

**IN THE COURT OF APPEALS OF THE STATE OF NEVADA**

VENETIAN CASINO RESORT, LLC;  
AND LAS VEGAS SANDS, LLC,

Petitioners,

vs.

THE EIGHTH JUDICIAL DISTRICT  
COURT OF THE STATE OF  
NEVADA, IN AND FOR THE  
COUNTY OF CLARK; AND THE  
HONORABLE KATHLEEN E.  
DELANEY, DISTRICT JUDGE,

Respondents,

and

JOYCE SEKERA, AN INDIVIDUAL,

Real Party in Interest.

No. 83600-COA

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**REAL PARTY IN  
INTEREST'S APPENDIX,  
VOLUME 7  
(Nos. 1259–1475)**

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1 BY MR. ROYAL:

2 Q. So while we were off the record, I had you look  
3 at the documents we marked as DD that are actually  
4 various pain diagrams from Dr. Shah. And the dates --  
5 I've got various dates from documents Bates-stamped  
6 Radar 020 through 074. They're not consecutive.  
7 They're just within that range. The dates that we  
8 looked at -- I had you look at were 4/11/17; 5/2/17;  
9 July 10, '17; October 23rd, '17.

10 And I'll represent to you that these are not  
11 all of them, that there's lots of these pain diagrams.  
12 But in all the diagrams that we've included in  
13 Exhibit DD, you've reviewed those and confirmed that you  
14 made the markings on these pain diagrams and signed  
15 them; correct?

16 A. Yes.

17 Q. It looks like they're all signed by the doctor.  
18 Did the doctor sign these in your presence? Do  
19 you remember?

20 A. Yes.

21 Q. When you would fill these out, would the doctor  
22 discuss them with you?

23 A. Yes.

24 Q. Let me -- well, my last -- I don't think I'm  
25 going to mark this, actually. I'm just going to show



1 this to you. This is -- this is Plaintiff Joyce  
2 Sekera's second supplemental early case conference  
3 disclosure statement, list of documents of witnesses,  
4 and NRCP 16.1 A3 pretrial disclosure.

5 I'm going to turn your attention to page 9 and  
6 10.

7 A. Okay.

8 Q. Have you seen this document before, by the way?

9 A. Not to my knowledge.

10 Q. Okay. Have you even -- under where it says  
11 "Computation of Damages," it lists all of your providers  
12 over the next -- over these two pages, 9 and 10.

13 I'd like you to look at this list and indicate  
14 for me if there are any providers that have rendered  
15 care to you as a result of this incident who are not  
16 listed.

17 A. (Reading document.)

18 Yes. It looks right.

19 Q. Okay. Now, when is the last time that you  
20 presented to a medical provider? Was it Dr. Smith? Was  
21 he the last provider that you saw?

22 A. Yes.

23 Q. And did -- I think you saw him within the last  
24 month; right?

25 A. Yes.

1 Q. And tell me about that visit.

2 Why did you go see Dr. Smith? Do you know?

3 A. Dr. Smith? You have to ask Keith. It was due  
4 to my back, of course.

5 Q. Did Dr. Smith -- what -- tell me about the  
6 visit.

7 Did you have a discussion with him about what  
8 your symptoms were or what your complaints were, what  
9 was still hurting?

10 A. Yes.

11 Q. And do you remember what you told him?

12 A. My back. It's just a constant thing.

13 Q. Did you tell him about your neck?

14 A. Yes, yes.

15 Q. Did he refer you for any kind of a test or  
16 procedure or refer you to a doctor? Do you remember?

17 A. No. He did not refer me, no.

18 Q. Okay. Do you remember what he did for you?  
19 Did he take x-rays? Did he --

20 A. Yes. He sent me for x-rays and I had them all  
21 done.

22 Q. Okay. What was x-rayed?

23 A. My back, I believe; my neck.

24 Q. Did you have a discussion with Dr. Smith about  
25 getting any more injections?

1 A. No.

2 Q. Did you have a discussion with Dr. Smith about  
3 future surgery?

4 A. Yes.

5 Q. What can you tell me about that?

6 A. I -- he explained -- I just cannot explain what  
7 he said as far as my back.

8 Q. Did he suggest to you that you might need  
9 surgery?

10 A. Yes.

11 Q. Did he say anything to you about what kind of  
12 surgery?

13 A. Yes, but I -- I couldn't tell you because  
14 medically, I don't have those words.

15 Q. Okay. Did he tell you, for example, that they  
16 might have to fuse any of your bones together in the  
17 spine? Did he use the word "fusion"? Do you recall  
18 that?

19 A. I do not recall.

20 Q. Okay. So the last time I have as you seeing  
21 Dr. Smith was February 7th of this year.

22 Have you since returned to him?

23 A. No.

24 Q. Do you have an appointment to return to him?

25 A. March, February -- you have what date?

1 Q. February 7th, 2019.

2 A. I want to say March 7th, but I'm not sure.

3 Q. Are you familiar with a Dr. Schifini? Do you  
4 know that name?

5 A. Yes.

6 Q. Have you -- how do you know that name?

7 A. I have a friend that went there.

8 Q. Okay. Have you presented to Dr. Schifini?

9 A. No. I won't go there.

10 Q. Why not?

11 A. I just won't. It's a personal thing.

12 Q. Okay. But no one referred you to Dr. Schifini,  
13 right, that you know of for injuries associated with  
14 that --

15 A. That would be the workers' comp.

16 Q. Oh, I see.

17 A. It has nothing -- yes.

18 Q. Well, it --

19 A. What I'm -- yeah.

20 Q. If they refer you to someone, it's ultimately  
21 going to have something to do with this case. So if  
22 they refer you to a doctor, it's something I need to  
23 know about.

24 A. Okay.

25 Q. So have you been referred for more -- strike

1 that.

2 Have you been referred to another doctor  
3 through your workers' comp?

4 A. They referred me -- Dr. Smith said to the  
5 doctor, Schifini, but I'm -- I told him I wouldn't go.

6 Q. Okay. Is there another doctor that you plan to  
7 go to other than Dr. Schifini?

8 A. Yes.

9 Q. And who is that?

10 A. Dr. Lee.

11 Q. Dr. who?

12 A. Lee.

13 Q. First name?

14 A. Daniel.

15 Q. Okay. So is that the only appointment you  
16 have? Do you -- you have an appointment with Dr. Lee?

17 A. Uh-huh.

18 Q. And that's the only thing you have on your  
19 calendar for medical care evaluation?

20 A. Yes.

21 Q. All right. I am -- I've just got a couple more  
22 questions and I'm going to wrap this up.

23 Now, while we were off the record earlier, I  
24 made copies of what I thought were bigger diagrams of  
25 the Grand Canal Shoppes, and I'm going to show this to

1 you. I am not going to mark it just yet. I'm just  
2 going to show it to you and see if you're able to -- if  
3 you can point to the areas where you had your kiosks,  
4 I'm just going to have you mark this.

5 Now, I will represent to you that it's my  
6 understanding that the bottom is pretty much west. You  
7 know where the parking garage is on the right side.

8 A. Did you say Tao is --

9 Q. I'm going -- I'll, again, represent to you that  
10 what we're looking at here, at the top it says "Grand  
11 Canal Shoppes" -- in fact, I probably ought to mark this  
12 since we're going through all this.

13 EE.

14 (Exhibit EE was marked.)

15 BY MR. ROYAL:

16 Q. If it doesn't work, it doesn't work, but see  
17 the Rialto Bridge.

18 You know where that is; right?

19 A. The --

20 Q. The moving walkway.

21 A. Yes.

22 Q. The moving walkway takes you up into this level  
23 here in the yellow at the bottom of the page. If you  
24 walk in these doors, right by the pink area that's  
25 indicated -- I'm working from the bottom of the page up,

1 so the first large pink area would be Tao, is my  
2 understanding.

3 And then you have escalators that are  
4 indicated, so --

5 A. I know the booth is right here in the entrance  
6 in.

7 Q. Okay. Can you mark that? Can you just circle  
8 it? Just write a "1" and circle it so we know that's  
9 the booth by Tao.

10 A. Right here (indicating).

11 Q. Just write a "1" with a circle.

12 A. (Complies.)

13 Then this right here.

14 Q. Okay. That's good.

15 So that would be the first --

16 A. That's the big booth in the great hall.

17 Q. Where would the next one be?

18 A. If I was walking through, I'd go here  
19 (indicating). That's where the gondolas are, I believe.  
20 And so I believe the hat shop is right here, so the  
21 other booth would be right here (indicating).

22 Q. Draw a circle and write "2."

23 A. Even though it's 3, I'll put "2."

24 Q. Where's the other one?

25 A. The other one, instead of going that way you've

1 got to go this way. That's where I got confused because  
2 I think it's right here. But I got confused in this  
3 area.

