200.00			200.00
01-14-10	90806	36	INDIVIDUAL PSYCHOTHERAPY	225.00			225.00
02-18-10	90806	36	INDIVIDUAL PSYCHOTHERAPY	225.00			225.00
03-03-10	90806	36	INDIVIDUAL PSYCHOTHERAPY	225.00			225.00
05-13-10	99049	36	MISSED APPT	225.00			225.00
05-18-10	90806	36	INDIVIDUAL PSYCHOTHERAPY	225.00			225.00
06-15-10	90806	36	INDIVIDUAL PSYCHOTHERAPY	225.00			225.00
08-09-10	99049	36	LATE CX	225.00			225.00

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LOUIS MORTILLARO, PH D
501 S RANCHO DRIVE STE F37
LAS VEGAS NV 89106-4828
702-256-1330

09-07-2010

JONATHAN WEBER, ESQ.
7408 W SAHARA AVE
LAS VEGAS NV 89117

Patient: RODRIGUEZ, ENRIQUE
Account #: 2483

Statement

Svc Date	Code	MD	Description	Charges	Credits	Insurance Status	Payable Now
08-10-10	90806	36	INDIVIDUAL PSYCHOTHERAPY	225.00			225.00

Current	Over 30	Over 60	Over 90	Acct. Balance
$450.00	$0.00	$225.00	$23,827.00	$24,502.00

Amount Due
$24,502.00

PLEASE CALL 256-1330 IF THERE ARE QUESTIONS.

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BENSON BERTOLDO BAKER & CARTER

7408 W SAHARA AVE
LAS VEGAS, NV 89117

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): N/A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ, ENRIQUE

3. PATIENT'S BIRTH DATE MM DD YY [redacted] SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

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

CITY: [redacted] STATE: [redacted]

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

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

CITY: [redacted] STATE: [redacted]

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

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

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

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

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: 09242010

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 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 PROVIDER OR OTHER SOURCE: GOVIND KOKA DO
17a.
17b. NPI

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 [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by Line)
1. 337.20
2.
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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 09222010	09222010	11		97113		1	264.00	4		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 721567165 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 462811A

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

28. TOTAL CHARGE: $ 264.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 264.00

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.)
STEVEN S NIETO
SIGNED DATE 09242010

32. SERVICE FACILITY LOCATION INFORMATION
TOTAL WELLNESS-RIVERSIDE
3191 B. MISSION INN AVE
RIVERSIDE, CA 92507
a. b.

33. BILLING PROVIDER INFO & PH # 9516842874
TOTAL WELLNESS INC
3191 B MISSION INN AVE
RIVERSIDE, CA 92507
a. b.

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

Fold — Fold

NUCC Instruction Manual available at: www.nucc.org
Mfd. by Medical Arts Press
Call toll-free: 1-800-328-2179

PLEASE PRINT OR TYPE

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BENSON BERTOLDO BAKER & CARTER

7408 W SAHARA AVE
LAS VEGAS, NV 89117

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): N/A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ, ENRIQUE

3. PATIENT'S BIRTH DATE MM DD YY [redacted] SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

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

CITY: [redacted] STATE: [redacted]

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

CITY: [redacted] STATE: [redacted]

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

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

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

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 [redacted] SEX M [X] 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 [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: 09032010

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 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 PROVIDER OR OTHER SOURCE: GOVIND KOKA DO

17a.

17b. NPI

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 [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by Line)

1. 337.20
2.
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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 06282010	06282010	11		97001		1	122.00	1		NPI	
2 06282010	06282010	11		97110		1	59.00	1		NPI	
3 06282010	06282010	11		97140		1	45.00	1		NPI	
4 06282010	06282010	11		97140		1	45.00	1		NPI	
5 06282010	06282010	11		97014		1	28.14	1		NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 721567165 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 415273C

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

28. TOTAL CHARGE: $ 299.14

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 299.14

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 S NIETO
09032010
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
TOTAL WELLNESS-RIVERSIDE
3191 B. MISSION INN AVE
RIVERSIDE, CA 92507
1922299338 b.

33. BILLING PROVIDER INFO & PH # 9516842874
TOTAL WELLNESS INC
3191 B MISSION INN AVE
RIVERSIDE, CA 92507
1922299338 b. 721567165

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BENSON BERTOLDO BAKER & CARTER

7408 W SAHARA AVE
LAS VEGAS, NV 89117

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): N/A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ, ENRIQUE

3. PATIENT'S BIRTH DATE MM DD YY [redacted] SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

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

CITY [redacted] STATE [redacted]

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

CITY [redacted] STATE [redacted]

ZIP CODE [redacted] TELEPHONE (Include Area Code) [redacted]

ZIP CODE [redacted] TELEPHONE (Include Area Code) [redacted]

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

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

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

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

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: 09032010

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 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 PROVIDER OR OTHER SOURCE: GOVIND KOKA DO
17a.
17b. NPI

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 [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by Line)
1. 337.20
2.
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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	07022010	07022010	11		97113		1	264.00	4		NPI	
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: 721567165 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 417579C

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

28. TOTAL CHARGE: $ 264.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 264.00

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.)
STEVEN S NIETO
09032010
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
TOTAL WELLNESS-RIVERSIDE
3191 B. MISSION INN AVE
RIVERSIDE, CA 92507
1922299338 b.

33. BILLING PROVIDER INFO & PH # 9516842874
TOTAL WELLNESS INC
3191 B MISSION INN AVE
RIVERSIDE, CA 92507
1922299338 b. 721567165

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PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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7408 W SAHARA AVE
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1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): N/A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ, ENRIQUE

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

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

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

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

CITY: [redacted] STATE: [redacted]

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

CITY: [redacted] STATE: [redacted]

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

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

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

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: [redacted] SEX M [X] 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 [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: 09032010

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 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 PROVIDER OR OTHER SOURCE: GOVIND KOKA DO

17a.

17b. NPI

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. 337.20
2.
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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07052010 07052010	11		97113		1	264.00	4		NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER: 721567165 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 417583C

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

28. TOTAL CHARGE: $ 264.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 264.00

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.)
STEVEN S NIETO
SIGNED 09032010 DATE

32. SERVICE FACILITY LOCATION INFORMATION
TOTAL WELLNESS-RIVERSIDE
3191 B. MISSION INN AVE
RIVERSIDE, CA 92507
a. 1922299338 b.

33. BILLING PROVIDER INFO & PH #: 9516942874
TOTAL WELLNESS INC
3191 B MISSION INN AVE
RIVERSIDE, CA 92507
a. 1922299338 b. 721567165

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

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7408 W SAHARA AVE
LAS VEGAS, NV 89117

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): N/A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ, ENRIQUE

3. PATIENT'S BIRTH DATE MM DD YY [redacted] SEX M X F

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

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

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

CITY: [redacted] STATE: [redacted]

8. PATIENT STATUS: Single Married Other X

CITY: [redacted] STATE: [redacted]

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

Employed Full-Time Student Part-Time Student

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

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 [redacted] SEX M X 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? 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 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: 09032010

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 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 PROVIDER OR OTHER SOURCE: GOVIND KOKA DO

17a.

17b. NPI

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

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. 337.20
2.
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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Fam. Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07142010	07142010	11		97113		1	264.00	4		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 721567165 SSN EIN X

26. PATIENT'S ACCOUNT NO.: 420699C

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

28. TOTAL CHARGE: $ 264.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 264.00

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.)

STEVEN S NIETO
09032010
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
TOTAL WELLNESS-RIVERSIDE
3191 B. MISSION INN AVE
RIVERSIDE, CA 92507
a. 1922299338 b.

33. BILLING PROVIDER INFO & PH # 9516842874
TOTAL WELLNESS INC
3191 B MISSION INN AVE
RIVERSIDE, CA 92507
a. 1922299338 b. 721567165

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PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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BENSON BERTOLDO BAKER & CARTER

7408 W SAHARA AVE
LAS VEGAS, NV 89117

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA [ ] | PICA [ ]

CARRIER

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): N/A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ, ENRIQUE

3. PATIENT'S BIRTH DATE MM DD YY [redacted] SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

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

CITY: [redacted] STATE: [redacted]

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

CITY: [redacted] STATE: [redacted]

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

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 [redacted] SEX M [X] 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? [ ] 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 [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: 09032010

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

PHYSICIAN OR SUPPLIER INFORMATION

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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: GOVIND KOKA DO

17a.

17b. NPI

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

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. 337.20
2.
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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 07192010	07192010	11		97113		1	264.00	4		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 721567165 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 426061C

27. ACCEPT ASSIGNMENT? (For Govt. Claims, See back) [X] YES [ ] NO

28. TOTAL CHARGE: $ 264.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 264.00

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.)

STEVEN S NIETO
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SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
TOTAL WELLNESS-RIVERSIDE
3191 B. MISSION INN AVE
RIVERSIDE, CA 92507
a. 1922299338 b.

33. BILLING PROVIDER INFO & PH # 9516842874
TOTAL WELLNESS INC
3191 B MISSION INN AVE
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LAS VEGAS, NV 89117

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA [ ] [ ] | PICA [ ] [ ]

CARRIER

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): N/A

PATIENT AND INSURED INFORMATION

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ, ENRIQUE

3. PATIENT'S BIRTH DATE MM DD YY [redacted] SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

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

CITY [redacted] STATE [redacted]

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

CITY [redacted] STATE [redacted]

ZIP CODE [redacted] TELEPHONE (Include Area Code) [redacted]

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

ZIP CODE [redacted] TELEPHONE (Include Area Code) [redacted]

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 [redacted] SEX M [X] 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 [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 09032010

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

PHYSICIAN OR SUPPLIER INFORMATION

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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: GOVIND KOKA DO

17a.

17b. NPI

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 [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by Line)

1. 337.20
2.
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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Fam'y Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07212010	07212010	11		97113		1	264.00	4		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER 721567165 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO. 426062C

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

28. TOTAL CHARGE $ 264.00

29. AMOUNT PAID $ 0.00

30. BALANCE DUE $ 264.00

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.)
STEVEN S NIETO
09032010
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
TOTAL WELLNESS-RIVERSIDE
3191 B. MISSION INN AVE
RIVERSIDE, CA 92507
1922299338 b.

33. BILLING PROVIDER INFO & PH # 9516842874
TOTAL WELLNESS INC
3191 B MISSION INN AVE
RIVERSIDE, CA 92507
1922299338 b.721567165

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Total Wellness 0000006

BENSON BERTOLDO BAKER & CARTER

7408 W SAHARA AVE
LAS VEGAS, NV 89117

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): N/A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ, ENRIQUE

3. PATIENT'S BIRTH DATE MM DD YY [redacted] SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

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

CITY: [redacted] STATE: [redacted]

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

CITY: [redacted] STATE: [redacted]

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

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 [redacted] SEX M [X] 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 [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: 09032010

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 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 PROVIDER OR OTHER SOURCE: GOVIND KOKA DO

17a.

17b. NPI

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 [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by Line)

1. 337.20
2.
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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07262010	07262010	11		97113		1	264.00	4		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 721567165 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 429216C

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

28. TOTAL CHARGE: $ 264.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 264.00

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.)

STEVEN S NIETO
09032010
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
TOTAL WELLNESS-RIVERSIDE
3191 B. MISSION INN AVE
RIVERSIDE, CA 92507
a. 1922299338 b.

33. BILLING PROVIDER INFO & PH # 9516842874
TOTAL WELLNESS INC
3191 B MISSION INN AVE
RIVERSIDE, CA 92507
a. 1922299338 b. 721567165

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

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BENSON BERTOLDO BAKER & CARTER

7408 W SAHARA AVE
LAS VEGAS, NV 89117

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): N/A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ, ENRIQUE

3. PATIENT'S BIRTH DATE MM DD YY [redacted] SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

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

CITY: [redacted] STATE: [redacted]

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

CITY: [redacted] STATE: [redacted]

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

c. EMPLOYER'S NAME OR SCHOOL NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]

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

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

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER:

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

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. INSURANCE PLAN NAME OR PROGRAM NAME:

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: 09032010

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 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 PROVIDER OR OTHER SOURCE: GOVIND KOKA DO

17a.

17b. NPI

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 [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 337.20
2.
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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Fam. Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07302010	07302010	11		97113		1	264.00	4		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 721567165 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 429222C

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

28. TOTAL CHARGE: $ 264.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 264.00

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.)
STEVEN S NIETO
SIGNED DATE: 09032010

32. SERVICE FACILITY LOCATION INFORMATION
TOTAL WELLNESS-RIVERSIDE
3191 B. MISSION INN AVE
RIVERSIDE, CA 92507
a. 1922299338 b.

33. BILLING PROVIDER INFO & PH #: 9516842874
TOTAL WELLNESS INC
3191 B MISSION INN AVE
RIVERSIDE, CA 92507
a. 1922299338 b. 721567165

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

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ATTY: BENSON/BERTOL /BAKER/CART
7408 W SAHARA AVE

LAS VEGAS, NV
891172740

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): 7

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ, ENRIQUE

3. PATIENT'S BIRTH DATE MM DD YY SEX [X] F

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

5. PATIENT'S ADDRESS (No., Street): 6667 INDIANA AVE APT 247F

CITY: RIVERSIDE, CA STATE

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

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

CITY STATE

ZIP CODE: 925060000 TELEPHONE (Include Area Code):

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

ZIP CODE: 925060000 TELEPHONE (INCLUDE AREA CODE): (9519610805

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

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

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

c. OTHER ACCIDENT? YES [X] NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

b. EMPLOYER'S NAME OR SCHOOL NAME: SELF EMPLOYED

c. INSURANCE PLAN NAME OR PROGRAM NAME: ATTY: BENSON/BERTOLDO/BAKER/CAR

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 072005

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 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: NATHAN HEAPS

17a. I.D. NUMBER OF REFERRING PHYSICIAN: H95537

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 11 22 04 TO MM DD YY

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. 844.9
2.
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 22 04		23	4	73564	26 LT	1	4300	1		Y		36698
					KNEE COMPLETE F								
2													
3													
4													
5													
6													

25. FEDERAL TAX I.D. NUMBER: 880098322 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: DR1762734

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

28. TOTAL CHARGE: $ 4300

29. AMOUNT PAID: $

30. BALANCE DUE: $ 4300

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.)

MICHAEL SCHUNK MD

SIGNED 072005 DATE

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

SPRING VALLEY HOSPITAL ER
111 RAINBOW BLVD
LAS VEGAS, NV 891170000

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, & PHONE #: 7022870868

DESERT RADIOLOGISTS
3090 S DURANGO STE200
LAS VEGAS, NV 891170000

PIN# 36698 GRP# WCCBT

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APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Desert Radiologist 0000002

HCI # 28 I

SPRING VALLEY HOSP MED CNTR
FILE 57361
LOS ANGELES,CA 90074 89119-5188
702 834-5700
FEI # 72-1549782

PAGE NO. 1

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
CYCLE	11/27/04	
INS.		

DISCHARGE DATE 13

HOSP.NO. CC6350

F	T	PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS	OUT PATIENT
		RODRIGUEZ ,ENRIQUE	900343948	M	41	11/22/04			

GUAR. PH.

GUARANTOR NAME AND ADDRESS: ENRIQUE RODRIGUEZ

C.O.B.	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	PRIVATE PAY		

AMOUNT OF PAYMENT $

DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
	DETAIL OF CURRENT CHARGES, PAYMENTS AND ADJUSTMENTS							
11/23	70541719 001		63.00	63.00				
	KNEE IMMBLZER UNIV	272						
11/22	53219150 001 73564		316.00	316.00				
	XR KNEE 4V LT	320						
11/22	43014901 001 29530		141.00	141.00				
	STRAPPING KNEE	450						
11/22	43022458 001 99284		673.00	673.00				
	LEVEL 4 ED W/ PROCEDURES	450						
11/23	54043971 001		3.00	3.00				
	HYDROCOD BT/APAP 5-500 1TB	637						
11/23	54046032 002		6.00	6.00				
	IBUPROFEN 400MG 1TB	637						
	BALANCE FORWARD			1202.00-				1202.00
	SUMMARY OF CURRENT CHARGES							
	MED/SURG SUPPLY		63.00	63.00				
	RADIOLOGY		316.00	316.00				
	EMERGENCY ROOM		814.00	814.00				
	PHARM OTHER		9.00	9.00				
	SUB-TOTAL OF CURR. CHARGES		1202.00	1202.00				
	EMPLOYER INFORMATION: ENRIQUE RODRIGUEZ							
	6							
	AMOUNTS DUE HEREUNDER HAVE BEEN ASSIGNED TO UHS RECEIVABLES CORP. & US BANK, N.A. AS TRUSTEE							
	T O T A L S		1202.00					1202.00

PATIENT NUMBER 900343948

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

SPRING VALLEY HOSP MED CNTR
LOS ANGELES,CA 90074

HCI # 28 1

SPRING VALLEY HOSP MED CNTR
FILE 57361
LOS ANGELES,CA 90074
702 894-5700
FEI # 72-1549752

89119-5188

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
CYCLE	11/27/04	
INS.		

PAGE NO. 2

HOSP.NO. CC6350

F T PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS	OUT PATIENT
RODRIGUEZ ENRIQUE	900343948	M	41	11/22/04			

GUAR PH

GUARANTOR NAME AND ADDRESS: ENRIQUE RODRIGUEZ [illegible] 7F

CODE	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	PRIVATE PAY		

AMOUNT OF PAYMENT $

DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
GUAR RELATIONSHIP: S	SEX: M		GUAR NO: 5622947 67					
ACC DATE: 11/22/04	TYPE: E	TIME: 7:15 PM	PLACE:			EMPL REL: N		
DIAGNOSIS:	844.9	KNEE & LEG SPRAIN NOS						
	719.46	JOINT PAIN-LOWER LEG						
PROCEDURE: 93.59	11/22/04	IMMOB/PRESS/WND ATTN NEC						
T O T A L S			1202.00					1202.00

PATIENT NUMBER
900343948

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

SPRING VALLEY HOSP MED CNTR
LOS ANGELES,CA 90074

SHADOW EMERGENCY PHYSICIANS VSD
PO BOX 13917
PHILADELPHIA, PA 19101-3917

TAX ID# 75-2807737

STATEMENT OF ACCOUNT (4)

Statement Date: 10/03/09

Payments received after this date will appear on your next statement

Account Number: VSD900343948

Patient Name: ENRIQUE RODRIGUEZ

Guarantor:

221904-0000900343948-06

#BWNJFDB
#00000VSD10419988#
ENRIQUE RODRIGUEZ

Account Summary

Account Balance:	0.00
Amount Pending Insurance:	0.00
Amount Due from Patient (Current):	0.00
Amount Due from Patient (Past Due):	0.00

YOUR ACCOUNT IS NOW SERIOUSLY PAST DUE, AND A DELINQUENCY REVIEW IS BEING CONDUCTED.

Pay this amount: **0.00**

Account Detail

Please refer to the coupon below for payment instructions.

DATE	#	DESCRIPTION	CHARGE	PAID BY FIRST INS.	PAID BY OTHER INS.	PAID BY PATIENT	AMOUNT ADJUSTED	DUE FROM INSURANCE	PATIENT BALANCE
11/22/04	1	99283 EMERG INJURY EVAL & MGMT-LVL 3 DX:844.9 DR. HEAPS/SPRING VALLEY MEDICAL CENTER	275.00						
12/21/05		COLLECTION BAD DEBT					275.00 -		0.00
11/22/04	2	99052 SERVICES REQUESTED 10PM-8AM DX:844.9 DR. HEAPS/SPRING VALLEY MEDICAL CENTER	25.00						
12/21/05		COLLECTION BAD DEBT					25.00 -		0.00
		THIS STATEMENT MAY NOT REFLECT ANY PAYMENTS YOU MADE AT TIME OF SERVICE.							
		Totals	300.00	0.00	0.00	0.00	300.00 -	0.00	0.00

Important Messages:

This statement is for the direct treatment and/or supervision of care you recently received from an Emergency Physician at Spring Valley Medical Center. The fees for this private physician are billed separately from any hospital charges or other professional fees for which you may also be responsible. Therefore, should you receive a bill from the hospital or other physicians for charges in connection with this visit, it will not include the items listed on this statement.

"Payment Plans" Accepted

Question about this statement? / Llame de Lunes a Viernes? Call 1-800-355-2470 Monday through Friday 7:00AM - 3:00PM. Your automated system access code is 0203-900343948, or you can send email to billing_questions@emcare.com.

PLEASE DETACH AND RETURN BOTTOM PORTION WITH YOUR REMITTANCE.

Statement Date: 10/03/09 (4)

Account Number: VSD900343948

Patient Name: ENRIQUE RODRIGUEZ

Guarantor:

ENRIQUE RODRIGUEZ
6667 INDIANA AVE APT 247F
RIVERSIDE, CA 92506

Payment Due By /	PAST DUE
Amount Due /	0.00
Amount Enclosed /	

Insurance information not on file

The insurance information in our file appears to the right. Please make any corrections and/or additions on the reverse side of this form and return it to us. Thank you.

YOU MAY PAY THIS BILL WITH YOUR CREDIT CARD PLEASE SEE REVERSE SIDE.

221904000090034394800000000000000000000006

Make Check/Money Order payable to :

☐ *If your address has changed, check this box and complete the reverse side of this form.*

SHADOW EMERGENCY PHYSICIANS VSD
PO BOX 13917
PHILADELPHIA, PA 19101-3917

Shadow Emergency 0000001

Patient Account Le[illegible]r

Physicians Management Solution
6700 Indiana Ave., Suite 145
Riverside, CA , 92506
(909) 788-9502 Fax: (909) 788-9632
Fed Tax ID # 573-92-2282

Patient	
Enrique Rodriguez	
6	

Visit ID	Medical Record Number	Social Security Number
4437		000-00-0000

Date	Invoice	CPT Code	Description	Qty	Amount	Balance
12/06/2004	17488	99244	(J Nork - 924.11) Office Consult Comprehensive	1	600.00	600.00
01/17/2005	17520	99213	(J Nork - 844.8) Established Office Visit Intermediate	1	67.59	667.59

01/21/2005 10:57:29 AM

lien [illegible]

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

CORY JONES ATTY
4475 S PELOS RD
LAS VEGAS, NV 89121

CARRIER

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 (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ, ENRIQUE J

3. PATIENT'S BIRTH DATE: N

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

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

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

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

CITY: JE | STATE: CA

ZIP CODE: 92506 | TELEPHONE (INCLUDE AREA CODE): ( ) 4

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

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

ZIP CODE: 92506 | TELEPHONE (INCLUDE AREA CODE): ( )

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

c. EMPLOYER'S NAME OR SCHOOL NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10. IS PATIENT'S CONDITION RELATED TO:

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

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

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

10d. RESERVED FOR LOCAL USE:

INSURED'S POLICY GROUP OR FECA NUMBER:

INSURED'S DATE OF BIRTH: SEX M [X] F [ ]

EMPLOYER'S NAME OR SCHOOL NAME:

INSURANCE PLAN NAME OR PROGRAM NAME: CORY JONES ATTY

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 the claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE | DATE: 07/27/05

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 — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

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

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

HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: ERIC CAMPBELL, MD

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

OUTSIDE LAB? YES [ ] NO [X] | $ CHARGES: 0.00

18. RESERVED FOR LOCAL USE:

MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.:

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

1. 71946 PAIN IN JOINT LOWE
2.
3.
4.

PRIOR AUTHORIZATION NUMBER:

24A 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
01 28 05	01 28 05	11	4	73675		1	550.00	1				
01 28 05	01 28 05	11	4	73721		1	1800.00	1				

25. FEDERAL TAX I.D. NUMBER: 943314077 | SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 37794

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

28. TOTAL CHARGE: $ 2350.00 | 29. AMOUNT PAID: $ 0.00 | 30. BALANCE DUE: $ 2350.00

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.)

CHRISTOPHER D VALLI

07/27/05

SIGNED | DATE

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

Open MRI of Inland Valley
36450 Inland Valley Dr#10
WILDOMAR, CA 92595
9433140

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

Open MRI of Inland Valley R
44274 George Cushman #108
Temecula, CA 92592
(909) 677-3192

PIN# | 943314077 GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
Mfd. by Medical Arts Press

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500
#29425 — Medical Arts Press
Use with Formset #14145 (laser) or #14146 (ink-jet)

Open MRI 0000001

REDHAWK IMAGING
*** Account Ledger ***

uly 22, 2005

'atient: # 37794 - RODRIGUEZ, ENRIQUE J
NCLUDED: Unapplieds, Refunds, Payment Summary Paid All Dates; Charge History, including Cre lin j Pmts, Closed Chgs, Cap Chgs, Pending Chgs,
Billing Info; Open Charges Performed All Dates; Closed/Cap Charges Performed All Dates

Date	Description	Prov	Dept	Responsibility/Payor	Amount	Left/Used	Balance
----	CHARGE HISTORY						
)1/28/05	73721 - MRI JOINT OF LWR EXTRE W	1	1	1-CORY JONES ATT\	1800.00	1800.00	1800.00
)2/03/05	Billed to CORY JONES ATTY						
)1/28/05	76375 - 3D/HOLOGRAPH RECONSTR	1	1	1-CORY JONES ATT\	550.00	550.00	2350.00
)2/03/05	Billed to CORY JONES ATTY						

Open MRI 0000002

ITEMIZED STATEMENT

03-09-07

REPLY TO / MAILING ADDRESS:	PATIENT INFORMATION:
Eric E. Campbell,DC QME P.O. Box 639 Wildomar, CA 92595 Ph# (951) 245-5130 Lic # DC22977 Tax ID: 33-0967757	Enrique (Henry) Rodriguez RE: Enrique (Henry) Rodriguez GRP/CLM # ATTY: JONATHAN WEBER
RECORDS LOCATION:	**BILLING INFORMATION:**
The Wellness Group 34740 Via Carnaghi Wildomar, Ca. 92595 (951) 245-5130 (951) 674-1111 fax	Benson,Bertoldo,Baker&Carter 7408 W. Sahara Ave. Las Vegas, NV 89117

DATE OF INJURY/ILLNESS : 11-22-04

DATE OF FIRST CONSULTATION : 01-24-05

DIAGNOSIS :

1. E886 Fall after collision with other person
2. 726.60 Bursitis, knee -L
3. 716.66 Inflammation of the Knee -L
4. 924.11 Contusion, Knee -L
5. 719.56 Stiffness, Knee -L
6. 844.9 Sprain/Strain, Knee or Leg -L

Date	RVS/CPT	Description	Amount
01-24-05	99204	Initial O.V., Moderate	150.00
02-01-05	97530	Therapeutic Activities	55.00
02-01-05	97139	Cold Laser Therapy	25.00
02-01-05	97014	Electrical Stim. (unattended)	25.00
02-01-05	L1830	Knee Support/Brace	17.00
			272.00

TOTAL BALANCE DUE : 272.00

Wellness Center 0000001

ITEMIZED STATEMENT

10-18-07

REPLY TO / MAILING ADDRESS:	PATIENT INFORMATION:
William E. Simpson, M.D. 21504 S. Avalon Blvd.,#200 Carson, CA 90746 Ph# (310) 518-1300 Lic # G43101 Tax ID: 56-2494623	Enrique (Henry) Rodriguez 7F 6 RE: Enrique (Henry) Rodriguez GRP/CLM # ATTY: JONATHAN WEBER
RECORDS LOCATION:	**BILLING INFORMATION:**
William Simpson, M.D. 21504 S. Avalon Blvd.,#200 Carson, CA 90746 (310)518-1300	Benson,Bertoldo,Baker&Carter 7408 W. Sahara Ave. Las Vegas, NV 89117

DATE OF INJURY/ILLNESS : 11-22-04 DATE OF FIRST CONSULTATION : 02-01-04

COMMENTS :

REFERRED BY DR ERIC CAMPBELL

DIAGNOSIS :

1. E886 Fall after collision with other person
2. 726.60 Bursitis, knee - Left
3. 716.66 Inflammation of the Knee - Left
4. 924.11 Contusion, Knee - Left
5. 719.56 Stiffness, Knee - Left
6. 844.9 Sprain/Strain, Knee - Left

Date	RVS/CPT	Description	Amount
02-01-05	99204	Initial O.V., Moderate	150.00
02-15-05	99214	Follow-up O.V., Complex	65.00
			215.00

TOTAL BALANCE DUE : 215.00

This fax was received by GFI FAXmaker fax server. For more information, visit: http://www.gfi.com

FP1398

Wellness Center 0000010

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

W JONATHAN WEBER ESQ
BENSON BERTOLDO BAKER & CARTER
7408 WEST SAHARA AVE
LAS VEGAS NV 89117

CLAIM NO:
ADJUSTER:
EMPLOYER:

PATIENT:
ENRIQUE RODRIGUEZ 589 PI

BIRTHDAY:
SEX:M
RELATIONSHIP:

INSURED:
I.D.#
GROUP:

OTHER INSURANCE:

WORK INJURY: NO
AUTO ACCIDENT: NO

INSUREDS ADDRESS:

RELEASE OF INFORMATION:ON FILE

ASSIGNMENT OF BENEFITS: ON FILE

ILLNESS/ACC DATE:11 22 2004

FIRST TREATMENT:02-19-2005

DIAGNOSIS:
844 8 SPRAIN/STRAIN KNEE/LEG
924 11 CONTUSION OF THE LOWER LIMB KNEE
716 96 INFLAMMATION KNEE/LEG
726 60 BURSITIS KNEE

DATE	DESCRIPTION	PROC CODE	AMOUNT
02-19-2005	*MRI/CT 2nd Opinion	76140	500.00
		TOTAL	$ 500.00

DATE:09 06 05

Employer ID No
88-0498593
Social Sec No

Vision Radiology Consultants
2600 Associated Rd A 50
Fullerton, CA 92835
714-529-6924

Steven L. Weiner, DC, DACBR

Vision Radiology Consultants 0000001

VQ OrthoCare

Orthopedic Surgical & Rehabilitation Products

AdvaMed MEMBER

CHRP accredited

18011 Mitchell South Irvine, CA 92614-6007
Tel: (949) - 261 3000 Fax: (949) - 261 - 3010

Bil g/Lien Statement

Tax ID #	VQ Acct #	Date
33-0350172	95013	10/24/2005

Claimant: ENRIQUEZ-RODRIGUEZ
SS:
Claim:
DOI: 11/24/2004
Employer: LPI

Bill To: CURRY M JONES ESQ
4475 S PECOS DR
LAS VEGAS NV, 89144

ATTN:

Invoice	DOS	Billing Code	Days or Units	Description	Charge	Payment/ Adjustment	Balance
O1062570	04/19/2005	L1858	1	BRACE KNEE EAGLE LEFT	1,495.00		1,495.00
O1062570	04/19/2005	A9901	1	NON-ROUTINE SERV REQ TECH SKILL	93.75		93.75
O1062570				ALLOWABLE ADJUSTMENT		0.00	

Totals:	$1,588.75	$0.00	$1,588.75
	Charge	Payment/ Adjustment	Balance

Billings over 60 days old have been previously submitted with Proof of Service. Our records indicate you have either submitted no objection to the bills and the time for objections has expired; or your objection is invalid, unmeritorious, and/or frivolous. Labor code requires late payments include self-assessed penalties and interest.

PLEASE include the VQ account number 95013 on checks and correspondence

VQ Orthocare 0000001

I V LEAGUE, INC.

6076 BRISTOL PKWY. SUITE 104
CULVER CITY, CA 90230
(310) 645-1500

Date	Invoice #
9/28/2005	22918

Bill To

RODRIQUEZ. ENRIQUE

P.O. No.	Terms	Project

Quantity	Description	Rate	Amount
14	LOVENOX 40MG 9/22-10/5/05	49.00	686.0
2	NURSING VISIT	100.00	200.0

YOUR PROMPT PAYMENT IS GREATLY APPRECIATED. WE ACCEPT VISA/MASTERCARD FOR YOUR CONVENIENCE.

Total $886

IV league 0000001

PLEASE DO NOT STAPLE IN THIS AREA

ATT LIEN JONATHAN
7400 W SAHARA AVE.
LAS VEGAS CA 89117 7022282600

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): AA451858

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ, ENRIQUE

3. PATIENT'S BIRTH DATE SEX X M F

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

5.

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

7. STATE CA

8. PATIENT STATUS: Single Married X Other

Employed Full-Time Student Part-Time Student

ZIP 50744

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

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) X NO

b. AUTO ACCIDENT? X NO PLACE (State)

c. OTHER ACCIDENT? X NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

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 On File 9/24/05
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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: HERNANDEZ, JUAN

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 X NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 3.
2. 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 22 05 10 05 05	12		S9372		1	158 56	14				
2 09 22 05 10 05 05	12		J1650		1	1561 35	56				
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER 95-4713173 SSN EIN X

26. PATIENT'S ACCOUNT NO. 128232

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

28. TOTAL CHARGE $ 1719 91

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 1719 91

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.)
SIGNED DATE 10 5 05

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
IVleague Pharmacy
6076 Bristol Pkwy, Suite 104
Culver City, CA 90230 310.645.1500
4364730001
PIN#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM (APPROVED OMB-1215-0055 FORM (FP1381

PATIENT AND INSURED INFORMATION — CARRIER

PHYSICIAN OR SUPPLIER INFORMATION

IV league 0000019

PLEASE DO NOT STAPLE IN THIS AREA

ATT LIEN JONATHAN ER
7408 W SAHARA AVE.
LAS VEGAS CA 89117 7022282600

APPROVED OMB-0938-0008

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 (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): AA451858

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ ENRIQUE

3. PATIENT'S BIRTH DATE SEX: M X F

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

5. PATIENT'S ADDRESS (No., Street)

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

7.

STATE: CA

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

STATE: CA

ZIP CODE: 90744

ZIP CODE: 90744 TELEPHONE (INCLUDE AREA CODE): (310) 463-3655

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: NONE

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 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.
SIGNED: Signature On File DATE: 12/28/05

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 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: SHANNON, MARY AN

17a. I.D. NUMBER OF REFERRING PHYSICIAN: D60867

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. 727.00 2. 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 24 05 09 25 05	12		99601		1	55000	2				
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER: 95-4713173 SSN EIN X

26. PATIENT'S ACCOUNT NO.: 132444

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

28. TOTAL CHARGE: $ 55000

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 55000

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.)
SIGNED: DATE: 12 7 05

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
IV League Pharmacy
6076 Bristol Pkwy. Suite 104
Culver City, CA 90230 310.645.1500
PIN# 4364730001 GRP#

CARRIER — 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 APPROVED OMB-1215-0055 FORM FP1382

IV league 0000020

VHMC-RODRIGUEZ, ENRIQUE-Enc #107839359-OPT-ASC-10/1/2005 UB92 EDITTED - 10/9/2005 - 1 pg

APPROVED OMB NO. 0938-0279

1 VALLEY HOSPITAL MED CTR
FILE 50026
LOS ANGELES CA 90074
7028945700 7023697591

3 PATIENT CONTROL NO. 107839359 — 4 TYPE OF BILL 131

5 FED. TAX NO. 232973511 — PATIENT COVERED — 100405 100405

12 PATIENT NAME: RODRIGUEZ, ENRIQUE

13 PATIENT ADDRESS

14 BIRTHDATE 3 — 15 SEX M — 16 ADMISSION DATE U 100405 — 06 — 1 — 17 STAT 01 — 18 MEDICAL RECORD NO. 8323803

CODE 11 DATE 100405

38 VALUE CODES AMOUNT — 39 VALUE CODES AMOUNT — 40 VALUE CODES AMOUNT

42 REV.CD	43 DESCRIPTION	44 HCPCS/RATE	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	48 NON-COVD CHRGS	49
0636	DRUGS/DETAIL CODE	J2765	100405	1	10.00		
0636	DRUGS/DETAIL CODE	J3010	100405	3	15.00		
0710	RECOVERY ROOM		100405	4	1356.00		
0730	EKG/ECG	93005			279.00		
0001	TOTAL CHARGES				15999.00		

50 PAYER: MED CARE SOLUTI — 51 PROVIDER NO. — 54 PRIOR PAYMENTS — 55 EST. AMOUNT DUE — 56

DUE FROM PATIENT

58 INSURED'S NAME: RODRIGUEZ,ENRIQUE — 59 P.REL 01 — 61 GROUP NAME — 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES: APPROVED — 65 EMPLOYER NAME — 66 EMPLOYER LOCATION

67 PRIN DIAG.CD 7172 — 68 7183 — 69 72700 — 70 71696 — 74 PRIN.PROC.CD 7179

77 P.C. — 80 PRINCIPAL PROCEDURE CODE 9 806 — DATE 100405 — 81 OTHER PROCEDURE A 8076 — DATE 100405 — B — OTHER PROCEDURE C — D — OTHER PROCEDURE E

84 REMARKS
MED CARE SOLUTI
10120 WFLAMINGO RD
SUITE 412
LAS VEGAS NV 89147

85 PROVIDER REPRESENTATIVE — DATE 10/09/05

UB 92 HCFA-1450 PAYER COPY

Page 1 of 1

MED CARE SOLUTIONS LLC-00015

VHMC-RODRIGUEZ, ENRIQUE-Enc #107839359-OPT-ASC-10/9/2005 UB92 EDITTED - 10/9/2005 - 1 pg

1 VALLEY HOSPITAL MED CTR
FILE 50026
LOS ANGELES CA 90074
7028945700 7023697591

3 PATIENT CONTROL NO. 107839359 | 131

5 FED. TAX NO. 232973511 | 6 STATEMENT COVERS PERIOD 100405 100405

12 PATIENT NAME: RODRIGUEZ, ENRIQUE

13 PATIENT ADDRESS

14 BIRTHDATE | 15 SEX M | 16 DATE | 17 STAT | 18 SOURCE | 19 PATIENT STATUS 01 | 20 HOSP. UNIT NO. 3323803

28 CODE	DATE	29 OCCURRENCE CODE	DATE	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 CODE	OCCURRENCE CODE	DATE
11	100405									

50 RODRIGUEZ, ENRIQUE E

42 REV.CD	43 DESCRIPTION	44 HCPCS/RATE	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	48 NON-COV'D CHRGS	49
0250	PHARMACY		100405	12	1776.00		
0258	IV SOLUTIONS		100405	1	1321.00		
0271	NON-STER SUPPLY		100405	6	73.00		
0272	STERILE SUPPLY		100405	10	2536.00		
0300	LABORATORY OR LAB	36415		1	11.00		
0300	LABORATORY OR LAB	80053		1	288.00		
0301	LAB/CHEMISTRY	82465		1	122.00		
0301	LAB/CHEMISTRY	84478		1	254.00		
0301	LAB/CHEMISTRY	84550		1	122.00		
0305	LAB/HEMATOLOGY	85025		1	185.00		
0307	LAB/UROLOGY	81001		1	18.00		
0320	DX X-RAY	71020		1	300.00		
0360	OR SERVICES	29881 LT	100405	1	3670.07		
0360	OR SERVICES	29870 LT		1	1835.33		
0370	ANESTHESIA		100405	4	2024.00		
0636	DRUGS/DETAIL CODE	J0330	100405	10	53.00		
0636	DRUGS/DETAIL CODE	J0690	100405	2	132.00		
0636	DRUGS/DETAIL CODE	J1260	100405	1	267.00		
0636	DRUGS/DETAIL CODE	J1650	100405	4	289.00		
0636	DRUGS/DETAIL CODE	J2001	100405	40	16.00		
0636	DRUGS/DETAIL CODE	J2250	100405	2	65.00		
0636	DRUGS/DETAIL CODE	J2270	100405	2	26.00		
0636	DRUGS/DETAIL CODE	J2710	100405	20	139.00		

50 PAYER: MED CARE SOLUTI | 51 PROVIDER NO. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56

DUE FROM PATIENT

60 INSURED'S NAME: RODRIGUEZ,ENRIQUE | 61 POLICY GROUP OR FECA NO. | 62 INSURANCE GROUP NO. | 63 GROUP NAME

63 TREATMENT AUTHORIZATION CODES: APPROVED | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION

67 PRIN. DIAG. CD: 7172 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 ADM. DIAG. CD: 7179 | 77 E-CODE | 78

79 P.C. NO | PRINCIPAL PROCEDURE CODE | PROCEDURE DATE | A OTHER PROCEDURE CODE | DATE | B OTHER PROCEDURE CODE | DATE
806 | 100405 | 8076 | 100405

C OTHER PROCEDURE CODE | DATE | D OTHER PROCEDURE CODE | DATE | E OTHER PROCEDURE CODE | DATE

80 ATTENDING PHYS. ID: D60887 SHANNON MARY
81 OTHER PHYS. ID (A): D60887 SHANNON MARY
82 OTHER PHYS. ID (B):

84 REMARKS: MED CARE SOLUTI
10120 WFLAMINGO RD
SUITE 412
LAS VEGAS NV 89147

97 PROVIDER REPRESENTATIVE: XN | 98 DATE: 10/09/05

UB 92 HCFA 1450 PAYER COPY

Page 1 of 1

MED CARE SOLUTIONS LLC-00016

HCI # 20 | VALLEY HOSPITAL MED CTR | PAGE NO. 1

P.O. BOX 98531
LAS VEGAS, NV
702-094-5700
FED # 232297011

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
CYCLE	10/09/05	
INS.		

BIRTH DATE | HOSP.NO.

H	S	PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS	
		RODRIGUEZ ,ENRIQUE	107839359	M	42	10/04/05			OUT PATIENT

GUAR.PH

GUARANTOR NAME AND ADDRESS: ENRIQUE RODRIGUEZ

CLOSE#	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	MED-CARE		

AMOUNT OF PAYMENT $

DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
	DETAIL OF CURRENT CHARGES, PAYMENTS AND ADJUSTMENTS							
10/04	69801009 001							
	OUTPATIENT SURGERY STAT CHARGE							
10/04	54049952 001		400.00	400.00				
	LABETALOL HCL 5MG/ML 20ML VIAL							
10/04	54051834 001		39.00	39.00				
	LIDOCAINE HCL 40MG/ML 50ML 250							
10/04	54096979 001		216.00	216.00				
	CISATRACURIUM 2MG/ML 5ML	250						
10/04	54098637 001		177.00	177.00				
	PROPOFOL 10MG/ML 20ML VIAL							
10/04	54104708 001		242.00	242.00				
	ELECTROLYTE-S PH7.4 1000ML BAG							
10/04	54302310 001		631.00	631.00				
	METHYLPRED ACT 80MG/ML 1ML 250							
10/04	54302559 001		46.00	46.00				
	FAMOTIDINE 10MG/ML 2ML VIAL							
10/04	54303326 003		186.00	186.00				
	BUPIVACAINE 0.5% W/EPI 10ML250							
10/04	54308044 003		81.00	81.00				
	GLYCOPYRROLATE 0.2MG/ML 1ML VL							
10/04	70500525 001		1043.00	1043.00				
	TAC-S THERMAL PROBE	272						
10/04	70505086 001		64.00	64.00				
	KNEE IMMOB. 3870-00	272						
10/04	70505300 001		121.00	121.00				
	CUFF TOURNIQUET 12-42" DPSB	272						
10/04	70514088 001		218.00	218.00				
	CUTTER AGGR PLUS	272						
10/04	70519160 001		45.00	45.00				
	LMA AIRWAY LARG MASK	272						
10/04	70523386 001		268.00	268.00				
	ARTHROSCOPY TUBING SET #C71	272						
10/04	70532304 002		26.00	26.00				
	GLOVE BIOGEL ALL SIZES	272						

PATIENT NUMBER

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI # 28 1

[illegible] HOSPITAL MED CTR
P O BOX 98581
LAS VEGAS, NV 89193-8581
702 892 5700
FEI # 23-29[illegible]

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
CYCLE	10/09/05	
INS.		

PAGE NO. 2

BIRTH-DATE

HOSP.NO.

H	S	PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	PAYG	
RODRIGUEZ , ENRIQUE			107839359	M	42	10/04/05			OUT PATIENT

GUARANTOR NAME AND ADDRESS: ENRIQUE RODRIGUEZ

CODE	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	MED-CARE		

AMOUNT OF PAYMENT: 0

DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
10/04	70532304 001		13.00	13.00				
GLOVE	BIOGEL ALL SIZES	272						
10/04	70553045 001		395.00	395.00				
PACK	ARTHROSCOPY	272						
10/04	70559653 001		54.00	54.00				
SYRINGE	20 CC MONOJECT	272						
10/04	70569819 001		27.00	27.00				
STOCKINETTE	IMPERVIOUS	1587271						
10/04	70571302 001		11.00	11.00				
SUCTION	CANNISTER 2000CC	40271						
10/04	70582622 001		6.00	6.00				
CAST	SPECIALIST	271						
10/04	70583463 002		26.00	26.00				
SUCTION	CANNISTER 3000CC	271						
10/04	70587555 001		29.00	29.00				
DURA	PREP TRAY 8630	272						
10/04	70587738 001		228.00	228.00				
MINISECTOMY	KIT 98013	272						
10/04	70588173 001		3.00	3.00				
TUBING	SUCTION 10' 50/C (S)	271						
10/04	70592043 001		27.00	27.00				
STYLET	INTUBATION 14FR (S)	272						
10/04	70597604 001		2.00	2.00				
DRESSING	XEROFOAM 1X8 (S)	272						
10/04	70597802 001		3.00	3.00				
YANKAUER	SUC.HAND 50/CS (S)	272						
09/26	51000081 001 80053		288.00	288.00				
CMP	PANEL	300						
09/26	51002012 001 81001		18.00	18.00				
UA	AU W/MICRO	307						
09/26	51003382 001 82465		122.00	122.00				
SERUM	CHOLESTEROL	301						
09/26	51008993 001 84478		254.00	254.00				
TRIGLY	CERIDES	301						

PATIENT NUMBER

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

SCT # 28 [illegible] HOSPITAL MED CTR
P.O. BOX [illegible]
LAS VEGAS, NV [illegible] 89193-8581
702 894-5700
FED # 23-297[illegible]511

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
CYCLE	10/09/05	
INS.		

PAGE NO. 3
BIRTH DATE
HOSP.NO.

H S	PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS	
	RODRIGUEZ , ENRIQUE	107839359	M	42	10/04/05			OUT PATIENT

GUARANTOR

GUARANTOR NAME AND ADDRESS: ENRIQUE RODRIGUEZ E

C O D E	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
	MED-CARE		

AMOUNT OF PAYMENT: 0

DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
09/26	51009165 001 84550		122.00	122.00				
	URIC ACID SERUM	301						
09/26	51009587 001 85027		85.00	85.00				
	CBC AUTO W/O AUTO DIFF	305						
09/26	51018851 001 36415		11.00	11.00				
	SPEC COLL VENOUS VENIPUNCT	300						
09/26	53203055 001 71020		300.00	300.00				
	CXR CHEST 2V							
10/04	70400015 001		1460.00	1460.00				
	ANESTHESIA - INITIAL 30MIN	370						
10/04	70400023 003		564.00	564.00				
	ANESTHESIA - EA ADDL 30MIN	370						
10/04	70200100 001		4024.00	4024.00				
	OR RM CHARGE-INITIAL 30MIN	360						
10/04	70200118 003		1482.00	1482.00				
	OR RM CHARGE-EA ADDL 30MIN	360						
10/04	54014337 001 J0690		132.00	132.00				
	CEFAZOLIN SODIUM PER 500MG							
10/04	54028873 001 J1260		262.00	262.00				
	DOLASETRON MESYLATE PER 10MG							
10/04	54034558 001 J3010		15.00	15.00				
	FENTANYL CITRATE PER 0.1MG							
10/04	54052071 001 J2001		16.00	16.00				
	LIDOCAINE PER 10MG INJ	636						
10/04	54059134 001 J2765		10.00	10.00				
	METOCLOPRAMIDE UP TO 10MG							
10/04	54061973 001 J2270		14.00	14.00				
	MORPHINE SULF UP TO 10MG							
10/04	54065255 001 J2710		139.00	139.00				
	NEOSTIGMINE TO 0.5MG INJ	636						
10/04	54085790 001 J0330		53.00	53.00				
	SUCCINYLCHOL INJ TO 20MG	636						
10/04	54098579 001 J2250		65.00	65.00				
	MIDAZOLAM INJ PER 1MG							

PATIENT NUMBER

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HOSP# 28 VALLEY HOSPITAL MED CTR
P O BOX 9858
LAS VEGAS, NV 89193-8581
702 894-5700
TEL # 247-2977 ext

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
CYCLE	10/09/05	
INS.		

PAGE NO. 4

BIRTH-DATE | HOSP.NO.

H	S	PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS	
		RODRIGUEZ ,ENRIQUE	107839359	M	42	10/04/05			OUT PATIENT

GUAR PH#

GUARANTOR NAME AND ADDRESS: ENRIQUE RODRIGUEZ
JE

CLOSE	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	MED-CARE		

AMOUNT OF PAYMENT $

DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
10/04	54304688 002 J2270		12.00	12.00				
	MORPHINE SULF UP TO 10MG							
10/04	54204607 001 J1650		289.00	289.00				
	ENOXAPARIN SOD INJ PER 10MG							
10/04	70100011 001		684.00	684.00				
	RECOVERY RM-INITIAL 30 MIN 710							
10/04	70100029 001		224.00	224.00				
	RECOVERY RM-EA ADDL 30 MIN 710							
10/04	70100029 001		224.00	224.00				
	RECOVERY RM-EA ADDL 30 MIN 710							
10/04	70100029 001		224.00	224.00				
	RECOVERY RM-EA ADDL 30 MIN 710							
09/26	53500047 001 93005		279.00	279.00				
	EKG TRACING							
	SUMMARY OF CURRENT CHARGES							
	PHARMACY		2736.00	2736.00				
	MED/SURG SUPPLY		2609.00	2609.00				
	LABORATORY		900.00	900.00				
	RADIOLOGY		300.00	300.00				
	ANESTHESIA		2024.00	2024.00				
	OPER ROOM		5506.00	5506.00				
	RECOVERY ROOM		1356.00	1356.00				
	EKG/ECG		279.00	279.00				
	PHARM OTHER		289.00	289.00				
	SUB-TOTAL OF CURR. CHARGES		15999.00	15999.00				
	EMPLOYER INFORMATION:							
	UNEMPLOYED							
	TOTALS		15999.00	15999.00				

PATIENT NUMBER 107839359

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

VALLEY HOSPITAL MED CTR
LAS VEGAS, NV

HCI 1 28 I

VALLEY HOSPITAL MED CTR
P O BOX 98501
LAS VEGAS NV 89193-8501
702-851-5700
FED ID: 23-2977511

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
CYCLE	10/09/05	
INS.		

PAGE NO. 5

BIRTH DATE | HOSP.NO.

H	S	PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS	
		RODRIGUEZ ,ENRIQUE	107839359	M	42	10/04/05			OUT PATIENT

GUAR DATA

GUARANTOR NAME AND ADDRESS: ENRIQUE RODRIGUEZ

CODE	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
	MED-CARE		

AMOUNT OF PAYMENT $

DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT

GUAR RELATIONSHIP: S SEX M GUAR NO: 562294767
ACC DATE: 09/26/05 TYPE: H TIME: 6:53 PM PLACE: EMPL REL: N
DIAGNOSIS: 717.2 DERANG POST MED MENISCUS
717.9 INT DERANGEMENT KNEE NOS
PROCEDURE: 80.6 10/04/05 EXC KNEE SEMILUNAR CART
80.76 10/04/05 KNEE SYNOVECTOMY
29881 10/04/05
29876 10/04/05

AMOUNTS DUE HEREUNDER HAVE BEEN ASSIGNED TO
UHS RECEIVABLES CORP. & US BANK, N.A. AS TRUSTEE

TOTALS	15999.00	15999.00					

PATIENT NUMBER
107839359

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

VALLEY HOSPITAL MED CTR
LAS VEGAS, NV

PLEASE DO NOT STAPLE IN THIS AREA

JONATHON WEBER, ESQ.
7408 W. SAHARA AVE
LAS VEGAS, NV 89117

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 (ID) [X]

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ, ENRIGUE

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

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

5. PATIENT'S ADDRESS (No., Street)

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

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

CITY: RIVERSIDE STATE: CA

8. PATIENT STATUS: Single Married Other [X]

Employed Full-Time Student Part-Time Student

CITY: RIVERSIDE STATE: CA

ZIP CODE: 92506 TELEPHONE (Include Area Code)

ZIP CODE: 92506 TELEPHONE (INCLUDE AREA CODE)

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

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

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

c. OTHER ACCIDENT? YES [X] NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM #: JONATHON WEBER, ESQ.

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: 09 05 2008

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 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: DR. NICOLA

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 [X] NO $ CHARGES

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

1. 847.0
2. 847.2
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
11 11 2005	11	4	72050	26	1	45 00	1				
11 11 2005	11	4	72100	26	2	40 00	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN: 87-0675044 [X]

26. PATIENT'S ACCOUNT NO: RODR20233

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

28. TOTAL CHARGE $ 85 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 85 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.)

Ammon G. Strehlow,DC DACBR

SIGNED DATE 09 05 2008

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

Strehlow Radiology Consulting
141 W BRIGHAM RD #D
ST GEORGE, UT 84790

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

Strehlow Radiology Consulting, LLC
5135 Camino Al Norte RD., Ste. 250
N. Las Vegas, NV 89031 (800) 330-0772

PIN# GRP#

09/17/2008 13:37 14356742588 STREHLOW RADIOLOGY PAGE 08/10

STREHLOW RADIOLOGY CONSULTING-00002

PLEASE DO NOT STAPLE IN THIS AREA

MED CARE SOLUTIONS
10120 W FLAMINGO #412
LAS VEGAS, NV 89147-

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)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ, ENRIQUE

3. PATIENT'S BIRTH DATE | SEX

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

5. PATIENT'S ADDRESS (No., Street): RIVERSIDE | STATE: CA | ZIP CODE: 92506- | TELEPHONE (Include Area Code)

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

7. INSURED'S ADDRESS (No., Street): RIVERSIDE | STATE: CA | ZIP CODE: 92506 | TELEPHONE (INCLUDE AREA CODE)

8. PATIENT STATUS: Single X | Married | Other | Employed | Student | Student

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): NONE

9a. OTHER INSURED'S POLICY OR GROUP NUMBER

9b. OTHER INSURED'S DATE OF BIRTH | SEX

9c. EMPLOYER'S NAME OR SCHOOL NAME: NONE

9d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO: EMPLOYMENT? YES | NO X

10a. AUTO ACCIDENT? YES | NO X | PLACE (State)

10b. OTHER ACCIDENT? YES | NO X

10c. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

11a. INSURED'S DATE OF BIRTH | SEX

11b. EMPLOYER'S NAME OR SCHOOL NAME

11c. INSURANCE PLAN NAME OR PROGRAM NAME

11d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO X

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: 11 22 2006

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): 11 22 2006

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: SHANNON, MD, MARY ANN

17a. I.D. NUMBER OF REFERRING PHYSICIAN: D60897

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 X | $ CHARGES: NO PURCHASED SVC

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by line): 719.46, V45.89

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24A. 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
11162005	11162005	11	4	73722	LT	12	1850 00	1				
11162005	11162005	11	4	A4649		12	50 00	1				
11162005	11162005	11	4	27370		12	765 00	1				
11162005	11162005	11	4	73580	LT	12	270 00	1				

25. FEDERAL TAX I.D. NUMBER: 52-1278857 | SSN | EIN X

26. PATIENT'S ACCOUNT NO.: 426-02885827

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

28. TOTAL CHARGE: $ 2635 00

29. AMOUNT PAID: $

30. BALANCE DUE: $2635 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.): HENRY, JR., MD, ROBE 11 22 2006

SIGNED | DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office): INSIGHT MOUNTAIN DIAGNOSTICS 800 SHADOW LANE LAS VEGAS, NV 89106

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #: INSIGHT HEALTH CORP DBA MT DIAGNOST FILE 57400 LOS ANGELES, CA 900747400

PIN# 52-1278857 | GRP# 52-1278857

IMPROVED BY AMA COUNCIL ON MED. SERV. (12/88) APPROVED OVB-0938-0008

PLEASE PRINT OR TYPE

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

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

MED CARE SOLUTIONS LLC-00003

Account Financial History By Service Date

LAS VEGAS NEUROSURGERY ORTHOPEDICS & REHAB

Selections:

Service Dates: 09/04/2004 - 07/14/2008
Accounts: 5106
Activity Types: Charges, Payments, Adjustments, Transfers, Refunds

Type Date Legend:
Charges - Service Date, Credits - Post Date

Account Date	Type	Name / Description	Provider	Proc Code		Ref Date	Diagnosis	Units	Amount
5106		RODRIGUEZ, ENRIQUE JAVIER							
03/28/2005	CHG	RODRIGUEZ, ENRIQUE JAVIER	MS	99244	OFFICE CONSULTATION	03/28/2005	836.2	1.00	420.00
09/26/2005	CHG	RODRIGUEZ, ENRIQUE JAVIER	MS	90782	INJECTION, SC/IM	09/28/2005	717.7	1.00	275.00
09/26/2005	CHG	RODRIGUEZ, ENRIQUE JAVIER	MS	99213	OFFICE/OUTPATIENT VISIT, EST	09/28/2005	717.7	1.00	135.00
10/04/2005	CHG	RODRIGUEZ, ENRIQUE JAVIER	MS	29877-59LT	KNEE ARTHROSCOPY/SURGERY	10/08/2005	836.1	1.00	3,822.00
10/04/2005	CHG	RODRIGUEZ, ENRIQUE JAVIER	MS	29879-59LT	KNEE ARTHROSCOPY/SURGERY	10/08/2005	836.1	1.00	3,822.00
10/04/2005	CHG	RODRIGUEZ, ENRIQUE JAVIER	MS	29881-LT	KNEE ARTHROSCOPY/SURGERY	10/08/2005	836.1	1.00	3,822.00
10/04/2005	CHG	RODRIGUEZ, ENRIQUE JAVIER	MS	29877-LT	KNEE ARTHROSCOPY/SURGERY	10/08/2005	836.1	1.00	3,822.00
10/10/2005	CHG	RODRIGUEZ, ENRIQUE JAVIER	MS	99024	POSTOP FOLLOW-UP VISIT	10/10/2005	836.1	1.00	0.00
10/10/2005	CHG	RODRIGUEZ, ENRIQUE JAVIER	MS	99212	OFFICE/OUTPATIENT VISIT, EST	10/10/2005	836.1	1.00	90.00
10/10/2005	CHG	RODRIGUEZ, ENRIQUE JAVIER	MS	99070,2	DRESSING NON-ABSORB	10/10/2005	836.1	1.00	15.00
10/10/2005	CHG	RODRIGUEZ, ENRIQUE JAVIER	MS	99070,3	4X4 PADS	10/10/2005	836.1	1.00	15.00
11/07/2005	CHG	RODRIGUEZ, ENRIQUE JAVIER	MS	99024	POSTOP FOLLOW-UP VISIT	11/11/2005	836.1	1.00	0.00
11/14/2005	CHG	RODRIGUEZ, ENRIQUE JAVIER	MS	S0020	MARCAINE	11/18/2005	836.0	4.00	60.00
11/14/2005	CHG	RODRIGUEZ, ENRIQUE JAVIER	MS	J1030	Depo Medrol	11/18/2005	836.0	2.00	44.00
11/14/2005	CHG	RODRIGUEZ, ENRIQUE JAVIER	MS	99024	POSTOP FOLLOW-UP VISIT	11/18/2005	836.0	1.00	0.00
11/14/2005	CHG	RODRIGUEZ, ENRIQUE JAVIER	MS	20610	DRAIN/INJECT, JOINT/BURSA	11/18/2005	836.0	1.00	175.00
11/14/2005	CHG	RODRIGUEZ, ENRIQUE JAVIER	MS	J2001	LIDOCAINE	11/18/2005	836.0	4.00	60.00
11/21/2005	CHG	RODRIGUEZ, ENRIQUE JAVIER	MS	99024	POSTOP FOLLOW-UP VISIT	11/30/2005	836.0	1.00	0.00
12/12/2005	CHG	RODRIGUEZ, ENRIQUE JAVIER	MS	73565	X-RAY EXAM OF KNEES	12/13/2005	836.0	1.00	92.50
12/12/2005	CHG	RODRIGUEZ, ENRIQUE JAVIER	MS	99024	POSTOP FOLLOW-UP VISIT	12/13/2005	836.0	1.00	0.00
01/13/2006	CHG	RODRIGUEZ, ENRIQUE JAVIER	MS	99080,MR	MEDICAL RECORDS	01/13/2006	MISC	1.00	32.00
01/25/2006	CHG	RODRIGUEZ, ENRIQUE JAVIER	MS	NOSHOW	NO SHOW VISITS	01/26/2006	MISC	1.00	0.00

Account Totals:	PMT:	0.00	RFD:	0.00	XFR:	0.00	ADJ:	0.00	CHG:	16,701.50	29.00	16,701.50
Report Totals:	PMT:	0.00	RFD:	0.00	XFR:	0.00	ADJ:	0.00	CHG:	16,701.50	29.00	16,701.50

Integrated Healthcare of Nevada
4517 W. Sahara Ave.
Las Vegas , NV 89102
(702) 252-7246

Name : Enrique Rodriguez ID#: 2797
Statement Date : 11/ 8/05 - 11/30/07

Joseph Nicola D.C.
TAX ID: 33-1010872

Mail To: Enrique Rodriguez

Current Diagnosis

847.0	Cervical Sprain/Strain Whiplash
847.1	Thoracic Sprain/Strain
847.2	Lumbar Sprain/Strain
723.4	Brachial Neuritis or Radiculitis NOS
722.91	Cervicothoracic disc disease
E917	Struck accidentally by objects or persons

Date	Code	Description	Units	Charges	Payments	Adjust/ Credits	Total
11/8/05	97014	Electric Stimulation	1	$35.00	$0.00	$0.00	$35.00
11/8/05	97010	Ice/Hot Pack	1	$25.00	$0.00	$0.00	$60.00
11/8/05	99070	Supplies-Electrodes	1	$10.00	$0.00	$0.00	$70.00
11/8/05	97140	Myofascial Release Technique	1	$50.00	$0.00	$0.00	$120.00
11/8/05	99203	New Patient Intermediate	1	$140.00	$0.00	$0.00	$260.00
11/9/05	97014	Electric Stimulation	1	$35.00	$0.00	$0.00	$295.00
11/9/05	97010	Ice/Hot Pack	1	$25.00	$0.00	$0.00	$320.00
11/9/05	98941	Manipulation 3-4 Areas	1	$50.00	$0.00	$0.00	$370.00
11/9/05	97140	Myofascial Release Technique	1	$50.00	$0.00	$0.00	$420.00
11/10/05	97014	Electric Stimulation	1	$35.00	$0.00	$0.00	$455.00
11/10/05	97010	Ice/Hot Pack	1	$25.00	$0.00	$0.00	$480.00
11/10/05	97140	Myofascial Release Technique	1	$50.00	$0.00	$0.00	$530.00
11/11/05	97014	Electric Stimulation	1	$35.00	$0.00	$0.00	$565.00
11/11/05	97010	Ice/Hot Pack	1	$25.00	$0.00	$0.00	$590.00
11/11/05	97140	Myofascial Release Technique	1	$50.00	$0.00	$0.00	$640.00
11/14/05	97014	Electric Stimulation	1	$35.00	$0.00	$0.00	$675.00
11/14/05	97010	Ice/Hot Pack	1	$25.00	$0.00	$0.00	$700.00
11/14/05	97140	Myofascial Release Technique	1	$50.00	$0.00	$0.00	$750.00
11/14/05	98941	Manipulation 3-4 Areas	1	$50.00	$0.00	$0.00	$800.00
11/15/05	97014	Electric Stimulation	1	$35.00	$0.00	$0.00	$835.00
11/15/05	97010	Ice/Hot Pack	1	$25.00	$0.00	$0.00	$860.00
11/15/05	98941	Manipulation 3-4 Areas	1	$50.00	$0.00	$0.00	$910.00
11/15/05	97140	Myofascial Release Technique	1	$50.00	$0.00	$0.00	$960.00
11/16/05	98941	Manipulation 3-4 Areas	1	$50.00	$0.00	$0.00	$1,010.00
11/16/05	97014	Electric Stimulation	1	$35.00	$0.00	$0.00	$1,045.00
11/16/05	97010	Ice/Hot Pack	1	$25.00	$0.00	$0.00	$1,070.00
11/16/05	97140	Myofascial Release Technique	1	$50.00	$0.00	$0.00	$1,120.00
11/17/05	97014	Electric Stimulation	1	$35.00	$0.00	$0.00	$1,155.00
11/17/05	97010	Ice/Hot Pack	1	$25.00	$0.00	$0.00	$1,180.00
11/17/05	97140	Myofascial Release Technique	1	$50.00	$0.00	$0.00	$1,230.00
11/17/05	98941	Manipulation 3-4 Areas	1	$50.00	$0.00	$0.00	$1,280.00
12/15/05	98941	Manipulation 3-4 Areas	1	$50.00	$0.00	$0.00	$1,330.00
12/15/05	97014	Electric Stimulation	1	$35.00	$0.00	$0.00	$1,365.00
12/15/05	97140	Myofascial Release Technique	2	$100.00	$0.00	$0.00	$1,465.00
12/16/05	97014	Electric Stimulation	1	$35.00	$0.00	$0.00	$1,500.00

Wednesday, November 28, 2007

EP1302

Intergrated 0000001

Name : Enrique Rodriguez ID#: 2797
Statement Date : 11/ 8/05 - 11/30/07

Joseph Nicola D.C.
TAX ID: 33-1010872

12/16/05	97140	Myofascial Release Technique	2	$100.00	$0.00	$0.00	$1,600.00
12/16/05	98941	Manipulation 3-4 Areas	1	$50.00	$0.00	$0.00	$1,650.00
12/19/05	98941	Manipulation 3-4 Areas	1	$50.00	$0.00	$0.00	$1,700.00
12/19/05	97010	Ice/Hot Pack	1	$25.00	$0.00	$0.00	$1,725.00
12/19/05	97140	Myofascial Release Technique	2	$100.00	$0.00	$0.00	$1,825.00
1/3/06	97010	Ice/Hot Pack	1	$25.00	$0.00	$0.00	$1,850.00
1/3/06	97140	Myofascial Release Technique	2	$100.00	$0.00	$0.00	$1,950.00
1/3/06	97014	Electric Stimulation	1	$35.00	$0.00	$0.00	$1,985.00
1/3/06	98941	Manipulation 3-4 Areas	1	$50.00	$0.00	$0.00	$2,035.00
1/3/06	99212	Office Visit Focused	1	$60.00	$0.00	$0.00	$2,095.00
1/4/06	98941	Manipulation 3-4 Areas	1	$50.00	$0.00	$0.00	$2,145.00
1/4/06	97010	Ice/Hot Pack	1	$25.00	$0.00	$0.00	$2,170.00
1/4/06	97140	Myofascial Release Technique	2	$100.00	$0.00	$0.00	$2,270.00
1/5/06	98941	Manipulation 3-4 Areas	1	$50.00	$0.00	$0.00	$2,320.00
1/5/06	97010	Ice/Hot Pack	1	$25.00	$0.00	$0.00	$2,345.00
1/5/06	97140	Myofascial Release Technique	2	$100.00	$0.00	$0.00	$2,445.00
1/6/06	98941	Manipulation 3-4 Areas	1	$50.00	$0.00	$0.00	$2,495.00
1/6/06	97010	Ice/Hot Pack	1	$25.00	$0.00	$0.00	$2,520.00
1/6/06	97014	Electric Stimulation	1	$35.00	$0.00	$0.00	$2,555.00
1/6/06	97140	Myofascial Release Technique	1	$50.00	$0.00	$0.00	$2,605.00
1/12/06	97140	Myofascial Release Technique	2	$100.00	$0.00	$0.00	$2,705.00
1/13/06	98941	Manipulation 3-4 Areas	1	$50.00	$0.00	$0.00	$2,755.00
1/13/06	97014	Electric Stimulation	1	$35.00	$0.00	$0.00	$2,790.00
1/13/06	97010	Ice/Hot Pack	1	$25.00	$0.00	$0.00	$2,815.00
1/13/06	97140	Myofascial Release Technique	2	$100.00	$0.00	$0.00	$2,915.00
1/17/06	97140	Myofascial Release Technique	2	$100.00	$0.00	$0.00	$3,015.00
1/18/06	98941	Manipulation 3-4 Areas	1	$50.00	$0.00	$0.00	$3,065.00
1/18/06	97014	Electric Stimulation	1	$35.00	$0.00	$0.00	$3,100.00
1/18/06	97010	Ice/Hot Pack	1	$25.00	$0.00	$0.00	$3,125.00
1/18/06	97140	Myofascial Release Technique	1	$50.00	$0.00	$0.00	$3,175.00
1/18/06	99070	Cervical pillow	1	$35.00	$0.00	$0.00	$3,210.00
				$3,210.00	$0.00	$0.00	$3,210.00

Wednesday, November 28, 2007

Intergrated 0000002

Integrated HealthCare of Nevada
4517 West Sahara
Las Vegas, NV 89120
(702) 252-7246

Dr. Teresa Charniga
TAX ID: 20-1303536

Enrique Rodriguez

Code	Description	Date Opened	Date Closed

Date	Code	CPT	Description	Charges	Payments	Adj/Credits	Balance
11/17/05	99212	99212	Office Visit Focused	$60.00	-.-	-.-	$60.00
	99204	99204	New Patient Extended	$200.00	-.-	-.-	$260.00
1/31/06	99215	99215	Office Visit Comprehensive	$180.00	-.-	-.-	$440.00
				$440.00	$0.00	$0.00	

Your balance is $440.00

Thursday, March 16, 2006

Intergrated 0000003

Nevada Sleep Diagnostics
62 N. Pecos Suite B
Henderson, NV 89074
(702)990-7660

Statement Date	Page
11/21/2007	1

Enrique Rodriguez

Chart Number
RODEN000

**********Please Return Upper Portion with Payment**********

Date	Document	Description	Case Number	Amount
			Previous Balance:	0.00
Patient: Enrique Rodriguez		Chart #: RODEN000		
Case Description: PSG		Date of Last Payment:	Amount: 0.00	
1/30/2006	0602080000	POLYSOMNOGRAM	9208	1,675.00
Patient: Enrique Rodriguez		Chart #: RODEN000		
Case Description: CPAP		Date of Last Payment:	Amount: 0.00	
2/2/2006	0602080000	SPLIT/CPAP/BI-PAP	9251	1,675.00

Total Charges	Total Payments	Total Adjustments	Balance Due
$3350.00	$0.00	$0.00	3,350.00

NEVADA SLEEP DIAGNOSTICS-00002

M E D I C A L E X P E N S E S

RODREN1
Patient: RODRIGUEZ, ENRIGUE J.
RespPty:

Birth:

Pharmacy: VILLAGE EAST DRUGS - SUNSET
2301 E. SUNSET RD.
LAS VEGAS NV 89119
RPh: MILLER, BETTY
NCPDP#: 2903296

Prescriptions: Date: 06/01/2006 TO 06/30/2006

LastFill	Rx #	Drug Name	Qty	Physician Name	T/P	Price
06/01/06	6735358	FLUOXETINE 20MG	30	Dr.KOKA	LAWAA	112.95
06/01/06	4718799	DIAZEPAM 10MG	30	Dr.KOKA	LAWAA	33.95
06/01/06	4718800	HYDROCO/APAP 10/660	45	Dr.KOKA	LAWAA	55.95

Report Date: 07/03/2006 $202.85

Village East Drugs 0000001

M E D C A L E X P E N S E S

RODREN1
Patient: RODRIGUEZ, ENRIGUE J.
RespPty:

Birth:

Pharmacy: VILLAGE EAST DRUGS - SUNSET
2301 E. SUNSET RD.
LAS VEGAS NV 89119
RPh: MILLER, BETTY
NCPDP#: 2903296

Prescriptions: Date: 05/01/2006 TO 05/31/2006

LastFill	Rx #	Drug Name	Qty	Physician Name	T/P	Price
05/08/06	6732917	BUSPIRONE 10MG	30	Dr.SHANNON	LAWAA	69.95
05/08/06	6735358	FLUOXETINE 20MG	30	Dr.KOKA	LAWAA	112.95
05/18/06	6732917	BUSPIRONE 10MG	30	Dr.SHANNON	LAWAA	69.95
05/18/06	6734949	FLUOXETINE 20MG	30	Dr.KOKA	LAWAA	112.95
05/20/06	4718600	HYDROCO/APAP 7.5-75	60	Dr.KOKA	LAWAA	51.95
05/22/06	6736826	AMITRIPTYLIN 25MG	60	Dr.KOKA	LAWAA	48.95
05/31/06	6737071	BUSPIRONE 10MG	60	Dr.KOKA	LAWAA	113.95

Report Date: 06/05/2006 $580.65

Village East Drugs 0000007

M E D I C A L E X P E N S E S

RODREN1
Patient: RODRIGUEZ, ENRIGUE J.
RespPty:

Birth:

Pharmacy: VILLAGE EAST DRUGS - SUNSET
2301 E. SUNSET RD.
LAS VEGAS NV 89119
RPh: MILLER, BETTY
NCPDP#: 2903296

Prescriptions: Date: 04/01/2006 TO 04/30/2006

LastFill	Rx #	Drug Name	Qty	Physician Name	T/P	Price
04/04/06	6733350	BUSPIRONE 10MG	60	Dr.KOKA	LAWAA	113.95
04/04/06	6735358	FLUOXETINE 20MG	30	Dr.KOKA	LAWAA	112.95
04/18/06	6734949	FLUOXETINE 20MG	30	Dr.KOKA	LAWAA	112.95
04/18/06	6732917	BUSPIRONE 10MG	30	Dr.SHANNON	LAWAA	69.95
04/29/06	6732917	BUSPIRONE 10MG	30	Dr.SHANNON	LAWAA	69.95
04/29/06	4718243	HYDROCO/APAP 7.5-75	60	Dr.KOKA	LAWAA	51.95
04/29/06	6736121	IBUPROFEN 800MG	90	Dr.KOKA	LAWAA	55.95

Report Date: 05/01/2006 $587.65

Village East Drugs 0000008

M E I C A L E X P E N S E S(

RODREN1
Patient: RODRIGUEZ, ENRIGUE J.
RespPty:

Birth: --------

Pharmacy: VILLAGE EAST DRUGS - SUNSET
2301 E. SUNSET RD.
LAS VEGAS NV 89119
RPh: MILLER, BETTY
NCPDP#: 2903296

Prescriptions: Date: 03/01/2006 TO 03/31/2006

LastFill	Rx #	Drug Name	Qty	Physician Name	T/P	Price
03/06/06	6733350	BUSPIRONE 10MG	60	Dr.KOKA	LAWAA	113.95
03/06/06	6733424	FLUOXETINE 20MG	30	Dr.KOKA	LAWAA	112.95
03/06/06	6733350	BUSPIRONE 10MG	60	Dr.KOKA	LAWAA	113.95
03/22/06	4717581	HYDROCO/APAP 7.5-75	60	Dr.KOKA	LAWAA	51.95
03/22/06	6734949	FLUOXETINE 20MG	30	Dr.KOKA	LAWAA	112.95
03/27/06	6732917	BUSPIRONE 10MG	30	Dr.SHANNON	LAWAA	69.95

Report Date: 04/03/2006 $575.70

Village East Drugs 0000009

M E D I C A L E X P E N S E S

Patient: RODRIGUEZ, ENRIGUE J.
RespPty:

Pharmacy: VILLAGE EAST DRUGS - SUNSET
2301 E. SUNSET RD.
LAS VEGAS NV 89119
RPh: MILLER, BETTY
NCPDP#: 2903296

Birth:

Prescriptions: Date: 02/01/2006 TO 02/28/2006

LastFill	Rx #	Drug Name	Qty	Physician Name	T/P	Price
02/02/06	6733424	FLUOXETINE 20MG	30	Dr.KOKA	LAWAA	112.95
02/20/06	4716361	HYDROCOD/IBU 7.5-20	60	Dr.SHANNON	LAWAA	100.95
02/20/06	6732695	AMITRIPTYLIN 50MG	30	Dr.SHANNON	LAWAA	44.95
02/20/06	6732917	BUSPIRONE 10MG	30	Dr.SHANNON	LAWAA	69.95

Report Date: 03/01/2006 $328.80

Village East Drugs 0000010

M E D I C A L E X P E N S E S

RODREN1
Patient: RODRIGUEZ, ENRIGUE J.
RespPty:

Birth:

Pharmacy: VILLAGE EAST DRUGS - SUNSET
2301 E. SUNSET RD.
LAS VEGAS NV 89119
RPh: MILLER, BETTY
NCPDP#: 2903296

Prescriptions: Date: 01/01/2006 TO 01/31/2006

LastFill	Rx #	Drug Name	Qty	Physician Name	T/P	Price
01/11/06	6732695	AMITRIPTYLIN 50MG	30	Dr.SHANNON	LAWAA	44.95
01/11/06	4716361	HYDROCOD/IBU 7.5-20	60	Dr.SHANNON	LAWAA	100.95
01/18/06	6732917	BUSPIRONE 10MG	30	Dr.SHANNON	LAWAA	69.95
01/31/06	6733350	BUSPIRONE 10MG	60	Dr.KOKA	LAWAA	113.95

Report Date: 02/01/2006 $329.80

Village East Drugs 0000011

Patient History - Detail

MATT SMITH PHYSICAL THERAPY

By Date of Service
All Date ranges
All Providers
Show last billed date
All Items

Chart #: RP18843
Patient Name: RODRIQUEZ,ENRIQUE J
Address:
City, State, Zip:

Home Phone:
Office Phone:
Resp. Party: RODRIQUEZ,ENRIQUE J
Resp. Acct# 142623

U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	97002		Y	Y	8/29/2008	SKOPH	631934	$57.00	$0.00	$0.00	$57.00	$57.00	957	09/10/2008	142623
	97140		Y	Y	8/19/2008	SKOPH	619248	$60.00	$0.00	$0.00	$60.00	$60.00	957	08/28/2008	142623
	97113		Y	Y	8/19/2008	SKOPH	619248	$204.00	$0.00	$0.00	$204.00	$204.00	957	08/28/2008	142623
	97110		Y	Y	8/19/2008	SKOPH	619248	$84.00	$0.00	$0.00	$84.00	$84.00	957	08/28/2008	142623
	97010		Y	Y	8/19/2008	SKOPH	619248	$20.00	$0.00	$0.00	$20.00	$20.00	957	08/28/2008	142623
	97110		Y	Y	8/18/2008	SMITHC	621859	$42.00	$0.00	$0.00	$42.00	$42.00	957	08/29/2008	142623
	97113		Y	Y	8/18/2008	SMITHC	621859	$153.00	$0.00	$0.00	$153.00	$153.00	957	08/29/2008	142623
	97140		Y	Y	8/11/2008	SKOPH	610865	$60.00	$0.00	$0.00	$60.00	$60.00	957	08/20/2008	142623
	97110		Y	Y	8/11/2008	SKOPH	610865	$84.00	$0.00	$0.00	$84.00	$84.00	957	08/20/2008	142623
	97113		Y	Y	8/11/2008	SKOPH	610865	$204.00	$0.00	$0.00	$204.00	$204.00	957	08/20/2008	142623
	97010		Y	Y	8/11/2008	SKOPH	610865	$20.00	$0.00	$0.00	$20.00	$20.00	957	08/20/2008	142623
	97140		Y	Y	7/30/2008	SKOPH	595829	$60.00	$0.00	$0.00	$60.00	$60.00	957	08/07/2008	142623
	97113		Y	Y	7/30/2008	SKOPH	595829	$204.00	$0.00	$0.00	$204.00	$204.00	957	08/07/2008	142623
	97110		Y	Y	7/30/2008	SKOPH	595829	$84.00	$0.00	$0.00	$84.00	$84.00	957	08/07/2008	142623
	97010		Y	Y	7/30/2008	SKOPH	595829	$20.00	$0.00	$0.00	$20.00	$20.00	957	08/07/2008	142623
	97113		Y	Y	7/25/2008	SKOPH	592573	$204.00	$0.00	$0.00	$204.00	$204.00	957	08/05/2008	142623
	97110		Y	Y	7/25/2008	SKOPH	592573	$84.00	$0.00	$0.00	$84.00	$84.00	957	08/05/2008	142623

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Patient History - Detail

MATT SMITH PHYSICAL THERAPY

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Chart #: RP18843
Patient Name: RODRIQUEZ,ENRIQUE J
Address:
City, State, Zip:

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Resp. Party: RODRIQUEZ,ENRIQUE J
Resp. Acct# 142623

U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	97010		Y	Y	7/25/2008	SKOPH	592573	$20.00	$0.00	$0.00	$20.00	$20.00	957	08/05/2008	142623
	97002		Y	Y	7/21/2008	SKOPH	587801	$57.00	$0.00	$0.00	$57.00	$57.00	957	07/30/2008	142623
	97113		Y	Y	7/21/2008	SKOPH	587801	$204.00	$0.00	$0.00	$204.00	$204.00	957	07/30/2008	142623
	97110		Y	Y	7/21/2008	SKOPH	587801	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/30/2008	142623
	97010		Y	Y	7/21/2008	SKOPH	587801	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/30/2008	142623
	97140		Y	Y	7/9/2008	SKOPH	577277	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/21/2008	142623
	97110		Y	Y	7/9/2008	SKOPH	577277	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/21/2008	142623
	97010		Y	Y	7/9/2008	SKOPH	577277	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/21/2008	142623
	97113		Y	Y	7/8/2008	SKOPH	574144	$204.00	$0.00	$0.00	$204.00	$204.00	957	07/17/2008	142623
	97110		Y	Y	7/8/2008	SKOPH	574144	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/17/2008	142623
	97010		Y	Y	7/8/2008	SKOPH	574144	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/17/2008	142623
	97113		Y	Y	7/7/2008	SKOPH	574428	$204.00	$0.00	$0.00	$204.00	$204.00	957	07/17/2008	142623
	97110		Y	Y	7/7/2008	SKOPH	574428	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/17/2008	142623
	97010		Y	Y	7/7/2008	SKOPH	574428	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/17/2008	142623
	97140		Y	Y	6/30/2008	SKOPH	566229	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/18/2008	142623
	97110		Y	Y	6/30/2008	SKOPH	566229	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/18/2008	142623
	97010		Y	Y	6/30/2008	SKOPH	566229	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623

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Patient Name: RODRIQUEZ,ENRIQUE J
Address:
City, State, Zip:

Home Phone:
Office Phone:
Resp. Party: RODRIQUEZ,ENRIQUE J
Resp. Acct# 142623

U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	97002		Y	Y	6/27/2008	SKOPH	602187	$57.00	$0.00	$0.00	$57.00	$57.00	957	09/04/2008	142623
	97110		Y	Y	6/27/2008	SKOPH	602187	$84.00	$0.00	$0.00	$84.00	$84.00	957	09/04/2008	142623
	97010		Y	Y	6/27/2008	SKOPH	602187	$20.00	$0.00	$0.00	$20.00	$20.00	957	09/04/2008	142623
	97110		Y	Y	6/25/2008	SKOPH	560688	$126.00	$0.00	$0.00	$126.00	$126.00	957	07/18/2008	142623
	97010		Y	Y	6/25/2008	SKOPH	560688	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97110		Y	Y	6/24/2008	SKOPH	554376	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/18/2008	142623
	97010		Y	Y	6/24/2008	SKOPH	554376	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97113		Y	Y	6/18/2008	SKOPH	554585	$204.00	$0.00	$0.00	$204.00	$204.00	957	07/18/2008	142623
	97110		Y	Y	6/18/2008	SKOPH	554585	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/18/2008	142623
	97010		Y	Y	6/18/2008	SKOPH	554585	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97110		Y	Y	6/17/2008	SKOPH	554405	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/18/2008	142623
	97113		Y	Y	6/17/2008	SKOPH	554405	$204.00	$0.00	$0.00	$204.00	$204.00	957	07/18/2008	142623
	97010		Y	Y	6/17/2008	SKOPH	554405	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97110		Y	Y	6/10/2008	SKOPH	546364	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/18/2008	142623
	97010		Y	Y	6/10/2008	SKOPH	546364	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97140		Y	Y	6/5/2008	SMITHC	537135	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/18/2008	142623
	97113		Y	Y	6/5/2008	SMITHC	537135	$51.00	$0.00	$0.00	$51.00	$51.00	957	07/18/2008	142623

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Patient History - Detail

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Chart #: RP18843
Patient Name: RODRIQUEZ,ENRIQUE J
Address:
City, State, Zip:

Home Phone:
Office Phone:
Resp. Party: RODRIQUEZ,ENRIQUE J
Resp. Acct# 142623

U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	97110		Y	Y	6/5/2008	SMITHC	537135	$42.00	$0.00	$0.00	$42.00	$42.00	957	07/18/2008	142623
	97010		Y	Y	6/5/2008	SMITHC	537135	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97140		Y	Y	6/2/2008	SMITHC	536521	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/18/2008	142623
	97113		Y	Y	6/2/2008	SMITHC	536521	$153.00	$0.00	$0.00	$153.00	$153.00	957	07/18/2008	142623
	97010		Y	Y	6/2/2008	SMITHC	536521	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97140		Y	Y	5/30/2008	SMITHC	531299	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/18/2008	142623
	97113		Y	Y	5/30/2008	SMITHC	531299	$153.00	$0.00	$0.00	$153.00	$153.00	957	07/18/2008	142623
	97010		Y	Y	5/30/2008	SMITHC	531299	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97140		Y	Y	5/29/2008	ELLIS	530103	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/18/2008	142623
	97113		Y	Y	5/29/2008	ELLIS	530103	$153.00	$0.00	$0.00	$153.00	$153.00	957	07/18/2008	142623
	97110		Y	Y	5/29/2008	ELLIS	530103	$42.00	$0.00	$0.00	$42.00	$42.00	957	07/18/2008	142623
	97010		Y	Y	5/29/2008	ELLIS	530103	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97001		Y	Y	5/21/2008	SKOPH	496755	$130.00	$0.00	$0.00	$130.00	$130.00	957	07/18/2008	142623
	97140		Y	Y	5/21/2008	SKOPH	496755	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/18/2008	142623
	97110		Y	Y	5/21/2008	SKOPH	496755	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/18/2008	142623
	97010		Y	Y	5/21/2008	SKOPH	496755	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97001		Y	Y	5/21/2008	SKOPH	529524	$130.00	$0.00	$0.00	$130.00	$130.00	957	07/18/2008	142623

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Patient History - Detail

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All Items

Chart #:	RP18843	**Home Phone:**	
Patient Name:	RODRIQUEZ,ENRIQUE J	**Office Phone:**	
Address:	7F	**Resp. Party:**	RODRIQUEZ,ENRIQUE J
City, State, Zip:		**Resp. Acct#**	142623

U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	97140		Y	Y	5/21/2008	SKOPH	529524	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/18/2008	142623
	97110		Y	Y	5/21/2008	SKOPH	529524	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/18/2008	142623
	97010		Y	Y	5/21/2008	SKOPH	529524	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97140		Y	Y	5/20/2008	SKOPH	520140	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/18/2008	142623
	97110		Y	Y	5/20/2008	SKOPH	520140	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/18/2008	142623
	97010		Y	Y	5/20/2008	SKOPH	520140	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97140		Y	Y	5/13/2008	SKOPH	492031	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/18/2008	142623
	97110		Y	Y	5/13/2008	SKOPH	492031	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/18/2008	142623
	97010		Y	Y	5/13/2008	SKOPH	492031	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97140		Y	Y	5/12/2008	SKOPH	490921	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/18/2008	142623
	97113		Y	Y	5/12/2008	SKOPH	490921	$204.00	$0.00	$0.00	$204.00	$204.00	957	07/18/2008	142623
	97110		Y	Y	5/12/2008	SKOPH	490921	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/18/2008	142623
	97010		Y	Y	5/12/2008	SKOPH	490921	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97140		Y	Y	5/7/2008	SKOPH	487627	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/18/2008	142623
	97113		Y	Y	5/7/2008	SKOPH	487627	$204.00	$0.00	$0.00	$204.00	$204.00	957	07/18/2008	142623
	97110		Y	Y	5/7/2008	SKOPH	487627	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/18/2008	142623
	97010		Y	Y	5/7/2008	SKOPH	487627	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623

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U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	97140		Y	Y	5/6/2008	SKOPH	487672	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/18/2008	142623
	97110		Y	Y	5/6/2008	SKOPH	487672	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/18/2008	142623
	97010		Y	Y	5/6/2008	SKOPH	487672	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97140		Y	Y	5/5/2008	SMITHC	487080	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/18/2008	142623
	97110		Y	Y	5/5/2008	SMITHC	487080	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/18/2008	142623
	97010		Y	Y	5/5/2008	SMITHC	487080	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97140		Y	Y	4/29/2008	SKOPH	484333	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/18/2008	142623
	97110		Y	Y	4/29/2008	SKOPH	484333	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/18/2008	142623
	97010		Y	Y	4/29/2008	SKOPH	484333	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97140		Y	Y	4/28/2008	SKOPH	529073	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/18/2008	142623
	97113		Y	Y	4/28/2008	SKOPH	529073	$204.00	$0.00	$0.00	$204.00	$204.00	957	07/18/2008	142623
	97110		Y	Y	4/28/2008	SKOPH	529073	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/18/2008	142623
	97010		Y	Y	4/28/2008	SKOPH	529073	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97140		Y	Y	4/25/2008	SKOPH	484267	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/18/2008	142623
	97110		Y	Y	4/25/2008	SKOPH	484267	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/18/2008	142623
	97010		Y	Y	4/25/2008	SKOPH	484267	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97140		Y	Y	4/22/2008	SKOPH	477011	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/18/2008	142623

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Resp. Acct# 142623

U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	97110		Y	Y	4/22/2008	SKOPH	477011	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/18/2008	142623
	97010		Y	Y	4/22/2008	SKOPH	477011	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97140		Y	Y	4/21/2008	SMITH	474919	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/18/2008	142623
	97124		Y	Y	4/21/2008	SMITH	474919	$34.00	$0.00	$0.00	$34.00	$34.00	957	07/18/2008	142623
	97113		Y	Y	4/21/2008	SMITH	474919	$153.00	$0.00	$0.00	$153.00	$153.00	957	07/18/2008	142623
	97010		Y	Y	4/21/2008	SMITH	474919	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97140		Y	Y	4/18/2008	SKOPH	485433	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/18/2008	142623
	97110		Y	Y	4/18/2008	SKOPH	485433	$42.00	$0.00	$0.00	$42.00	$42.00	957	07/18/2008	142623
	97010		Y	Y	4/18/2008	SKOPH	485433	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97140		Y	Y	4/17/2008	SMITHC	471937	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/18/2008	142623
	97113		Y	Y	4/17/2008	SMITHC	471937	$153.00	$0.00	$0.00	$153.00	$153.00	957	07/18/2008	142623
	97010		Y	Y	4/17/2008	SMITHC	471937	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97140		Y	Y	4/11/2008	SKOPH	465481	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/18/2008	142623
	97110		Y	Y	4/11/2008	SKOPH	465481	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/18/2008	142623
	97010		Y	Y	4/11/2008	SKOPH	465481	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97140		Y	Y	4/10/2008	SMITHC	464603	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/18/2008	142623
	97110		Y	Y	4/10/2008	SMITHC	464603	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/18/2008	142623

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Patient History - Detail

MATT SMITH PHYSICAL THERAPY

By Date of Service
All Date ranges
All Providers
Show last billed date
All Items

Chart #: RP18843
Patient Name: RODRIQUEZ,ENRIQUE J
Address:
City, State, Zip:

Home Phone:
Office Phone:
Resp. Party: RODRIQUEZ,ENRIQUE J
Resp. Acct# 142623

U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	97010		Y	Y	4/10/2008	SMITHC	464603	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97140		Y	Y	3/28/2008	SKOPH	454200	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/18/2008	142623
	97110		Y	Y	3/28/2008	SKOPH	454200	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/18/2008	142623
	97010		Y	Y	3/28/2008	SKOPH	454200	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97113		Y	Y	3/27/2008	METROS	445856	$204.00	$0.00	$0.00	$204.00	$204.00	957	07/18/2008	142623
	97110		Y	Y	3/27/2008	METROS	445856	$42.00	$0.00	$0.00	$42.00	$42.00	957	07/18/2008	142623
	97124		Y	Y	3/27/2008	METROS	445856	$34.00	$0.00	$0.00	$34.00	$34.00	957	07/18/2008	142623
	97010		Y	Y	3/27/2008	METROS	445856	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97140		Y	Y	3/25/2008	SKOPH	445515	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/18/2008	142623
	97110		Y	Y	3/25/2008	SKOPH	445515	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/18/2008	142623
	97010		Y	Y	3/25/2008	SKOPH	445515	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97140		Y	Y	3/18/2008	SKOPH	440533	$60.00	$0.00	$0.00	$60.00	$60.00	957	07/18/2008	142623
	97110		Y	Y	3/18/2008	SKOPH	440533	$84.00	$0.00	$0.00	$84.00	$84.00	957	07/18/2008	142623
	97010		Y	Y	3/18/2008	SKOPH	440533	$20.00	$0.00	$0.00	$20.00	$20.00	957	07/18/2008	142623
	97140		Y	Y	3/14/2008	SMITHC	438040	$60.00	$0.00	$0.00	$60.00	$60.00	957	03/24/2008	142623
	97110		Y	Y	3/14/2008	SMITHC	438040	$84.00	$0.00	$0.00	$84.00	$84.00	957	03/24/2008	142623
	97010		Y	Y	3/14/2008	SMITHC	438040	$20.00	$0.00	$0.00	$20.00	$20.00	957	03/24/2008	142623

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Patient History - Detail

MATT SMITH PHYSICAL THERAPY

By Date of Service
All Date ranges
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All Items

Chart #:	RP18843	**Home Phone:**	
Patient Name:	RODRIQUEZ,ENRIQUE J	**Office Phone:**	
Address:		**Resp. Party:**	RODRIQUEZ,ENRIQUE J
City, State, Zip:		**Resp. Acct#**	142623

U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	97140		Y	Y	3/11/2008	SKOPH	432920	$60.00	$0.00	$0.00	$60.00	$60.00	957	03/19/2008	142623
	97110		Y	Y	3/11/2008	SKOPH	432920	$84.00	$0.00	$0.00	$84.00	$84.00	957	03/19/2008	142623
	97010		Y	Y	3/11/2008	SKOPH	432920	$20.00	$0.00	$0.00	$20.00	$20.00	957	03/19/2008	142623
	97140		Y	Y	3/10/2008	SKOPH	432653	$60.00	$0.00	$0.00	$60.00	$60.00	957	03/19/2008	142623
	97113		Y	Y	3/10/2008	SKOPH	432653	$204.00	$0.00	$0.00	$204.00	$204.00	957	03/19/2008	142623
	97110		Y	Y	3/10/2008	SKOPH	432653	$84.00	$0.00	$0.00	$84.00	$84.00	957	03/19/2008	142623
	97010		Y	Y	3/10/2008	SKOPH	432653	$20.00	$0.00	$0.00	$20.00	$20.00	957	03/19/2008	142623
	97110		Y	Y	3/7/2008	SMITHC	428659	$84.00	$0.00	$0.00	$84.00	$84.00	957	03/13/2008	142623
	97124		Y	Y	3/7/2008	SMITHC	428659	$34.00	$0.00	$0.00	$34.00	$34.00	957	03/13/2008	142623
	97010		Y	Y	3/7/2008	SMITHC	428659	$20.00	$0.00	$0.00	$20.00	$20.00	957	03/13/2008	142623
	97113		Y	Y	3/5/2008	SKOPH	427318	$204.00	$0.00	$0.00	$204.00	$204.00	957	03/17/2008	142623
	97140		Y	Y	3/5/2008	SKOPH	427318	$60.00	$0.00	$0.00	$60.00	$60.00	957	03/17/2008	142623
	97110		Y	Y	3/5/2008	SKOPH	427318	$84.00	$0.00	$0.00	$84.00	$84.00	957	03/17/2008	142623
	97010		Y	Y	3/5/2008	SKOPH	427318	$20.00	$0.00	$0.00	$20.00	$20.00	957	03/17/2008	142623
	97140		Y	Y	3/4/2008	SKOPH	426508	$60.00	$0.00	$0.00	$60.00	$60.00	957	03/12/2008	142623
	97110		Y	Y	3/4/2008	SKOPH	426508	$84.00	$0.00	$0.00	$84.00	$84.00	957	03/12/2008	142623
	97113		Y	Y	3/4/2008	SKOPH	426508	$204.00	$0.00	$0.00	$204.00	$204.00	957	03/12/2008	142623

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Chart #: RP18843
Patient Name: RODRIQUEZ,ENRIQUE J
Address:
City, State, Zip:

Home Phone:
Office Phone:
Resp. Party: RODRIQUEZ,ENRIQUE J
Resp. Acct# 142623

U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	97010		Y	Y	3/4/2008	SKOPH	426508	$20.00	$0.00	$0.00	$20.00	$20.00	957	03/12/2008	142623
	97140		Y	Y	2/19/2008	SKOPH	414801	$60.00	$0.00	$0.00	$60.00	$60.00	957	02/27/2008	142623
	97110		Y	Y	2/19/2008	SKOPH	414801	$84.00	$0.00	$0.00	$84.00	$84.00	957	02/27/2008	142623
	97113		Y	Y	2/19/2008	SKOPH	414801	$204.00	$0.00	$0.00	$204.00	$204.00	957	02/27/2008	142623
	97010		Y	Y	2/19/2008	SKOPH	414801	$20.00	$0.00	$0.00	$20.00	$20.00	957	02/27/2008	142623
	97140		Y	Y	2/14/2008	SKOPH	405890	$60.00	$0.00	$0.00	$60.00	$60.00	957	02/26/2008	142623
	97110		Y	Y	2/14/2008	SKOPH	405890	$84.00	$0.00	$0.00	$84.00	$84.00	957	02/26/2008	142623
	97113		Y	Y	2/14/2008	SKOPH	405890	$204.00	$0.00	$0.00	$204.00	$204.00	957	02/26/2008	142623
	97010		Y	Y	2/14/2008	SKOPH	405890	$20.00	$0.00	$0.00	$20.00	$20.00	957	02/26/2008	142623
	97140		Y	Y	2/13/2008	SKOPH	411013	$60.00	$0.00	$0.00	$60.00	$60.00	957	02/22/2008	142623
	97113		Y	Y	2/13/2008	SKOPH	411013	$204.00	$0.00	$0.00	$204.00	$204.00	957	02/22/2008	142623
	97110		Y	Y	2/13/2008	SKOPH	411013	$84.00	$0.00	$0.00	$84.00	$84.00	957	02/22/2008	142623
	97010		Y	Y	2/13/2008	SKOPH	411013	$20.00	$0.00	$0.00	$20.00	$20.00	957	02/22/2008	142623
	97140		Y	Y	2/11/2008	SKOPH	409491	$60.00	$0.00	$0.00	$60.00	$60.00	957	02/21/2008	142623
	97110		Y	Y	2/11/2008	SKOPH	409491	$84.00	$0.00	$0.00	$84.00	$84.00	957	02/21/2008	142623
	97113		Y	Y	2/11/2008	SKOPH	409491	$204.00	$0.00	$0.00	$204.00	$204.00	957	02/21/2008	142623
	97010		Y	Y	2/11/2008	SKOPH	409491	$20.00	$0.00	$0.00	$20.00	$20.00	957	02/21/2008	142623

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Patient History - Detail

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Chart #: RP18843
Patient Name: RODRIQUEZ,ENRIQUE J
Address:
City, State, Zip:
Home Phone:
Office Phone:
Resp. Party: RODRIQUEZ,ENRIQUE J
Resp. Acct# 142623

U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	97140		Y	Y	2/6/2008	SKOPH	406608	$60.00	$0.00	$0.00	$60.00	$60.00	957	02/18/2008	142623
	97110		Y	Y	2/6/2008	SKOPH	406608	$84.00	$0.00	$0.00	$84.00	$84.00	957	02/18/2008	142623
	97113		Y	Y	2/6/2008	SKOPH	406608	$204.00	$0.00	$0.00	$204.00	$204.00	957	02/18/2008	142623
	97010		Y	Y	2/6/2008	SKOPH	406608	$20.00	$0.00	$0.00	$20.00	$20.00	957	02/18/2008	142623
	97110		Y	Y	2/1/2008	SMITHC	401562	$160.00	$0.00	$0.00	$160.00	$160.00	957	02/11/2008	142623
	97140		Y	Y	2/1/2008	SMITHC	401562	$75.00	$0.00	$0.00	$75.00	$75.00	957	02/11/2008	142623
	97010		Y	Y	2/1/2008	SMITHC	401562	$20.00	$0.00	$0.00	$20.00	$20.00	957	02/11/2008	142623
	97110		Y	Y	1/31/2008	SMITHC	400824	$80.00	$0.00	$0.00	$80.00	$80.00	957	02/07/2008	142623
	97140		Y	Y	1/31/2008	SMITHC	400824	$75.00	$0.00	$0.00	$75.00	$75.00	957	02/07/2008	142623
	97113		Y	Y	1/31/2008	SMITHC	400824	$200.00	$0.00	$0.00	$200.00	$200.00	957	02/07/2008	142623
	97010		Y	Y	1/31/2008	SMITHC	400824	$20.00	$0.00	$0.00	$20.00	$20.00	957	02/07/2008	142623
	97110		Y	Y	1/23/2008	SKOPH	396909	$160.00	$0.00	$0.00	$160.00	$160.00	957	02/06/2008	142623
	97140		Y	Y	1/23/2008	SKOPH	396909	$75.00	$0.00	$0.00	$75.00	$75.00	957	02/06/2008	142623
	97113		Y	Y	1/23/2008	SKOPH	396909	$200.00	$0.00	$0.00	$200.00	$200.00	957	02/06/2008	142623
	97010		Y	Y	1/23/2008	SKOPH	396909	$20.00	$0.00	$0.00	$20.00	$20.00	957	02/06/2008	142623
	97140		Y	Y	1/21/2008	SKOPH	391201	$75.00	$0.00	$0.00	$75.00	$75.00	957	01/29/2008	142623
	97113		Y	Y	1/21/2008	SKOPH	391201	$200.00	$0.00	$0.00	$200.00	$200.00	957	01/29/2008	142623

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Patient History - Detail

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All Items

Chart #: RP18843
Patient Name: RODRIQUEZ,ENRIQUE J
Address:
City, State, Zip:

Home Phone:
Office Phone:
Resp. Party: RODRIQUEZ,ENRIQUE J
Resp. Acct# 142623

U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	97010		Y	Y	1/21/2008	SKOPH	391201	$20.00	$0.00	$0.00	$20.00	$20.00	957	01/29/2008	142623
	97110		Y	Y	1/18/2008	SMITHC	390541	$80.00	$0.00	$0.00	$80.00	$80.00	957	01/31/2008	142623
	97140		Y	Y	1/18/2008	SMITHC	390541	$75.00	$0.00	$0.00	$75.00	$75.00	957	01/31/2008	142623
	97113		Y	Y	1/18/2008	SMITHC	390541	$150.00	$0.00	$0.00	$150.00	$150.00	957	01/31/2008	142623
	97010		Y	Y	1/18/2008	SMITHC	390541	$20.00	$0.00	$0.00	$20.00	$20.00	957	01/31/2008	142623
	97110		Y	Y	1/11/2008	SMITHC	385813	$80.00	$0.00	$0.00	$80.00	$80.00	957	01/24/2008	142623
	97140		Y	Y	1/11/2008	SMITHC	385813	$75.00	$0.00	$0.00	$75.00	$75.00	957	01/24/2008	142623
	97113		Y	Y	1/11/2008	SMITHC	385813	$100.00	$0.00	$0.00	$100.00	$100.00	957	01/24/2008	142623
	97010		Y	Y	1/11/2008	SMITHC	385813	$20.00	$0.00	$0.00	$20.00	$20.00	957	01/24/2008	142623
	97110		Y	Y	1/10/2008	SMITHC	384297	$160.00	$0.00	$0.00	$160.00	$160.00	957	01/17/2008	142623
	97140		Y	Y	1/10/2008	SMITHC	384297	$150.00	$0.00	$0.00	$150.00	$150.00	957	01/17/2008	142623
	97010		Y	Y	1/10/2008	SMITHC	384297	$20.00	$0.00	$0.00	$20.00	$20.00	957	01/17/2008	142623
	97110		Y	Y	1/4/2008	SKOPH	377713	$160.00	$0.00	$0.00	$160.00	$160.00	957	01/14/2008	142623
	97140		Y	Y	1/4/2008	SKOPH	377713	$75.00	$0.00	$0.00	$75.00	$75.00	957	01/14/2008	142623
	97113		Y	Y	1/4/2008	SKOPH	377713	$200.00	$0.00	$0.00	$200.00	$200.00	957	01/14/2008	142623
	97010		Y	Y	1/4/2008	SKOPH	377713	$20.00	$0.00	$0.00	$20.00	$20.00	957	01/14/2008	142623
	97110		Y	Y	1/3/2008	SMITHC	377110	$160.00	$0.00	$0.00	$160.00	$160.00	957	01/14/2008	142623

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Patient History - Detail

MATT SMITH PHYSICAL THERAPY

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All Date ranges
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All Items

Chart #: RP18843
Patient Name: RODRIQUEZ,ENRIQUE J
Address:
City, State, Zip:

Home Phone:
Office Phone:
Resp. Party: RODRIQUEZ,ENRIQUE J
Resp. Acct# 142623

U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	97140		Y	Y	1/3/2008	SMITHC	377110	$75.00	$0.00	$0.00	$75.00	$75.00	957	01/14/2008	142623
	97010		Y	Y	1/3/2008	SMITHC	377110	$20.00	$0.00	$0.00	$20.00	$20.00	957	01/14/2008	142623
	97110		Y	Y	1/2/2008	SKOPH	377026	$160.00	$0.00	$0.00	$160.00	$160.00	957	01/14/2008	142623
	97140		Y	Y	1/2/2008	SKOPH	377026	$75.00	$0.00	$0.00	$75.00	$75.00	957	01/14/2008	142623
	97113		Y	Y	1/2/2008	SKOPH	377026	$200.00	$0.00	$0.00	$200.00	$200.00	957	01/14/2008	142623
	97010		Y	Y	1/2/2008	SKOPH	377026	$20.00	$0.00	$0.00	$20.00	$20.00	957	01/14/2008	142623
	97110		Y	Y	12/27/2007	SMITHC	372953	$160.00	$0.00	$0.00	$160.00	$160.00	957	01/14/2008	142623
	97140		Y	Y	12/27/2007	SMITHC	372953	$150.00	$0.00	$0.00	$150.00	$150.00	957	01/14/2008	142623
	97113		Y	Y	12/27/2007	SMITHC	372953	$200.00	$0.00	$0.00	$200.00	$200.00	957	01/14/2008	142623
	97110		Y	Y	12/19/2007	SKOPH	370617	$160.00	$0.00	$0.00	$160.00	$160.00	957	01/14/2008	142623
	97140		Y	Y	12/19/2007	SKOPH	370617	$75.00	$0.00	$0.00	$75.00	$75.00	957	01/14/2008	142623
	97113		Y	Y	12/19/2007	SKOPH	370617	$200.00	$0.00	$0.00	$200.00	$200.00	957	01/14/2008	142623
	97010		Y	Y	12/19/2007	SKOPH	370617	$20.00	$0.00	$0.00	$20.00	$20.00	957	01/14/2008	142623
	97140		Y	Y	12/18/2007	SKOPH	370243	$75.00	$0.00	$0.00	$75.00	$75.00	957	01/14/2008	142623
	97110		Y	Y	12/18/2007	SKOPH	370243	$160.00	$0.00	$0.00	$160.00	$160.00	957	01/14/2008	142623
	97113		Y	Y	12/18/2007	SKOPH	370243	$200.00	$0.00	$0.00	$200.00	$200.00	957	01/14/2008	142623
	97010		Y	Y	12/18/2007	SKOPH	370243	$20.00	$0.00	$0.00	$20.00	$20.00	957	01/14/2008	142623

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Patient History - Detail

MATT SMITH PHYSICAL THERAPY

By Date of Service
All Date ranges
All Providers
Show last billed date
All Items

Chart #: RP18843
Patient Name: RODRIQUEZ,ENRIQUE J
Address:
City, State, Zip:

Home Phone:
Office Phone:
Resp. Party: RODRIQUEZ,ENRIQUE J
Resp. Acct# 142623

U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	97110		Y	Y	12/17/2007	SKOPH	368129	$160.00	$0.00	$0.00	$160.00	$160.00	957	01/14/2008	142623
	97140		Y	Y	12/17/2007	SKOPH	368129	$75.00	$0.00	$0.00	$75.00	$75.00	957	01/14/2008	142623
	97113		Y	Y	12/17/2007	SKOPH	368129	$200.00	$0.00	$0.00	$200.00	$200.00	957	01/14/2008	142623
	97010		Y	Y	12/17/2007	SKOPH	368129	$20.00	$0.00	$0.00	$20.00	$20.00	957	01/14/2008	142623
	97140		Y	Y	12/14/2007	SMITHC	367628	$75.00	$0.00	$0.00	$75.00	$75.00	957	12/19/2007	142623
	97113		Y	Y	12/14/2007	SMITHC	367628	$200.00	$0.00	$0.00	$200.00	$200.00	957	12/19/2007	142623
	97010		Y	Y	12/14/2007	SMITHC	367628	$20.00	$0.00	$0.00	$20.00	$20.00	957	12/19/2007	142623
	97140		Y	Y	12/12/2007	SMITHC	367061	$75.00	$0.00	$0.00	$75.00	$75.00	957	12/18/2007	142623
	97113		Y	Y	12/12/2007	SMITHC	367061	$150.00	$0.00	$0.00	$150.00	$150.00	957	12/18/2007	142623
	97010		Y	Y	12/12/2007	SMITHC	367061	$20.00	$0.00	$0.00	$20.00	$20.00	957	12/18/2007	142623
	97110		Y	Y	12/10/2007	SKOPH	365619	$160.00	$0.00	$0.00	$160.00	$160.00	957	12/18/2007	142623
	97140		Y	Y	12/10/2007	SKOPH	365619	$75.00	$0.00	$0.00	$75.00	$75.00	957	12/18/2007	142623
	97113		Y	Y	12/10/2007	SKOPH	365619	$200.00	$0.00	$0.00	$200.00	$200.00	957	12/18/2007	142623
	97010		Y	Y	12/10/2007	SKOPH	365619	$20.00	$0.00	$0.00	$20.00	$20.00	957	12/13/2007	142623
	97113		Y	Y	12/7/2007	SMITHC	363783	$200.00	$0.00	$0.00	$200.00	$200.00	957	12/13/2007	142623
	97010		Y	Y	12/7/2007	SMITHC	363783	$20.00	$0.00	$0.00	$20.00	$20.00	957	12/10/2007	142623
	97110		Y	Y	12/5/2007	SKOPH	361894	$160.00	$0.00	$0.00	$160.00	$160.00	957		

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Patient History - Detail

MATT SMITH PHYSICAL THERAPY

By Date of Service
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All Items

Chart #: RP18843
Patient Name: RODRIQUEZ,ENRIQUE J
Address:
City, State, Zip:

Home Phone:
Office Phone:
Resp. Party: RODRIQUEZ,ENRIQUE J
Resp. Acct# 142623

U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	97140		Y	Y	12/5/2007	SKOPH	361894	$75.00	$0.00	$0.00	$75.00	$75.00	957	12/10/2007	142623
	97113		Y	Y	12/5/2007	SKOPH	361894	$200.00	$0.00	$0.00	$200.00	$200.00	957	12/10/2007	142623
	97010		Y	Y	12/5/2007	SKOPH	361894	$20.00	$0.00	$0.00	$20.00	$20.00	957	12/10/2007	142623
	97110		Y	Y	12/3/2007	SKOPH	361156	$160.00	$0.00	$0.00	$160.00	$160.00	957	12/10/2007	142623
	97140		Y	Y	12/3/2007	SKOPH	361156	$75.00	$0.00	$0.00	$75.00	$75.00	957	12/10/2007	142623
	97113		Y	Y	12/3/2007	SKOPH	361156	$200.00	$0.00	$0.00	$200.00	$200.00	957	12/10/2007	142623
	97010		Y	Y	12/3/2007	SKOPH	361156	$20.00	$0.00	$0.00	$20.00	$20.00	957	12/06/2007	142623
	97140		Y	Y	11/28/2007	SKOPH	358609	$75.00	$0.00	$0.00	$75.00	$75.00	957	12/06/2007	142623
	97110		Y	Y	11/28/2007	SKOPH	358609	$160.00	$0.00	$0.00	$160.00	$160.00	957	12/06/2007	142623
	97113		Y	Y	11/28/2007	SKOPH	358609	$200.00	$0.00	$0.00	$200.00	$200.00	957	12/06/2007	142623
	97010		Y	Y	11/28/2007	SKOPH	358609	$20.00	$0.00	$0.00	$20.00	$20.00	957	11/29/2007	142623
	97140		Y	Y	11/19/2007	SKOPH	356023	$70.00	$0.00	$0.00	$70.00	$70.00	957	11/29/2007	142623
	97110		Y	Y	11/19/2007	SKOPH	356023	$90.00	$0.00	$0.00	$90.00	$90.00	957	11/29/2007	142623
	97010		Y	Y	11/19/2007	SKOPH	356023	$20.00	$0.00	$0.00	$20.00	$20.00	957	11/19/2007	142623
	97140		Y	Y	11/8/2007	SKOPH	349667	$70.00	$0.00	$0.00	$70.00	$70.00	957	11/19/2007	142623
	97110		Y	Y	11/8/2007	SKOPH	349667	$45.00	$0.00	$0.00	$45.00	$45.00	957	11/19/2007	142623
	97113		Y	Y	11/8/2007	SKOPH	349667	$200.00	$0.00	$0.00	$200.00	$200.00	957		

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Patient History - Detail

MATT SMITH PHYSICAL THERAPY

By Date of Service
All Date ranges
All Providers
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All Items

Chart #:	RP18843	**Home Phone:**	
Patient Name:	RODRIQUEZ,ENRIQUE J	**Office Phone:**	
Address:	7F	**Resp. Party:**	RODRIQUEZ,ENRIQUE J
City, State, Zip:		**Resp. Acct#**	142623

U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	97010		Y	Y	11/8/2007	SKOPH	349667	$20.00	$0.00	$0.00	$20.00	$20.00	957	11/19/2007	142623
	97140		Y	Y	11/7/2007	SKOPH	349431	$70.00	$0.00	$0.00	$70.00	$70.00	957	11/19/2007	142623
	97110		Y	Y	11/7/2007	SKOPH	349431	$90.00	$0.00	$0.00	$90.00	$90.00	957	11/19/2007	142623
	97113		Y	Y	11/7/2007	SKOPH	349431	$200.00	$0.00	$0.00	$200.00	$200.00	957	11/19/2007	142623
	97010		Y	Y	11/7/2007	SKOPH	349431	$20.00	$0.00	$0.00	$20.00	$20.00	957	11/19/2007	142623
	97140		Y	Y	11/5/2007	SKOPH	348580	$70.00	$0.00	$0.00	$70.00	$70.00	957	11/19/2007	142623
	97110		Y	Y	11/5/2007	SKOPH	348580	$90.00	$0.00	$0.00	$90.00	$90.00	957	11/19/2007	142623
	97113		Y	Y	11/5/2007	SKOPH	348580	$200.00	$0.00	$0.00	$200.00	$200.00	957	11/19/2007	142623
	97010		Y	Y	11/5/2007	SKOPH	348580	$20.00	$0.00	$0.00	$20.00	$20.00	957	11/19/2007	142623
	97140		Y	Y	11/2/2007	SKOPH	348321	$70.00	$0.00	$0.00	$70.00	$70.00	957	11/15/2007	142623
	97110		Y	Y	11/2/2007	SKOPH	348321	$90.00	$0.00	$0.00	$90.00	$90.00	957	11/15/2007	142623
	97113		Y	Y	11/2/2007	SKOPH	348321	$200.00	$0.00	$0.00	$200.00	$200.00	957	11/15/2007	142623
	97010		Y	Y	11/2/2007	SKOPH	348321	$20.00	$0.00	$0.00	$20.00	$20.00	957	11/15/2007	142623
	97140		Y	Y	10/22/2007	SKOPH	339775	$70.00	$0.00	$0.00	$70.00	$70.00	957	10/31/2007	142623
	97110		Y	Y	10/22/2007	SKOPH	339775	$90.00	$0.00	$0.00	$90.00	$90.00	957	10/31/2007	142623
	97113		Y	Y	10/22/2007	SKOPH	339775	$200.00	$0.00	$0.00	$200.00	$200.00	957	10/31/2007	142623
	97010		Y	Y	10/22/2007	SKOPH	339775	$20.00	$0.00	$0.00	$20.00	$20.00	957	10/31/2007	142623

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All Items

Chart #: RP18843
Patient Name: RODRIQUEZ,ENRIQUE J
Address:
City, State, Zip:
Home Phone:
Office Phone:
Resp. Party: RODRIQUEZ,ENRIQUE J
Resp. Acct# 142623

U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	97140		Y	Y	10/12/2007	SKOPH	333839	$70.00	$0.00	$0.00	$70.00	$70.00	957	10/22/2007	142623
	97110		Y	Y	10/12/2007	SKOPH	333839	$90.00	$0.00	$0.00	$90.00	$90.00	957	10/22/2007	142623
	97113		Y	Y	10/12/2007	SKOPH	333839	$200.00	$0.00	$0.00	$200.00	$200.00	957	10/22/2007	142623
	97010		Y	Y	10/12/2007	SKOPH	333839	$20.00	$0.00	$0.00	$20.00	$20.00	957	10/22/2007	142623
	97140		Y	Y	10/10/2007	SKOPH	332212	$70.00	$0.00	$0.00	$70.00	$70.00	957	10/18/2007	142623
	97110		Y	Y	10/10/2007	SKOPH	332212	$90.00	$0.00	$0.00	$90.00	$90.00	957	10/18/2007	142623
	97113		Y	Y	10/10/2007	SKOPH	332212	$200.00	$0.00	$0.00	$200.00	$200.00	957	10/18/2007	142623
	97010		Y	Y	10/10/2007	SKOPH	332212	$20.00	$0.00	$0.00	$20.00	$20.00	957	10/18/2007	142623
	97140		Y	Y	10/9/2007	SKOPH	333355	$70.00	$0.00	$0.00	$70.00	$70.00	957	10/22/2007	142623
	97113		Y	Y	10/9/2007	SKOPH	333355	$200.00	$0.00	$0.00	$200.00	$200.00	957	10/22/2007	142623
	97110		Y	Y	10/9/2007	SKOPH	333355	$90.00	$0.00	$0.00	$90.00	$90.00	957	10/22/2007	142623
	97010		Y	Y	10/9/2007	SKOPH	333355	$20.00	$0.00	$0.00	$20.00	$20.00	957	10/22/2007	142623
	97140		Y	Y	10/3/2007	SKOPH	328638	$70.00	$0.00	$0.00	$70.00	$70.00	957	10/11/2007	142623
	97002		Y	Y	10/3/2007	SKOPH	328638	$60.00	$0.00	$0.00	$60.00	$60.00	957	10/11/2007	142623
	97113		Y	Y	10/3/2007	SKOPH	328638	$200.00	$0.00	$0.00	$200.00	$200.00	957	10/11/2007	142623
	97110		Y	Y	10/3/2007	SKOPH	328638	$90.00	$0.00	$0.00	$90.00	$90.00	957	10/11/2007	142623
	97010		Y	Y	10/3/2007	SKOPH	328638	$20.00	$0.00	$0.00	$20.00	$20.00	957	10/11/2007	142623

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Patient History - Detail

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Chart #: RP18843
Patient Name: RODRIQUEZ,ENRIQUE J
Address:
City, State, Zip:

Home Phone:
Office Phone:
Resp. Party: RODRIQUEZ,ENRIQUE J
Resp. Acct# 142623

U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	97140		Y	Y	10/1/2007	SKOPH	325611	$70.00	$0.00	$0.00	$70.00	$70.00	957	10/09/2007	142623
	97110		Y	Y	10/1/2007	SKOPH	325611	$90.00	$0.00	$0.00	$90.00	$90.00	957	10/09/2007	142623
	97113		Y	Y	10/1/2007	SKOPH	325611	$200.00	$0.00	$0.00	$200.00	$200.00	957	10/09/2007	142623
	97010		Y	Y	10/1/2007	SKOPH	325611	$20.00	$0.00	$0.00	$20.00	$20.00	957	10/09/2007	142623
	97140		Y	Y	9/27/2007	SKOPH	324247	$70.00	$0.00	$0.00	$70.00	$70.00	957	10/03/2007	142623
	97110		Y	Y	9/27/2007	SKOPH	324247	$90.00	$0.00	$0.00	$90.00	$90.00	957	10/03/2007	142623
	97113		Y	Y	9/27/2007	SKOPH	324247	$200.00	$0.00	$0.00	$200.00	$200.00	957	10/03/2007	142623
	97010		Y	Y	9/27/2007	SKOPH	324247	$20.00	$0.00	$0.00	$20.00	$20.00	957	10/03/2007	142623
	97530		Y	Y	9/24/2007	SKOPH	323052	$100.00	$0.00	$0.00	$100.00	$100.00	957	10/02/2007	142623
	97140		Y	Y	9/24/2007	SKOPH	323052	$70.00	$0.00	$0.00	$70.00	$70.00	957	10/02/2007	142623
	97113		Y	Y	9/24/2007	SKOPH	323052	$200.00	$0.00	$0.00	$200.00	$200.00	957	10/02/2007	142623
	97110		Y	Y	9/24/2007	SKOPH	323052	$90.00	$0.00	$0.00	$90.00	$90.00	957	10/02/2007	142623
	97010		Y	Y	9/24/2007	SKOPH	323052	$20.00	$0.00	$0.00	$20.00	$20.00	957	10/02/2007	142623
	97140		Y	Y	9/17/2007	SMITHC	318308	$70.00	$0.00	$0.00	$70.00	$70.00	957	09/28/2007	142623
	97113		Y	Y	9/17/2007	SMITHC	318308	$100.00	$0.00	$0.00	$100.00	$100.00	957	09/28/2007	142623
	97110		Y	Y	9/17/2007	SMITHC	318308	$45.00	$0.00	$0.00	$45.00	$45.00	957	09/28/2007	142623
	97010		Y	Y	9/17/2007	SMITHC	318308	$20.00	$0.00	$0.00	$20.00	$20.00	957	09/28/2007	142623

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Patient History - Detail

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Chart #: RP18843
Patient Name: RODRIQUEZ,ENRIQUE J
Address:
City, State, Zip:

Home Phone:
Office Phone:
Resp. Party: RODRIQUEZ,ENRIQUE J
Resp. Acct# 142623

U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	97140		Y	Y	9/14/2007	SKOPH	317340	$70.00	$0.00	$0.00	$70.00	$70.00	957	09/28/2007	142623
	97113		Y	Y	9/14/2007	SKOPH	317340	$200.00	$0.00	$0.00	$200.00	$200.00	957	09/28/2007	142623
	97110		Y	Y	9/14/2007	SKOPH	317340	$90.00	$0.00	$0.00	$90.00	$90.00	957	09/28/2007	142623
	97010		Y	Y	9/14/2007	SKOPH	317340	$20.00	$0.00	$0.00	$20.00	$20.00	957	09/28/2007	142623
	97530		Y	Y	9/13/2007	METROS	317456	$100.00	$0.00	$0.00	$100.00	$100.00	957	09/21/2007	142623
	97140		Y	Y	9/13/2007	METROS	317456	$70.00	$0.00	$0.00	$70.00	$70.00	957	09/21/2007	142623
	97113		Y	Y	9/13/2007	METROS	317456	$200.00	$0.00	$0.00	$200.00	$200.00	957	09/21/2007	142623
	97110		Y	Y	9/13/2007	METROS	317456	$90.00	$0.00	$0.00	$90.00	$90.00	957	09/21/2007	142623
	97010		Y	Y	9/13/2007	METROS	317456	$20.00	$0.00	$0.00	$20.00	$20.00	957	09/21/2007	142623
	97140		Y	Y	9/7/2007	SMITHC	313541	$70.00	$0.00	$0.00	$70.00	$70.00	957	09/18/2007	142623
	97113		Y	Y	9/7/2007	SMITHC	313541	$100.00	$0.00	$0.00	$100.00	$100.00	957	09/18/2007	142623
	97110		Y	Y	9/7/2007	SMITHC	313541	$45.00	$0.00	$0.00	$45.00	$45.00	957	09/18/2007	142623
	97010		Y	Y	9/7/2007	SMITHC	313541	$20.00	$0.00	$0.00	$20.00	$20.00	957	09/18/2007	142623
	97140		Y	Y	9/6/2007	METROS	311417	$70.00	$0.00	$0.00	$70.00	$70.00	957	09/18/2007	142623
	97530		Y	Y	9/6/2007	METROS	311417	$100.00	$0.00	$0.00	$100.00	$100.00	957	09/18/2007	142623
	97113		Y	Y	9/6/2007	METROS	311417	$200.00	$0.00	$0.00	$200.00	$200.00	957	09/18/2007	142623
	97110		Y	Y	9/6/2007	METROS	311417	$90.00	$0.00	$0.00	$90.00	$90.00	957	09/18/2007	142623

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Chart #:	RP18843	**Home Phone:**	
Patient Name:	RODRIQUEZ,ENRIQUE J	**Office Phone:**	
Address:		**Resp. Party:**	RODRIQUEZ,ENRIQUE J
City, State, Zip:		**Resp. Acct#**	142623

U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	97010		Y	Y	9/6/2007	METROS	311417	$20.00	$0.00	$0.00	$20.00	$20.00	957	09/18/2007	142623
	97113		Y	Y	9/4/2007	SKOPH	309168	$200.00	$0.00	$0.00	$200.00	$200.00	957	09/19/2007	142623
	97110		Y	Y	9/4/2007	SKOPH	309168	$90.00	$0.00	$0.00	$90.00	$90.00	957	09/19/2007	142623
	97140		Y	Y	9/4/2007	SKOPH	309168	$70.00	$0.00	$0.00	$70.00	$70.00	957	09/19/2007	142623
	97010		Y	Y	9/4/2007	SKOPH	309168	$20.00	$0.00	$0.00	$20.00	$20.00	957	09/19/2007	142623
	97140		Y	Y	8/30/2007	SKOPH	307697	$70.00	$0.00	$0.00	$70.00	$70.00	957	09/18/2007	142623
	97113		Y	Y	8/30/2007	SKOPH	307697	$100.00	$0.00	$0.00	$100.00	$100.00	957	09/18/2007	142623
	97110		Y	Y	8/30/2007	SKOPH	307697	$45.00	$0.00	$0.00	$45.00	$45.00	957	09/18/2007	142623
	97010		Y	Y	8/30/2007	SKOPH	307697	$20.00	$0.00	$0.00	$20.00	$20.00	957	09/18/2007	142623
	97530		Y	Y	8/29/2007	SKOPH	307097	$100.00	$0.00	$0.00	$100.00	$100.00	957	09/18/2007	142623
	97140		Y	Y	8/29/2007	SKOPH	307097	$70.00	$0.00	$0.00	$70.00	$70.00	957	09/18/2007	142623
	97113		Y	Y	8/29/2007	SKOPH	307097	$200.00	$0.00	$0.00	$200.00	$200.00	957	09/18/2007	142623
	97110		Y	Y	8/29/2007	SKOPH	307097	$90.00	$0.00	$0.00	$90.00	$90.00	957	09/18/2007	142623
	97010		Y	Y	8/29/2007	SKOPH	307097	$20.00	$0.00	$0.00	$20.00	$20.00	957	09/18/2007	142623
	97530		Y	Y	8/28/2007	SKOPH	307084	$100.00	$0.00	$0.00	$100.00	$100.00	957	09/18/2007	142623
	97140		Y	Y	8/28/2007	SKOPH	307084	$70.00	$0.00	$0.00	$70.00	$70.00	957	09/18/2007	142623
	97113		Y	Y	8/28/2007	SKOPH	307084	$200.00	$0.00	$0.00	$200.00	$200.00	957	09/18/2007	142623

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Patient History - Detail

MATT SMITH PHYSICAL THERAPY

By Date of Service
All Date ranges
All Providers
Show last billed date
All Items

Chart #:	RP18843	**Home Phone:**	
Patient Name:	RODRIQUEZ,ENRIQUE J	**Office Phone:**	
Address:	F	**Resp. Party:**	RODRIQUEZ,ENRIQUE J
City, State, Zip:		**Resp. Acct#**	142623

U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	97110		Y	Y	8/28/2007	SKOPH	307084	$90.00	$0.00	$0.00	$90.00	$90.00	957	09/18/2007	142623
	97010		Y	Y	8/28/2007	SKOPH	307084	$20.00	$0.00	$0.00	$20.00	$20.00	957	09/18/2007	142623
	97530		Y	Y	8/15/2007	SKOPH	300349	$100.00	$0.00	$0.00	$100.00	$100.00	957	08/30/2007	142623
	97140		Y	Y	8/15/2007	SKOPH	300349	$70.00	$0.00	$0.00	$70.00	$70.00	957	08/30/2007	142623
	97113		Y	Y	8/15/2007	SKOPH	300349	$200.00	$0.00	$0.00	$200.00	$200.00	957	08/30/2007	142623
	97110		Y	Y	8/15/2007	SKOPH	300349	$90.00	$0.00	$0.00	$90.00	$90.00	957	08/30/2007	142623
	97010		Y	Y	8/15/2007	SKOPH	300349	$20.00	$0.00	$0.00	$20.00	$20.00	957	08/30/2007	142623
	97530		Y	Y	8/14/2007	SKOPH	299774	$90.00	$0.00	$0.00	$90.00	$90.00	957	08/30/2007	142623
	97113		Y	Y	8/14/2007	SKOPH	299774	$200.00	$0.00	$0.00	$200.00	$200.00	957	08/30/2007	142623
	97110		Y	Y	8/14/2007	SKOPH	299774	$70.00	$0.00	$0.00	$70.00	$70.00	957	08/30/2007	142623
	97010		Y	Y	8/14/2007	SKOPH	299774	$20.00	$0.00	$0.00	$20.00	$20.00	957	08/30/2007	142623
	97530		Y	Y	8/13/2007	SKOPH	298090	$90.00	$0.00	$0.00	$90.00	$90.00	957	08/30/2007	142623
	97140		Y	Y	8/13/2007	SKOPH	298090	$60.00	$0.00	$0.00	$60.00	$60.00	957	08/30/2007	142623
	97113		Y	Y	8/13/2007	SKOPH	298090	$200.00	$0.00	$0.00	$200.00	$200.00	957	08/30/2007	142623
	97110		Y	Y	8/13/2007	SKOPH	298090	$70.00	$0.00	$0.00	$70.00	$70.00	957	08/30/2007	142623
	97010		Y	Y	8/13/2007	SKOPH	298090	$20.00	$0.00	$0.00	$20.00	$20.00	957	08/30/2007	142623
	97113		Y	Y	8/7/2007	SKOPH	297201	$200.00	$0.00	$0.00	$200.00	$200.00	957	08/30/2007	142623

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Patient History - Detail

MATT SMITH PHYSICAL THERAPY

By Date of Service
All Date ranges
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Show last billed date
All Items

Chart #:	RP18843	**Home Phone:**	
Patient Name:	RODRIQUEZ,ENRIQUE J	**Office Phone:**	
Address:		**Resp. Party:**	RODRIQUEZ,ENRIQUE J
City, State, Zip:		**Resp. Acct#**	142623

U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	97140		Y	Y	8/7/2007	SKOPH	297201	$40.00	$0.00	$0.00	$40.00	$40.00	957	08/30/2007	142623
	97110		Y	Y	8/7/2007	SKOPH	297201	$70.00	$0.00	$0.00	$70.00	$70.00	957	08/30/2007	142623
	97530		Y	Y	8/7/2007	SKOPH	297201	$35.00	$0.00	$0.00	$35.00	$35.00	957	08/30/2007	142623
	97014		Y	Y	8/7/2007	SKOPH	297201	$30.00	$0.00	$0.00	$30.00	$30.00	957	08/30/2007	142623
	97010		Y	Y	8/7/2007	SKOPH	297201	$20.00	$0.00	$0.00	$20.00	$20.00	957	08/30/2007	142623
	97002		Y	Y	8/6/2007	SKOPH	297197	$60.00	$0.00	$0.00	$60.00	$60.00	957	08/30/2007	142623
	97140		Y	Y	8/6/2007	SKOPH	297197	$40.00	$0.00	$0.00	$40.00	$40.00	957	08/30/2007	142623
	97110		Y	Y	8/6/2007	SKOPH	297197	$70.00	$0.00	$0.00	$70.00	$70.00	957	08/30/2007	142623
	97113		Y	Y	8/6/2007	SKOPH	297197	$200.00	$0.00	$0.00	$200.00	$200.00	957	08/30/2007	142623
	97530		Y	Y	8/6/2007	SKOPH	297197	$35.00	$0.00	$0.00	$35.00	$35.00	957	08/30/2007	142623
	97010		Y	Y	8/6/2007	SKOPH	297197	$20.00	$0.00	$0.00	$20.00	$20.00	957	08/30/2007	142623
	97010	VOID	Y	N	7/1/2008	SMITHC	537135		$0.00						142623
	97010	VOID	Y	N	6/11/2008	SMITHC	537135		$0.00						142623
	97110	VOID	Y	N	7/1/2008	SMITHC	537135		$0.00						142623
	97110	VOID	Y	N	6/11/2008	SMITHC	537135		$0.00						142623
	97113	VOID	Y	N	7/1/2008	SMITHC	537135		$0.00						142623

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Patient History - Detail

MATT SMITH PHYSICAL THERAPY

By Date of Service
All Date ranges
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Show last billed date
All Items

Chart #:	RP18843	**Home Phone:**	
Patient Name:	RODRIQUEZ,ENRIQUE J	**Office Phone:**	
Address:		**Resp. Party:**	RODRIQUEZ,ENRIQUE J
City, State, Zip:		**Resp. Acct#**	142623

U	Code	Source	I	B	Service Date	Prov	Visit#/ Check#	Charge Amount	Paid/ Applied	Patient Balance	Insurance Balance	Total Balance	Last Billed Carrier	Date Billed	Resp Party This Charge
	97113	VOID	Y	N	6/11/2008	SMITHC	537135		$0.00						142623
Grand Total:								$31,300.00	$0.00	$0.00	$31,300.00	$31,300.00			

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Medical District Surgery Center
2020 Goldring Avenue
Las Vegas, NV 89106
(702) 477-7000

ENRIQUE RODRIGUEZ (106590)

RI

Billing message: No message assigned

Trans date	Post date	Facility	Proc/jnl qc	Procedure / journal description	DX1	Provider	Amount	Due
03/30/06	04/04/06	MDSC	64483	INJECTION, ANESTHETIC AGENT	724.4	KIDWELL	4,564.94	4,564.94
03/30/06	04/04/06	MDSC	76005	FLUOROSCOPIC GUIDANCE (ESI,	724.4	KIDWELL	570.35	570.35
04/13/06	04/18/06	MDSC	62310	INJECTION, SINGLE (NOT VIA INI	723.1	KIDWELL	2,100.00	2,100.00
04/13/06	04/18/06	MDSC	76005	FLUOROSCOPIC GUIDANCE (ESI,	723.1	KIDWELL	570.35	570.35
04/27/06	05/02/06	MDSC	64483	INJECTION, ANESTHETIC AGENT	724.2	KIDWELL	4,564.94	4,564.94
04/27/06	05/02/06	MDSC	76005	FLUOROSCOPIC GUIDANCE (ESI,	724.2	KIDWELL	570.35	570.35
05/04/06	05/09/06	MDSC	62310	INJECTION, SINGLE (NOT VIA INI	723.1	KIDWELL	2,100.00	2,100.00
05/04/06	05/09/06	MDSC	76005	FLUOROSCOPIC GUIDANCE (ESI,	723.1	KIDWELL	570.35	570.35
07/20/06	07/26/06	MDSC	64479	INJECTION, ANESTHETIC AGENT	723.1	KIDWELL	4,200.00	4,200.00
07/20/06	07/26/06	MDSC	64483	INJECTION, ANESTHETIC AGENT	724.2	KIDWELL	4,564.94	4,564.94
07/20/06	07/26/06	MDSC	64484	INJECTION, ANESTHETIC AGENT	724.2	KIDWELL	2,076.00	2,076.00
07/20/06	07/26/06	MDSC	76005	FLUOROSCOPIC GUIDANCE (ESI,	724.2	KIDWELL	570.35	570.35

Totals:				
	Charge:	27,022.57		
	Payment:	0.00	CP:	0.00
	Writeoff:	0.00	CW:	0.00
	Debit:	0.00	CD:	0.00
	Patient bal:	0		
	Account bal:	27022.57		

YAKOV B TREYZON, M.D.
5901 OLYMPIC BLVD., #203
LOS ANGELES CA 90036

(323) 930-1331

04/29/09

BILLING:
JONATHAN WEBER, ESQ
2029 CEONTURY PK E 2100
LOS ANGELES CA 90067

PATIENT:
ENRIQUE RODRIGUEZ

DATE	PROC ID	DESCRIPTION	AMOUNT
04/20/06	99243	CONFIRMATORY CONSULTATIO	285.00
04/20/06	93000	EKG, RESTING	60.00
04/20/06	93010	EKG INTERPRETATION	25.00
04/20/06	93040	RHYTHM STRIP	35.00
04/20/06	71020	CHEST X-RAY, PA & LATERAL	98.00
04/20/06	36415	VENIPUNCTURE	16.00
04/20/06	99000	HANDLING	10.00
04/20/06	99080	INTERPRETATION, MED / LAB	52.00
04/20/06	85021	COMPLETE BLOOD COUNT	5.00
04/20/06	85007	DIFFERENTIAL	5.00
04/20/06	85650	ESR	10.00
04/20/06	86610	PROTHROMBIN TIME	5.40
04/20/06	85730	PARTIAL PROTHROMBIN TIME	6.60
04/20/06	81000	UA & MICRO	8.50
04/20/06	80004	ELECTROLYTE PANEL	52.00

BALANCE DUE: 673.50

INVOICE #: 35305-09040132
CLAIM #:
FEDERAL TAX ID# : 95-4029808

MAR-24-2010 10:47 From:MIHS/TREYZON/ROBERTS 3239301354 To:17022282333 P.2/10

PLEASE DO NOT STAPLE IN THIS AREA

PERSONAL INJURY

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)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ ENRIQUE

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

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

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

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

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

CITY: STATE: CA

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

CITY: STATE: CA

ZIP CODE: 92506 TELEPHONE (Include Area Code):

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

ZIP CODE: 92506 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: NA

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH 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? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: PERSONAL INJURY

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 SIGNED DATE 07/25/2006

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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: TAUBER , JACOB

17a. I.D. NUMBER OF REFERRING PHYSICIAN: A48598

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 [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 726 90
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: LIEN 7/26

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 25 06	07 25 06	11	4	73721	LT	1	1430.00	1				009803920
				MRI LOWER EXTREMITY ANY								
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN: 95-4651287 [X]

26. PATIENT'S ACCOUNT NO.: 1589676

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

28. TOTAL CHARGE: $ 1430.00

29. AMOUNT PAID: $

30. BALANCE DUE: $1430.00

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.)
DARDASHTI, SIAMAK MD
SIGNED 07/31/2006 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
BEVERLY RADIOLOGY MED G
RP-- WILSHIRE
8750 WILSHIRE BLVD # 100
BEVERLY HILLS CA 90211

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
BEVERLY RADIOLOGY MED GRP - W
PO BOX 240086
LOS ANGELES, CA 90024
PIN# 009803920 GRP#

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

Beverly Tower Imaging 0000003 347/BCF /P/ 7

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

ENRIQUE RODRIQUEZ

Store #	Rx #	Pt First Name	Pt Last Name	Filled Date	NDC	Drug Name	Filled Qty	Birthdate	Sex	Address	City	St	Zip	Prescriber First	Prescriber Last	DEA #	Ins. Billed	Price	Pt Co-Pay
2688	6052041	ENRIQUE	RODRIQUEZ	08/02/2006	49884077901	IBUPROFEN 800MG TAB PAR	90	07/15/1963	M	15980 RAWHIDE LANE	RIVERSIDE	CA	92504	VIDHYA	KOKA	BT5160798	Y	$06.50	$00.00
2688	6052042	ENRIQUE	RODRIQUEZ	08/02/2006	00603221321	AMITRIPTYLINE 25MG TAB QUAL	60	07/15/1963	M	15980 RAWHIDE LANE	RIVERSIDE	CA	92504	VIDHYA	KOKA	BT5160798	Y	$05.56	$00.00
2688	4006829	ENRIQUE	RODRIQUEZ	08/02/2006	00378047701	DIAZEPAM 10MG TAB MYLA	30	07/15/1963	M	15980 RAWHIDE LANE	RIVERSIDE	CA	92504	VIDHYA	KOKA	BT5160798	Y	$03.68	$00.00
2688	6052043	ENRIQUE	RODRIQUEZ	08/02/2006	50111004801	FLUOXETINE 20MG CAP PLIV	60	07/15/1963	M	15980 RAWHIDE LANE	RIVERSIDE	CA	92504	VIDHYA	KOKA	BT5160798	Y	$13.97	$00.00
2688	6052039	ENRIQUE	RODRIQUEZ	08/02/2006	00591065801	BUSPIRONE 10MG TAB WATS	60	07/15/1963	M	15980 RAWHIDE LANE	RIVERSIDE	CA	92504	VIDHYA	KOKA	BT5160798	Y	$11.71	$00.00
2688	2001415	ENRIQUE	RODRIQUEZ	08/02/2006	60951065370	MORPHINE SUL 30MG ERTAB ENDO	60	07/15/1963	M	15980 RAWHIDE LANE	RIVERSIDE	CA	92504	VIDHYA	KOKA	BT5160798	Y	$71.19	$00.00
2688	4006830	ENRIQUE	RODRIQUEZ	08/23/2006	00071101468	LYRICA 75MG CAP PFIZ	30	07/15/1963	M	15980 RAWHIDE LANE	RIVERSIDE	CA	92504	VIDHYA	KOKA	BT5160798	Y	$54.60	$00.00

Statement of Account

JACOB E TAUBER MD
9033 WILSHIRE BL STE 401
BEVERLY HILLS, CA 90211
Tax ID 953746611
(323) 655-2968

Page #
1

Account No.	Date
0000059650	06/29/2009

WM. JONATHAN WEBER ESQ
BENSON,BERTOLDO,BAKER,CARTER
7408 W SAHARA AVE
LAS VEGAS, NV 89117

PATIENT ENRIQUE RODRIGUEZ
DATE OF INJURY 11/22/2004
CASE #
VS
FILE #

Date	CPT	Description	Ref	Charges	Credits
04/21/2006	29881	ARTHROS KNEE; W/MENISECT (	61114	3500.00	
04/21/2006	29874 51	ARTHROSCOPY KNEE SURG; RE	61114	1450.00	
04/21/2006	29876 51	ARTHROSCOPY KNEE; SYNOVE	61114	1450.00	
04/21/2006	29877 51	ARTHROS KNEE; DEBRID/SHAV	61114	1450.00	
02/14/2006	99245	OFFIC CONS NEW/ESTAB MOD-I	916220	500.00	
02/14/2006	73600	RAD EXAM ANK; AP & LAT VIE	916220	75.00	
02/14/2006	99080	SPEC REPORT >INFO IN USUAL	916220	60.00	
02/14/2006	99080	SPEC REPORT >INFO IN USUAL	916220	160.00	
05/02/2006	99211	OFFIC/OUTPT E&M ESTAB 5 MIN	916785		0.00
05/02/2006	99080	SPEC REPORT >INFO IN USUAL	916785	60.00	
06/06/2006	99244	OFFIC CONS NEW/ESTAB MOD-I	917071	200.00	
06/06/2006	99080	SPEC REPORT >INFO IN USUAL	917071	60.00	
07/25/2006	99244	OFFIC CONS NEW/ESTAB MOD-I	917424	200.00	
07/25/2006	99080	SPEC REPORT >INFO IN USUAL	917424	60.00	
08/01/2006	99244	OFFIC CONS NEW/ESTAB MOD-I	917495	200.00	
08/01/2006	99080	SPEC REPORT >INFO IN USUAL	917495	60.00	
09/19/2006	99244	OFFIC CONS NEW/ESTAB MOD-I	917874	200.00	

0 - 30 Days Current	31 - 60 Days Past Due	61 - 90 Days Past Due	91 - 120 Days Past Due	> 120 Days Past Due

Balance Due

DIAGNOSIS 717.9 INT DERANGEMENT KNEE NOS

Statement of Account

JACOB E TAUBER MD
9033 WILSHIRE BL STE 401
BEVERLY HILLS, CA 90211
Tax ID:953746611
(323) 655-2968

Page #
2

Account No.	Date
0000059650	06/29/2009

WM. JONATHAN WEBER ESQ
BENSON,BERTOLDO,BAKER,CARTER
7408 W SAHARA AVE
LAS VEGAS, NV 89117

PATIENT ENRIQUE RODRIGUEZ
DATE OF INJURY 11/22/2004
CASE #
VS
FILE #

Date	CPT	Description	Ref	Charges	Credits
09/19/2006	99080	SPEC REPORT >INFO IN USUAL I	917874	60.00	

0 - 30 Days Current	31 - 60 Days Past Due	61 - 90 Days Past Due	91 - 120 Days Past Due	> 120 Days Past Due
$0.00	$0.00	$0.00	$0.00	$9745.00

Balance Due
$9745.00

DIAGNOSIS 717.9 INT DERANGEMENT KNEE NOS

UNIVERSITY OF CALIFORNIA, LOS ANGELES

UCLA

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

POSTED
OCT 19 2006

F. Michael Ferrante, M.D.
Director, Pain Medicine Center
Professor of Clinical Anesthesiology and Medicine
Office 310 319-2241
Fax 310 319-2260
E-mail mferrante@mednet.ucla.edu

PAIN MEDICINE CENTER
1245 16th STREET, SUITE 225
SANTA MONICA, CALIFORNIA 90404

check request per Jonathan 10/26/05

October 12, 2006

Jonathan Webber
Benson, Bertoldo, Baker & Carter
7408 W. Sahara Ave
Las Vegas, NV 89117

RE: Enrique (Henry) Rodriguez

Dear Mr. Webber:

Thank you for the opportunity to review pertinent records, to interview the patient, and to offer opinions in the above referenced case. Below please find an itemized list of my fees for work regarding this case:

	0.75hours	History	0.75 hours@ $500/hour = $375
	0.75hours	Physical exam	0.75 hours@ $500/hour = $375
	1.5 hours	Preparation of report	1.5 hours @ $500/hour = $750
Totals	3 hours @ $500/hour = $1500		

Total = $1500

My Tax ID # is: 32-0149526.