4 Q. Because the -- I'll represent to you that the  
5 food court on the top right as you walk to, you know,  
6 the end of the hallway and turn right, there's going to  
7 be an elevator on that level right in that area.

8 A. Right around the corner. Oh, yeah, the  
9 elevator right here.

10 Q. It's in that area, yeah. You go in a little  
11 nook area and --

12 A. Oh, yeah, yeah, yeah, yeah. That would be the  
13 elevator. So then the booth would be...

14 I would say right here.

15 Q. So when you would leave your booth to go to the  
16 elevator, would you go to your right or your left?

17 A. I go to the right.

18 Q. Okay. So at your booth, were you able to see  
19 people going down the escalator from your booth?

20 A. The escalators are here, then.

21 Q. I think the escalators are in the green.

22 A. No, because they'd be going down from that way  
23 or up and I wouldn't see that. Because the way the  
24 booth is with the wall, it's like a blind spot.

25 Q. Okay. Just -- we can keep it general. So just



1 make it general. You've made a circle here indicating  
2 maybe the elevator's just somewhere in this area.  
3 You've drawn a line.

4 A. What is this opening? That's what's throwing  
5 me off.

6 Q. I know this area in the food court. I know  
7 that there's a Sin City bar or something right here.

8 A. Oh, when you come in, if that's a Sin City bar,  
9 then our booth is right here.

10 Q. Okay. So let's circle that and write "3."

11 A. (Complies.)

12 Q. Were you at No. 3 on the day of the incident?

13 A. I was at this one -- no, no, I was at this one.  
14 Where is it? This is actually a third booth, but, yes,  
15 I'll call it 2.

16 Q. We'll call it 2 for purposes --

17 A. Okay.

18 Q. What I'd like you to do is darken each of these  
19 numbers. You don't have to darken 1. That looks pretty  
20 easy.

21 A. Okay.

22 Q. Darken the number 2.

23 A. Just this one?

24 Q. That's okay. Darken the number 2 for me.

25 A. Oh, like this? Bigger?

1 Q. Yeah. Just so we know -- there you go. And  
2 darken the number 3 if you -- I don't see No. 3, but  
3 make it really obvious.

4 A. (Complies.)

5 Q. Number 1 looks pretty good.

6 So you were at what you've marked as No. 3 on  
7 the date of the incident -- no, no, I'm sorry. Strike  
8 that.

9 You were at No. 2 on the date of the incident,  
10 at Kiosk No. 2. So you would have walked from No. 2 to  
11 the area close to No. 3 where the elevator is; is that  
12 right?

13 A. Yeah, because this is where I went back to get  
14 my books, it had to be that booth, and then I would go  
15 to the elevator down, yes.

16 Q. Okay. So you would have been at No. 2. You  
17 take your break, you go near the kiosk at No. 3 in order  
18 to take the elevator to go downstairs?

19 A. Well, 3 is over here. If I just turn the  
20 corner and they were busy with guests, they wouldn't see  
21 me.

22 Q. Okay. How about if we indicate the elevator.  
23 You've made a circle here?

24 A. Uh-huh.

25 Q. That's the area you think is the elevator or

1 you recall?

2 A. Well, you said Sin City bar is here.

3 Q. It's okay. We don't need to get too technical.

4 Stay off the record for a minute.

5 (Discussion held off the record.)

6 MR. ROYAL: Back on the record.

7 BY MR. ROYAL:

8 Q. And this document we marked as EE, and I'm  
9 going to have you just sign at the left -- bottom left  
10 with today's date of 3/14/19.

11 A. Name and date?

12 Q. Just your initial and 3/14/19.

13 A. (Complies.)

14 Q. Have we -- have I covered everything -- have I  
15 covered everything related to your recollection of how  
16 the incident occurred?

17 A. Yes.

18 Q. Have we covered everything that you can recall  
19 about the injuries that you sustained? And I'm not  
20 asking you to be a doctor. I'm just -- you know, based  
21 on what you personally experienced.

22 A. Yes.

23 Q. Have we talked about and covered all the  
24 symptoms that you're presently feeling?

25 A. Yes.

1 Q. Okay. Is it fair to say that on the date  
2 that -- when you were working for Brand Vegas, if people  
3 come up to you and ask you questions related to Venetian  
4 events and so forth, that you would provide the  
5 information with a smile?

6 A. Definitely. Oh, yes.

7 Q. And when you were on Venetian property or Grand  
8 Canal Shoppes, you had -- wasn't there some kind of a  
9 code of conduct that you --

10 A. Yes.

11 Q. What was the code of conduct that -- your  
12 understanding about it?

13 A. Just be pleasant, smile a lot, and make sure  
14 you give the right information for the Venetian.

15 Q. Okay. Because it's important to your employer  
16 to represent the Venetian appropriately?

17 A. That's correct.

18 Q. Oh, you know what, I didn't ask you about your  
19 wage loss claim.

20 When I showed you that document before about  
21 the -- can we look at that again? I almost ended and  
22 didn't ask you about that.

23 MR. KUNZ: I believe you were on 9.

24 MR. ROYAL: Turn to page 10. I completely  
25 spaced that.

1 BY MR. ROYAL:

2 Q. Item No. 15 of the second supplement to the  
3 16.1, page 10, line between 4 and 5, it says, "Wage Loss  
4 and Loss of Earning Capacity."

5 Do you see that?

6 A. Yes.

7 Q. Do you have any information, as you sit here  
8 today, about what you plan to claim at trial as your  
9 loss of earnings?

10 A. No.

11 Q. Have you spoken -- other than with your  
12 attorney, have you spoken with any doctors about whether  
13 or not you would ever be able to work again?

14 A. No.

15 Q. Is there --

16 A. Just about getting better.

17 Q. Is there -- have any doctors ever given you any  
18 kind of what we call -- I forgot what they call it. I  
19 was going to say part time but it's more of an  
20 accommodation.

21 Have you talked to your prior employer about  
22 making accommodations for you so you can return to work?

23 A. No.

24 Q. I mean, what kind of accommodations do you  
25 think you would need -- like, something to sit -- you

1 know, a place to sit down -- if you were to return to  
2 work? What would you need?

3 MR. KUNZ: Just -- objection. Calls for expert  
4 opinion, but go ahead and answer, if you can.

5 BY MR. ROYAL:

6 Q. I'm just asking what do you feel -- strike  
7 that. Let me just ask it another way.

8 Are there -- can you envision a circumstance  
9 where if your employer made certain accommodations for  
10 you, that you could return to work physically?

11 MR. KUNZ: Same objection.

12 Go ahead.

13 THE WITNESS: Can you rephrase or help me  
14 understand this?

15 MR. ROYAL: Yeah.

16 BY MR. ROYAL:

17 Q. Did you have a chair at your kiosk?

18 A. Yes.

19 Q. So you didn't have to stand a hundred percent  
20 of the time?

21 A. Not a hundred percent of the time, but you had  
22 to stand for a guest, yes, otherwise you wouldn't make  
23 contact -- eye contact with them.

24 Q. Have you sought any kind of occupational  
25 therapy? Do you know what that is?

1 A. No.

2 Q. Have you considered -- have you looked for any  
3 employment whatsoever in any capacity?

4 A. No, I couldn't. Not the way my pain was and  
5 is.

6 Q. Okay. So your testimony today is that there's  
7 no way you could work at anything at this point?

8 A. Not that I wouldn't, I won't say that. If I'm  
9 better, I -- I have to keep busy.

10 Q. So is there -- is there work you could do from  
11 home from a laptop computer or from a desktop computer  
12 if that were made available to you? I'm not talking  
13 about necessarily selling tickets, I'm just talking  
14 about some other job. What would you --

15 A. Possibly. I just don't know.

16 Q. Okay. Have you sent a job application or a  
17 resume or anything to anybody?

18 A. No.

19 Q. So since you left the Brand Vegas since the  
20 incident, you haven't even inquired about employment  
21 with anyone?

22 A. No.

23 Q. Is that correct?

24 A. That's correct.

25 Q. And you have not had any kind of discussion

1 with any of your doctors about what kind of work you  
2 might be able to do based upon your limitations?

3 A. No.

4 Q. Okay. Is that something that you intend to  
5 have at some future point or is it better -- do you feel  
6 it's better for you to remain retired?

7 A. No. I want to get better. I can't take the  
8 pain at night and waking up three or four times a night.  
9 My whole life's been in a tizzy since that.

10 Q. Is it still in a tizzy?

11 A. Yes. I still have that pain and I want to know  
12 why.

13 Q. Okay. And when you talk about that pain, it's  
14 limited to the neck and back; correct?

15 A. Yes. I will never say never.

16 Q. All right. Well, I have -- that's all the  
17 questions I have for you today. I'm going to just, on  
18 the record, reserve my right to call you again and take  
19 your deposition in the event that we have -- if you get  
20 a surgical recommendation or --

21 A. Okay.

22 Q. -- if there's other -- you know, something else  
23 comes up, which I would cover records and stuff that are  
24 obtained from -- you know, between now and then. Okay?