Please send a check made **payable to Ferrante & Associates, Inc.** for $1,500. Please mail to:

528 Pacific Palisades Drive, #713
Pacific Palisades, CA
90272-1903

Thank you,

F. Michael Ferrante

F. Michael Ferrante, MD

QUALITY RESP SOLUTION
20818 HIGGINS COURT
TORRANCE CA 90501
310-533-5414

DATE 12/12/2006
PO:

TAX ID: 43-1565704

ACCOUNT:000000000833

ENRIQUE RODRIGUEZ

AMOUNT ENCLOSED $

W JONATHAN WEBER ESQ
LAW OFFICE
7408 W SAHARA AVENUE
LAS VEGAS NV 89117

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

ATE FROM/THRU	INVOICE #	QTY	CODE	DESCRIPTION	UNIT COST	CHARGE	PAYMENTS
/2/06/06 - 12/06/06	0000008677	1	A7030	FULL FACE MASK FOR CPAP SN:	315.03	315.03	
/2/06/06 - 12/06/06	0000008677	1	A7036	CHINSTRAP FOR CPAP DEVICE SN:	30.39	30.39	

TOTAL CHARGES = 345.42
PMTS/CRED/DISC = 0.00
BALANCE DUE = 345.42

Quality Resp. Solu. 0000001

INVOICE

QUALITY RESP SOLUTON<KMS>

20816 HIGGINS COURT
TORRANCE CA 90501
PHONE: 310-533-8800

000000000833 . 0000002147

DATE: 10/26/2006 PAGE: 1

BILL TO:

ENRIQUE RODRIGUEZ

ADDITIONAL BILLING INFORMATION

W JONATHAN WEBER ESQ
LAW OFFICE 7408 W SAHARA AVENUE
LAS VEGAS NV 89117

DOCTOR INFORMATION

REFERRING DOCTOR: DANIEL H KIM
PROVIDER #:
UPIN #: F89258

ADDITIONAL INFORMATION

DX1: 780.51 OSA OBSTRUCTIVE SLEEP APNEA
DX2:
DX1:
DX4:

DATE	CODE				*RENT IND	CHARGE	ALLOWABLE	PATIENT PORTION
********	**********				****	*********	*********	*********
02/17/2006	E0601	1	RR	CPAP POLARIS EX W HEAT HUMIDIFER	R	1757.80	1757.80	
02/17/2006	A7034	1	P	NASAL PILLOW INTERFACE FOR CPAP	P	196.46	196.46	
02/17/2006	A7035	1	P	HEADGEAR FOR CPAP DEVICE	P	66.38	66.38	
02/17/2006	A7036	1	P	CHINSTRAP FOR CPAP DEVICE	P	30.39	30.39	
02/17/2006	A7037	1	P	TUBING FOR CPAP DEVICE	P	68.50	68.50	
02/17/2006	A7038	1	P	FILTER FOR CPAP DEVICE	P	9.00	9.00	
02/17/2006	E0562	1	P	HUMIDIFIER HEATED FOR CPAP/BIPAP	P	503.04	503.04	

NOTE: R=Rental P=Purchase O=N/A

TOTALS:

2631.57 2631.57

FP1503

INVOICE

QUALITY RESP SOLUTON<KMS>

20816 HIGGINS COURT
TORRANCE CA 90501
PHONE: 310-533-8800

000000000833 0000005376

DATE: 10/26/2006 PAGE: 1

BILL TO:

ENRIQUE RODRIGUEZ

ADDITIONAL BILLING INFORMATION

W JONATHAN WEBER ESQ
LAW OFFICE 7408 W SAHARA AVENUE
LAS VEGAS NV 89117

DOCTOR INFORMATION

REFERRING DOCTOR: DANIEL H KIM
PROVIDER #:
UPIN #: F89258

ADDITIONAL INFORMATION

DX1: 780.51 OSA OBSTRUCTIVE SLEEP APNEA
DX2:
DX1:
DX4:

DATE	CODE				*RENT IND	CHARGE	ALLOWABLE	PATIENT PORTION
********	**********				****	*********	*********	*********
07/20/2006	A7034	1	P	NASAL MASK COMFORT LITE II M/L	P	196.46	117.64	
07/20/2006	A7035	1	P	HEADGEAR FOR CPAP DEVICE	P	66.38	39.75	
07/20/2006	A7033	1	P	PILLOWS FOR CPAP	P	47.44	28.41	
07/26/2006	WA			WRITE-OFF ALLOWABLE	0			

NOTE: R=Rental P=Purchase 0=N/A

TOTALS:

310.28 185.80

FP1504

Quality Resp. Solu. 0000017

Family Wellness Clinic
10001 S. Eastern Ave #209
Henderson, NV 89052
(702)837-4397

Statement Date	Page
2/14/2007	1

Enrique J. Rodriguez

Chart Number
RODEN000

MasterCard and Visa Accepted

Date of Last Patient Payment: Amount: 0.00

Patient: Enrique J. Rodriguez Chart Number: RODEN000 Case: EMG

Dates	Procedure	Procedure	Charge	Amount Paid by Insurance	Paid By Guarantor	Adjustments	Remainder
01/18/07	95861	EMG 2 Extremities	630.00	0.00		0.00	630.00
01/18/07	95900	NRV Conduction Motor EA	740.00	0.00		0.00	740.00
01/18/07	95904	Nerve Conduction Motor EA	748.00	0.00		0.00	748.00

Total Charges	Total Payments	Total Adjustments	Balance Due
2,118.00	0.00	0.00	**2,118.00**

Family Wellness 0000001

Run Date: 8/27/08

Patient Ledger History

WALTER M KIDWELL, P O BOX 80210, LAS VEGAS, NV 89180-0000
702 878-8252

Acct Num: 14939.00
SSN:
Pat Type: 8/LIEN
DOB: Sex: M
Empl/Sch: NONE
Home Ph:
Work Ph: 000 000-0000

ENRIQUE RODRIGUEZ

Ins:4816 BENSON, BERTOLDO, Pol #: 562294767 Group:

Date	Patient	Procedure Description	Amount	DailyTot	Balance
		--Filed: 7/11/06--BENSON, BERTOLDO, BAKER &			
7/10/06	ENRIQUE	/EST. PT OFFICE 4	255.00	255.00	6735.00
7/13/06	ENRIQUE	PINSFILE/BENSON, BERTOLDO, BAKER			0.00
		--Filed: 7/27/06--BENSON, BERTOLDO, BAKER &			
7/20/06	ENRIQUE	/TRANSFORAMINAL EPID CERV/T	850.00	850.00	7585.00
7/20/06	ENRIQUE	/TRANSFORAMINAL EPID CERV	425.00	1275.00	8010.00
7/20/06	ENRIQUE	/FLOUROSCOPY	190.00	1465.00	8200.00
7/20/06	ENRIQUE	/CONSCIOUS SEDATION 30 MINS	240.00	1705.00	8440.00
7/20/06	ENRIQUE	/TRANSFORAMINAL EPID LUMB/S	680.00	2385.00	9120.00
7/20/06	ENRIQUE	058/TRANSFORAMINAL EPID LU	340.00	2725.00	9460.00
7/27/06	ENRIQUE	PINSFILE/BENSON, BERTOLDO, BAKER			0.00
		--Filed: 8/10/06--BENSON, BERTOLDO, BAKER &			
8/07/06	ENRIQUE	/EST. PT OFFICE 4	255.00	255.00	9715.00
8/10/06	ENRIQUE	PINSFILE/BENSON, BERTOLDO, BAKER			0.00
		--Filed: 9/21/06--BENSON, BERTOLDO, BAKER &			
9/12/06	ENRIQUE	/EST. PT OFFICE 4	255.00	255.00	9970.00
9/22/06	ENRIQUE	PINSFILE/BENSON, BERTOLDO, BAKER			0.00
		--Filed:10/11/06--BENSON, BERTOLDO, BAKER &			
10/09/06	ENRIQUE	/EST. PT OFFICE 4	255.00	255.00	10225.00
10/12/06	ENRIQUE	PINSFILE/BENSON, BERTOLDO, BAKER			0.00
		--Filed:11/15/06--BENSON, BERTOLDO, BAKER &			
11/06/06	ENRIQUE	/EST. PT OFFICE 4	255.00	255.00	10480.00
11/16/06	ENRIQUE	PINSFILE/BENSON, BERTOLDO, BAKER			0.00
		--Filed:12/13/06--BENSON, BERTOLDO, BAKER &			
12/04/06	ENRIQUE	/EST. PT OFFICE 4	255.00	255.00	10735.00
12/14/06	ENRIQUE	PINSFILE/BENSON, BERTOLDO, BAKER			0.00
		--Filed: 1/18/07--BENSON, BERTOLDO, BAKER &			
1/03/07	ENRIQUE	/EST. PT OFFICE 4	255.00	255.00	10990.00
1/22/07	ENRIQUE	PINSFILE/BENSON, BERTOLDO, BAKER			0.00
		--Filed: 2/12/07--BENSON, BERTOLDO, BAKER &			
2/05/07	ENRIQUE	/EST. PT OFFICE 4	382.00	382.00	11372.00
2/13/07	ENRIQUE	PINSFILE/BENSON, BERTOLDO, BAKER			0.00

Curr: 0.00 30: 0.00 60: 0.00 90: 0.00 120: 11372.00

Run Date: 8/27/08

Patient Ledger History

WALTER M KIDWELL, P O BOX 80210, LAS VEGAS, NV 89180-0000

702 878-8252 Acct Num: 14939.00

ENRIQUE RODRIGUEZ

SSN:
Pat Type: 8/LIEN
DOB: Sex: M
Empl/Sch: NONE
Home Ph:
Work Ph: 000 000-0000

Ins:4816 BENSON, BERTOLDO, Pol #: 562294767 Group:

Date	Patient	Procedure Description	Amount	DailyTot	Balance
Curr: 0.00	30: 0.00	60: 0.00	90: 0.00	120: 0.00	
---------- Open Claims with Insurance ----------					
		--Filed: 3/24/06--BENSON, BERTOLDO, BAKER &			
3/20/06	ENRIQUE	/CONSULT OFFICE 4	595.00	595.00	595.00
3/24/06	ENRIQUE	PINSFILE/BENSON, BERTOLDO, BAKER			0.00
6/22/06	ENRIQUE	PINSFILE/BENSON, BERTOLDO, BAKER			0.00
		--Filed: 4/03/06--BENSON, BERTOLDO, BAKER &			
3/30/06	ENRIQUE	/TRANSFORAMINAL EPID LUMB/S	680.00	680.00	1275.00
3/30/06	ENRIQUE	/TRANSFORAMINAL EPID LUMB	340.00	1020.00	1615.00
3/30/06	ENRIQUE	/FLOUROSCOPY	190.00	1210.00	1805.00
3/30/06	ENRIQUE	/CONSCIOUS SEDATION 30 MINS	240.00	1450.00	2045.00
4/03/06	ENRIQUE	PINSFILE/BENSON, BERTOLDO, BAKER			0.00
6/22/06	ENRIQUE	PINSFILE/BENSON, BERTOLDO, BAKER			0.00
		--Filed: 4/19/06--BENSON, BERTOLDO, BAKER &			
4/13/06	ENRIQUE	/EPIDRAL/SUBARACH INJ. CERV	765.00	765.00	2810.00
4/13/06	ENRIQUE	/FLOUROSCOPY	190.00	955.00	3000.00
4/13/06	ENRIQUE	/CONSCIOUS SEDATION 30 MINS	240.00	1195.00	3240.00
4/19/06	ENRIQUE	PINSFILE/BENSON, BERTOLDO, BAKER			0.00
6/22/06	ENRIQUE	PINSFILE/BENSON, BERTOLDO, BAKER			0.00
		--Filed: 5/02/06--BENSON, BERTOLDO, BAKER &			
4/27/06	ENRIQUE	/TRANSFORAMINAL EPID LUMB/S	680.00	680.00	3920.00
4/27/06	ENRIQUE	/TRANSFORAMINAL EPID LUMB	340.00	1020.00	4260.00
4/27/06	ENRIQUE	/FLOUROSCOPY	190.00	1210.00	4450.00
4/27/06	ENRIQUE	/CONSCIOUS SEDATION 30 MINS	240.00	1450.00	4690.00
5/03/06	ENRIQUE	PINSFILE/BENSON, BERTOLDO, BAKER			0.00
6/22/06	ENRIQUE	PINSFILE/BENSON, BERTOLDO, BAKER			0.00
		--Filed: 5/08/06--BENSON, BERTOLDO, BAKER &			
5/04/06	ENRIQUE	/EPIDRAL/SUBARACH INJ. CERV	765.00	765.00	5455.00
5/04/06	ENRIQUE	/FLOUROSCOPY	190.00	955.00	5645.00
5/04/06	ENRIQUE	/CONSCIOUS SEDATION 30 MINS	240.00	1195.00	5885.00
5/08/06	ENRIQUE	PINSFILE/BENSON, BERTOLDO, BAKER			0.00
6/22/06	ENRIQUE	PINSFILE/BENSON, BERTOLDO, BAKER			0.00
		--Filed: 6/30/06--BENSON, BERTOLDO, BAKER &			
6/29/06	ENRIQUE	/CONSULT OFFICE 4	595.00	595.00	6480.00
7/06/06	ENRIQUE	PINSFILE/BENSON, BERTOLDO, BAKER			0.00

PATIENT STATEMENT OF ACCOUNT

STATEMENT OF SERVICES RENDERED

SERVICE DATE	CASE NUMBER	CPT CODE	DESCRIPTION OF PROCEDURE OR SERVICE	CHARGES / PAYMENT & ADJ. PATIENT	INSURANCE
03/14/2007	5171380	64520	Anesthesiology Services by Dr. G. MARTINEZ for Dr. L.Miller Billed To Patient	700.00	
04/18/2007	5231819	64520	Anesthesiology Services by Dr. B. PAKULA for Dr. L.Miller Billed To Patient	800.00	

FINAL NOTICE BEFORE COLLECTIONS

You must respond within 15 days

CURRENT	OVER 30 DAYS	OVER 60 DAYS	OVER 90 DAYS	OVER 120 DAYS	NEW BALANCE	PATIENT	INSURANCE
$ 0.00	$ 0.00	$ 0.00	$ 1500.00	$ 0.00		$ 1500.00	$ 0.00

ACCOUNT NO.	STATEMENT DATE
396700000	10/24/2007

PATIENT IS RESPONSIBLE FOR "PATIENT NEW BALANCE"
PAYMENT IS DUE WITHIN 15 DAYS OF RECEIPT OF STATEMENT.

OFFICE HOURS 8:00AM-7:00PM EST

Phone No: 1-800-835-4495

** CREDIT CARD PAYMENTS PROCESSED BY ANESTHESIOLOGY SERVICES AUGUSTA, GA **

THIS IS A BILL FOR SERVICES NOT INCLUDED ON YOUR HOSPITAL BILL. PLEASE CALL OUR OFFICE WITH QUESTIONS CONCERNING YOUR BILL. IF PAYMENT HAS BEEN MADE PLEASE DISREGARD THIS BILL. THANK YOU.

Should we be required to place this account with a collections agency you may be responsible for all collection and or legal fees associated with that action.

Olympic Anesthesia Partnership
804 Scott Nixon Memorial Dr
Augusta, GA 30907-2464

ACCOUNT NO.	CODE	STATEMENT DATE
396700000	FP456	10/24/2007

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ VISA ☐ DISCOVER ☐ AM. EX.

CARD NUMBER | EXP. DATE

SIGNATURE (REQUIRED)

PRINT NAME ON CARD | PAY THIS AMOUNT $ 1500.00

SHOW AMOUNT PAID HERE $

Pay your bill Online at: WWW.PATIENTACCOUNTS.NET

ADDRESSEE

☐ CHECK HERE FOR ADDRESS CHANGE. PLEASE MAKE CHANGES ON BACK

7607******MIXED AADC 308
Enrique Rodriguez
7408 W Sahara Ave
C O JONATHAN WEBER
Las Vegas, NV 89117-2740

MAKE CHECK PAYABLE TO

Olympic Anesthesia Partnership
804 Scott Nixon Memorial Dr
Augusta, GA 30907-2464

DETACH AND RETURN BOTTOM PORTION WITH PAYMENT

Service History Record
11/03/08

WILSHIRE SURGICENTER, INC.
11999 SAN VICENTE BL,#440
LOS ANGELES, CA 90049
310-440-3131

Provider
WILSHIRE SURGICENTER, IN
Dr ID: 954716116
Lic#:
ATTYSB8
PL

ENRIQUE J RODRIGUEZ

Rc: ENRIQUE J RODRIGUEZ

Date	CPT	Dx	Description	Charges
04/21/06	360	836.0	Surgical Room Charges29881	9,580.00
04/21/06	270	836.0	Med/Surg Suppl29881	7,308.00
04/21/06	250	836.0	Medication Chrg29881	1,103.00

Total Charges 17,991.00

BALANCE 17,991.00

rsuperb 4.38 09:46

Service History Record
11/03/08

WILSHIRE SURGICENTER, INC.
11999 SAN VICENTE BL,#440
LOS ANGELES, CA 90049
310-440-3131

Provider
WILSHIRE SURGICENTER, IN
Dr ID: 954716116
Lic#:
ATTYSB8
PL

ENRIQUE J RODRIGUEZ

Re: ENRIQUE J RODRIGUEZ

Date	CPT	Dx	Description	Charges
03/14/07	360	355.8	Surgical Room Charges64520	2,332.00
03/14/07	270	355.8	Med/Surg Suppl64520	1,312.00
03/14/07	250	355.8	Medication Chrg64520	486.00
04/18/07	360	355.8	Surgical Room Charges64520	2,305.00
04/18/07	270	836.0	Med/Surg Suppl64520	1,395.00
04/18/07	250	355.8	Medication Chrg64520	430.00

Total Charges 8,260.00

BALANCE 8,260.00

rsuperb 4.38 09:46

TOTAL P.03

NEVADA EAR,NOSE&THROAT CENTER

Patient Ledger

Sorted By: Case Number

Entry	Date	POS	Description	Case	Procedure	Document	Provider	Amount
RODEN000	ENRIQUE J RODRIGUEZ			2				
	Last Payment: -14.00		On: 6/24/2007					
34731	1/4/2006	11		8097	99243	0601060000	DHK	360.00
35170	1/7/2006		Patient statement was billed	8097	BILLED	0601060000	DHK	0.00
39870	3/1/2006		Patient statement was billed	8097	BILLED	0601060000	DHK	0.00
91044	10/25/2007		Patient statement was billed	8097	PTBILLED	0601060000	DHK	0.00
91053	10/25/2007		Patient statement was billed	8097	PTBILLED	0601060000	DHK	0.00
37932	2/8/2006	11		8716	99213	0602090000	DHK	155.00
38027	2/10/2006		Patient statement was billed	8716	BILLED	0602090000	DHK	0.00
39871	3/1/2006		Patient statement was billed	8716	BILLED	0602090000	DHK	0.00
91045	10/25/2007		Patient statement was billed	8716	PTBILLED	0602090000	DHK	0.00
64408	11/28/2006	11		12823	99213	0612010000	DHK	162.00
64516	12/3/2006		Patient statement was billed	12823	PTBILLED	0612010000	DHK	0.00
91046	10/25/2007		Patient statement was billed	12823	PTBILLED	0612010000	DHK	0.00
68187	1/5/2007	11		13305	99213	0701160000	DHK	183.00
68408	1/16/2007		Patient statement was billed	13305	PTBILLED	0701160000	DHK	0.00
91047	10/25/2007		Patient statement was billed	13305	PTBILLED	0701160000	DHK	0.00
79859	5/24/2007	11		15252	99213	0705260000	DHK	183.00
79978	5/28/2007		Patient statement was billed	15252	PTBILLED	0705260000	DHK	0.00
91048	10/25/2007		Patient statement was billed	15252	PTBILLED	0705260000	DHK	0.00
79860	5/24/2007	11		15253	SINUS	0705260000	DHK	14.00
79861	5/24/2007	11	COPAYMENT-CASH	15253	COPAYCASH	0705260000	DHK	-14.00
79979	5/28/2007		Patient statement was billed	15253	PTBILLED	0705260000	DHK	0.00
91054	10/25/2007		Patient statement was billed	15253	PTBILLED	0705260000	DHK	0.00
102256	2/20/2008	11		18484	99213	0802230000	DHK	183.00
102257	2/20/2008	11		18484	30901	0802230000	DHK	292.00
102889	2/28/2008		Patient statement was billed	18484	PTBILLED	0802230000	DHK	0.00
							Patient Total	$1,518.00

Printed on 8/20/2008 11:36:16 AM

FOOT & ANKLE SURGICAL GROUPLLP
129 WEST LAKE MEAD DR BLD B18
HENDERSON NV 89015 702-4563668
BILLING 702-564-8022

10/17/2007 014068

ENRIQUE H RODRIGUEZ

014068 RODRIGUEZ ENRIQUE

06/12/2007	NAIL AVULSION SINGLE	703.0	11730	160.00	160.00
06/19/2007	MATRIXECTOMY	703.0	11750	565.00	725.00
06/19/2007	UNCLASSIFIED	703.0	J3490	7.50	732.50
07/26/2007	ESTABLISHED E/M STRAIGH	703.0	99212	50.00	782.50

TOTAL AMOUNT PENDING INSURANCE 0.00
TOTAL AMOUNT DUE NOW: 782.50

0.00	0.00	50.00	732.50	782.50
00%				0.00

FINAL NOTICE - THIS ACCOUNT WILL BE SENT TO COLLECTION IF PAYMENT IS NOT RECEIVED IN 15 DAYS.

DOUGLAS S STACEY 129 W LAKE MEAD DR HENDERSON NV 89015
Page: 1 TEL: 702-456-3668

Dr. Stacey DPM 0000002

North Valley Medical Supply 2006
3053 W. Craig Road
Suite B
North Las Vegas, NV 89032

Invoice

Date	Invoice #
3/5/2007	2362

Bill To
[illegible]

Ship To
Enrique Rodriguez

P.O. Number	Terms	Due Date	Rep	Ship	Via	F.O.B.	Project
	Net90	6/3/2007	CR	3/5/2007	Pick up		

Quantity	Item Code	Description	Price Each	Amount
1	FLA-25-120	Thumb Spica Soft Fit Univ Rx on file	36.95	36.95
		Total		$36.95

By signing above, you agree to the following terms: Return Policy- There will be a 25% restocking fee on any items returned. Any items that are pre-ordered and not purchased are subject to a 25% return fee. No returns after 30 days. Should the above listed customer be placed with a collection agency or attorney to collect the account, the Customer agrees to pay in full all costs and expenses incurred by North Valley Medical Supply to collect monies owed. This includes, but is not limited to, court costs, collection fees, and attorney fees.

Phone #	Fax #	E-mail	Web Site
702-638-1190	702-638-1542	shelbyr@northvalleymedicalsupply.com	northvalleymedicalsupply.com

NORTH VALLEY MEDICAL SUPPLY-00013

North Valley Medical Supply 2006

3053 W. Craig Road
Suite B
North Las Vegas, NV 89031

Invoice

Date	Invoice #
7/11/2006	757

Bill To	Ship To
Enrique Rodriguez	Enrique Rodriguez

P.O. Number	Terms	Rep	Ship	Via	F.O.B.	Project
	Net90	SLR		Delivery		

Quantity	Item Code	Description	Price Each	Amount
1	FLA-10-231039	Collar Reg Dens Hi 3"	17.95	17.95T
		Sales Tax 7.75%	7.75%	1.39

Thank You for Choosing North Valley Medical Supply for your Medical needs.

Total $19.34

NORTH VALLEY MEDICAL SUPPLY-00014

North Valley Medical Supply

3053 W. Craig Road
Suite B
North Las Vegas, NV 89031
(702) 638-1190

Invoice

Date	Invoice #
10/1/2007	627

Bill To	Ship To
Enrique Rodriguez	

P.O. Number	Terms	Rep	Ship	Via	F.O.B.	Project
	Net90	SMR	6/12/2006	Delivery		

Quantity	Item Code	Description	Price Each	Amount
1	GAL-Quick	Golden Luxury Adjustable bed	3,899.00	3,899.00T
2	GAL-SRYL	Golden Dual King Matress, Visco Foam	1,299.00	2,598.00T
1	GAL-MAT	Golden Remoteless Controller	429.00	429.00T
1	Freight	Delivery Charges & Set Up Fee	600.00	600.00
1	NON-INVENTOR...	Misc	583.27	583.27T
		Sales Tax 7.75%	7.75%	581.97

Thank You for Choosing North Valley Medical Supply for your Medical needs.

Total $8,691.24

NORTH VALLEY MEDICAL SUPPLY-00016

North Valley Medical Supply
3053 W. Craig Road
Suite B
North Las Vegas, NV 89031
(702) 638-1190

Invoice

Date	Invoice #
3/6/2008	5491

Bill To	Ship To
Enrique Rodriguez	Enrique Rodriguez

P.O. Number	Terms	Due Date	Rep	Ship	Via	F.O.B.	Project
	Net90	6/4/2008	SMR	3/6/2008			

Quantity	Item Code	Description	Price Each	Amount
1	NON-INVENTO...	CPAP MASK	395.92	395.92

Thank You for Choosing North Valley Medical Supply for your Medical needs.

Total $395.92

By signing above, you agree to the following terms: Return Policy- There will be a 25% restocking fee on any items returned. Any items that are pre-ordered and not purchased are subject to a 25% return fee. No returns after 30 days. ANY HYGIENE PRODUCTS ARE NOT RETURNABLE!! Should the above listed customer be placed with a collection agency or attorney to collect the account, the Customer agrees to pay in full all costs and expenses incurred by North Valley Medical Supply to collect monies owed. This includes, but is not limited to, court costs, collection fees, and attorney fees.

Phone #	Fax #	E-mail	Web Site
702-638-1190	702-638-1542	shelbyr@northvalleymedicalsupply.com	www.northvalleymedicalsupply.com

NORTH VALLEY MEDICAL SUPPLY-00017

LAKE MEAD RADIOLOGISTS
5495 S. Rainbow Blvd., Suite 101
Las Vegas NV, 89118
(702) 597-1145

INVOICE

To: ATTNY BENSON & BERTOLDO
7408 W SAHARA AVE
LAS VEGAS NV, 89117

Statement Date
12-13-2007
Account Number
11878

PATIENT NAME: RODRIGUEZ ENRIQUE J

Date	Description of Transaction	Charges	Receipts
2007-12-04	78315 - BONE SCAN/3 PHASE/FLOW NM	681.15	0.00
2007-12-04	NM: Tc99m HDP PER DOSE	60.00	

Total Due	741.15

***PLEASE MAKE CHECK PAYABLE TO - LAKE MEAD RADIOLOGISTS ***
**BILLING INQUIRIES PLEASE CALL (702) 597-1145 **

Lakemead Rad. 0000001

11/25/09

PATIENT FINANCIAL HISTORY BY DT SERVICE

LAKE MEAD RADIOLOGISTS GALLER

Accounts 79908 - 79908 All Dates

Acct	Date	Dep #	Name	Dx#	Procedure		Ref Dt	Diag	Units	Amount
79908	RODRIGUEZ,ENRIQUE									
					Previous Balance :					0.00
	01/12/06	0	RODRIGUEZ,ENRIQUE	12	72141	MRI CERVICAL WO		722.0	1.00	1305.50
	01/26/06	0	RODRIGUEZ,ENRIQUE	11	72148	MRI LUMBAR WO		722.10	1.00	1305.50
	07/11/06	0	RODRIGUEZ,ENRIQUE	2	73221	MRI U/E ANY JNT WO		842.02	1.00	1305.50
	08/15/07	0	RODRIGUEZ,ENRIQUE	21	70551	MRI BRAIN WO		340.8	1.00	1362.30
	08/28/08	0	RODRIGUEZ,ENRIQUE	1	MEDICAL	MEDICAL RECORDS CHAR		MEDICAL	1.00	10.20
	08/28/08		Check Payment	JC1		Other	08/28/08			-10.20
	09/12/08	0	RODRIGUEZ,ENRIQUE	1	FILM	FILM CHARGE DUPLICAT		FILM	1.00	70.00
	09/12/08		Check Payment	JC1		Other	09/12/08			-70.00

TOTALS FOR ACCOUNT 79908 PAYMENTS : 80.20 ADJUSTS : 0.00 CHARGES : 5359.00 6.00 5278.80

REFUNDS: 0.00

80.20 0.00 5359.00 5278.80

Account Activity for Enrique Rodriguez

Printed on August 19, 2008

Demographics

Sex:	**Male**	Marital Status:	**Single**
DOB:		Account Num:	**16780**
SSN:			
Home Address:		Employer:	**Disabled**
Home Phone:		Work Phone:	
Alert:	**Patient Balance: $3,352.20**		
	Lien signed Attn Susan Anderson assist. Medical records 8/19/08 41.40		

Insurance Information

Insurance #1 Info:		**Insured Info:**	
Financial Class:	**LIEN**	Name of Insured:	
Carrier:	**Jonathan Weber Aty**	Relationship:	**Himself**
Contract:	**LIEN**		
Address:	**7408 W Sahara Ave Las Vegas, NV 89117**	ID:	
		Group:	
Phone:	**228-2600**	Plan:	
Deductible:	**$0.00**	Effective Date:	
Copay:	**$0.00**	Signature on File:	
Patient Percent:	**0.00%**		

Guarantor:			
Name:	**Jonathan Weber, aty**	Relationship:	**Attorney**
Address:		Sex:	**Female**
		SSN:	
Phone:	**228-2600**	DOB:	

Fee Ticket Information

Fee Ticket	Svc Date	Provider / Ref. Provider		Loc	Auth #	Charges	Payments	Adj	Balance	Status
00016903	**08/21/2006**	**Robert C Gutierrez MD Govind Koka**		**11**		**$1,296.00**	**$0.00**	**$0.00**	**$1,296.00**	
99203-25	08/21/2006	lorrie	OFFICE/OP VISIT, NEW PT, 3 KEY COMPONENTS: DETAILED HX; DETAILED EXAM; MED DECISION LOW COMPLEXITY --- 719.43,354.0			$497.00	$0.00	$0.00	$497.00	
	09/04/2006	lorrie	Ins 1.1(1): Jonathan Weber Aty							Closed
20605-lt	08/21/2006	lorrie	DRAIN/INJECT, JOINT/BURSA --- 719.43,354.0			$300.00	$0.00	$0.00	$300.00	
	09/04/2006	lorrie	Ins 1.1(1): Jonathan Weber Aty							Closed
20526-rt	08/21/2006	lorrie	THER INJECTION, CARP TUNNEL --- 354.0			$400.00	$0.00	$0.00	$400.00	
	09/04/2006	lorrie	Ins 1.1(1): Jonathan Weber Aty							Closed
J1030	08/21/2006	lorrie	Methylprednisolone 40 MG Inj --- 719.43			$54.00	$0.00	$0.00	$54.00	
	09/04/2006	lorrie	Ins 1.1(1): Jonathan Weber Aty							Closed

Account Activity for Enrique Rodriguez

Printed on August 19, 2008

J2001	08/21/2006	lorrie	Lidocaine injection --- 719.43	$30.00	$0.00	$0.00	$30.00	
	09/04/2006	lorrie	Ins 1.1(1): Jonathan Weber Aty					Closed
A4550	08/21/2006	lorrie	Surgical trays --- 719.43,354.0	$15.00	$0.00	$0.00	$15.00	
	09/04/2006	lorrie	Ins 1.1(1): Jonathan Weber Aty					Closed
00017418	**10/02/2006**	**Robert C Gutierrez MD Govind Koka**	**11**	**$270.00**	**$0.00**	**$0.00**	**$270.00**	
99213	10/02/2006	lorrie	OFFICE/OP VISIT, EST PT, 2 KEY COMPONENTS: EXPAND PROB HX; EXPAND PROB EXAM;MED DECISION LOW COMPLEX --- 719.43,354.0	$270.00	$0.00	$0.00	$270.00	
	10/10/2006	lorrie	Ins 1.1(1): Jonathan Weber Aty					Closed
-misc-	**10/10/2006**	**Robert C Gutierrez MD**		**$10.20**	**$10.20**	**$0.00**	**$0.00**	
RecCopy	10/10/2006	lorrie	Copy Medical Records ---	$10.20	$10.20	$0.00	$0.00	
	02/04/2007	lorrie	Patient Pmt Check 50949		$10.20			
00018684	**01/15/2007**	**Robert C Gutierrez MD Govind Koka**	**11**	**$270.00**	**$0.00**	**$0.00**	**$270.00**	
99213	01/15/2007	lorrie	OFFICE/OP VISIT, EST PT, 2 KEY COMPONENTS: EXPAND PROB HX; EXPAND PROB EXAM;MED DECISION LOW COMPLEX --- 719.43	$270.00	$0.00	$0.00	$270.00	
	01/25/2007	lorrie	Ins 1.1(1): Jonathan Weber Aty					Closed
00018879	**01/31/2007**	**Robert C Gutierrez MD Govind Koka**	**11**	**$270.00**	**$0.00**	**$0.00**	**$270.00**	
99213	01/31/2007	lorrie	OFFICE/OP VISIT, EST PT, 2 KEY COMPONENTS: EXPAND PROB HX; EXPAND PROB EXAM;MED DECISION LOW COMPLEX --- 354.0,719.43	$270.00	$0.00	$0.00	$270.00	
	02/07/2007	lorrie	Ins 1.1(1): Jonathan Weber Aty					Closed
00019724	**04/11/2007**	**Robert C Gutierrez MD Govind Koka**	**11**	**$618.00**	**$0.00**	**$0.00**	**$618.00**	
99213	04/11/2007	lorrie	OFFICE/OP VISIT, EST PT, 2 KEY COMPONENTS: EXPAND PROB HX; EXPAND PROB EXAM;MED DECISION LOW COMPLEX --- 727.03	$270.00	$0.00	$0.00	$270.00	
	04/18/2007	lorrie	Ins 1.1(1): Jonathan Weber Aty					Closed
A4550	04/11/2007	lorrie	Surgical trays --- 727.03	$15.00	$0.00	$0.00	$15.00	
	04/18/2007	lorrie	Ins 1.1(1): Jonathan Weber Aty					Closed
20550	04/11/2007	lorrie	INJ TENDON SHEATH/LIGAMENT --- 727.03	$300.00	$0.00	$0.00	$300.00	
	04/18/2007	lorrie	Ins 1.1(1): Jonathan Weber Aty					Closed
J1030	04/11/2007	lorrie	Methylprednisolone 40 MG inj --- 719.43,727.03	$18.00	$0.00	$0.00	$18.00	
	04/18/2007	lorrie	Ins 1.1(1): Jonathan Weber Aty					Closed
J2001	04/11/2007	lorrie	Lidocaine injection --- 727.03	$15.00	$0.00	$0.00	$15.00	
	04/18/2007	lorrie	Ins 1.1(1): Jonathan Weber Aty					Closed
00020322	**05/23/2007**	**Robert C Gutierrez MD Govind Koka**	**11**	**$270.00**	**$0.00**	**$0.00**	**$270.00**	
99213	05/23/2007	lorrie	OFFICE/OP VISIT, EST PT, 2 KEY COMPONENTS: EXPAND PROB HX; EXPAND PROB EXAM;MED DECISION LOW COMPLEX --- 727.03	$270.00	$0.00	$0.00	$270.00	
	06/05/2007	lorrie	Ins 1.1(1): Jonathan Weber Aty					Closed
-misc-	**10/23/2007**	**Robert C Gutierrez MD**		**$16.80**	**$0.00**	**$0.00**	**$16.80**	
RecCopy	10/23/2007	lorrie	Copy Medical Records ---	$16.80	$0.00	$0.00	$16.80	

IN THE SUPREME COURT OF THE STATE OF NEVADA

ENRIQUE RODRIGUEZ, AN INDIVIDUAL, Appellant, vs. FIESTA PALMS, LLC, A NEVADA LIMITED LIABILITY COMPANY, D/B/A PALMS CASINO RESORT, N/K/A FCH1, LLC, A NEVADA LIMITED LIABILITY COMPANY, Respondents.	Case No.: 72098 Electronically Filed Jul 31 2017 11:55 a.m. Elizabeth A. Brown Clerk of Supreme Court Appeal from the Eighth Judicial District Court, The Honorable Joe Hardy Presiding

APPELLANT'S APPENDIX
(Volume 3, Bates Nos. 471–709)

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INDEX TO APPELLANT'S APPENDIX

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Amended Complaint (filed 07/08/09)	Volume 1, Bates Nos. 20–29
Notice of Entry of Order [for Stipulation and Order to Continue Discovery and Trial] with Stipulation and Order (filed 11/25/09)	Volume 1, Bates Nos. 30–35
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Notice of Entry of Order [Granting Plaintiff's Motion on the Issue of Liability] with Order (filed 03/14/11)	Volume 1, Bates Nos. 48–53
Notice of Entry of Order [Granting Plaintiff's Motion to Strike Defendant Fiesta Palms, LLC's Expert Witnesses] with Order (filed 03/14/11)	Volume 1, Bates Nos. 54–59
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Order Scheduling Status Check: Trial Setting (filed 12/04/14)	Volume 1, Bates No. 130

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DOCUMENT DESCRIPTION		LOCATION
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Exhibit	**Document Description**	
A	Excerpted Deposition Transcript of Brandy L. Beavers (dated 04/17/09)	Volume 2, Bates Nos. 249–252
B	Excerpted Deposition Transcript of Sheri Long (dated 01/09/09)	Volume 2, Bates Nos. 253–257
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Exhibit	**Document Description**	
A	Partial Transcript of October 25, 2010 Bench Trial—Testimony of Vikki Kooinga (filed 11/18/10)	Volume 2, Bates Nos. 318–331

DOCUMENT DESCRIPTION		LOCATION
Exhibits to Defendant, Fiesta Palms, LLC's Motion in Limine No. 1 to Exclude Testimony Regarding Witnesses Vikki Kooinga and Sheri Long (cont.)		
Exhibit	**Document Description**	
B	Excerpted Deposition Transcript of Vikki Kooinga (dated 01/09/09)	Volume 2, Bates Nos. 332–347
C	Partial Transcript of October 25, 2010 Bench Trial—Testimony of Sheri Long (filed 11/18/10)	Volume 2, Bates Nos. 348–375
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Defendant, Fiesta Palms, LLC's Motion in Limine No. 2 to Exclude Any Reference that Any Motion in Limine Has Been Filed: that the Court Has Ruled, or May Rule on Any Part of Outside the Presence of the Jury: or Suggesting or Implying to Potential Jurors During Voir Dire or Seated Jurors in Any Manner Whatsoever that Defendant Moved to Exclude Proof in Any Manner or that the Court Has Excluded Proof of Any Manner (filed 03/07/16)		Volume 2, Bates Nos. 391–397
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Defendant, Fiesta Palms, LLC's Motion in Limine No. 5 to Exclude Any Reference that the "Golden Rule" or that the Jury Panel or the Jury Should Do Unto Others as You Have Them Done Unto You (filed 03/07/16)		Volume 2, Bates Nos. 411–416