25 A. Okay.



1 MR. ROYAL: Do you have any questions?

2 MR. KUNZ: I'm good right now. Thank you. I  
3 do have questions when we're off the record.

4 MR. ROYAL: Okay.

5 Your attorney will get notice when this  
6 transcript is ready, and you'll have an opportunity to  
7 review the transcript and make any changes.

8 THE WITNESS: Okay.

9 MR. ROYAL: If you see an incorrect spelling of  
10 your mother's name or whatever, you know, you can fill  
11 out a form and you sign it. If you don't do that, you  
12 waive your right to do that. Okay?

13 THE WITNESS: Okay.

14 MR. ROYAL: That's all I have. Go off the  
15 record.

16 MR. KUNZ: We will take a mini and regular  
17 copy. We will read and sign. And bill to the Galliher  
18 Law Firm. Her contact is Deena, D-e-e-n-a, Mooney,  
19 M-o-o-n-e-y.

20 (The proceedings concluded at 3:49 p.m.)  
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## 1 CERTIFICATE OF DEPONENT

2 PAGE LINE CHANGE REASON

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18

I, Joyce P. Sekera, deponent herein, do  
 certify and declare under penalty of perjury the within  
 and foregoing transcription to be my deposition in said  
 action; that I have read, corrected and do hereby affix  
 my signature to said deposition.

21

22

JOYCE P. SEKERA, Deponent

23

This \_\_\_\_ day of \_\_\_\_\_, 2019.

24

25

REPORTER'S CERTIFICATE

STATE OF NEVADA )  
                              ) ss:  
COUNTY OF CLARK )

I, Blanca I. Cano, CCR No. 861, RPR, do hereby declare:

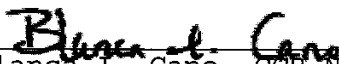
That I reported the taking of the deposition of JOYCE P. SEKERA, commencing on Thursday, March 14, 2019.

That prior to being examined, the witness was by me duly sworn to testify the truth, the whole truth, and nothing but the truth.

That I thereafter transcribed my said shorthand notes into typewriting and that the typewritten transcript is a complete, true, and accurate transcription of my said shorthand notes, and that a request has been made to review the transcript.

I further certify that I am not a relative or employee of counsel, of any of the parties, nor a relative or employee of the parties involved in said action, nor a person financially interested in the action.

IN WITNESS WHEREOF, I have set my hand in my office in the County of Clark, State of Nevada, this 28th day of March 2019.

  
Blanca I. Cano, CCR No. 861, RPR







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<b>8 (9)</b>			





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10 DISTRICT COURT  
11 CLARK COUNTY, NEVADA

13 JOYCE SEKERA, an Individual,  
14 Plaintiff,

15 v.

16 VENETIAN CASINO RESORT, LLC,  
17 d/b/a THE VENETIAN LAS VEGAS, a  
18 Nevada Limited Liability Company;  
19 LAS VEGAS SANDS, LLC d/b/a THE  
20 VENETIAN LAS VEGAS, a Nevada  
21 Limited Liability Company; YET  
22 UNKNOWN EMPLOYEE; DOES I  
23 through X, inclusive,

24 Defendants.

CASE NO.: A-18-772761-C  
DEPT. NO.: 25

24 PLAINTIFF, JOYCE SEKERA'S, ANSWERS TO DEFENDANT VENETIAN CASINO  
25 RESORT, LLC'S FIRST SET OF INTERROGATORIES

26  
27 TO: VENETIAN CASINO RESORT, LLC, Defendant  
28

EXHIBIT A  
WIT: Sekera  
DATE: 3-14-19  
REPORTER: B. CANO

THE G/HER LAW FIRM  
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1 TO: MICHAEL A. ROYAL, ESQ. and GREGORY A. MILES, ESQ. of ROYAL & MILES,  
2 LLP, Attorney for Defendant

3 Plaintiff, JOYCE SEKERA, by and through her undersigned attorneys, hereby answers

4 Defendants' First Set of Interrogatories as follows:

5 INTERROGATORY NO. 1:

6 Please identify your employer as of the date of the subject incident and the starting date of  
7 your employment.

8 ANSWER NO. 1:

9 I was employed by Brand Vegas. My start date was December 26, 2015.

10 INTERROGATORY NO. 2:

11 Please state your scheduled work hours on the date of the subject incident for the employer  
12 identified in your response to Interrogatory No. 1.

13 ANSWER NO. 2:

14 I believe my hours were 9:00 a.m. to 7:00 p.m.

15 INTERROGATORY NO. 3:

16 Please state whether the incident described in the Complaint occurred in the course and scope  
17 of your employment for the employer identified in your response to Interrogatory No. 1.

18 ANSWER NO. 3:

19 Yes.

20 INTERROGATORY NO. 4:

21 Please state what you were doing at the time the subject incident occurred.

22 ANSWER NO. 4:

23 I was walking to the restroom.

1 INTERROGATORY NO. 5:

2 Please, to the best of your recollection, the number of occasions during a typical work shift  
3 where you would walk to the bathroom area on the Venetian casino floor nearest where the subject  
4 incident occurred.

5  
6 ANSWER NO. 5:

7 Approximately two times a day.

8 INTERROGATORY NO. 6:

9 Please state in detail (and in your own words) all events that occurred from the time you  
10 reported for work on the date of the subject incident (November 4, 2016) until the subject incident  
11 occurred.

12 ANSWER NO. 6:

13 I don't recall all of the events that occurred from the time I reported to work. I know when  
14 the fall occurred I was on break and was walking to the restroom.

15  
16 INTERROGATORY NO. 7:

17 Please provide a detailed description (in your own words) of how and (to the best of your  
18 knowledge) why the subject incident occurred, including a description of each act engaged in by  
19 Defendant you claim to have caused you injury.

20  
21 ANSWER NO. 7:

22 Objection. Calls for expert opinions. Without waiving said objection, I slipped in liquid on  
23 the floor which caused me to fall.

24 INTERROGATORY NO. 8:

25 To the very best of your recollection, please identify (in detail and in your own words) all  
26 communications you recall having with Defendant's personnel responding to the scene after the  
27 subject incident from the time of its occurrence until you left the property on November 4, 2016.

28

1 ANSWER NO. 8:

2 I know I had a conversation with a man but I don't remember what was said.

3 INTERROGATORY NO. 9:

4 In Paragraph IV of the Complaint, you provide that Defendants "*allowed liquid on the floor*  
5 *causing the Plaintiff to slip and fall.*" Please describe the color, size and location of the "*liquid*"  
6 referenced in this factual allegation.  
7

8 ANSWER NO. 9:

9 I don't know. I just know that I slipped and fell. After I fell my pants felt wet. I felt liquid on  
10 the floor with my hand.

11 INTERROGATORY NO. 10:

12 Attached hereto as Exhibit A is a color photograph of the subject incident area. Using a  
13 marker, to the best of your knowledge, please identify the size of the liquid area referenced in your  
14 response to Interrogatory No. 9 by drawing a circle in the area where you fell on November 4, 2016.  
15 Once marked, please sign and date the marked photograph and attach it as Exhibit A to your  
16 response to these interrogatories.  
17

18 ANSWER NO. 10:

19 Objection. Not a proper interrogatory. I don't know the size of the liquid area. I know that I  
20 slipped and fell very hard to the ground. I struck my left side, elbow, back and head. My pants were  
21 wet.  
22

23 INTERROGATORY NO. 11:

24 Attached hereto as Exhibit B is a copy of the Narrative portion of the Venetian security  
25 report related to the subject incident. A portion of the Narrative reads as Follows: "*Sekera*  
26 *apologized for falling ....*" Please state whether you have a recollection of this conversation and, if  
27 so, please provide further details surrounding this reported apology, such as why it was made.  
28



1 ANSWER NO. 11:

2 I don't remember saying that. I was dazed after the fall and shocked. I know I had  
3 conversations with people but I don't remember what was said.

4 INTERROGATORY NO. 12:

5 Attached hereto as Exhibit B is a copy of the Narrative portion of the Venetian security  
6 report related to the subject incident. A portion of the Narrative reads as Follows: "*She stated she*  
7 *was walking through the area when she slipped in what she believed was water on the floor.*" Please  
8 state whether this is an accurate description of your statement; if not, please provide what you  
9 contend to be an accurate statement.

11 ANSWER NO. 12:

12 Please see my answer to Interrogatory No. 11. I know I slipped in liquid.

14 INTERROGATORY NO. 13:

15 Attached hereto as Exhibit B is a copy of the Narrative portion of the Venetian security  
16 report related to the subject incident. A portion of the Narrative reads as Follows: "*She reported that*  
17 *he fell backwards and put her right hand behind her head to protect it. She landed on the marble*  
18 *flooring and her left elbow struck the base of a pillar next to her. She denied any head pain, neck*  
19 *pain, back pain, weakness, dizziness, or nausea at that time.*" Please state whether the above quoted  
20 portions of the report is an accurate description of information you provided to Defendants'  
21 responding security; if not, please provide what you contend to be an accurate statement.

23 ANSWER NO. 13:

24 Please see my answer to Interrogatory No. 11.

25 INTERROGATORY NO. 14:

26 Attached hereto as Exhibit B is a copy of the Narrative portion of the Venetian security  
27 report related to the subject incident. A portion of the Narrative reads as Follows: "*She refused to*  
28

1 complete a Voluntary Statement for the incident and completed a medical release." Please state  
2 whether the above quoted portions of the report is an accurate description of information you  
3 provided to Defendants' responding security as per you best recollection; if not, please provide what  
4 you contend to be an accurate statement.

5  
6 ANSWER NO. 14:

7 Please see my answer to Interrogatory No. 11. I don't remember refusing to complete a  
8 voluntary statement. I just wanted to get to the hospital and go home.

9 INTERROGATORY NO. 15:

10 To the very best of your recollection, please identify (in detail and in your own words) all  
11 communications you recall having with any other person (including but not limited to those  
12 identified in your responses to Interrogatory No. 8) regarding the subject incident on November 4,  
13 2016.

14  
15 ANSWER NO. 15:

16 Please see my answer to Interrogatory No. 11.

17 INTERROGATORY NO. 16:

18 Please describe in detail (and in your own words) all events, actions, activities and  
19 communications that occurred from the time the subject incident occurred on or about November 4,  
20 2016 from the time you left the accident scene until departed Centennial Hills Hospital.

21  
22 ANSWER NO. 16:

23 I don't recall. I drove myself to the hospital. I was seen by nurses and doctors but I don't  
24 recall the conversations.

25 INTERROGATORY NO. 17:

26 Please identify all damages you claim to have experienced or believe you will yet incur as a  
27 result of the subject incident, including but not limited to medical expenses, loss of earnings, etc.  
28

1 ANSWER NO. 17:

2 Please see Plaintiff's Early Case Conference Disclosure. Specifically the Computation of  
3 Damages section. Discovery is continuing.

4 INTERROGATORY NO. 18:

5 Please identify, with information sufficient for service of a subpoena, all medical providers  
6 with whom you sought or received treatment for five (5) years preceding the subject incident of  
7 November 5, 2016 (*i.e.* dating back to November 5, 2011).

8 ANSWER NO. 18:

9 To the best of my recollection I have been seen by the following providers:

10 Centennial Hills Hospital 6900 N. Durango Drive, Las Vegas, Nevada 89149

11 Darin Swainston, M.D. is my OB/Gyn. His address is 2050 Mariner Drive, #120, Las Vegas,  
12 Nevada 89128.

13 Shahid Wahid, M.D. Gastroenterologist. His address is 2031 N. McDaniel Street, North Las  
14 Vegas, Nevada 89030

15 Valley View Surgery Center for a colonoscopy. 1330 S. Valley View Boulevard, Las Vegas,  
16 Nevada 89102

17 INTERROGATORY NO. 19:

18 Please identify, with information sufficient for service of a subpoena, all medical providers  
19 with whom you sought or received treatment at any time as it pertains to any body part for which  
20 you are claiming injuries in this case, including but not limited to your left elbow, head, neck or  
21 back.

22 ANSWER NO. 19:

23 To the best of my recollection I have seen the following providers:

24 Centennial Hills Hospital 6900 N. Durango Drive, Las Vegas, Nevada 89149. \$4,454.00  
25

1 Shadow Emergency Physicians 1000 River Road, Ste. 100, Conshohocken, PA 19428.  
2 \$1,272.00  
3  
4 Desert Radiologists 2020 Palomino Lane, #100, Las Vegas, Nevada 89106. \$77.00  
5  
6 Jason Webber, D.C. CoreRehab 10620 Southern Highlands Pkwy., Ste. 110-329, Las Vegas,  
7 Nevada 89141. \$10,756.00  
8  
9 Las Vegas Radiology 3201 S. Maryland Parkway, Ste. 102, Las Vegas, Nevada 89109.  
10 \$848.00  
11  
12 Michelle Hyla, D.O. Southern Nevada Medical Group 1485 E. Flamingo Road, Las Vegas,  
13 Nevada 89119. \$1,975.00  
14  
15 Russell J. Shah, M.D. Radar Medical Group 10624 S. Eastern Avenue, Henderson, Nevada  
16 89052. \$17,613.50  
17  
18 PayLater/WellCare Pharmacy P.O. Box 1200, Las Vegas, Nevada 89125. \$282.33  
19  
20 Las Vegas Pharmacy 2600 W. Sahara Avenue, Ste. 120, Las Vegas, Nevada 89102.  
21 \$1,090.93  
22  
23 Walter M. Kidwell, M.D. Katherine D. Travnick, M.D. Pain Institute of Nevada 7435 W.  
24 Azure Drive, Ste. 190, Las Vegas, Nevada 89130. \$16,000.00  
25  
26 Valley View Surgery Center 1330 S. Valley View Blvd., Las Vegas, Nevada 89102.  
27 \$15,489.48  
28  
29 Steinberg Diagnostic P.O. Box 36900, Las Vegas, Nevada 89133. \$1,400.00  
30  
31 Andrew Cash, M.D. Desert Institute of Spine Care 339 W. Sunset Road, Ste. 100, Las Vegas,  
32 Nevada 89148. \$1,750.00.  
33  
34 William D. Smith, M.D. Western Regional Center for Brain & Spine 3061 S. Maryland  
35 Pkwy, Ste. 200, Las Vegas, Nevada 89109.

1 INTERROGATORY NO. 20:

2 If you are making a claim for loss of past, present, or future earnings, please identify your  
3 employers, with information sufficient for service of a subpoena, for the five (5) years preceding the  
4 subject incident, to date (*i.e.* November 5, 2011 to the present), and indicate duration of employment  
5 for each.

6  
7 ANSWER NO. 20:

8 I was hired by Brand Vegas on December 26, 2015. In 2010 I worked for Allstate Ticketing.  
9 I was laid off and unable to find work until 2015. I worked for Allstate Ticketing for 15 years.  
10 Allstate was bought and sold several times so I worked for several different companies but held the  
11 same position.

12 INTERROGATORY NO. 21:

13 With regard to any claim you have ever made prior to or since the present action against any  
14 person or organization for damages for personal injuries or damage to your property, please identify  
15 each such person or organization for damages for personal injuries or damage to your property,  
16 please identify each such person or organization, and the date and location of the occurrence out of  
17 which the claim arose. (This interrogatory request extends to every matter, whether litigated or not.  
18 If litigated, please provide the case name, case number and jurisdiction in which the litigation was  
19 filed).

20  
21  
22 ANSWER NO. 21:

23 None that I can recall.

24 INTERROGATORY NO. 22:

25 Please identify all places to which you have travelled beyond fifty (50 miles since the subject  
26 incident of November 4, 2011 through the present, including the date(s) associated with each travel  
27 event (from departure to your return), the purpose of your travel (*i.e.* business or pleasure), the type  
28

1 of travel (i.e. air, ground), and identify all persons traveling with you (with information sufficient for  
2 service of a subpoena).

3 ANSWER NO. 22:

4 The incident occurred on November 4, 2016. I have not travelled anywhere since the fall  
5 occurred.

6  
7 INTERROGATORY NO. 23:

8 Please state whether you are aware of anyone (other than documents herein identified by  
9 Defendant pursuant to NRCP 16.1) who took any pictures or made any recordings of events  
10 surrounding the subject incident and, if so, please identify each and every such person (with  
11 information sufficient for service of a subpoena) and what you understand to have been recorded or  
12 photographed.

13  
14 ANSWER NO. 23:

15 None that I am aware of.

16 INTERROGATORY NO. 24:

17 Please state whether you have possession of the shoes you were wearing at the time of the  
18 subject incident and, if so, where they are presently located.

19  
20 ANSWER NO. 24:

21 Yes. My attorney's office has my shoes.

22 INTERROGATORY NO. 25:

23 With regard to any statements, memoranda, or writings concerning any of the events  
24 described in the Complaint on file herein, made by any witness, or any of the parties hereto, whether  
25 or not signed or prepared by such witness or party, please:

- 26 a. Identify the person making the item including name, address and telephone number(s);  
27 b. State the nature and description of the item; and,  
28

1 c. State the present location of the item.

2 ANSWER NO. 25:

3 None that I am aware of.

4 INTERROGATORY NO. 26:

5 Please identify all blogs, online forums, and social media websites that you have belonged or  
6 had membership to from November 4, 2016 to the present.