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Defendant, Fiesta Palms, LLC's Motion in Limine No. 8 to Exclude Any Questions that Would Invade the Attorney/Client Privilege (filed 03/07/16)	Volume 2, Bates Nos. 431–436
Defendant, Fiesta Palms, LLC's Motion in Limine No. 9 to Exclude Any Statement or Implication that Defendant Sought to Delay This Trial (filed 03/07/16)	Volume 2, Bates Nos. 437–443
Defendant, Fiesta Palms, LLC's Motion in Limine No. 10 to Exclude Any Comments Regarding the Number of Attorneys Representing the Defendant (filed 03/07/16)	Volume 2, Bates Nos. 444–449
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A	Plaintiff's 16.1 List of Documents and Witnesses (filed 09/24/07)	Volume 3, Bates Nos. 480–491
B	Plaintiff's Supplemental Expert Disclosure (dated 06/15/10)	Volume 3, Bates Nos. 492–495
Defendant, Fiesta Palms, LLC's Motion in Limine No. 15 to Preclude Plaintiff from Claiming Medical Specials Exceeding Amounts Disclosed by Plaintiff Pursuant to NRCP 16.1 (filed 03/07/16)		Volume 3, Bates Nos. 496–502
Exhibits to Defendant, Fiesta Palms, LLC's Motion in Limine No. 15 to Preclude Plaintiff from Claiming Medical Specials Exceeding Amounts Disclosed by Plaintiff Pursuant to NRCP 16.1		
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A	Plaintiff's 29th Supplemental Early Case Conference List of Documents and Witnesses (dated 10/04/10)	Volume 3, Bates Nos. 503–524
B	Plaintiff's Second Supplemental Pre-Trial Disclosures (dated 09/14/10)	Volume 3, Bates Nos. 525–534
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D	Patient Account Information from Various Providers	Volume 3, Bates Nos. 557–709

DOCUMENT DESCRIPTION		LOCATION
Defendant, Fiesta Palms, LLC's Motion in Limine No. 16 to Preclude Plaintiff from Arguing that the Violation of Defendant's Internal Policies Constitutes Negligence Per Se (filed 03/07/16)		Volume 4, Bates Nos. 710–717
Exhibit to Defendant, Fiesta Palms, LLC's Motion in Limine No. 16 to Preclude Plaintiff from Arguing that the Violation of Defendant's Internal Policies Constitutes Negligence Per Se		
Exhibit	**Document Description**	
A	Excerpted Deposition Transcript of Sheri Long (filed 01/09/09)	Volume 4, Bates Nos. 718–721
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DOCUMENT DESCRIPTION		LOCATION
Notice of Entry of Order [Denying Defendant, Fiesta Palms, LLC's Motion for Partial Summary Judgment on Punitive Damages as Moot] with Order (filed 04/21/16)		Volume 4, Bates Nos. 776–779
Notice of Entry of Order [Granting Defendant, Fiesta Palms, LLC's Motion to Dismiss] with Order (filed 04/21/16)		Volume 4, Bates Nos. 780–784
Plaintiff's Substitution of Attorney (filed 10/14/16)		Volume 4, Bates Nos. 785–787
Motion for Relief—NRCP 60 (filed 10/14/16)		Volume 4, Bates Nos. 788–809
Exhibits to Motion for Relief—NRCP 60		
Exhibit	**Document Description**	
1	Notice of Filing Order Granting Withdrawal of Plaintiff's Counsel with Order (filed 02/16/16)	Volume 4, Bates Nos. 810–817
2	Sixth Amended Order Setting Civil Jury Trial, Pre-Trial Conference and Calendar Call (filed 02/04/16)	Volume 4, Bates Nos. 818–821
3	Minutes of February 1, 2016 Pre-Trial Conference	Volume 4, Bates Nos. 822–823
4	Motion to Withdraw as Counsel of Record for Plaintiff on Order Shortening Time with Notice of Filing (filed 01/20/16) 508	Volume 4, Bates Nos. 824–839
5	February 9, 2016 Minute Order on Motion to Withdraw as Counsel of Record for Plaintiff	Volume 4, Bates Nos. 840–841
6	Defendant, Fiesta Palms, LLC's Motion to Dismiss Pursuant to NRCP 16.1 and EDCR 2.67 (filed 03/07/16)	Volume 4, Bates Nos. 842–850

DOCUMENT DESCRIPTION		LOCATION
Exhibits to Motion for Relief—NRCP 60 (cont.)		
Exhibit	**Document Description**	
7	Order [Granting Defendant, Fiesta Palms, LLC's Motions in Limine No[s]. 1–16] (filed 04/13/16)	Volume 4, Bates Nos. 851–856
8	Certificate of Service for Defendant, Fiesta Palms, LLC's Motion in Limine No. 16 to Preclude Plaintiff from Arguing that the Violation of Defendant's Internal Policies Constitutes Negligence Per Se (filed 03/07/16)	Volume 4, Bates Nos. 857–858
9	Order [Granting Defendant, Fiesta Palms, LLC's Motion to Dismiss] (filed 04/20/16)	Volume 4, Bates Nos. 859–866
10	In-Home Supportive Services Provider Notification (dated 06/01/15)	Volume 4, Bates Nos. 867–871
Defendant, Fiesta Palms, LLC's Opposition to Plaintiff's Motion for Relief Under NRCP 60 (filed 10/26/16)		Volume 5, Bates Nos. 872–885
Exhibits to Defendant, Fiesta Palms, LLC's Opposition to Plaintiff's Motion for Relief Under NRCP 60		
Exhibit	**Document Description**	
A	Notice of Filing Order Granting Withdrawal of Plaintiff's Counsel with Order (filed 02/16/16)	Volume 5, Bates Nos. 886–890
B	Motion to Withdraw as Counsel of Record for Plaintiff on Order Shortening Time (filed 01/20/16)	Volume 5, Bates Nos. 891–897
C	Notice of Filing Motion to Withdraw as Counsel of Record for Plaintiff on Order Shortening Time with Motion (filed 01/20/16)	Volume 5, Bates Nos. 898–907
D	Minutes of February 1, 2016 Pre-Trial Conference	Volume 5, Bates Nos. 908–909

DOCUMENT DESCRIPTION		LOCATION
Exhibits to Defendant, Fiesta Palms, LLC's Opposition to Plaintiff's Motion for Relief Under NRCP 60		
Exhibit	**Document Description**	
E	Sixth Amended Order Setting Civil Jury Trial, Pre-Trial Conference and Calendar Call (filed 02/04/16)	Volume 5, Bates Nos. 910–913
F	Defendant, Fiesta Palms, LLC's Motion to Dismiss Pursuant to NRCP 16.1 and EDCR 2.67 (filed 03/07/16)	Volume 5, Bates Nos. 914–922
G	Minutes of April 7, 2016 Hearing on All Pending Motions	Volume 5, Bates Nos. 923–925
H	Minutes of April 14, 2016 Hearing on All Pending Motions	Volume 5, Bates Nos. 926–927
I	Order [Granting Defendant, Fiesta Palms, LLC's Motion to Dismiss] (filed 04/20/16)	Volume 5, Bates Nos. 928–931
J	Notice of Entry of Order [Granting Defendant, Fiesta Palms, LLC's Motion to Dismiss] without Order (dated 04/21/16)	Volume 5, Bates Nos. 932–934
K	Mediation Settlement (dated 05/16/11)	Volume 5, Bates Nos. 935–937
Reply in Support of Plaintiff's Motion for NRCP 60 Relief (filed 11/10/16)		Volume 5, Bates Nos. 938–947
Minutes of November 15, 2016 Hearing on Plaintiff's Motion for Relief—NRCP 60		Volume 5, Bates No. 948
Transcript of November 15, 2016 Hearing on Plaintiff's Motion for Relief—NRCP 60 (filed 02/21/17)		Volume 5, Bates Nos. 949–962
Notice of Appearance (filed 12/20/16)		Volume 5, Bates Nos. 963–965

<table>
<tr><th colspan="2">DOCUMENT DESCRIPTION</th><th>LOCATION</th></tr>
<tr><td colspan="2">Notice of Entry of Order [Denying Plaintiff's Motion for NRCP 60 Relief] with Order (filed 12/28/16)</td><td>Volume 5,
Bates Nos. 966–972</td></tr>
<tr><td colspan="2">Notice of Appeal (filed 01/05/17)</td><td>Volume 5,
Bates Nos. 973–975</td></tr>
<tr><td colspan="2">Exhibits to Notice of Appeal</td><td></td></tr>
<tr><td>Exhibit</td><td>Document Description</td><td></td></tr>
<tr><td>1</td><td>Order [Denying Plaintiff's Motion for NRCP 60 Relief] (filed 12/23/16)</td><td>Volume 5,
Bates Nos. 976–981</td></tr>
<tr><td colspan="2">Case Appeal Statement (filed 01/05/17)</td><td>Volume 5,
Bates Nos. 982–987</td></tr>
<tr><td colspan="2">Docket of Case No. A531538</td><td>Volume 5,
Bates Nos. 988–1004</td></tr>
</table>

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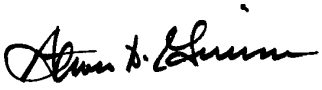

CLERK OF THE COURT

MLIM
LEW BRANDON, JR., ESQ.
Nevada Bar No.: 5880
JUSTIN W. SMERBER, ESQ.
Nevada Bar No.: 10761
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Attorneys for Defendant,
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PALMS CASINO RESORT

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Telephone: (775) 786-6868 / Facsimile: (775) 786-9716
rle@lge.net
Attorneys for Defendant,
FIESTA PALMS, LLC d/b/a
PALMS CASINO RESORT

DISTRICT COURT
CLARK COUNTY, NEVADA

ENRIQUE RODRIGUEZ, an individual, Plaintiff, v. FIESTA PALMS, L.L.C., a Nevada Limited Liability Company, d/b/a PALMS CASINO RESORT; BRANDY L. BEAVERS, individually, DOES I through X, and ROE CORPORATIONS I through X, inclusive, Defendants.	CASE NO.: 06A531538 DEPT. NO.: XV **DEFENDANT, FIESTA PALMS, LLC'S MOTION IN LIMINE NO. 14 TO PRECLUDE PLAINTIFF'S TREATING PHYSICIANS AND MEDICAL EXPERT FROM TESTIFYING AT TRIAL**

MORAN BRANDON BENDAVID MORAN
ATTORNEYS AT LAW
630 SOUTH 4TH STREET
LAS VEGAS, NEVADA 89101
PHONE (702) 384-8424
FAX: (702) 348-6568

DEFENDANT, FIESTA PALMS, LLC'S MOTION IN LIMINE NO. 14 TO PRECLUDE PLAINTIFF'S TREATING PHYSICIANS AND MEDICAL EXPERT FROM TESTIFYING AT TRIAL

COMES NOW, Defendant, FIESTA PALMS, LLC., by and through its undersigned attorneys, LEW BRANDON, JR., ESQ. and JUSTIN W. SMERBER, ESQ., of MORAN BRANDON BENDAVID MORAN, and ROBERT L. EISENBERG of LEMONS, GRUNDY & EISENBERG, hereby submit the following Motion in Limine No. 14 to Preclude Plaintiff's Treating Physicians and Medical Expert from Testifying at Trial.

This Motion is made and based upon the Points and Authorities attached hereto, along with all papers and pleadings on file herein, and oral arguments at the time of hearing.

DATED this 7th day of March, 2016.

MORAN BRANDON BENDAVID MORAN

/s/ Justin W. Smerber, Esq.
LEW BRANDON, JR., ESQ.
Nevada Bar No. 5880
JUSTIN W. SMERBER, ESQ.
Nevada Bar No.: 10761
630 S. Fourth Street
Las Vegas, Nevada 89101
Attorneys for Defendant,
FIESTA PALMS, LLC d/b/a
PALMS CASINO RESORT

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ATTORNEYS AT LAW
630 SOUTH 4TH STREET
LAS VEGAS, NEVADA 89101
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FAX: (702) 348-6568

NOTICE OF MOTION

TO: ALL PARTIES;

YOU, AND EACH OF YOU, will please take notice that the foregoing **DEFENDANT'S MOTION IN LIMINE NO. 14** has been set for Hearing on the 07 day of APRIL, 2015 at the hour of 9:00A:___ __.m., before the Eighth Judicial District Court in Dept. XV.

DATED this 7th day of March, 2016.

MORAN BRANDON BENDAVID MORAN

/s/ Justin W. Smerber, Esq.
LEW BRANDON, JR., ESQ.
Nevada Bar No. 5880
JUSTIN W. SMERBER, ESQ.
Nevada Bar No. 10761
630 S. Fourth Street
Las Vegas, Nevada 89101
Attorneys for Defendant,
FIESTA PALMS, LLC d/b/a
PALMS CASINO RESORT

MEMORANDUM OF POINTS AND AUTHORITIES

I.
INTRODUCTION

Defendant is filing a series of Motions in Limine in compliance with EDCR 2.47. In order to avoid duplicative reading by this court, Defendant directs the Court to its Motion in Limine No. 1 for Defendant's Affidavit required by EDCR 2.47, and its Motion in Limine Standard Section.

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II.
FACTS

Plaintiff in this action is alleging significant medical damages. During the course of discovery, Plaintiff identify approximately 50 medical providers. See *Plaintiff's 16.1* Disclosure*, attached hereto as Exhibit "A."* Further, Plaintiff identify one retained medical expert pursuant to NRCP 16.1(a)(2). *See Plaintiff's Supp*lemental Expert Disclosure, attached *hereto as Exhibit "B."* However, Plaintiff's disclosure of his treating physicians and his disclosure of his retained medical expert fail to comply with NRCP 16.1(a)(2). See Id.

With regard to Plaintiff's disclosure of his treating physicians, each provider was disclosed with the same generic description as to their anticipated testimony. Specifically, each provider was disclosed in the following fashion:

> "[Provider] will testify as to Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. . ."

See *Plaintiff's 16.1 Disclosure*, attached hereto as Exh*ibit "A."* No further information, i.e. Curriculum Vitae (CV), expert reports, records reviewed, fee schedules etc., were received for the doctors disclosed in Plaintiff's 16.1 Disclosures.

With regards to Plaintiff's disclosed retained medical expert, Firooz Mashood, M.D., this disclosure is also incomplete. Plaintiff stated in the disclosure that Dr. Mashood's report would be disclosed once received; however, Plaintiff never disclosed a report generated by Dr. Mashood. *See Plaintiff's Supp*lemental Expert Disclosure*, attached hereto as Exhibit "B."* Nor did Plaintiff disclose Dr. Mashood's CV, fee schedule, list of records reviewed, case testimony list, or any other information aside from the description of his testimony provided in the disclosure. See id. Accordingly, Defendant now files the instant Motion to preclude Plaintiff's medical providers and medical expert from testifying at the time of trial.

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III.
LEGAL ARGUMENT

Plaintiff's medical providers and retained medical expert should be precluded from testifying at trial. Plaintiff's medical providers were disclosed with the intent that they would improperly testify as to matters appropriate for retained expert witnesses according to FCH1, LLC v. Rodriguez, 335 P.3d 183 (2014). The medical providers are thus subject to the requirements of NRCP 16.1(a)(2), which Plaintiff failed to comply with. Further, Plaintiff's disclosure of one retained medical expert also failed to comply with NRCP 16(a)(2) because Plaintiff did not disclose the required documentation.

A. PLAINTIFF'S MEDICAL PROVIDERS SHOULD BE PRECLUDED FROM TESTIFYING BECAUSE, ACCORDING TO FCH1, LLC v. RODRIGUEZ, PLAINTIFF FAILED TO COMPLY WITH NRCP 16.1(a)(2).

Under NRCP 16.1, treating medical providers are generally exempt from the expert report requirements. However, they are only exempt if their testimony is limited to "opinions [that] were formed during the course of treatment." FCH1, LLC v. Rodriguez, 335 P.3d 183, 189 (2014). Thus, if a treating physician or medical provider testifies to opinions that exceed that scope, that person is then subject to the requirements for the disclosure of experts under NRCP 16.1(a)(2)(B). See id. Where treating physicians or medical providers have reviewed Plaintiff's medical records, the physicians may testify as to their review of the materials only as non-retained physicians if they reviewed records during the normal course of treating the Plaintiff. Id. NRCP 37(c) provides that a party that fails to disclose information required by NRCP 16.1 is not permitted to use that witness as evidence at trial. NRCP 37(c)(1).

In this case, Plaintiff has disclosed numerous treating providers and physicians. Further, Plaintiff's 16.1 disclosures do not limit the testimony the providers are expected to give. The language in Plaintiff's 16.1 disclosures is as follows:

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> "[Provider] will testify as to Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. . ."

See Exhibit "A." This language indicates that Plaintiff is attempting to call his treating providers and physicians to testify as to (1) Plaintiff's injuries, treatments, etc., (2) causation for same, and (3) the reasonableness of the treatment. This expected testimony is thus far more broad than that allowable under FCH1, LLC v. Rodriguez for treating physicians and providers. The providers, then, must have been disclosed as retained experts under NRCP 16.1(a)(2)(B). However, no expert reports or materials were disclosed to Defendant as required by NRCP 16.1(a)(2). Therefore, Defendant respectfully requests that Plaintiff's medical providers and physicians be precluded from giving testimony due to Plaintiff's failure to comply with NRCP 16.1(a)(2).

Further, Plaintiff cannot be allowed to call these treating providers to testify as non-retained experts. Under NRCP 16.1(a)(2)(B), a medical provider may be called to provide expert testimony without satisfying the report writing requirements. However, the rule is clear, that if medical experts will be called to testify in such a capacity, the Plaintiff must disclosed the providers and provide a summary of their testimony, a summary of their qualifications (or produce a CV), and their fees associated with their testimony. Here, Plaintiff has not provided any of this information for any of his treating providers. Accordingly, these treating providers should be excluded from testifying at trial in any capacity.[1]

B. <u>PLAINTIFF'S RETAINED MEDICAL EXPERT SHOULD BE PRECLUDED FROM TESTIFYING BECAUSE PLAINTIFF FAILED TO COMPLY WITH NRCP 16.1(a)(2).</u>

[1] The purpose of discovery is to take the surprise out of trials, so that all relevant facts and information is ascertained in advance of trial. FCH1, LLC v. Rodriquez, supra. Here, Defense Counsel cannot possibly be expected to prepare for 50 potential treating physician witnesses called by Plaintiff's counsel at trial. Plaintiff's generic disclosures regarding the treating physicians are worthless in taking the surprise out of trial.

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NRCP 16.1(a)(2)(B) contains the requirements for the disclosure of retained experts expected to give testimony. Under this rule, disclosure of such an expert must be accompanied by a written report prepared by the expert containing the expert's opinions, the data or information considered by the expert, qualifications, compensation, publications, and other cases in which the expert testified. See NRCP 16.1(a)(2)(B). As noted above, NRCP 37(c) provides that a party that fails to disclose information required by NRCP 16.1 is not permitted to introduce that witness as evidence at trial. NRCP 37(c)(1).

In this case, Plaintiff has disclosed Dr. Mashood as a retained medical expert. Plaintiff also noted that Dr. Mashood's report would be disclosed once received. *See Exhibit "B."* However, Plaintiff has failed to provide any of the information required by NRCP 16.1(a)(2)(B). Plaintiff has not disclosed Dr. Mashood's report, CV, fee schedule or case testimony list. See id. Therefore, Plaintiff has failed to disclose information required by NRCP 16.1 and under NRCP 37(c) should be prevented from presenting Dr. Mashood's testimony as evidence at trial.

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IV.
CONCLUSION

Based upon the foregoing, Defendant, FIESTA PALMS, LLC D/B/A PALMS CASINO RESORT respectfully requests that this Court grant Defendant's Motion in Limine No. 14 and issue an order precluding Plaintiff's medical providers and retained medical expert from testifying at trial.

DATED this 7th day of March, 2016.

MORAN BRANDON BENDAVID MORAN

/s/ Justin W. Smerber, Esq.
LEW BRANDON, JR., ESQ.
Nevada Bar No. 5880
JUSTIN W. SMERBER, ESQ.
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Attorneys for Defendant,
FIESTA PALMS, LLC d/b/a
PALMS CASINO RESORT

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CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I hereby certify that on the _____ day of March, 2016, I served the foregoing **DEFENDANT, FIESTA PALMS, LLC'S MOTION IN LIMINE NO. 14 TO PRECLUDE PLAINTIFF'S TREATING PHYSICIANS AND MEDICAL EXPERTS FROM TESTIFYING AT TRIAL** via the Court's electronic filing and service systems ("Wiznet") to all parties on the current service list.

VIA U.S. MAIL

ENRIQUE RODRIGUEZ
6673 YELLOWSTONE DRIVE
RIVERSIDE, CALIFORNIA 92506
TELEPHONE: 951-751-1440
Plaintiff, In Proper Person

/s/ Angelina M. Martinez
An Employee of Moran Brandon Bendavid Moran

MORAN BRANDON BENDAVID MORAN
ATTORNEYS AT LAW
630 SOUTH 4TH STREET
LAS VEGAS, NEVADA 89101
PHONE (702) 384-8424
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EXHIBIT "A"

EXHIBIT "A"

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ORIGINAL

16

LTWT
STEVEN BAKER, ESQ.
Nevada Bar No. 4522
BENSON, BERTOLDO,
BAKER & CARTER, CHTD.
7408 W. Sahara Avenue
Las Vegas, Nevada 89117
(702) 228-2600
Attorneys for Plaintiff
ENRIQUE RODRIGUEZ

FILED

SEP 24 11 04 AM '07

CLERK OF THE COURT

DISTRICT COURT

CLARK COUNTY, NEVADA

* * * * *

ENRIQUE RODRIGUEZ, an individual; Plaintiffs, vs. FIESTA PALMS, L.L.C., a Nevada Limited Liability Company, d/b/a PALMS CASINO RESORT; DOES I through X, inclusive; and ROE BUSINESS ENTITIES I through X, inclusive, Defendants.	CASE NO.: A531538 DEPT. NO.: X

PLAINTIFF'S 16.1 LIST OF DOCUMENTS AND WITNESSES

Pursuant to NRCP 16.1, Plaintiff hereby submits the following list of knowledgeable persons and documents with attached materials as follows:

I.

LIST OF KNOWLEDGEABLE PERSONS

1. PMK, Custodian of Records
American Medical Response
1200 S. Martin Luther King Blvd.
Las Vegas, NV 89102

Persons Most Knowledgeable of American Medical Response will testify as to Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby.

7408 WEST SAHARA AVENUE • LAS VEGAS, NEVADA 89117 • (702) 228-2600 • FAX (702) 228-2333
BENSON BERTOLDO BAKER & CARTER ATTORNEYS AT LAW
RECEIVED SEP 24 2007 CLERK OF THE COURT

7408 WEST SAHARA AVENUE • LAS VEGAS, NEVADA 89117 • (702) 228-2600 • FAX (702) 228-2333

BENSON BERTOLDO BAKER & CARTER ATTORNEYS AT LAW

The Custodian of Records will testify regarding the authenticity of medical records and bills.

2. PMK, Custodian of Records
Spring Valley Hospital and Medical Center
5400 S. Rainbow Blvd.
Las Vegas, NV 89118

Persons Most Knowledgeable of Spring Valley Hospital and Medical Center will testify as to Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

3. PMK, Custodian of Records
Physician's Management Solution
6700 Indiana Ave., Suite 145
Riverside, CA 92506

Persons Most Knowledgeable of Physician's Management Solution will testify as to Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

4. PMK, Custodian of Records
Rancho Physical Therapy, Inc.
630 E. Latham Ave.
Hemet, CA 92564

Persons Most Knowledgeable of Rancho Physical Therapy will testify as to Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

5. Eric E. Campbell, DC
Custodian of Records
The Wellness Group
34740 Via Carnaghi
Wildomar, CA 92595

Eric E. Campbell, DC will testify regarding Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

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6. PMK, Custodian of Records
MRI of Inland Valley
44274 George Cushman #108
Temecula, CA 92592

Persons Most Knowledgeable of MRI of Inland Valley will testify as to Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

7. William Simpson, M.D.
Custodian of Records
32395 Clinton Keith Rd. #104
Wildomar, CA 92595

William Simpson, M.D., will testify regarding Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

8. PMK, Custodian of Records
Las Vegas Neurosurgery,
Orthopaedics & Rehabilitation
600 S. Rancho Dr., Suite 107
Las Vegas, NV 89106

Persons Most Knowledgeable of Las Vegas Neurosurgery, Orthopaedics & Rehabilitation will testify regarding Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

9. PMK, Custodian of Records
Louis Mortillaro, M.D.
501 S. Rancho Dr. Suite F37
Las Vegas, NV 89106

Persons Most Knowledgeable will testify regarding Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

10. PMK, Custodian of Records
I.V. League Pharmacy, Inc.
6076 Bristol Pkwy. Suite 104
Culver City, CA 90230

7408 WEST SAHARA AVENUE • LAS VEGAS, NEVADA 89117 • (702) 228-2600 • FAX (702) 228-2333
BENSON BERTOLDO BAKER & CARTER ATTORNEYS AT LAW

Persons Most Knowledgeable of I.V. League Pharmacy will testify regarding Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

11. PMK, Custodian of Records
Valley Hospital and Medical Center
620 Shadow Lane
Las Vegas, NV 89106

Persons Most Knowledgeable of Valley Hospital and Medical Center will testify regarding Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

12. PMK, Custodian of Records
Matt Smith, Physical Therapy
600 S. Rancho Dr. Box 357
Las Vegas, NV 89107

Persons Most Knowledgeable of Matt Smith, Physical Therapy will testify regarding Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

13. PMK, Custodian of Records
Russell J. Shah, M.D., Ltd.
2628 W. Charleston Blvd.
Las Vegas, NV 89102

Persons Most Knowledgeable of Russell J. Shah, Ltd. will testify regarding Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

14. PMK, Custodian of Records
Lawrence R. Miller, M.D.
8641 Wilshire Blvd. Suite 200
Beverly Hills, CA 90211

Persons Most Knowledgeable of Lawrence R. Miller, M.D. will testify regarding Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the

7408 WEST SAHARA AVENUE • LAS VEGAS, NEVADA 89117 • (702) 228-2600 • FAX (702) 228-2333
BENSON BERTOLDO BAKER & CARTER ATTORNEYS AT LAW

charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

15. PMK, Custodian of Records
North Valley Medical Supply
3053 W. Craig Rd. Suite B
North Las Vegas, NV 89032

Persons Most Knowledgeable of Lawrence R. Miller, M.D. will testify regarding Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

16. PMK, Custodian of Records
Pain Institute of Nevada
600 S. Rancho Dr. Suite 113
Las Vegas, Nevada 89106

Persons Most Knowledgeable of Pain Institute of Nevada will testify regarding Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

17. PMK, Custodian of Records
Quality RESP Solutions
20818 Higgins Court
Torrance, CA 90501

Persons Most Knowledgeable of Quality RESP Solutions will testify regarding Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

18. PMK, Custodian of Records
California Hand Surgery & Orthopedics
P.O. Box 515110
Los Angeles, CA 900515110

Persons Most Knowledgeable of California Hand Surgery & Orthopedics will testify regarding Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

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BENSON BERTOLDO BAKER & CARTER ATTORNEYS AT LAW

19. PMK, Custodian of Records
Jacob E. Tauber, M.D.
9033 Wilshire Blvd. Suite 401
Beverly Hills, CA 90211

Persons Most Knowledgeable of Jacob E. Tauber, M.D. will testify regarding Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

20. PMK, Custodian of Records
Lake Mead Radiology/Nevada Imaging Centers
5495 S. Rainbow Blvd. #101
Las Vegas, Nevada 89118

Persons Most Knowledgeable of Lake Mead Radiology / Nevada Imaging testify regarding Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

21. PMK, Custodian of Records
Wilshire Surgicenter, Inc.
11999 San Vicente BL, #440
Los Angeles, CA 90049

Persons Most Knowledgeable of Wilshire Surgicenter, Inc. will testify regarding Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

22. PMK, Custodian of Records
Medical District Surgery Center
2020 Goldring, Suite 300
Las Vegas, Nevada 89106

Persons Most Knowledgeable of Medical District Surgery Center will testify regarding Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

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...

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23. PMK, Custodian of Records
Nevada Sleep Diagnostics
62 N. Pecos Rd. Suite B
Henderson, Nevada 89074

Persons Most Knowledgeable of Nevada Sleep Diagnostics will testify regarding Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

24. PMK, Custodian of Records
Nevada ENT Center
1815 E. Lake Mead Blvd. #307
Las Vegas, Nevada 89030

Persons Most Knowledgeable of Nevada ENT Center will testify regarding Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

25. PMK, Custodian of Records
Insight Mountain Diagnostics
800 Shadow Lane
Las Vegas, Nevada 89106

Persons Most Knowledgeable of Insight Mountain Diagnostics will testify regarding Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

26. Custodian of Records
Med-Care Solutions
10120 W. Flamingo Rd. Suite 412
Las Vegas, Nevada 89147

The Custodian of Records of Med-Care Solutions will testify regarding the authenticity of medical bills.

27. PMK, Custodian of Records
Strehlow Radiology
3742 E. Tropicana Ave. Suite 1
Las Vegas, Nevada 89121

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BENSON BERTOLDO BAKER & CARTER ATTORNEYS AT LAW

Persons Most Knowledgeable of Strehlow Radiology will testify regarding Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

28. PMK, Custodian of Records
Integrated Healthcare of Nevada
4517 W. Sahara Ave.
Las Vegas, NV 89120

Persons Most Knowledgeable of Integrated Healthcare of Nevada will testify regarding Mr. Rodriguez' injuries, care, treatment, prognosis, the necessity of that treatment, causation for which that care and treatment was rendered and the reasonableness of the charges thereby. The Custodian of Records will testify regarding the authenticity of medical records and bills.

Plaintiff reserves the right to amend and supplement this list of knowledgeable persons as discovery continues. Plaintiff reserves the right to take the depositions of any and all knowledgeable persons and/or to call any and all knowledgeable persons to testify as witnesses at the time of arbitration and/or trial. Plaintiff reserves the right to call any and all medical providers to testify as expert witnesses at the time of arbitration and/or trial.

II.

LIST OF DOCUMENTS

1. Medical records and triage reports from American Medical Response;
2. Medical records and billing statements from Spring Valley Medical Center;
3. Medical records and billing statements from Physician's Management Solution;
4. Billing statement from Rancho Physical Therapy, Inc.;
5. Billing statement from Eric E. Campbell, D.C.;
6. Medical records and billing statements from MRI of Inland Valley;
7. Medical records from William Simpson, M.D.;

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8. Medical records and billing statements from Las Vegas Neurosurgery, Orthopedics and Rehabilitation;

9. Medical records and billing statements from Louis Mortillaro, M.D.;

10. Billing statements from IV League Pharmacy;

11. Medical records and billing statements from Valley Hospital and Medical Center;

12. Billing statements from Matt Smith, Physical Therapy;

13. Medical records and billing statements from Russell J. Shah, M.D.;

14. Medical records from Lawrence R. Miller, M.D.;

15. Billing statement from North Valley Medical Supply;

16. Medical records from Pain Institute of Nevada;

17. Billing statements from Quality Resp Solutions;

18. Billing statement from Cal Hand Surgery & Orthopaedics;

19. Medical records and billing statements from Jacob E. Tauber, M.D.;

20. Reports and billing statements from Lake Mead Radiology/Nevada Imaging Centers;

21. Medical records and billing statement from Wilshire Surgicenter, Inc.;

22. Medical record and billing statement from Medical District Surgery Center;

23. Medical records and billing statement from Nevada Sleep Diagnostics;

24. Medical records and billing statements from Nevada ENT Center;

25. Medical records and billing statement from Insight Mountain Diagnostics;

26. Medical record and billing statement from Strehlow Radiology;

27. Medical record and billing statements from Integrated Healthcare of Nevada.

Plaintiff reserves the right to amend the above list of documents and to submit additional documents as discovery continues. Plaintiff reserves the right to submit all

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documents as evidence at the time of arbitration and/or trial.

DAMAGES:

Plaintiff has incurred the following medical expenses as a result of this incident:

No.	Provider	Amount
1	AMR – Mercy Ambulance	$ 534.70
2.	Spring Valley Hospital	$ 1,202.00
3.	Physicians Management Solution	$ 1,267.59
4.	Rancho Physical Therapy	$ 10,933.00
5.	Eric E. Campbell, D.C.	$ 272.00
6.	MRI of Inland Valley	$ 2,350.00
7.	William Simpson, M.D.	$ UNKNOWN
8.	Las Vegas Neurosurgery, Orthopedics & Rehabilitation	$ 16,659.50
9.	Louis Mortillaro, M.D.	$ 13,217.00
10.	I.V. League Pharmacy	$ 3,155.91
11.	Valley Hospital and Medical Center	$ 15,999.00
12.	Matt Smith Physical Therapy	$ 2,055.00
13.	Russell J. Shah, M.D.	$ 400.00
14.	Lawrence R. Miller, M.D.	$ UNKNOWN
15.	North Valley Medical Supply	$ 36.95
16.	Pain Institute of Nevada	$ UNKNOWN
17.	Quality Resp. Solutions	$ 3,287.27
18.	Cal Hand Surgery & Orthopedics	$ 2,338.83
19.	Jacob E. Tauber, M.D.	$ 9,745.00
20.	Lake Mead Radiology/Nevada Imaging Centers	$ 3,915.00
21.	Wilshire Surgicenter, Inc.	$ 17,991.00
22.	Medical District Surgery Center	$ 5,135.29
23.	Nevada Sleep Diagnostics	$ 3,350.00
24.	Nevada ENT Center	$ 1,030.00
25.	Insight Mountain Diagnostics	$ 2,635.00
26.	Strehlow Radiology	$ 85.00
27.	Integrated Healthcare of Nevada	$ 3,650.00
------	----------TOTAL CHARGES----------	$ 121,245.04

Plaintiff's treatment for his injuries is continuing in nature, and the list of past medical expenses will change. Plaintiff reserves the right to supplement this list accordingly.

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Plaintiff has incurred loss of income and therefore, will supplement these damages.

Dated this 20th day of September, 2007.

BENSON, BERTOLDO,
BAKER & CARTER, CHTD.

STEVEN M. BAKER, ESQ.
Nevada Bar No. 4522
7408 West Sahara Avenue
Las Vegas, Nevada 89117
(702) 228-2600
Attorneys for Plaintiff

RECEIPT OF COPY

RECEIPT OF COPY of **PLAINTIFF'S EARLY CASE CONFERENCE LIST OF PERSONS MOST KNOWLEDGEABLE AND LIST OF DOCUMENTS PRODUCED** is hereby acknowledged:

This 20 day of September, 2007.

Moran & Associates
Jeffery A. Bendavid, Esq.
630 S. Fourth St.
Las Vegas, NV 89101
Attorneys for Defendant Fiesta Palms, LLC

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EXHIBIT "B"

EXHIBIT "B"

MB
BM
MORAN BRANDON
BENDAVID MORAN
ATTORNEYS AT LAW
630 SOUTH 4TH STREET
LAS VEGAS, NEVADA 89101
PHONE:(702) 384-8424
FAX: (702) 384-6568

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BENSON BERTOLDO BAKER & CARTER ATTORNEYS AT LAW

SUPP

STEVEN M. BAKER, ESQ.
Nevada Bar No. 4522
Benson, Bertoldo, Baker & Carter
7408 W. Sahara Avenue
Las Vegas, Nevada 89117
(702) 228-2600
Attorneys for Plaintiff

DISTRICT COURT

CLARK COUNTY, NEVADA

ENRIQUE RODRIGUEZ, an individual, Plaintiffs vs. FIESTA PALMS, L.L.C., a Nevada Limited Liability Company, d/b/a PALMS CASINO RESORT; DOES I through X, inclusive; and ROE BUSINESS ENTITIES I through X, inclusive, Defendants.	)	CASE NO: A531538 DEPT. NO: X

PLAINTIFF'S SUPPLEMENTAL EXPERT DISCLOSURE

COMES NOW, Plaintiff, Enrique Rodriguez, by and through his attorney of record, Steven M. Baker, Esq., of the law firm of Benson, Bertoldo, Baker & Carter, and pursuant to Nevada Rules of Civil Procedure herein submits the following expert witness as follows:

EXPERT WITNESSES

1. Terrance Dinneen, M.S., C.R.C., C.R.E.
   Kathleen Hartmann, RN, BSN, CCM
   Devinney & Dinneen
   445 Apple Street, Suite 102
   Reno, Nevada 89502
   775-825-5558 Telephone

It is anticipated that Mr. Dinneen will provide expert testimony consistent with his vocational and economical report, a copy of which is attached hereto. A copy of Mr. Dinneen's

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curriculum vitae and fee schedule is also attached.

2. Firooz Mashood, M.D.
734 East Sahara Avenue
Las Vegas, NV 89104

Dr. Mashood is anticipated to testify regarding the reasonable and necessary treatment of Mr. Rodriguez for injuries sustained resultant of the subject fall as well as prognosis and anticipated future treatment. Dr. Mashood will further testify regarding reasonable and customary charges for past and future treatment of Plaintiff. It is anticipated that Dr. Mashhood will provide expert testimony consistent with his report, to be supplemented upon receipt, along with a copy of Dr. Mashhood's curriculum vitae and fee schedule.

Plaintiff reserves the right to call any and all experts designated by other parties in this case to render expert testimony. This plaintiff may ask expert witness questions of any percipient and/or expert witnesses called by any party at trial.

Plaintiff reserves the right to call any and all witnesses necessary for impeachment or rebuttal purposes.