7 ANSWER NO. 26:

8 Objection. Overly broad. Unduly burdensome. Harassing. Not reasonably calculated to lead  
9 to discoverable evidence.

10 INTERROGATORY NO. 27:

11 For each blog, forum, and/or website identified in your responses to Interrogatory No. 26,  
12 above, please identify the user name, email address and login password for all such accounts.

13 ANSWER NO. 27:

14 Please see my answer to Interrogatory No. 26.

15 INTERROGATORY NO. 28:

16 Please set forth in detail the duties associated with your employment identified in your  
17 response to Interrogatory No. 1.

18 ANSWER NO. 28:

19 I sold show tickets for Brand Vegas for shows up and down the Strip.

20 INTERROGATORY NO. 29:

21 Please state how the subject incident impacted your life in the following areas:

22 a. Personal/social

23 b. Employment

24 c. Family relationships

1 d. Other

2 ANSWER NO. 29:

3 I'm in pain all the time. I don't go out with friends. I get crabby because of my pain. I'm  
4 unable to do housework. I have a hard time walking up stairs. I'm unable to work due to the pain.  
5 Being in pain all the time has put a strain on my relationship with my mom, daughter and grandkids.  
6

7 INTERROGATORY NO. 30:

8 If you made a claim for workers compensation as a result of the subject incident, please  
9 identify all medical providers associated with your course of case, including any medical specialists  
10 who have determined you to sustained a permanent partial disability.  
11

12 ANSWER NO. 30:

13 I was treated at Centennial Hills Hospital the date of the fall. I was also examined by William  
14 Smith, M.D. to determine the scope of the workers compensation claim.

15 INTERROGATORY NO. 31:

16 Please set forth the body parts you complained of and associated symptoms on November 4,  
17 2016 when presenting to Centennial Hills Hospital.

18 ANSWER NO. 31:

19 I believe I complained of pain to my elbow, neck, shoulder, back and head.

20 INTERROGATORY NO. 32:

21 Please set forth the body parts you complained of and associated symptoms on November 8,  
22 2016 when presenting to Jordan Webber, DC.  
23

24 ANSWER NO. 32:

25 I believe I complained of pain to my elbow, neck, shoulder, back and head.  
26  
27  
28



1 INTERROGATORY NO. 33:

2 Please set forth the body parts you complained of and associated symptoms on November 21,  
3 2016 when presenting to Southern NV Medical Group.

4 ANSWER NO. 33:

5 I believe I complained of pain to my elbow, neck, shoulder, back and head.  
6

7 INTERROGATORY NO. 34:

8 Please set forth the body parts you complained of and associated symptoms on December 1,  
9 2016 when presenting to Radar Medical Group.

10 ANSWER NO. 34:

11 I believe I complained of pain to my elbow, neck, shoulder, back and head.  
12

13 INTERROGATORY NO. 35:

14 Please set forth the body parts you complained of and associated symptoms on January 9,  
15 2017 when presenting to Pain Institute of Nevada.

16 ANSWER NO. 35:

17 I believe I complained of pain to my elbow, neck, shoulder, back and head.  
18

19 INTERROGATORY NO. 36:

20 Please set forth the body parts you complained of and associated symptoms on October 5,  
21 2017 when presenting to Desert Institute of Spine Care.

22 ANSWER NO. 36:

23 I believe I complained of pain to my elbow, neck, shoulder, back and head.  
24

25 INTERROGATORY NO. 37:

26 Please set forth the body parts you complained of and associated symptoms when you  
27 reported the subject incident to your employer identified in Interrogatory No. 1.  
28

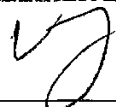
THE GALLIHER LAW FIRM  
1850 E. Sahara Avenue, Suite 107  
Las Vegas, Nevada 89104  
702-735-0049 Fax: 702-735-0204

1 ANSWER NO. 37:

2 I believe I complained of pain to my elbow, neck, shoulder, back and head.

3 DATED this 27<sup>th</sup> day of August, 2018.

4 THE GALLIHER LAW FIRM

5   
6  
7 Keith E. Galliner, Jr., Esq.  
8 Nevada Bar No. 220  
9 1850 E. Sahara Avenue, Suite 107  
10 Las Vegas, Nevada 89104  
11 *Attorneys for Plaintiff*

THE GAHER LAW FIRM  
1850 E. Sahara Avenue, Suite 107  
Las Vegas, Nevada 89104  
702-735-0049 Fax: 702-735-0204

**VERIFICATION**

STATE OF NEVADA )

COUNTY OF CLARK )

ss.

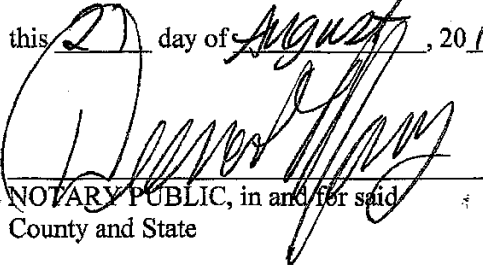
JOYCE SEKERA, being first duly sworn, deposes and says:

That she is the Plaintiff in the above-entitled action; that she has read the foregoing Answers to Defendants' Interrogatories and knows the contents thereof; and that the same are true of her own knowledge, except for those matters therein stated on information and belief and, as to those matters, she believes them to be true.

  
JOYCE SEKERA

SUBSCRIBED AND SWORN to before me

this 27 day of August, 2018.

  
NOTARY PUBLIC, in and for said  
County and State



THE GALLIHER LAW FIRM  
1850 E. Sahara Avenue, Suite 107  
Las Vegas, Nevada 89104  
702-735-0049 Fax: 702-735-0204

**CERTIFICATE OF SERVICE**

I HEREBY CERTIFY that I am an employee of THE GALLIHER LAW FIRM and that service of a true and correct copy of the above and foregoing **ANSWERS TO DEFENDANTS INTERROGATORIES** was served on the 27 day of August, 2018, to the following addressed parties by:

☐ First Class Mail, postage prepaid from Las Vegas, Nevada pursuant to N.R.C.P 5(b)

☐ Facsimile, pursuant to EDCR 7.26 (as amended)

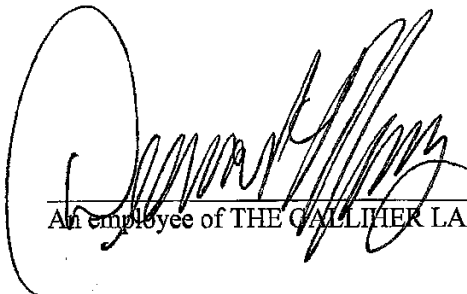
☒ Electronic Mail/Electronic Transmission

☐ Hand Delivered to the addressee(s) indicated

☐ Receipt of Copy on this \_\_\_\_\_ day of \_\_\_\_\_, 2015,

acknowledged by, \_\_\_\_\_

Michael A. Royal, Esq.  
Gregory A. Miles, Esq.  
ROYAL & MILES LLP  
1522 W. Warm Springs Rad  
Henderson, Nevada 89014  
Attorney for Defendant

  
An employee of THE GALLIHER LAW FIRM



THE GALLIHER LAW FIRM  
1850 E. Sahara Avenue, Suite 107  
Las Vegas, Nevada 89104  
702-735-0049 Fax: 702-735-0204

1 THE GALLIHER LAW FIRM  
2 Keith E. Galliher, Jr., Esq.  
3 Nevada Bar No. 220  
4 Jeffrey L. Galliher, Esq.  
5 Nevada Bar Number 8078  
6 George J. Kunz, Esq.  
7 Nevada Bar Number 12245  
8 1850 East Sahara Avenue, Suite 107  
9 Las Vegas, Nevada 89104  
10 Telephone: (702) 735-0049  
11 Facsimile: (702) 735-0204  
12 kgalliher@galliherlawfirm.com  
13 igalliher@galliherlawfirm.com  
14 gkunz@lvlawguy.com  
15 Attorneys for Plaintiffs

DISTRICT COURT  
CLARK COUNTY, NEVADA

13 JOYCE SEKERA, an Individual,  
14 Plaintiff,

CASE NO.: A-18-772761-C  
DEPT. NO.: 25

15 v.

16 VENETIAN CASINO RESORT, LLC,  
17 d/b/a THE VENETIAN LAS VEGAS, a  
18 Nevada Limited Liability Company;  
19 LAS VEGAS SANDS, LLC d/b/a THE  
20 VENETIAN LAS VEGAS, a Nevada  
21 Limited Liability Company; YET  
22 UNKNOWN EMPLOYEE; DOES 1  
23 through X, inclusive,

Defendants.