Plaintiff reserves the right to supplement this list of expert witnesses as discovery continues and as new information becomes available.

DATED this 15th day of June, 2010.

BENSON, BERTOLDO, BAKER & CARTER

BY: _____

STEVEN M. BAKER, ESQ.
Nevada Bar No.4522
7408 West Sahara Avenue
Las Vegas, Nevada 89117
Attorneys for Plaintiff

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BENSON BERTOLDO BAKER & CARTER
ATTORNEYS AT LAW

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 15th day of June, 2010, a true and correct copy of the foregoing PLAINTIFF'S SUPPLEMENTAL EXPERT WITNESS DISCLOSURE was mailed in a sealed envelope by U.S. Mail, postage prepaid to the following addressees:

10676-05 Jeffery A. Bendavid, Esq. Moran & Associates 630 S. Fourth St. Las Vegas, NV 89101 Attorneys for Defendant Fiesta Palms	384-8424 Telephone 384-6568 Facsimile
10676-05 Keith Gillette, Esq. Archer Norris 2033 North Main Street, Suite 800 P.O. Box 8035 Walnut Creek, California 94596 Co-counsel for Fiesta Palms	925-930-6600 Telephone 925-930-6620 Facsimile
10676-05 Marsha L. Stephenson, Esq. Stephenson & Dickinson 2820 West Charleston Blvd., Suite 19 Las Vegas, Nevada 89102 Co-counsel for Fiesta Palms	474-7229 Telephone 474-7237 Facsimile

An Employee of Benson, Bertoldo, Baker & Carter

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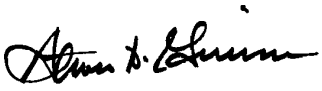

CLERK OF THE COURT

MLIM
LEW BRANDON, JR., ESQ.
Nevada Bar No.: 5880
JUSTIN W. SMERBER, ESQ.
Nevada Bar No.: 10761
MORAN BRANDON BENDAVID MORAN
630 S. Fourth Street
Las Vegas, Nevada 89101
(702) 384-8424
(702) 384-6568 - facsimile
l.brandon@moranlawfirm.com
Attorneys for Defendant,
FIESTA PALMS, LLC d/b/a
PALMS CASINO RESORT

ROBERT L. EISENBERG, ESQ.
Nevada Bar No. 0950
LEMONS, GRUNDY & EISENBERG
6005 Plumas Street, Third Floor
Reno, Nevada 89519
Telephone: (775) 786-6868 / Facsimile: (775) 786-9716
rle@lge.net
Attorneys for Defendant,
FIESTA PALMS, LLC d/b/a
PALMS CASINO RESORT

DISTRICT COURT
CLARK COUNTY, NEVADA

ENRIQUE RODRIGUEZ, an individual, Plaintiff, v. FIESTA PALMS, L.L.C., a Nevada Limited Liability Company, d/b/a PALMS CASINO RESORT; BRANDY L. BEAVERS, individually, DOES I through X, and ROE CORPORATIONS I through X, inclusive, Defendants.	CASE NO.: 06A531538 DEPT. NO.: V

DEFENDANT, FIESTA PALMS, LLC'S MOTION IN LIMINE NO. 15 TO PRECLUDE PLAINTIFF FROM CLAIMING MEDICAL SPECIALS EXCEEDING AMOUNTS DISCLOSED BY PLAINTIFF PURSUANT TO NRCP 16.1

MORAN BRANDON BENDAVID MORAN
ATTORNEYS AT LAW
630 SOUTH 4TH STREET
LAS VEGAS, NEVADA 89101
PHONE (702) 384-8424
FAX: (702) 348-6568

COMES NOW, Defendant, FIESTA PALMS, LLC., by and through its undersigned attorneys, LEW BRANDON, JR., ESQ. and JUSTIN W. SMERBER, ESQ., of MORAN BRANDON BENDAVID MORAN, and and ROBERT L. EISENBERG of LEMONS, GRUNDY & EISENBERG, hereby submit the following Motion in Limine No. 15 to Preclude Plaintiff From Claiming Medical Specials Exceeding Amounts Disclosed by Plaintiff Pursuant to NRCP 16.1.

This Motion is made and based upon the Points and Authorities attached hereto, along with all papers and pleadings on file herein, and oral arguments at the time of hearing.

DATED this 7th day of March, 2016.

MORAN BRANDON BENDAVID MORAN

/s/ Justin W. Smerber, Esq.
LEW BRANDON, JR., ESQ.
Nevada Bar No. 5880
JUSTIN W. SMERBER, ESQ.
Nevada Bar No.: 10761
630 S. Fourth Street
Las Vegas, Nevada 89101
Attorneys for Defendant,
FIESTA PALMS, LLC d/b/a
PALMS CASINO RESORT

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MORAN BRANDON BENDAVID MORAN
ATTORNEYS AT LAW
630 SOUTH 4TH STREET
LAS VEGAS, NEVADA 89101
PHONE (702) 384-8424
FAX: (702) 348-6568

NOTICE OF MOTION

TO: ALL PARTIES;

YOU, AND EACH OF YOU, will please take notice that the foregoing **DEFENDANT'S MOTION IN LIMINE NO. 15** has been set for Hearing on the 07 day of APRIL, 2015 at the hour of 9:00A.m., before the Eighth Judicial District Court in Dept. V.

DATED this 7th day of March, 2016.

MORAN BRANDON BENDAVID MORAN

/s/ Justin W. Smerber, Esq.
LEW BRANDON, JR., ESQ.
Nevada Bar No. 5880
JUSTIN W. SMERBER, ESQ.
Nevada Bar No. 10761
630 S. Fourth Street
Las Vegas, Nevada 89101
Attorneys for Defendant,
FIESTA PALMS, LLC d/b/a
PALMS CASINO RESORT

MEMORANDUM OF POINTS AND AUTHORITIES

I.
INTRODUCTION

Defendant is filing a series of Motions in Limine in compliance with EDCR 2.47. In order to avoid duplicative reading by this court, Defendant directs the Court to its Motion in Limine No. 1 for Defendant's Affidavit required by EDCR 2.47, and its Motion in Limine Standard Section.

II.
FACTS

This matter involves negligence claims stemming from an incident on November 22, 2004. *See Plaintiff's Complaint, on file herein.* On that date, ENRIQUE RODRIGUEZ

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(hereinafter "Plaintiff") was watching a televised football at Palms Resort and during half time a "Palms girl" threw a promotional item into the crowd. Id. An unknown patron dove for the item and struck Plaintiff; Plaintiff has since alleged injuries to his left knee, head, and neck. Id. Plaintiff filed suit against FIESTA PALMS, LLC d/b/a PALMS CASINO RESORT (hereinafter "Defendant") as owner of the resort.

The final computation of Plaintiff's damages received by Defendant in this case is from Plaintiff's 29th Supplemental Early Case Conference disclosures. *See Plaintiff's 29th* Supplemental Early Case Conference List of Documents and Witnesses, attached hereto as *Exhibit "A."* This disclosure indicates that Plaintiff's past medical expenses total "$543,896.66." Further, the disclosure contains a list showing medical providers, treatment dates, and total bills from those providers. Id.

However, the computation of "$543,896.66" in this disclosure is incorrect. By adding the figures provided in Plaintiff's computation, it gives a total of $396,572.84. Id. Further, when actually adding the medical bills produced by Plaintiff in this action, it results in a total of $392,489.97; not $543,896.66. *See Plaintiff's Billing Records, attached hereto as Exhibit "D."* Accordingly, Defendant now moves for an order clarifying the total amount of Plaintiff's past medical specials that can be presented as damages at trial.

III.
LEGAL ARGUMENT

At the time of trial, Plaintiff should be limited to presenting only those medical specials that have previously been disclosed by Plaintiff pursuant to NRCP 16.1. Specifically, Plaintiff should be limited to presenting a total of $392,489.97. This is the total amount of past medical bills that have been disclosed in this matter. To allow Plaintiff to produce additional medical specials, which have never been disclosed would be highly prejudicial to the Defendant.

MBBM
MORAN BRANDON BENDAVID MORAN
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Plaintiff was required, under NRCP 16.1(a)(1)(C), to disclose, among other things, the following:

> A computation of any category of damages claimed by the disclosing party, making available for inspection and copying as under Rule 34 the documents or other evidentiary matter, not privileged or protected from disclosure, on which such computation is based, including materials bearing on the nature and extent of injuries suffered . . . .

Further, 16.1(a)(3) required Plaintiff to disclose all exhibits Plaintiff would rely upon at trial. NRCP 37(c)(1) provides that "A party that without substantial justification fails to disclose information required by Rule 16.1 . . .is not, unless such failure is harmless, permitted to use as evidence at a trial, at a hearing, or on a motion any witness or information not so disclosed."

In the instant case, Plaintiff provided a final computation of damages indicating that Plaintiff's damages totaled $543,896.66 on Plaintiff's 29th Supplement. *See Exhibit "A."* Upon calculating the amounts Plaintiff provided, Defendant has found that Plaintiff's disclosed past medical specials total only $396,572.84. Further, after a thorough review of Plaintiff's disclose medical bills, the total amount of medical bills actually disclosed to Defendant totals $392,489.97. *See Exhibit "D."* Therefore, Plaintiff has failed to provide an accurate computation of damages and has failed to provide a complete disclosure supporting his damages claim. Accordingly, Plaintiff should be precluded from alleging medical damages in excess of $392,489.97, the actual amount of medical bills disclosed to Defendant during discovery.

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MORAN BRANDON BENDAVID MORAN
ATTORNEYS AT LAW
630 SOUTH 4TH STREET
LAS VEGAS, NEVADA 89101
PHONE (702) 384-8424
FAX: (702) 348-6568

IV.
CONCLUSION

Based upon the foregoing, Defendant, Fiesta Palms, LLC d/b/a Palms Casino Resort respectfully requests that this Court grant Defendant's Motion in Limine No. 15 and issue an order precluding Plaintiff from claiming medical specials exceeding the amount actually disclosed by Plaintiff Pursuant to NRCP 16.1.

DATED this 7th day of March, 2016.

MORAN BRANDON BENDAVID MORAN

/s/ Justin W. Smerber, Esq.
LEW BRANDON, JR., ESQ.
Nevada Bar No. 5880
JUSTIN W. SMERBER, ESQ.
Nevada Bar No.: 10761
630 S. Fourth Street
Las Vegas, Nevada 89101
Attorneys for Defendant,
FIESTA PALMS, LLC d/b/a
PALMS CASINO RESORT

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PHONE (702) 384-8424
FAX: (702) 348-6568

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I hereby certify that on the _____ day of March, 2016, I served the foregoing **DEFENDANT, FIESTA PALMS, LLC'S MOTION IN LIMINE NO. 15 TO PRECLUDE PLAINTIFF FROM CLAIMING MEDICAL SPECIALS EXCEEDING AMOUNTS DISCLOSED BY PLAINTIFF PURSUANT TO NRCP 16.1** via the Court's electronic filing and service systems ("Wiznet") to all parties on the current service list.

VIA U.S. MAIL

ENRIQUE RODRIGUEZ
6673 YELLOWSTONE DRIVE
RIVERSIDE, CALIFORNIA 92506
TELEPHONE: 951-751-1440
Plaintiff, In Proper Person

/s/ Angelina M. Martinez
An Employee of Moran Brandon Bendavid Moran

MORAN BRANDON BENDAVID MORAN
ATTORNEYS AT LAW
630 SOUTH 4TH STREET
LAS VEGAS, NEVADA 89101
PHONE (702) 384-8424
FAX: (702) 348-6568

EXHIBIT "A"

EXHIBIT "A"

MB
BM
MORAN BRANDON
BENDAVID MORAN
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630 SOUTH 4TH STREET
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BENSON BERTOLDO BAKER & CARTER ATTORNEYS AT LAW

STEVEN M. BAKER, ESQ.
Nevada Bar No. 4522
Benson, Bertoldo, Baker & Carter
7408 W. Sahara Avenue
Las Vegas, Nevada 89117
(702) 228-2600
Attorneys for Plaintiff

DISTRICT COURT

CLARK COUNTY, NEVADA

ENRIQUE RODRIGUEZ, an individual, Plaintiffs vs. FIESTA PALMS, L.L.C., a Nevada Limited Liability Company, d/b/a PALMS CASINO RESORT; DOES I through X, inclusive; and ROE BUSINESS ENTITIES I through X, inclusive, Defendants.	)	CASE NO: A531538 DEPT. NO: X

PLAINTIFF'S 29th SUPPLEMENTAL EARLY CASE CONFERENCE LIST OF DOCUMENTS AND WITNESSES

COMES NOW, Plaintiff, Enrique Rodriguez, by and through his attorney of record, Steven M. Baker, Esq., of the law firm of Benson, Bertoldo, Baker & Carter, and pursuant to Nevada Rules of Civil Procedure herein submits the following supplement of comprehensive documents pursuant to NRCP 16.1(a)(1) and NRCP 16.1(a)(1)(3):

DOCUMENTS

1. Medical records from Marketplace Physical Therapy
2. Billing statement from Total Wellness, Inc.

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BENSON BERTOLDO BAKER & CARTER ATTORNEYS AT LAW

COMPUTATION OF DAMAGES

1. Past Medical Expenses:

Providers	Dates of Service	Fees
American Medical Response	11-22-04	$ 534.70
Desert Radiologists	11-22-04	$ 43.00
Spring Valley Hospital	11-22-04	$ 1,202.00
Shadow Emergency Physicians	11-22-04	$ 300.00
John G. Nork, M.D. (Associated Physicians)	12-06-04 & 01-17-05	$ 667.59
Open MRI of Inland Valley	01-28-05	$ 2,350.00
William Simpson, M.D. and Eric E. Campbell, D.C. (The Wellness Group)	01-24-05 to 02-15-05	$ 487.00
Vision Radiology Consultants	02-19-05	$ 500.00
VQ Ortho Care	04-19-05	$ 1,588.75
IV League Pharmacy	09-22-05 & 09-28-05	$ 3,155.91
Valley Hospital Medical Center	10-04-05	$ 15,999.00
Strehlow Radiology	11-11-05	$ 85.00
Insight Mountain Diagnostics	11-16-05	$ 2,635.00
Mary Ann Shannon, M.D. (Las Vegas Neurosurgery)	03-28-05 to 12-12-05	$ 16,701.50
Joseph R. Nicola, D.C. and Teresa Charniga, M.D. (Integrated Health Care)	11-08-05 to 01-31-06	$ 3,650.00
Michael Labanowski, M.D. (NV Sleep Diagnostics)	01-30-06 & 02-02-06	$ 3,350.00
George Graf, M.D.	04-21-06	$ 720.00

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Village East Drugs	01-11-06 to 06-01-06	$ 2,605.45
Valley Rehab & Sports Therapy	02-22-06 to 02-09-07 08-06-07 – 08-29-08	$31,300.00
Medical District Surgery Center	03-30-06 to 07-20-06	$ 27,022.57
Yakov Treyzon, M.D.	04-22-06	$ 673.50
Beverly Tower Wilshire Advanced Imaging	07-25-06	$ 1,430.00
Safeway Pharmacy	08-02-06 to 08-23-06	$ 167.21
Jacob Tauber, M.D.	02-14-06 to 09-19-06	$ 9,745.00
F. Michael Ferrante, M.D. (UCLA Pain Medicine Center)	11-14-06	$ 1,500.00
Quality Respiratory Solutions/ King Medical Supply	02-17-06 to 12-06-06	$ 3,287.27
Casiano Flaviano, M,D. (Family Wellness Clinic)	01-18-07	$ 2,118.00
Walter M. Kidwell, M.D. (Pain Institute of NV)	03-20-06 to 02-05-07	$ 11,372.00
Olympic Anesthesia	03-14-07 & 04-18-07	$ 1,500.00
Wilshire Surgicenter	04-21-06 to 04-18-07	$ 26,897.00
Daniel Kim, D.O. (NV Ear, Nose & Throat)	01-04-06 to 05-24-07	$ 1,043.00
Douglas S. Stacey, D.P.M. (Foot & Ankle Surgical Group)	06-12-07 to 07-26-07	$ 782.50
North Valley Medical Supply	06-12-06 to 09-11-07	$ 9,149.33
Nevada Imaging Centers/ Lake Mead Radiologists	01-12-06 to 12-04-07	$ 6,019.95
Robert Gutierrez, M.D.	08-21-06 to 03-26-08	$ 3,294.00

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Advanced Urgent Care	04-02-08 & 04-07-08	$ 313.00
Michael J. Crovetti, D.O. (Bone & Joint Institute)	03-13-08 & 05-12-08	$ 700.00
John Thalgott, M.D. (Center for Diseases & Surgery of the Spine)	02-21-06 to 05-13-08	$ 4,154.50
Las Vegas Surgery Center	11-30-07 & 07-14-08	$ 34,522.00
Joseph J. Schifini, M.D.	11-26-07 to 07-14-08	$ 9,000.00
Lawrence Miller, M.D. (Cal Hand Surgery)	03-04-07 to 07-17-08	$ 2,901.91
Govind Koka, D.O. (Medical Assocs. of So NV or Primary Care Consultants)	01-26-06 to 07-23-08	$ 6,004.60
	08-20-08 to 03-03-10	$ 3,989.43
Matt Smith Physical Therapy	08-23-06 to 08-29-08	$ 29,330.00
n/k/a Rancho Physical Therapy	12-08-04 to 12-07-05	$ 10,933.00
Centennial Upright MRI	09-17-08	$ 7,500.00
G. Michael Elkanich, M.D. (Bone & Joint Specialists)	09-02-08 & 09-30-08	$ 1,025.00
Walgreen's Pharmacy	11-23-04 to 11-28-08	$ 29,483.03
Russell J. Shah, M.D.	07-11-06 to 02-03-09	$ 27,500.00
	11-04-09	425.00
	08-10-10	375.00
Chynoweth, Hill & Leavitt (Kelly Hawkins P.T.)	10-22-08 to 04-01-09	$ 8,227.00
Thomas Vater, D.O.	10-13-08	$ 300.00
Louis F. Mortillaro, Ph.D.	08-31-05 to 11-05-09	$ 22,052.00
	12-17-09 to 03-03-10	875.00
	05-13-10 to 05-18-10	450.00
	06-15-10	225.00

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Total Wellness Clinic	06-28-10 to 07-30-10	$ 2,147.14
	09-22-10	**264.00**
Marketplace Physical Therapy	**06-28-10 to 09-27-10**	**TBD**
	PAST MEDICAL EXPENSES TOTAL:	**$543,896.66+**

** Plaintiff reserves the right to supplement medical records and bills.

2. **Past General Damages:** **TBD**

3. **Past Lost Wages/Loss of Opportunity:** **$290,000**

Please see expert report of Terrence Dinneen.

4. **Future Medical Expenses:** **$2,000,000**

Plaintiff has been advised that a pain stimulator is needed. Please see expert report of Terrence Dinneen.

5. **Future Lost Wages/Loss of Opportunity:** **$968,000**

Please see expert report of Terrence Dinneen.

6. **Future General Damages:** **TBD**

DATED this 4th day of Oct, 2010.

BENSON, BERTOLDO, BAKER & CARTER

BY: _____

STEVEN M. BAKER, ESQ.
Nevada Bar No.4522
7408 West Sahara Avenue
Las Vegas, Nevada 89117
Attorneys for Plaintiff

7408 WEST SAHARA AVENUE • LAS VEGAS, NEVADA 89117 • (702) 228-2600 • FAX (702) 228-2333

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 4th day of Oct, 2010, a true and correct copy of the foregoing PLAINTIFF'S TWENTY-NINTH SUPPLEMENTAL EARLY CASE CONFERENCE LIST OF WITNESSES AND DOCUMENTS was mailed in a sealed envelope by U.S. Mail, postage prepaid to the following addressees:

10676-05 Jeffery A. Bendavid, Esq. Adam S. Davis, Esq. Moran Law Firm 630 South Fourth Street Las Vegas, Nevada 89101 702-384-8424 Telephone 702-384-6568 Facsimile Co-Counsel for Defendant Fiesta Palms, LLC	10676-05 Keith Gillette, Esq. Archer, Norris 2033 North Main Street, Suite 800 P.O. Box 8035 Walnut Creek, California 94596-3728 925-930-6600 Telephone 925-930-6620 Facsimile Attorneys for Defendant
10676-05 Marsha L. Stephenson, Esq. Stephenson & Dickinson 2820 West Charleston Blvd., Suite 19 Las Vegas, Nevada 89102-1942 702-474-7229 Telephone 702-474-7237 Facsimile Co-counsel for Defendant	

An Employee of Benson, Bertoldo, Baker & Carter

Serving the Cities of Riverside, Corona, Chino and San Bernardino

FAX

Date:	9/27/2010
Pages including cover sheet:	14

To:	Steven Baker
Phone	
Fax	*+1 (702) 228-2333*

From:	Silvia Valencia
	Marketplace Physical Therapy
	3191 B. Mission Inn Ave.
	Riverside
	CA 92507
Phone	*+1 (951) 684-2874*
Fax	*+1 (951) 684-2980*

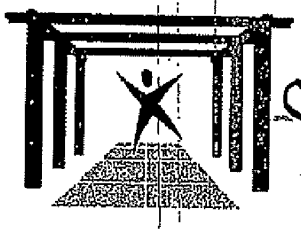
NOTE:

Patient:Rodriguez,Enrique

Hi!

Following are the records that you requested. If you have any questions or concerns feel free to give us a call.

Thank you!:)
Silvia Valencia



MARKETPLACE PHYSICAL THERAPY

3191 B. Mission Inn Avenue Riverside, California 92507
♦Office: (951) 684-2874 ♦Fax: (951) 684-2980

Comprehensive Initial Evaluation

Patient Name: ENRIQUE RODRIGUEZ	Physician: Koka
Evaluation Date: 2010-06-28	Date of Birth: [redacted]
Diagnosis: CRPS, RSD	Onset: 2004

Subjective: Mr. Rodriguez reports initially injuring his left knee when he was hit from behind while at a nightclub. This caused a knee injury which eventually required surgery. This lead to a series of setbacks that eventually led to development of CRPS, RSD. He has attended PT for aquatic therapy at another facility with good progress. Currently the patient reports pain to the following locations; C/S, L/S, Knees, wrists. The patient is eager to resume aquatic therapy as he is fearful of gaining weight which would exacerbate all the symptoms.

Medical History: Seizures. No contraindications for PT

Current Status: The patient is currently medically disabled.

Objective Findings:

AROM: L/S flexion 20%, extension 20%.
Strength: Quad 3/5, core 2+/5
Visual Inspection: The patient ambulates with the use of a knee brace on the left.
Precautions: General
Clinical Impression: Poor core stability

Assessment:

Problems:

1. Decreased range of motion
2. Decreased strength
3. Lack of home exercise program
4. Decreased tolerance to activities of daily living performance
5. Poor postural awareness
6. Antalgic gait

Goals:

1. Increased range of motion to within functional limits
2. Increased strength to 5/5
3. Patient to perform home exercise program daily

4. Increase tolerance to activities of daily living performance
5. Improve postural awareness
6. Restore normal gait

Rehab Potential: Guarded
Frequency: 3X4

Plan of Intervention:
1. Therapeutic Exercise
2. Modalities as needed
3. Soft tissue mobilization
4. Patient education, home exercise program designed to correct deficits in ROM, strength and posture.

Steven S. Nieto, DPT, OCS
Doctor of Physical Therapy, Orthopedic Certified Specialist
Physical Therapist
Marketplace Physical Therapy
Office: 951.684.2874
Fax: 951.684.2980
DrNieto@marketplaceWellnessCenter.com

3191 B. Mission Inn Ave ♦ 4270 Riverwalk Pkwy, Ste 114 ♦ 14682 Central Ave.
Riverside, CA 92507 Riverside, CA 92505 Chino, CA 91710

♦Office: (951) 684-2874 ♦Fax: (951) 684-2980

Progress Report

Patient: ENRIQUE RODRIGUEZ	Physician: Koka
Date of Report: 2010-09-27	Date of Birth: [redacted]
Dates covered by this report: 6/28/10 to 9/27/10	Total Visits:

Diagnosis: CRPS, RSD
Treatment: Treatment has consisted of aquatic therapeutic exercise and soft tissue mobilization.
Subjective: Mr. Rodriguez states that he is please with progress thus far. He feels improvement regarding core strength and stability.
Functional Capacity: The patient is currently medically disabled. He is limited in most ADL's involving prolonged standing.
Assessment: Mr. Rodriguez has made good progress to date. He is now able to tolerate 60 minutes of calculated aquatic therapeutic exercises. There have been no substantial changes regarding AROM. Strength of the core has improved to 3/5. Frequent verbal and tactile cues are necessary to assure proper mechanics during exercise. The patient is highly motivated and demonstrates excellent devotion to all exercises prescribed.
Recommendations: Continue PT per MD orders.

Thank you for this referral,

Steven S. Nieto, DPT, OCS
Doctor of Physical Therapy, Orthopedic Certified Specialist
Marketplace Physical Therapy
Office: 951.684.2874 Fax: 951.684.2980
DrNieto@MarketplaceWellnessCenter.com

Marketplace Physical Therapy

Patient: Rodriguez, Enrique
Diagnosis: chronic pain - neck, lumbar, reflex sympathetic dystrophy
Physician: Dr. Koka

Daily Progress Notes

6.28.10 Eval Completed. Vescent X 15 [illegible]
7/2/10 S: Most painful area today is (L) knee. O: Per F/S A: Pt has good posture awareness. P: Cont. Margarita Santos PTA
7/5/10 S: Felt "ok" after last visit. Reports no soreness. O: Per F/S A: Tol 5 e/o P: Cont. Margarita Santos PTA
7/14/10 S: No new c/o O: Per F/S A: Tol 5 c/o P: Cont. Margarita Santos PTA
7/19/10 S: No A's. O: Per F/S A: Tol 5 e/o P: Cont. Margarita Santos PTA
7/21/10 S: No A's O: Per F/S A: Tol 5 c/o P: Cont. Margarita Santos PTA
7/26/10 S: c/o new c/o O: Per F/S A: Tol 5 c/o P: Cont. Margarita Santos PTA
7/30/10 S: Reports taking 10 different medications for various conditions including PT. O: Per F/S A: Tol 5 c/o P: Cont Margarita Santos PTA
8/2/10 S: No A's O: Per F/S A: Tol therex 5 c/o PT P: Continue as planned. Margarita Santos PTA
9/22/10 S: No new c/o O: Per F/S A: Tol 5+ c/o Tol PT P: Continue as planned. Margarita Santos PTA

MPWC2003PN

PROGRESS REPORT

Date: _____

Patient: _____

Physician: _____

Report type: _____

Number of visits: _____

Diagnosis: _____

Treatment: _____

Subjective: _____

Functional Capacity: _____

Assessment: _____

Recommendations: _____

MWC2003PRF

Marketplace Physical Therapy
Treatment Flow Sheet

Patient: Rodriguez, Enrique
Diagnosis: reflex sympathetic dystrophy

Date/Number of visits

Treatment	7/2/10	7/8/10	7/14/10	7/19/10	7/21/10	7/26/10	7/30/10	8/2/10	9/22/10
Refer a Friend									
Results Form									
High Knees	2 laps	✓	✓	✓	✓	✓	✓	✓	✓
Side Step	2 laps	✓	✓	✓	✓	✓	✓	✓	✓
Hip Circles	10	✓	✓	✓	✓	✓	✓	✓	✓
Walking	2 laps +10		✓	✓	✓	✓		✓	✓
Hip	10	2x10	✓	✓	✓	✓	✓	✓	✓
Arm Circles	10	2x10	✓	✓	✓	✓	✓	✓	✓
Hip Abd	10	2x10	✓	✓	✓	✓	✓	✓	✓
Sh. Horiz abd acid	10	2x10	✓	✓	✓	✓	✓	✓	✓
Sh.	10	2x10	✓	✓	✓	✓	✓	✓	✓
Chop	10	2x10	✓	✓	✓	✓	✓	✓	✓
Calf Raises	10	2x10	✓	✓	✓	✓	✓	✓	✓
Squats	10	10	✓	✓	✓	✓	✓	✓	✓
Flutter Kicks	30x	✓	✓	✓	✓	✓	✓	✓	✓
X Punch			2x10	✓	✓	✓	✓	✓	✓
Knee			2x10	✓	✓	✓	✓	✓	✓
Stretch	✓		✓	✓	✓	✓	✓	✓	✓

MPWC2003TFS

My List of Medications	Strength	Times/Day
Valium	10 mg ← as needed every	
Albuterol	17 gm ← as needed	
Vicodin	7.5mg/750mg	3
Morphine	30mg	3
Effexor XR	75mg	2
Topamax	100 mg	2
Lovastatin	20 mg	1
Cyclobenzaprine	10 mg	1
Doc-Q-Lace	100mg	3
Enulose Syrup	30gm	2
Singulair	10 mg	1
Advair Disk	250/50	2

Non-Prescription Drugs	Strength	Times/Day
NEUROTIN 300 Mg		3
MuPROCIN	22gm	2
Viagra	100mg ← as needed	
Zyrtek	10 g	1

Known Allergies

Sleep Apnea - Must sleep with C-Pap machine

Asthma

pro air oral inhaler

ADVANCED URGENT CARE

8975 S. Eastern Ave., Ste. 110. • Las Vegas, NV 89123 • Ph.: (702) 361-2273 • Fax: (702) 361-6685

- ☐ Craig Jorgenson, MD — DEA # BJ8921642 — Lic. # NV 0529
- ☑ Goylad Koke, DO — DEA # BK7303566 — Lic. # NV 1001
- ☐ Nickolas Karajohn, MD — DEA # BK7004194 — Lic. # NV 10508
- ☐ Don E. Gregory, MD — DEA # AG8588673 — Lic. # NV 12135

PATIENT NAME: ENRIQUE RODRIGUEZ

ADDRESS: DATE: 6.25.10

PT EVAL + TREAT

SIP MVA = [illegible] + [illegible]

C-C-T: [illegible]

Spondylosis, LBP = radiculopathy, (L) knee

reflex sympathetic dystrophy

[illegible]

BLUE BACKGROUND, REFLECTIVE WATERMARK ON BACK, SECURITY FEATURES LISTED ON BACK.

reflex sympathetic dystrophy

IC-9 code:
337.20

Primary Care Consultants

Fax cover sheet

P.O. Box 778195
Henderson, Nevada 89077-8195

Office: (702) 896-8372
Fax: (702) 492-6368

Date: 6-25-10

Attention: Sylvia

Fax #: 951-684-2980

From: Barbara

Number of pages (including cover sheet): 2

Re: Enrique Rodriguez

Information:

PT RX

Confidentiality Notice: This facsimile communication and any attachments may contain confidential and privileged information for the use of the designated recipients named above. If you are not the intended recipient, you have received this communication in error. Please notify the sender immediately. Thank you.

*Date: 6-28-2010

Patient Information

*Name ENRIQUE RODRIGUEZ Male ☒ Female ☐
First Middle Last

*Address [redacted] City [redacted] State [redacted] ZIP [redacted]

*Phone [redacted] *Date of Birth [redacted] Age 46 Marital Status S *Social Security # [redacted]

*Cell [redacted] E-Mail (Please sign up to receive our monthly newsletters) _____

*Date of injury or onset of symptoms: 11-28-2004

*Describe *briefly* the history of your present illness or injury: left Knee has had 2 surgeries and has CRPS left side lower extremities, neck bulging disc. lower back bulging disc left wrist torn ligament, right wrist carpel tunnel

*Employer: _____

*Address _____ City: _____ State: CA ZIP _____

*Work Phone _____ Occupation _____ Driver's License # _____

*Emergency Contact _____ Relationship to Patient _____

Home Phone: _____ Cell Phone: _____

Person Responsible for Charges (if a minor) _____ Relationship to Patient _____

Address _____ City _____ State CA ZIP _____

*Referring Physician DR. KOKA Phone _____

Address _____ City _____ State CA ZIP _____

Personal Insurance Information

*Insurance Company _____ Phone _____

Insurance Address _____ City _____ State CA ZIP _____

Name of Policy Holder _____ Date of Birth _____ Relationship to Patient _____

Address _____ City _____ State _____ ZIP _____

Does the patient have additional insurance coverage? Yes ☐ No ☐ Policy Holder

*Required

MWC2003PIF

How did you hear about Marketplace Physical Therapy? Physician Referral ☐ Friend ☐ Yellow Pages ☐ Advertisement ☐

Other ☐ *(please explain)* Internet

Severity of symptoms: 1 2 3 4 5 6 7 8 9 10
(1 being the least and 10 the worst)

Frequency of symptoms: 1 2 3 4 5 6 7 8 9 10
(1 being the least and 10 the worst)

***Medical History**
Have you ever had any of the following?

	Yes	No		Yes	No
High Blood Pressure	☐	☒	Kidney Problems	☐	☒
Cardiac conditions	☐	☒	Liver Problems	☐	☒
Heart Attack	☐	☒	Cancer	☐	☒
Circulation Problems	☐	☒	Claustrophobia	☐	☒
Pacemaker	☐	☒	Nervous Disorders	☐	☒
Seizures	☒	☒	Vision Problems	☐	☒
Dizzy Spells	☐	☒	Sensitivity to Heat	☐	☒
Diabetes	☐	☒	Sensitivity to Cold	☐	☒
Allergies	☐	☒	Speech problems	☐	☒
Fractures	☐	☒	Metal Implants	☐	☒
Stroke	☐	☒	Are you pregnant	☐	☒
Arthritis	☐	☒			
Any other illnesses?	☐	☐	Please explain: episodic seizure in sleep,		

Have you ever had surgery? Knee, ganglion blocks, spinal cord stimulator implant temporary

List any medications you are currently taking:

Have you ever had physical therapy? Yes ☒ No ☐

Date 5. 2010 Location Rancho Physical Therapy Riverside Condition Aquatic, CRPS

*Required

MWC2003PIF

Financial Agreement
(Private Insurance Only)

I understand and agree that I am totally responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I understand that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am primarily responsible for all charges regardless of my existing medical coverage. In the event that my insurance company forwards payment directly to me, instead of Marketplace Physical Therapy, I will immediately deliver such payment directly to Marketplace Physical Therapy. I understand and agree that if it becomes necessary to commence legal action for the collection of any outstanding charges on my account, I will be responsible for any costs and or court fees, in addition to the outstanding balance. There will be a 1.5% late charge of any balance 30 days or over; once the insurance company pays.

Please initial _____

(Worker's Compensation—minus 2nd & 3rd sentences)

I hereby give authorization for payment of insurance benefits to be made directly to Marketplace Physical Therapy for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of the agreement is as valid as the original.

_____ *Date 6 / 28 / 2010

*Signature *(Parent or guardian signature if patient is a minor)*

Appointment Policy

I understand my doctor has prescribed therapy for me and physical therapy is an ongoing process which requires regular attendance to be optimally effective.

Co-Payment Policy
(Private Insurance Only)

Patients that carry health care insurance should remember that some policies require a co-payment for each visit. Consequently it is your responsibility, as defined by your policy, to make these co-payments. Also important is that you are responsible for any and all supplies, such as braces and exercise equipment, which are provided to you and not covered by your particular plan.

I understand and agree that I am solely responsible for all co-payments and charges incurred which are not covered under my health care plan. I also authorize the release of any medical information necessary to process this claim.

Authorization for Treatment

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgments of the attending physician may be considered necessary or advisable for the diagnosis or treatment for the above named patient at Marketplace Physical Therapy.

_____ *Date 6 / 28 / 2010

*Signature *(Parent or guardian signature if patient is a minor)*

*Required

MWC2003PIP

Authorization to Release Information in File

To: (Provider) _____

Address _____ City _____

State CA ZIP _____

I, ENRIQUE RODRIGUEZ request that my records, diagnosis, and any other information needed concerning my accident/injury/illness,

Be released to: Marketplace Physical Therapy, Total Wellness, Inc., or personnel, which are approved by the above mentioned person, and to the treating physician for reporting purposes.

For the purpose of Physical Therapy, I understand that I have a right to receive a copy of this authorization upon my request.

*Patient's Signature _____ *Date 6.28.2010

*Patient: ENRIQUE RODRIGUEZ *SS# [redacted]

*DOB: [redacted] *DOI: 11.24.2004

Marketplace Physical Therapy Representative

Privacy Policy Statement

Marketplace Physical Therapy conforms to all HIPAA (Health Insurance Portability and Accountability Act) privacy regulations. Patients' information will only be used for authorization of treatment and reimbursement for services provided. I have received a copy of the Notice of Privacy Practices.