24 PLAINTIFF, JOYCE SEKERA'S, SECOND AMENDED RESPONSES TO DEFENDANT  
25 VENETIAN CASINO RESORT, LLC'S FIRST SET OF REQUEST FOR ADMISSIONS

26  
27 TO: VENETIAN CASINO RESORT, LLC, Defendant  
28

EXHIBIT B  
WIT: Sekera  
DATE: 3.14.19  
REPORTER: B. CANO

THE GA IER LAW FIRM  
1850 E. Sahara Avenue, Suite 107  
Las Vegas, Nevada 89104  
702-735-0049 Fax: 702-735-0204

1 TO: MICHAEL A. ROYAL, ESQ. and GREGORY A. MILES, ESQ. of ROYAL & MILES,  
2 LLP, Attorney for Defendant

3 Plaintiff, JOYCE SEKERA, by and through her undersigned attorneys, hereby responds

4 Defendants' First Set of Request for Admissions as follows:

5 REQUEST NO. 1:

6 Admit that you did not see liquid on the floor of the subject area before your fall on  
7 November 4, 2016.

8 RESPONSE NO. 1:

9 Admit.

10 REQUEST NO. 2:

11 Admit that you did not see liquid on the floor of the subject area after your fall on November  
12 4, 2016.

13 RESPONSE NO. 2:

14 Deny.

15 REQUEST NO. 3:

16 Admit that you did not see a foreign substance on the floor potentially causing your fall on  
17 November 4, 2016 at any time.

18 RESPONSE NO. 3:

19 Deny.

20 REQUEST NO. 4:

21 Admit that you did not fall on November 4, 2016 due to a foreign substance on the floor of  
22 Defendants' property.

23 RESPONSE NO. 4:

24 Deny.

1 REQUEST NO. 5:

2 Admit that you were in the course and scope of your employment at the time of the subject  
3 incident on November 4, 2016.

4 RESPONSE NO. 5:

5 Admit.

6 REQUEST NO. 6:

7 Admit that your employer at the time of the November 4, 2016 incident was Brand Vegas,  
8 LLC.

9 RESPONSE NO. 6:

10 Admit.

11 REQUEST NO. 7:

12 Admit that you parked your personal vehicle on the property of Venetian Casino Resort,  
13 LLC, on November 4, 2016 when reporting to work for Brand Vegas, LLC.

14 RESPONSE NO. 7:

15 Admit.

16 REQUEST NO. 8:

17 Admit that as part of your employment for Brand Vegas, LLC, in 2016 you promoted events  
18 occurring on the property of Venetian Casio Resort, LLC.

19 RESPONSE NO. 8:

20 Deny.

21 REQUEST NO. 9:

22 Admit that as part of your employment for Brand Vegas, LLC in 2016 you sold tickets for  
23 events occurring on the property of Venetian Casino Resort, LLC.

24  
25  
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1 RESPONSE NO. 9:

2 Deny.

3 REQUEST NO. 10:

4 Admit that your employment for Brand Vegas, LLC, in 2016 was pursuant to a contract  
5 between Brand Vegas, LLC, and Venetian Casino Resort, LLC.  
6

7 RESPONSE NO. 10:

8 Deny.

9 REQUEST NO. 11:

10 Admit that your employment for Brand Vegas, LLC, in 2016 required that you come upon  
11 the property of Venetian Casino Resort, LLC for each work shift.

12 RESPONSE NO. 11:

13 Admit.

14 REQUEST NO. 12:

15 Admit that you regularly used restroom facilities on the property of Venetian Casino Resort,  
16 LLC, while in the course of your employment for Brand Vegas, LLC, in 2016.

17 RESPONSE NO. 12:

18 Admit.

19 REQUEST NO. 13:

20 Admit that you did not strike your head in the subject incident of November 4, 2016.  
21

22 RESPONSE NO. 13:

23 Deny.

24 REQUEST NO. 14:

25 Admit that you did not lose consciousness in the subject incident of November 4, 2016.  
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1 RESPONSE NO. 14:

2 Deny.

3 REQUEST NO. 15:

4 Admit that you denied head pain to Defendants' security personnel responding to the subject  
5 incident on November 4, 2016.

6 RESPONSE NO. 15:

7 Deny.

8 REQUEST NO. 16:

9 Admit that you denied striking your head to Defendants' security personnel responding to the  
10 subject incident on November 4, 2016.

11 RESPONSE NO. 16:

12 Deny.

13 REQUEST NO. 17:

14 Admit that you denied losing consciousness to Defendants' security personnel responding to  
15 the subject incident on November 4, 2016.

16 RESPONSE NO. 17:

17 Deny.

18 REQUEST NO. 18:

19 Admit that you advised medical personnel at Centennial Hills Hospital on November 4, 2016  
20 that you did not strike your head in the subject incident.

21 RESPONSE NO. 18:

22 Deny.

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1 REQUEST NO. 19:

2 Admit that you advised medical personnel at Centennial Hills Hospital on November 4, 2016  
3 that you did not lose consciousness as a result of your fall in the subject incident.

4 RESPONSE NO. 19:

5 Deny.

6 REQUEST NO. 20:

7 Admit that Jordan Webber, D.C., accurately related in his report of your November 8, 2016  
8 visit that you denied being involved in any prior injury causing accidents.

9 RESPONSE NO. 20:

10 Admit.

11 REQUEST NO. 21:

12 Admit that Michelle Hyla, D.O., accurately related in her report of your November 21, 2016  
13 visit that you struck your head as a result of the subject incident.

14 RESPONSE NO. 21:

15 Admit.

16 REQUEST NO. 22:

17 Admit that Michelle Hyla, D.O., accurately related in her report of your November 21, 2016  
18 visit that you lost consciousness as a result of the subject incident.

19 RESPONSE NO. 22:

20 Objection. Calls for an expert medical opinion, therefore deny.

21 REQUEST NO. 23:

22 Russell L. Shah, M.D., accurately related in his report of your December 1, 2016 visit that  
23 you lost consciousness as a result of the subject incident.

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1 RESPONSE NO. 23:

2 Objection. Calls for an expert medical opinion, therefore deny.

3 REQUEST NO. 24:

4 Admit that Katherine Travnicek, M.D., accurately related in her report of your January 9,  
5 2017 visit that you struck your head in your fall on November 4, 2016.

6 RESPONSE NO. 24:

7 Admit.

8 REQUEST NO. 25:

9 Admit that Katherine Travnicek, M.D., accurately related in her report of your January 9,  
10 2017 visit that you lost consciousness as a result of the subject incident.

11 RESPONSE NO. 25:

12 Objection. Calls for an expert medical opinion, therefore deny.

13 REQUEST NO. 26:

14 Admit that Andrew Cash, MD., accurately related in his report of your October 5, 2017 visit  
15 that you did not strike your head as a result of the subject incident.

16 RESPONSE NO. 26:

17 Deny.

18 REQUEST NO. 27:

19 Admit that William D. Smith, M.D., accurately related in his report of your February 22,  
20 2018 visit that you lost consciousness as a result of the subject incident.

21 RESPONSE NO. 27:

22 Objection. Calls for an expert medical opinion, therefore deny.

23

24

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1 REQUEST NO. 28:

2 Admit that William D. Smith, M.D., accurately related in his report of your February 22,  
3 2018 visit that you did not drive yourself to Centennial Hills Hospital on November 4, 2016.

4 RESPONSE NO. 28:

5 Deny.

6 REQUEST NO. 29:

7 Admit that you have not had any gainful employment since the date of the subject incident.

8 RESPONSE NO. 29:

9 Admit.

10 REQUEST NO. 30:

11 Admit that you have been physically unable to work since the date of the subject incident.

12 RESPONSE NO. 30:

13 Admit.

14 REQUEST NO. 31:

15 Admit that you have been physically unable to work since the date of the subject incident.

16 RESPONSE NO. 31:

17 This request is the same as No. 30. Please see my response to Request No. 30.

18 REQUEST NO. 32:

19 Admit that you fell on November 4, 2016 due to the shoes you were wearing at the time.

20

21

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27

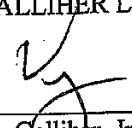
28

1 RESPONSE NO. 32:

2 Deny.

3 DATED this 8<sup>th</sup> day of October, 2018.

4 THE GALLIHER LAW FIRM

5  
6   
7 Keith E. Galliher, Jr., Esq.  
8 Nevada Bar No. 220  
9 1850 E. Sahara Avenue, Suite 107  
10 Las Vegas, Nevada 89104  
11 *Attorneys for Plaintiff*

12 THE GALLIHER LAW FIRM  
13 1850 E. Sahara Avenue, Suite 107  
14 Las Vegas, Nevada 89104  
15 702-735-0049 Fax: 702-735-0204  
16

THE GALLIHER LAW FIRM  
1850 E. Sahara Avenue, Suite 107  
Las Vegas, Nevada 89104  
702-735-0049 Fax: 702-735-0204

**CERTIFICATE OF SERVICE**

I HEREBY CERTIFY that I am an employee of THE GALLIHER LAW FIRM and that service of a true and correct copy of the above and foregoing **SECOND AMENDED RESPONSES TO DEFENDANTS REQUEST FOR ADMISSIONS** was served on the 9th day of October, 2018, to the following addressed parties by:

\_\_\_\_\_ First Class Mail, postage prepaid from Las Vegas, Nevada pursuant to N.R.C.P 5(b)

\_\_\_\_\_ Facsimile, pursuant to EDCR 7.26 (as amended)


☒ Electronic Mail/Electronic Transmission

\_\_\_\_\_ Hand Delivered to the addressee(s) indicated

\_\_\_\_\_ Receipt of Copy on this \_\_\_\_\_ day of \_\_\_\_\_, 2015,

acknowledged by, \_\_\_\_\_

Michael A. Royal, Esq.  
Gregory A. Miles, Esq.  
ROYAL & MILES LLP  
1522 W. Warm Springs Rad  
Henderson, Nevada 89014  
Attorney for Defendant

  
An employee of THE GALLIHER LAW FIRM

THE GALLIHER LAW FIRM  
1850 E. Sahara Avenue, Suite 107  
Las Vegas, Nevada 89104  
702-735-0049 Fax: 702-735-0204

1 THE GALLIHER LAW FIRM  
2 Keith E. Galliher, Jr., Esq.  
3 Nevada Bar No. 220  
4 Jeffrey L. Galliher, Esq.  
5 Nevada Bar Number 8078  
6 George J. Kunz, Esq.  
7 Nevada Bar Number 12245  
8 1850 East Sahara Avenue, Suite 107  
9 Las Vegas, Nevada 89104  
10 Telephone: (702) 735-0049  
11 Facsimile: (702) 735-0204  
12 kgalliher@galliherlawfirm.com  
13 jgalliher@galliherlawfirm.com  
14 gkunz@lvlawguy.com  
15 Attorneys for Plaintiffs

DISTRICT COURT  
CLARK COUNTY, NEVADA

13 JOYCE SEKERA, an Individual,  
14 Plaintiff,

15 v.

16 VENETIAN CASINO RESORT, LLC,  
17 d/b/a THE VENETIAN LAS VEGAS, a  
18 Nevada Limited Liability Company;  
19 LAS VEGAS SANDS, LLC d/b/a THE  
20 VENETIAN LAS VEGAS, a Nevada  
21 Limited Liability Company; YET  
22 UNKNOWN EMPLOYEE; DOES I  
23 through X, inclusive,

24 Defendants.

CASE NO.: A-18-772761-C  
DEPT. NO.: 25

24 PLAINTIFF, JOYCE SEKERA'S, SECOND AMENDED RESPONSES TO DEFENDANT  
25 VENETIAN CASINO RESORT, LLC'S FIRST SET OF REQUEST FOR ADMISSIONS

26  
27 TO: VENETIAN CASINO RESORT, LLC, Defendant  
28



THE GA IER LAW FIRM  
1850 E. Sahara Avenue, Suite 107  
Las Vegas, Nevada 89104  
702-735-0049 Fax: 702-735-0204

1 TO: MICHAEL A. ROYAL, ESQ. and GREGORY A. MILES, ESQ. of ROYAL & MILES,  
2 LLP, Attorney for Defendant

3 Plaintiff, JOYCE SEKERA, by and through her undersigned attorneys, hereby responds

4 Defendants' First Set of Request for Admissions as follows:

5 REQUEST NO. 1:

6 Admit that you did not see liquid on the floor of the subject area before your fall on  
7 November 4, 2016.

8 RESPONSE NO. 1:

9 Admit.

10 REQUEST NO. 2:

11 Admit that you did not see liquid on the floor of the subject area after your fall on November  
12 4, 2016.

13 RESPONSE NO. 2:

14 Deny.

15 REQUEST NO. 3:

16 Admit that you did not see a foreign substance on the floor potentially causing your fall on  
17 November 4, 2016 at any time.

18 RESPONSE NO. 3:

19 Deny.

20 REQUEST NO. 4:

21 Admit that you did not fall on November 4, 2016 due to a foreign substance on the floor of  
22 Defendants' property.

23 RESPONSE NO. 4:

24 Deny.

1 REQUEST NO. 5:

2 Admit that you were in the course and scope of your employment at the time of the subject  
3 incident on November 4, 2016.

4 RESPONSE NO. 5:

5 Admit.

6 REQUEST NO. 6:

7 Admit that your employer at the time of the November 4, 2016 incident was Brand Vegas,  
8 LLC.

9 RESPONSE NO. 6:

10 Admit.

11 REQUEST NO. 7:

12 Admit that you parked your personal vehicle on the property of Venetian Casino Resort,  
13 LLC, on November 4, 2016 when reporting to work for Brand Vegas, LLC.

14 RESPONSE NO. 7:

15 Admit.

16 REQUEST NO. 8:

17 Admit that as part of your employment for Brand Vegas, LLC, in 2016 you promoted events  
18 occurring on the property of Venetian Casio Resort, LLC.

19 RESPONSE NO. 8:

20 Deny.

21 REQUEST NO. 9:

22 Admit that as part of your employment for Brand Vegas, LLC in 2016 you sold tickets for  
23 events occurring on the property of Venetian Casino Resort, LLC.

24  
25  
26  
27  
28

1 RESPONSE NO. 9:

2 Deny.

3 REQUEST NO. 10:

4 Admit that your employment for Brand Vegas, LLC, in 2016 was pursuant to a contract  
5 between Brand Vegas, LLC, and Venetian Casino Resort, LLC.  
6

7 RESPONSE NO. 10:

8 Deny.

9 REQUEST NO. 11:

10 Admit that your employment for Brand Vegas, LLC, in 2016 required that you come upon  
11 the property of Venetian Casino Resort, LLC for each work shift.  
12

13 RESPONSE NO. 11:

14 Admit.

15 REQUEST NO. 12:

16 Admit that you regularly used restroom facilities on the property of Venetian Casino Resort,  
17 LLC, while in the course of your employment for Brand Vegas, LLC, in 2016.

18 RESPONSE NO. 12:

19 Admit.

20 REQUEST NO. 13:

21 Admit that you did not strike your head in the subject incident of November 4, 2016.  
22

23 RESPONSE NO. 13:

24 Deny.

25 REQUEST NO. 14:

26 Admit that you did not lose consciousness in the subject incident of November 4, 2016.  
27  
28

1 RESPONSE NO. 14:

2 Deny.

3 REQUEST NO. 15:

4 Admit that you denied head pain to Defendants' security personnel responding to the subject  
5 incident on November 4, 2016.

6 RESPONSE NO. 15:

7 Deny.

8 REQUEST NO. 16:

9 Admit that you denied striking your head to Defendants' security personnel responding to the  
10 subject incident on November 4, 2016.

11 RESPONSE NO. 16:

12 Deny.

13 REQUEST NO. 17:

14 Admit that you denied losing consciousness to Defendants' security personnel responding to  
15 the subject incident on November 4, 2016.

16 RESPONSE NO. 17:

17 Deny.

18 REQUEST NO. 18:

19 Admit that you advised medical personnel at Centennial Hills Hospital on November 4, 2016  
20 that you did not strike your head in the subject incident.

21 RESPONSE NO. 18:

22 Deny.

23

24

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26

1 REQUEST NO. 19:

2 Admit that you advised medical personnel at Centennial Hills Hospital on November 4, 2016  
3 that you did not lose consciousness as a result of your fall in the subject incident.

4 RESPONSE NO. 19:

5 Deny.

6 REQUEST NO. 20:

7 Admit that Jordan Webber, D.C., accurately related in his report of your November 8, 2016  
8 visit that you denied being involved in any prior injury causing accidents.

9 RESPONSE NO. 20:

10 Admit.

11 REQUEST NO. 21:

12 Admit that Michelle Hyla, D.O., accurately related in her report of your November 21, 2016  
13 visit that you struck your head as a result of the subject incident.

14 RESPONSE NO. 21:

15 Admit.

16 REQUEST NO. 22:

17 Admit that Michelle Hyla, D.O., accurately related in her report of your November 21, 2016  
18 visit that you lost consciousness as a result of the subject incident.

19 RESPONSE NO. 22:

20 Objection. Calls for an expert medical opinion, therefore deny.

21 REQUEST NO. 23:

22 Russell L. Shah, M.D., accurately related in his report of your December 1, 2016 visit that  
23 you lost consciousness as a result of the subject incident.

24  
25  
26  
27  
28

1 RESPONSE NO. 23:

2 Objection. Calls for an expert medical opinion, therefore deny.

3 REQUEST NO. 24:

4 Admit that Katherine Travnicek, M.D., accurately related in her report of your January 9,  
5 2017 visit that you struck your head in your fall on November 4, 2016.