* _____ * 6-28.2010

Patient Signature (parent if a minor) *Date

*Required

MWC2003PIF

BENSON BERTOLDO BAKER & CARTER

7408 W SAHARA AVE
LAS VEGAS, NV 89117

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): N/A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODRIGUEZ, ENRIQUE

3. PATIENT'S BIRTH DATE MM DD YY [redacted] SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

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

CITY [redacted] STATE [redacted]

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

CITY [redacted] STATE [redacted]

ZIP CODE [redacted] TELEPHONE (Include Area Code) [redacted]

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

ZIP CODE [redacted] TELEPHONE (Include Area Code) [redacted]

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 [redacted] SEX M [X] 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 [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 09242010

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 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 PROVIDER OR OTHER SOURCE: GOVIND KOKA DO
17a.
17b. NPI

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 [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by Line)
1. 337.20
2.
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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	09222010	09222010	11		97113		1	264.00	4		NPI	
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER 721567165 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO. 462811A

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

28. TOTAL CHARGE $ 264.00

29. AMOUNT PAID $ 0.00

30. BALANCE DUE $ 264.00

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.)
STEVEN S NIETO
SIGNED 09242010 DATE

32. SERVICE FACILITY LOCATION INFORMATION
TOTAL WELLNESS-RIVERSIDE
3191 B. MISSION INN AVE
RIVERSIDE, CA 92507
a. b.

33. BILLING PROVIDER INFO & PH # 9516842874
TOTAL WELLNESS INC
3191 B MISSION INN AVE
RIVERSIDE, CA 92507
a. b.

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

Fold — Fold

NUCC Instruction Manual available at: www.nucc.org
Mfd. by Medical Arts Press
Call toll-free: 1-800-328-2179

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)
#14710 - Medical Arts Press
Use with Envelope #14145 (gummed) or #14146 (self-seal)

EXHIBIT "B"

EXHIBIT "B"

MB
BM
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Attorneys for Plaintiff

DISTRICT COURT

CLARK COUNTY, NEVADA

* * *

ENRIQUE RODRIGUEZ, an individual, Plaintiff, vs. FIESTA PALMS, L.L.C., a Nevada Limited Liability Company, d/b/a PALMS CASINO RESORT, BRANDY L. BEAVERS, individually, DOES 1 through X, inclusive, and ROE BUSINESS ENTITIES I through X, inclusive, Defendants.	CASE NO: A531538 DEPT NO: 10 **PLAINTIFF'S SECOND SUPPLEMENTAL PRE-TRIAL DISCLOSURES** NON-JURY TRIAL DATE: 10/4/10

COMES NOW, Plaintiff ENRIQUE RODRIGUEZ by and through his attorney of record, Steven M. Baker, Esq. of Benson, Bertoldo, Baker & Carter, Chtd. and pursuant to Nevada Rules of Civil Procedure 16.1(a)(3) herein submits the following disclosures as follows:

A. WITNESSES EXPECTED TO TESTIFY

1. Enrique Rodriguez, c/o Benson, Bertoldo, Baker & Carter, Chtd.
2. Maria Perez, c/o Benson, Bertoldo, Baker & Carter, Chtd.
3. Chris Poe, Lay Witness
4. Josh Gonzalez, Lay Witness
5. Joaquin Mendoza, c/o Archer Norris
6. Ron Merkerson, c/o Archer Norris
7. Steve Ferrero, c/o Archer Norris
8. Vikki Kooinga, c/o Archer Norris
9. Sherri Long, c/o Archer Norris
10. Frank Schiula, c/o Archer Norris

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11. Govind Koka, D.O., Treating Physician
12. Firooz Mashood, M.D., Expert Witness
13. Joseph Schifini, M.D., Treating Physician
14. Mary Ann Shannon, M.D., Treating Physician
15. Russell Shah, M.D., Treating Physician
16. Terrance Dinneen, M.S., C.R.C., C.R.E., Expert Witness
17. Steven T. Baker, C.P.P., P.S.P., P.C.I., Expert Witness
18. **Nick Tavaglione, [redacted] Mr. Tavaglione is anticipated to testify regarding Mr. Rodriguez's general health, lifestyle, and business performance prior to and following the subject incident.**
19. **Rich Ramirez, [redacted] Mr. Ramirez is anticipated to testify regarding Mr. Rodriguez's general health, lifestyle, and business performance prior to and following the subject incident.**
20. **Dell Roberts, [redacted] Mr. Roberts is anticipated to testify regarding Mr. Rodriguez's general health, lifestyle, and business performance prior to and following the subject incident.**

B. <u>WITNESSES WHO HAVE BEEN, OR WILL BE, SUBPOENAED FOR TRIAL</u>

1. Ron Merkerson, Security, Fiesta Palms
2. Joaquin Mendoza, Security, Fiesta Palms
3. Josh Gonzalez, Lay Witness
4. Chris Poe, Lay Witness

C. <u>WITNESSES WHO MAY BE CALLED, IF THE NEED ARISES</u>

1. Steve Ferrero – Sports Book Manager, c/o Archer Norris

2. Maureen Holden – Marketing Manager, c/o Archer Norris

3. PMK, Custodian of Records, Joseph Schifini, M.D., Medical District Surgery Center, 2020 Goldring, Suite 300, Las Vegas, Nevada 89106.

4. PMK, Custodian of Records, Michael Labanowski, M.D., Nevada Sleep Diagnostics, 62 N. Pecos Rd. Suite B, Henderson, Nevada 89074.

5. PMK, Custodian of Records, Daniel Kim, D.O., Nevada ENT Center. 1815 E. Lake Mead Blvd. #307, Las Vegas, Nevada 89030.

6. PMK, Custodian of Records, Amman Strehlow, M.D., Strehlow Radiology, 3742 E. Tropicana Ave. Suite 1, Las Vegas, Nevada 89121.

7. PMK, Custodian of Records, Dr. Teresa Charniga, Joseph R. Nicola, D.C., Integrated Healthcare of Nevada, 4517 W. Sahara Ave., Las Vegas, NV 89120.

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8. William Simpson, M.D., Eric Campbell, D.C., PMK, Custodian of Records, The Wellness Group, 34740 Via Carnaghi, Wildomar, CA 92595.

9. Adam Attoun, D.O., PMK, Custodian of Records, Open MRI of Inland Valley, 44274 George Cushman #108, Temecula, CA 92592.

10. William Simpson, M.D., Custodian of Records, 32395 Clinton Keith Rd. #104, Wildomar, CA 92595.

11. Mary Ann Shannon, M.D., PMK, Custodian of Records, Las Vegas Neurosurgery, Orthopaedics & Rehabilitation, 600 S. Rancho Dr., Suite 107, Las Vegas, NV 89106.

12. PMK, Custodian of Records, I.V. League Pharmacy, Inc., 6076 Bristol Pkwy. Suite 104, Culver City, CA 90230.

13. PMK, Custodian of Records, Valley Hospital and Medical Center, 620 Shadow Lane, Las Vegas, NV 89106.

14. PMK, Custodian of Records, Lawrence R. Miller, M.D., 8641 Wilshire Blvd. Suite 200, Beverly Hills, CA 90211.

15. PMK, Custodian of Records, North Valley Medical Supply, 3053 W. Craig Rd. Suite B, North Las Vegas, NV 89032.

16. Walter Kidwell, M.D., PMK, Custodian of Records, Pain Institute of Nevada, 600 S. Rancho Dr. Suite 113, Las Vegas, Nevada 89106.

17. PMK, Custodian of Records, Quality RESP Solutions, 20818 Higgins Court, Torrance, CA 90501.

18. Medical Attendants, PMK, Custodian of Records, American Medical Response, 1200 S. Martin Luther King Blvd., Las Vegas, NV 89102.

19. PMK, Custodian of Records, Spring Valley Hospital and Medical Center, 5400 S. Rainbow Blvd., Las Vegas, NV 89118.

20. PMK, Custodian of Records, Physician's Management Solution, 6700 Indiana Ave., Suite 145, Riverside, CA 92506.

21. Douglas S. Stacey, D.P.M., PMK, Custodian of Records, Foot and Ankle Surgical Group, 10001 S. Eastern Ave. Suite 401, Las Vegas, NV 89052.

22. PMK, Custodian of Records, Olympic Anesthesia Partnership, 804 Scott Nixon Memorial Dr., Augusta, GA 30907-2464.

23. Lake Mead Radiologists, Person Most Knowledgeable and/or Custodian of Records, 5496 South Rainbow Blvd., Suite 101, Las Vegas, Nevada 89118.

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24. Wilshire Surgicenter, Inc., Person Most Knowledgeable and/or Custodian of Records, 8641 Wilshire Blvd., Suite 201, Beverly Hills, California 90211.

25. Lawrence Miller, M.D., California Hand Surgery & Orthopeadic Specialty Medical Clinic, Person Most Knowledgeable and/or Custodian of Records, 8541 Wilshire Blvd., Suite 200, Beverly Hills, California 90211.

26. Joseph J. Schifini, M.D., Person Most Knowledgeable and/or Custodian of Records, 526 South Tonopah Drive, Suite 160, Las Vegas, Nevada 89106.

27. Matt Smith Physical Therapy, aka Valley Rehabilitation, Person Most Knowledgeable and/or Custodian of Records, 848 North Rainbow Blvd., Box 357, Las Vegas, Nevada 89107.

28. Centennial Upright MRI, Person Most Knowledgeable and/or Custodian of Records, 4640 West Craig Road, North Las Vegas, Nevada 89032.

29. Vons Pharmacy / Safeway, Person Most Knowledgeable and/or Custodian of Records, 5918 Stoneridge Mall Road, Pleasanton, California 94588-2339

30. Russell J. Shah, M.D., Person Most Knowledgeable and/or Custodian of Records, 10624 South Eastern Avenue, Suite A-425, Las Vegas, Nevada 89102.

31. Louis Mortillaro, Ph.D., Person Most Knowledgeable and/or Custodian of Records, 501 South Rancho Drive, Suite F37, Las Vegas, Nevada 89106,

32. G. Michael Elkanich, M.D., Bone & Joint Specialists, Person Most Knowledgeable and/or Custodian of Records, 2680 Crimson Canyon Drive, Las Vegas, Nevada 89128-9995.

33. Walgreen Pharmacy / Walgreen Company, Person Most Knowledgeable and/or Custodian of Records, P.O. Box 4039, MS #735, Danville, Illinois 61834.

34. Robert Gutierrez, M.D., Person Most Knowledgeable and/or Custodian of Records, 5380 South Rainbow, Suite 100, Las Vegas, Nevada 89118.

35. Advanced Urgent Care—Primary, Govind Koka, D.O., Craig Jorgenson, M.D., Person Most Knowledgeable and/or Custodian of Records, 9975 South Eastern Avenue, #110, Las Vegas, Nevada 89183.

36. Rancho Physical Therapy, John G. Nork, M.D., Person Most Knowledgeable and/or Custodian of Records, 630 East Latham Avenue, Hemet, California 92543.

37. Chynoweth, Hill and Leavitt, 3831 West Charleston Blvd., Las Vegas, Nevada 89102, 877-325-2776 Telephone. (Billing for Kelly Hawkins, P.T.)

38. Jacob E. Tauber, M.D. , 9033 Wilshire Blvd., Suite 401, Beverly Hills, A 90211, (323) 655-2968.

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39. Yakov Treyzon, M.D., 5901 W. Olympic Blvd., #100, Los Angeles, CA 90036. (323) 930-1331.

40. Wilshire Surgicenter, Inc., 11999 San Vicente Bl., #440, Los Angeles, CA 90049, (310) 440-3131.

41. Thomas Vater, D.O., 7200 Cathedral Rock, Suite 210, Las Vegas, NV 89128. (702) 430-5000.

42. Michael Crovetti, M.D., 2779 West Horizon Ridge, Suite 200, Henderson, NV 89052 (702) 932-8361.

43. Shadow Emergency Physicians, POB 13917, Philadelphia, PA 19101-3917, (800) 355-2470.

44. Stephen L. Weiner, D.C., D.A.C.B.R., PMK, COR, Vision Radiology, 2600 Associated Road, # A 50, Fullerton, CA 92835.

45. Melinda Hunter, PMK, COR, VQ Orthocare, 18011 Mitchell South, Irvine, CA 92614.

D. DEPOSITIONS TO BE RELIED UPON

1. Enrique Rodriguez
2. Brandy Beavers
3. Fiesta Palms PMK – Ms. Vikki Kooinga
4. Fiesta Palms PMK – Ms. Sherri Long
5. Fiesta Palms PMK – Mr. Frank Schiula

E. EXHIBITS EXPECTED TO BE OFFERED

** COPIES OF THE FOLLOWING DOCUMENTS HAVE BEEN PROVIDED ON CD:

1. Incident Report (FP0118-124) – produced by Defendant
2. Palms Security Policy Manual – produced by Defendant
3. Medical records and billing statement from Spring Valley Hospital (SVMC 0000001-11)
4. Medical records and billing statement from Desert Radiologists (Desert Radiologist 0000001-2)
5. Medical records and billing statement from Shadow Emergency Physicians (Shadow Emergency 0000001-4)
6. Medical records and billing statement from Associated Physicians (Associated Physicians 0000001-16)
7. Medical records and billing statement from Open MRI of Inland Valley (OPEN MRI 0000001-4)
8. Medical records and billing statement from Wellness Group (Wellness Center 0000001-14)

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9. Medical records and billing statement from Vision Radiology (Vision Radiology Consultants 0000001-3)
10. Medical records and billing statement from VQ Ortho Care (VQ Orthocare 0000001-6)
11. Medical records and billing statement from IV League Pharmacy (IV League 0000001-22)
12. Medical records and billing statement from Valley Hospital Medical Center (VHMC 0000001-61)
13. Medical records and billing statement from Strehlow Radiology (Strehlow 0000001-2)
14. Medical records and billing statement from Insight Mountain Diagnostics (INSIGHT 0000001-24)
15. Medical records and billing statement from Rancho Physical Therapy (Rancho P.T. 0000001-302)
16. Medical records and billing statement from Las Vegas Neurosurgery, Orthopedics & Rehabilitation (LVNORA 0000001-24)
17. Medical records and billing statement from Integrated Health Care (Integrated 0000001- 33)
18. Medical records and billing statement from NV Sleep Diagnostics (NV Sleep 0000001- 20)
19. Medical records and billing statement from Village East Drugs (Village East Drugs 0000001-11)
20. Medical records and billing statement from Medical District Surgery Center (Medical District Surgery Center 0000001- 79)
21. Medical records and billing statement from Beverly Tower Wilshire Advanced Imaging (Beverly Tower Imaging 0000001- 3)
22. Pharmacy Record from Safeway Pharmacy (Safeway 0000001)
23. Medical records and billing statement from Jacob Tauber, M.D. and George Graf, M.D. (Dr. Tauber 0000001-28)
24. Medical records and billing statement from Yakov Treyzon, M.D. (Treyzon, M.D. 0000001-9)
25. Medical records and billing statement from F. Michael Ferrante, M.D. (UCLA 0000001-6)
26. Medical records and billing statement from Quality Respiratory Solutions/King Medical Supply (Quality Resp. Solu. 0000001- 24)
27. Medical records and billing statement from Casiano Flaviano, M.D., Family Wellness Center (Family Wellness 0000001-3)
28. Medical records and billing statement from Walter Kidwell, M.D., Pain Institute of Nevada (Kidwell 0000001-22)
29. Medical records and billing statement from Olympia Anesthesia (Olympic 0000001- 10)
30. Medical records and billing statement from Wilshire Surgicenter (Wilshire Surgicenter 0000001-121; Wilshire 0000001-3)
31. Daniel Kim, D.O., Nevada Ear, Nose & Throat
32. Medical records and billing statement from Douglas S. Stacey, D.P.M., Foot & Ankle Surgical Group (Dr. Stacey, D.P.M. 0000001-5)
33. Medical records and billing statement from North Valley Medical Supply (0000001- 6)

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34. Medical records and billing statement from Nevada Imaging Centers/Lake Mead Radiology (Lake Mead Rad. 0000001-18)
35. Medical records and billing statement from Robert Gutierrez, M.D. (Robert Gutierrrez, M.D. 0000001-59)
36. Craig Jorgenson, M.D., Govind Koka, D.O., Advanced Urgent Care (Advanced Urgent Care 0000001- 2)
37. Medical records and billing statement from Govind Koka, D.O., Medical Associates of Southern Nevada/Primary Care Consultants (Primary Care Consultants KOKA 0000001-330)
38. Medical records and billing statement from Michael J. Crovetti, D.O., Bone & Joint Institute (Crovetti 0000001-38)
39. Medical records and billing statement from John Thalgott, M.D., Center for Disease and Surgery of the Spine (CDSS 0000001-72)
40. Medical records and billing statement from Las Vegas Surgery Center (LV Survery Center 0000001-10)
41. Medical records and billing statement from Joseph J. Schifini, M.D. (Schifini 0000001-19)
42. Medical records and billing statement from Lawrence Miller, M.D., Cal Hand Surgery (Cal. Hand 0000001-86)
43. Medical records and billing statement from Matt Smith Physical Therapy (Dr. Matt Smith 0000001-143; Valley Rehab. 0000001- 180)
44. Medical records and billing statement from Centennial Upright MRI (Centennial Upright MRI 0000001-12)
45. Billing statement from G. Michael Elkhanich, M.D., Bone & Joint Institute (Elkhanich 000001-2)
46. Pharmacy Statement from Walgreen's Pharmacy (Walgreens 0000001-75)
47. Medical records and billing statement from Thomas Vater, D.O. (Dr. Vater 0000001-18)
48. Medical records and billing statement from Russell J. Shah, M.D. (Shah 0000001-88)
49. Medical records and billing statement from Kelly Hawkins Physical Therapy/ Chynoweth, Hill & Leavitt (KHPT 0000001-44)
50. Medical records and billing statement from Louis F. Mortillaro, Ph.D. & Associates (Mortillaro 0000001-243)
51. Medical records and billing statement from Quest Diagnostics (Quest Diagnostics 0000001-15)
52. 1999 Tax Records (W-2 1999 0000001-8)
53. 2001 Tax Records (W-2 2001 0000001-8)
54. 2004 Tax Records (W-2 2004 0000001-10)
55. Medical bills from Total Wellness Clinic (Total Wellness 000001-8) – *Records will be supplemented upon receipt*
56. Expert Report of Terrence Dinneen (provided previously)
57. Expert Report of Steven T. Baker (provided previously)
58. List of Past Medical Expenses (Plaintiff's Computation of Damages)
59. Any exhibits designated by Defendants, and/or items produced pursuant to NRCP 16.1.
60. Any and all disclosures by Plaintiff and Defendants
61. Any and all responsive documents to Requests for Production of Documents

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F. DEMONSTRATIVE EXHIBITS TO BE USED AT TRIAL

1. Pain Stimulator
2. CPAP Machine
3. Cane
4. Model of Knee
5. Poster of R.S.D. explanation

G. EXHIBITS WHICH MAY BE OFFERED, IF THE NEED ARISES

1. Any and all of Defendants' exhibits disclosed pursuant to NRCP 16.1.
2. Any and all of Plaintiff's exhibits disclosed pursuant to NRCP 16.1.
3. Any and all responses to Discovery.
4. Any and all exhibits submitted during depositions.

DATED this 14th day of Sept, 2010.

BENSON, BERTOLDO, BAKER & CARTER

BY: _____

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CERTIFICATE OF SERVICE

I hereby certify that on the 14th day of September, 2010, I served a copy of the foregoing PLAINTIFF'S SECOND SUPPLEMENTAL PRE-TRIAL DISCLOSURES via 1st Class, U.S. Mail, postage thereon fully prepaid to the following:

10676-05
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Co-Counsel for Fiesta Palms

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Attorneys for Fiesta Palms

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Co-Counsel for Fiesta Palms

An employee of Benson, Bertoldo, Baker & Carter, Chtd.

EXHIBIT "C"

EXHIBIT "C"

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Attorneys for Plaintiff

DISTRICT COURT

CLARK COUNTY, NEVADA

* * *

ENRIQUE RODRIGUEZ, an individual, Plaintiff, vs. FIESTA PALMS, L.L.C., a Nevada Limited Liability Company, d/b/a PALMS CASINO RESORT, BRANDY L. BEAVERS, individually, DOES I through X, inclusive, and ROE BUSINESS ENTITIES I through X, inclusive, Defendants.	CASE NO: A531538 DEPT NO: 10 BENCH TRIAL: 10/25/10 **PLAINTIFF'S CONFIDENTIAL TRIAL BRIEF**

COMES NOW, Plaintiff, ENRIQUE RODRIGUEZ, by and through his counsel, and hereby submits his Trial Brief as allowed and permitted by EDCR 7.27. As permitted further by EDCR 7.27, Plaintiff reserves the right not to serve opposing counsel with a copy of this Brief until after the close of evidence. This Trial Brief is intended to assist the Court in understanding the planned order of the trial as well as to educate the Court regarding Plaintiff's cause of action and the evidence to support that cause of action accordingly.

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I.
STATEMENT OF FACTS

This is a premises liability matter that occurred November 22, 2004 at the Palms Sports Bar/Sports Book. Plaintiff ENRIQUE RODRIGUEZ was an invited guest to watch a football game. During half-time, agents, employees and/or assigns of the Palms (hereinafter known as the "PALMS GIRLS") were participating in a promotion wherein they were throwing souvenirs to Sports Bar/Sports Book patrons while blindfolded.

In response to the Palms Girl, Brandy Beavers, throwing souvenirs in the Sports Bar/Sports Book while blind-folded, a customer within the Sports Bar/Sports Book dove for a thrown souvenir and hit Mr. Rodriguez's extended and stationary left knee. Mr. Rodriguez then struck the person next to him, hitting the left side of his head, then falling down, thereby sustaining extensive injuries and damages.

II.
PROCEDURAL HISTORY

On or about November 15, 2006, Plaintiff filed the Complaint against Fiesta Palms L.L.C. Fiesta Palms, L.L.C. filed its Answer on April 23, 2007. The Joint Case Conference Report was filed on October 29, 2007 and the parties began discovery pursuant to Nevada Rule of Civil Procedure 26. On or about May 8, 2009, Plaintiff filed his motion for leave to amend Complaint to include Defendant BRANDY BEAVERS.

BRANDY L. BEAVERS, Defendant herein, was duly served with a copy of the Amended Summons and Amended Complaint on the day 11th day of January, 2010. The

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default of Defendant BRANDY L. BEAVERS for failing to answer or otherwise plead to Plaintiff's Amended Complaint was entered by this Honorable Court on February 25, 2010.

III.

THEORY OF LIABILITY

Plaintiff has sued the Defendant the theory of negligence. This theory will be discussed below:

A. Negligence

In order to prevail on the issue of negligence, Plaintiff must show: 1) that the Defendant owed a duty of care to Plaintiff; 2) that Defendant breached his duty of care toward Plaintiff; 3) that Defendant's breach was the actual cause of Plaintiff's damages; 4) that Defendant's breach was the proximate cause of Plaintiff's damages; 5) that Plaintiff suffered damages as a result of Defendant's breach. Perez v. Las Vegas Medical Center, 107 Nev. 1, 4, 805 P.2d 589, 590-591 (1996).

Nevada's controlling law on "slip and fall" premises liability can be found in Moody v. Manny's Auto Repair, 110 Nev. 320, 871 P.2d 935 (1994), Sprague v. Lucky Stores, Inc., 109 Nev. 247, 849 P.2d 320 (1993), Asmussen v. New Golden Hotel Company, 392 P.2d 49 (1964), Worth v. Reed, 384 P.2d 1017 (1963), Eldorado Club, Inc. v. Graff, 377 P.2d 174 (1962), and Galloway v. McDonalds Restaurants, 102 Nev. 534, 728 P.2d 826 (1986). Determinations of liability should primarily depend upon whether the owner or occupier of land acted reasonably under the circumstances. Moody v. Manny's Auto Repair, supra. In Asmussen, the Court stated that a proprietor's liability may be found if the

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condition was 1) created by the proprietor or his agent, or 2) created by another and the proprietor had actual or constructive notice of its existence. The proprietor "who knows or in the exercise of reasonable care should know, of their dangerous and unsafe condition, and who invites others to enter upon the property, owes to such invitees a duty to warn them of the danger, where the peril is hidden, latent, or concealed, or the invitees are without knowledge thereof." Galloway.

Through the course of discovery, Plaintiff has established that prior to the subject incident, Defendant PALMS was aware that promotional items were thrown into crowds; that Defendant PALMS acknowledged this behavior was inappropriate because it was a safety issue and could foreseeably cause injury to an individual; and that Defendant PALMS failed to implement any written safety standards, procedures and/or policies instructing employees and/or independent contractors not to throw items into crowds.

Further, Defendant PALMS has conceded that they are not sure if they ever instructed employees and/or independent contractors not to throw promotional items into crowds, and have no recollection as to whether they ever specifically instructed Ms. Beavers not to throw items into the crowd.

Specifically, Sheri Long, the Director of Marketing at The Palms testified that she was aware that promotional items were thrown into crowds; that Defendant acknowledged this behavior was inappropriate because it was a safety issue and could foreseeably cause injury to an individual.

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For purposes of this case, the Honorable Court is advised that the Key West Room discussed below is where promotions were held before being moved to the subject sports-book.

Q. Was there a custom and practice of bringing pretty girls in to help in the Monday Night Football party as part of the promotion?

A. Yes.

Q. Was that routine each Monday night football party?

A. Yes.

Q. Okay. And where did they come from?

A. Usually from outside vendors.

Q. Third parties?

A. Yes.

Q. And, of course, the purpose there is just to create a kind party atmosphere, is that right?

A. Correct.

Q. Were you aware -- do you need that?

A. No.

Q. Were you of any of these girls throwing promotional items into the crowd while the party was being held in the banquet room?

A. In the Key West?

Q. In the Key West.

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A. I believe that it did happen once.

Q. In the Key West room?

A. Yes.

Q. And do you know who was throwing those things?

A. No.

Q. What was your opinion of that conduct?

A. **That it wasn't appropriate.**

Q. Why wasn't it appropriate?

A. **Because it definitely is a safety issue.**

Q. And it could foreseeably cause injury to somebody, is that right?

A. **Absolutely.**[1]

Ms. Long reiterated her safety concerns, but could not even recall if she ever instructed her staff that items should not be thrown into crowds during promotional events.

Q. Okay. And at the time in the Key West room when you discovered someone was throwing promotional items out into the crowd, who was it that you spoke to?

A. I'm sure it was the marketing manager.

Q. Who was that at that time?

A. I believe it was Maureen.

Q. Do you remember the substance of your conversation?

[1] See Exhibit "1," Long Deposition, 48:1-25; 49:1-9.

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A. No, I don't recall.

Q. But you discussed that it wasn't safe to throw promotional items out into the crowd, is that right?

A. I believe so, yes.

Q. For the reason that you said, that there's a real safety concern associated with that?

A. Yes.

Q. And because it's foreseeable that, if you throw promotional items out during a Monday Night Football party, somebody could get hurt?

A. Correct.

Q. Okay. And did you follow that up with a memoranda in your department instructing your people that promotional items would not be thrown out during these parties?

A. I don't recall.

Q. Would it have been your responsibility to do that if there was a responsibility to do that, would you have been the one to do it?

A. Likely.

Q. I mean, how concerned were you? Were you pissed, for lack of a better legal word?

A. I don't -- I really don't recall. I mean, you know, obviously, I deal with a lot of different things every day.

Q. I see your phone ringing.

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A. Some minor, some not minor.

Q. Did you feel it was a minor or not minor issue?

A. I really don't recall at the time. I'm thinking that it would have been more from the security side of things, the safety and security side of things that that concern would have have been addressed. Likely my manager sent an e-mail out.

Q. To whom?

A. Within the company to the couple people in my department that it might have involved, just, you know, just a reminder, please don't do this.

Q. Did you personally contact the security department, do you recall?

A. No, I wouldn't have.

Q. Did you bring it up at one of the staff meetings when the different directors from different departments met I think you said monthly?

A. I really don't recall at the time if I did that. I know I have brought it up for other things with regard to safety, but specifically for that, not necessarily.

Q. You brought it up -- oh. You've made your safety concerns known --

A. Correct.

Q. -- on other issues?

A. Correct.

Q. But you don't recall specifically with this issue?

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A. I don't recall.

Q. When you're hiring girls to do the promotions, do you interview them personally?

A. Did I? No.

Q. Who did?

A. My marketing manager generally did.

Q. Did you instruct your marketing manager to tell these girls don't throw stuff out in the crowd after you became aware that that was occurring in the Key West room?

A. I don't recall if we had the conversation.

Q. Do you know if you maybe you put it in writing to anybody?

A. I don't recall. That, I have no idea.[2]

Despite awareness of the foreseeable danger, Ms. Long testified that she cannot even recall if the issue was raised during staff and/or safety meetings.

Q. At any time during those meetings, did your manager or you or anybody bring up the issue that we shouldn't have girls throwing stuff at these promotional events?

A. I don't recall.

Q. You can't say one way or another?

A. No.[3]

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[2] Id., at 53:17-25; 54-55:1-25; 56:1-9.
[3] Id., at 57:20-25; 58:1

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Continuing, Ms. Long indicated that she does not know if she instructed Ms. Beavers not to throw promotional items into the crowd, and cannot recall making any departmental procedures to instruct others.

> Q. And it's fair to say that you don't know whether or not Denise specifically instructed Brandy not to throw promotional items into the crowd?
>
> A. I don't know.
>
> Q. Did you make it a departmental procedure to instruct these girls not to throw promotional items into the crowd after what happened in the Key West room?
>
> A. I really don't recall.[4]

Lastly, Ms. Long acknowledged that there is no formal policy or procedure to prevent promotional items from being thrown into the crowd.

> Q. Is there now a formal policy or procedure to prevent that from happening?
>
> A. I don't have one in writing.[5]

Vikki Kooinga, Risk Manager at The Palms has also testified that she is unaware of any regulation against throwing promotional items into crowds. Importantly, she also testified that throwing items into a crowd could foreseeably cause injury to someone in the audience.

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[4] Id., at 69: 8-16.
[5] Id., at 72: 3-5.

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Q. Is there any regulation which has to do with throwing of objects during promotional events during the Palms Casino that was in existence in November 2004 that you're aware of?

A. I am not aware of.

Q. As a risk manager, would you instruct or allow employees of the Palms hotel to throw objects into an audience during a promotional event?

A. No.

Q. You would not?

A. I would not.

Q. And why would you not?

A. Just for the simple fact that, one, you could break the item, depending on what the item is, and common sense.

Q. You try to utilize common sense when you're risk managing, is that right?

A. Correct.

Q. And part of risk management is to provide for the safety, the reasonable safety of people upon the premises, is that true?

A. Correct.

Q. And as the risk manager of the Palms hotels, is it fair to say that you agree with me that throwing objects during a promotional event could foreseeably cause injury to someone in the audience?

MR. GILLETTE: That calls for a legal conclusion.

A. It could foreseeably, yes.

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Q. And that's one of the reasons why you as the risk manager would instruct employees of the Palms hotel not to throw those objects, is that fair to say?

MR. GILLETTE: Well, that calls for speculation, and it also misstates her prior testimony. You can go ahead and answer.

A. Could you repeat it?

Q. Sure. As the risk manager, one of the reasons -- using your common sense -- that you would tell your employees not to throw something into a crowd is because that could result in an injury to somebody in that crowd?

A. Correct.

Q. And that wouldn't be reasonable in terms of risk management, is that fair to say?

A. It's not something --

MR. GILLETTE: That calls for a legal But you can answer that.

A. It's not something that I would advise.

Q. Is there a policy or procedure in effect now at the Palms hotel not to throw objects into the audience during a promotional event?

A. I don't know if there's a specific policy, a written policy.[6]

[6] See Exhibit "2," Kooinga Deposition, 30: 23-25; 31: 1-25; 32: 1-25; 33:1-7.

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Ms. Kooinga has acknowledged that throwing promotional items into the crowd was inappropriate, wrong and beneath the standard of care for the hotel protecting the safety of their patrons upon the premises.

Q. Did you have any thoughts about the appropriateness of Brandy Beavers throwing promotional bottles out into the audience?

A. My personal opinion?

Q. Yes.

A. It is not appropriate.

Q. So you think that was wrong?

A. Yes.

Q. If Brandy Beavers was an employee of the Palms hotel at that time –

A. I'm sorry. Can I clarify something?

Q. Absolutely.

A. Based upon the report, he is stating that she threw it. I do not know if it was actually thrown.

Q. But, hypothetically, if it was thrown, in your opinion, that would be wrong?

A. Hypothetically, yes.

Q. Okay. And if Brandy Beavers was an employee of the Palms hotel at the time she threw that water bottle, she would have done something wrong?

A. I don't believe she was employed.

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Q. Hypothetically?

A. Hypothetically, I believe yes.

Q. Okay. And something that was beneath the standard of care for the hotel protecting the safety of their patrons upon the premises?

MR. GILLETTE: That calls for a legal conclusion.

BY MR. BAKER:

Q. You can answer.
When he makes those objections, later a Judge might read these objections, and the Judge will decide if my question is profoundly stupid or not.
MR. BAKER: Would you read the question back, please?

(Thereupon, the requested portion was read back.)

A. I think you had asked me in my opinion.

Q. Correct?

A. Yes, it would be.[7]

Lastly, Ms. Kooinga has testified that she would have expected Security to stop anyone from throwing items into the crowd.

Q. And if a security individual working at the Palms hotel in November of 2004 saw somebody throwing promotional items out into an audience, would you expect that security officer to tell them to stop doing it?

A. Yes.

[7] Id., at 39: 16-25; 40: 1-25; 41: 1-8.

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MR. GILLETTE: Well, there's a relevance objection in there somewhere, Steve, simply because she doesn't control them. She doesn't supervise the activities of those individuals.

MR. BAKER: I understand.

BY MR. BAKER:

Q. You understood my question though?

A. Repeat it, please.

Q. Sure.
The security officers using their common sense, as risk manager, you would expect them to stop the person throwing promotional items out into the audience?

MR. GILLETTE: Incomplete hypothetical.
Go ahead and answer.

A. I would expect that they would, yes.

Q. And as the risk manager for the Palms hotel, it's your opinion that the standard of care would require that any security officer in the area would stop an individual from throwing promotional items out into the audience?

A. That they would if they had prior knowledge it was about to happen, if hypothetically this is exactly what happened is that Brandy Beavers threw a water bottle, once it left her hand, he may have seen it, he's it in no position to stop it at that point. However, he may have gone to her afterwards and said do not do it again.

Q. However, just to get my question, I understand how you're framing it.
But it would be appropriate for a security officer in the area to stop her from throwing those objects into the audience?

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A. If she had done it more than once, yes.

Q. And that would be what you would expect of security officers as the risk manager of the Palms hotel?

A. Yes.[8]

In this case, Defendant PALMS was aware that promotional items were thrown into crowds. Defendant has acknowledged this behavior was inappropriate because it was a safety issue and could *foreseeably* cause injury to an individual. Defendant acknowledged that the behavior was wrong and fell below the standard of for the hotel protecting the safety of their patrons upon the premises Yet, Defendant failed to implement any written safety standards, procedures and/or policies instructing employees and/or independent contractors *not* to throw items into crowds.

Lastly, Defendant PALMS conceded that they are not sure if they ever instructed employees and/or independent contractors not to throw promotional items into crowds, and have no recollection as to whether they ever specifically instructed Ms. Beavers not to throw items into the crowd.

Under NRS 42.001, implied malice is a discrete basis for assessing punitive damages where conscious disregard can be demonstrated. NRS 42.001(3).

Plaintiff submits that the evidence and testimony elicited to date demonstrate "conscious disregard."

///

[8] Id., at 43: 12-25; 44: 1-25; 45: 1-6.

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IV.

BRIEF STATEMENT OF DAMAGES

Plaintiff's claimed injuries include the following:

1. Neck
2. Left wrist
3. Right hand and right fingers
4. Lower back
5. Left shoulder
6. Right shoulder
7. Left knee, shin, ankle, foot, left toe
8. Right foot
9. Right leg
10. Headaches
11. Sleep apnea

Plaintiff is permanently disabled and will require extensive future medical treatment.

Plaintiff presented to Dr. Shah, a neurologist, on August 10, 2010 for continued burning sensation in the left knee, pain in the right shoulder, sensory right hand tingling, numbness and decreased strength. Plaintiff awaits surgery for the permanent pain stimulator implant which is anticipated to negate the lower extremity symptoms. Dr. Shah's impression on August 10, 2010 follows:

1. Right lumbar radiculopathy
2. Right carpal tunnel regional abnormality

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3. Left knee pain
4. Cervical strain with sensory right arm radicular complaints
5. Right shoulder strain
6. Right ankle pain and weakness secondary to asymmetric weight on walking from left knee pain

1. **Special Damages:**

a.	*Past* Medical Expenses	$543,633
b.	*Future* Medical Expenses	$2,000,000
c.	Past Loss of Earnings	$290,000
d.	Future Loss of Earnings	$968,000

2. **General Damages:**

a.	Past Pain, Suffering, and Loss of Enjoyment of Life	$ Court's discretion
b.	Future Pain, Suffering and Loss of Enjoyment of Life	$ Courts discretion

3. **Total Damages:** $ Depending on the state of the evidence, Plaintiff will likely ask for total damages in the amount of $5,000,000.00.

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VI.

Conclusion

Plaintiff respectively thanks this Court for the opportunity to present this case.

DATED this 27th day of September, 2010.

BENSON, BERTOLDO, BAKER & CARTER

BY: _____

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DISTRICT COURT

CLARK COUNTY, NEVADA

* * *

ENRIQUE RODRIGUEZ, an individual, Plaintiff, vs. FIESTA PALMS, L.L.C., a Nevada Limited Liability Company, d/b/a PALMS CASINO RESORT, BRANDY L. BEAVERS, individually, DOES I through X, inclusive, and ROE BUSINESS ENTITIES I through X, inclusive, Defendants.	CASE NO: A531538 DEPT NO: 10

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 14th day of January, 2011, a true and correct copy of Plaintiff's Confidential Trial Brief was served via 1st Class, U.S. Mail, postage thereon fully prepaid to the following interested parties:

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EXHIBIT "D"

EXHIBIT "D"

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