6 RESPONSE NO. 24:

7 Admit.

8 REQUEST NO. 25:

9 Admit that Katherine Travnicek, M.D., accurately related in her report of your January 9,  
10 2017 visit that you lost consciousness as a result of the subject incident.

11 RESPONSE NO. 25:

12 Objection. Calls for an expert medical opinion, therefore deny.

13 REQUEST NO. 26:

14 Admit that Andrew Cash, MD., accurately related in his report of your October 5, 2017 visit  
15 that you did not strike your head as a result of the subject incident.

16 RESPONSE NO. 26:

17 Deny.

18 REQUEST NO. 27:

19 Admit that William D. Smith, M.D., accurately related in his report of your February 22,  
20 2018 visit that you lost consciousness as a result of the subject incident.

21 RESPONSE NO. 27:

22 Objection. Calls for an expert medical opinion, therefore deny.

23

24

25

26

1 REQUEST NO. 28:

2 Admit that William D. Smith, M.D., accurately related in his report of your February 22,  
3 2018 visit that you did not drive yourself to Centennial Hills Hospital on November 4, 2016.

4 RESPONSE NO. 28:

5 Deny.

6 REQUEST NO. 29:

7 Admit that you have not had any gainful employment since the date of the subject incident.

8 RESPONSE NO. 29:

9 Admit.

10 REQUEST NO. 30:

11 Admit that you have been physically unable to work since the date of the subject incident.

12 RESPONSE NO. 30:

13 Admit.

14 REQUEST NO. 31:

15 Admit that you have been physically unable to work since the date of the subject incident.

16 RESPONSE NO. 31:

17 This request is the same as No. 30. Please see my response to Request No. 30.

18 REQUEST NO. 32:

19 Admit that you fell on November 4, 2016 due to the shoes you were wearing at the time.

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THE GALLIHER LAW FIRM  
1850 E. Sahara Avenue, Suite 107  
Las Vegas, Nevada 89104  
702-735-0049 Fax: 702-735-0204

1 RESPONSE NO. 32:

2 Deny.

3 DATED this 8<sup>th</sup> day of October, 2018.

4 THE GALLIHER LAW FIRM

5  
6   
7 Keith E. Galliher, Jr., Esq.  
8 Nevada Bar No. 220  
9 1850 E. Sahara Avenue, Suite 107  
10 Las Vegas, Nevada 89104  
11 *Attorneys for Plaintiff*



**CERTIFICATE OF SERVICE**

I HEREBY CERTIFY that I am an employee of THE GALLIHER LAW FIRM and that service of a true and correct copy of the above and foregoing **SECOND AMENDED RESPONSES TO DEFENDANTS REQUEST FOR ADMISSIONS** was served on the 9th day of October, 2018, to the following addressed parties by:

\_\_\_\_\_ First Class Mail, postage prepaid from Las Vegas, Nevada pursuant to N.R.C.P 5(b)

\_\_\_\_\_ Facsimile, pursuant to EDCR 7.26 (as amended)

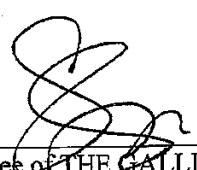
☒ Electronic Mail/Electronic Transmission

\_\_\_\_\_ Hand Delivered to the addressee(s) indicated

\_\_\_\_\_ Receipt of Copy on this \_\_\_\_\_ day of \_\_\_\_\_, 2015,

acknowledged by, \_\_\_\_\_

Michael A. Royal, Esq.  
Gregory A. Miles, Esq.  
ROYAL & MILES LLP  
1522 W. Warm Springs Rad  
Henderson, Nevada 89014  
Attorney for Defendant

  
An employee of THE GALLIHER LAW FIRM

THE GALLIHER LAW FIRM  
1850 E. Sahara Avenue, Suite 107  
Las Vegas, Nevada 89104  
702-735-0049 Fax: 702-735-0204



Arrest <input type="checkbox"/> Crime <input type="checkbox"/> Non-Criminal <input checked="" type="checkbox"/>	<b>Venetian Security</b> 3355 LAS VEGAS BLVD., S. LAS VEGAS, NV 89109	CASE # <b>1611V-0680</b>
<b>Narrative Report</b>		Page 1 of 2
OFFENSE(S) <b>Protected Health Information</b>		OFFENSE(S) cont'd
DATE, TIME AND DAY OF OCCURRENCE <b>11/04/16 12:39 Friday</b>		DATE AND TIME REPORTED <b>11/04/16 12:39</b>
LOCATION OF OCCURRENCE	LOCATION NAME <b>Outside Grand Lux Cafe Restrooms</b>	TYPE OF LOCATION MEAT SECTOR
NARRATIVE		
<p>On November 4th, 2016 at 12:39pm, I was dispatched to the area outside of the restrooms adjacent to the Grand Lux Cafe for report of a slip and fall incident. I arrived on scene and met with Las Vegas Tours (business located in Grand Canal Shoppes) employee Sekera, Joyce who was seated on the marble flooring. I noted that a Public Areas Department team member was on scene and mopping the flooring in the area. Sekera apologized for falling and did not appear to be in any immediate distress. I did not observe an obvious injuries to threats to life at that time.</p> <p>Sekera was alert and oriented to person, place, time, and events, had a patent airway, and was breathing adequately. She stated she was walking through the area when she slipped in what she believed was water on the floor. She reported that she fell backwards and put her right hand behind her head to protect it. She landed on the marble flooring and her left elbow struck the base of a pillar next to her. She denied striking her head during the fall and denied losing consciousness prior to, or after, falling. She denied any head pain, neck pain, back pain, weakness, dizziness, or nausea at that time. I noted that she was guarding her left elbow and reported she was only experiencing pain there at that time. She stated she was embarrassed to which I offered to assist her to a more private area. She agreed and was assisted to a standing position. I asked if she felt any new pain, weakness, dizziness, or nausea to which she denied at that time. She agreed to be assessed in the Medical Room and refused wheelchair assistance. She was able to ambulate on her own to the Medical Room and was able to sit without assistance.</p> <p>Sekera's left elbow was exposed which presented with an abrasion. I did not observe any other injuries or deformities to the area. Palpation of the area showed an increase in tenderness with no obvious signs of instability or crepitation. Distal circulation, motor function, and sensory function were found intact in the left arm. Grip strength was found to be equal bilaterally in the upper extremities. She rated her pain at approximately 7 on a 1-10 severity scale. She had a limited range of motion in the left elbow due to increasing pain on movement. She stated that she was starting to feel a tingling sensation in left phalanges II and III (index and middle finger). A SAM splint was formed on the right arm and applied to the left arm. The splint covered the left elbow and wrist and was secured using four-inch Kerlix gauze and tape. Distal circulation, motor function, and sensory function were rechecked and found to be intact with no changes. The splinted left arm was placed into a</p>		
<b>ADMINISTRATION</b>		
BY OFFICER <b>J. Larson 000025821</b>	DATE/TIME <b>11/04/2016 15:30</b>	APPROVED BY <b>Michael Dean 000041303</b>
OFFICER	UNIT/SHIFT	DATE APPROVED <b>11/05/16</b>
ASSIGNED TO		CASE STATUS <b>Closed</b>

CR-1 Larso/025821 Entered by: Joseph Larson

Page 1 of 2

APDC (Rev. 01/22/13) Print Date: 11/18/2016

EXHIBIT <b>C</b>
WIT: <b>Sekera</b>
DATE: <b>3-14-19</b>
REPORTER: B. CANO

VEN 008

1358

Arrest <input type="checkbox"/> Crime <input type="checkbox"/> Non-Criminal <input checked="" type="checkbox"/>	<b>Venetian Security</b> 3355 LAS VEGAS BLVD., S. LAS VEGAS, NV 89109	CASE # <b>1611V-0680</b>
<b>Narrative Report</b>		Page 2 of 2
OFFENSE(S) <b>Protected Health Information</b>		OFFENSE(S) cont'd
DATE, TIME AND DAY OF OCCURRENCE <b>11/04/16 12:39 Friday</b> TO <b>11/04/16 13:31 Friday</b>		DATE AND TIME REPORTED <b>11/04/16 12:39</b>
LOCATION OF OCCURRENCE	LOCATION NAME <b>Outside Grand Lux Cafe Restrooms</b>	TYPE OF LOCATION BEAT SECTOR
NARRATIVE		
<p>             sling made out of a triangle bandage to which she reported the treatment provided some relief from her pain. She added that she was beginning to feel minor pain and soreness to her left lower back and left side (localized to the axillary line).           </p> <p>             Sekera agreed to seek further medical attention, but refused ambulance transport. She stated her job did not provide Workers' Compensation and did not know where she should go. After some discussion, she opted to self-transport to Centennial Hills Hospital as it was close to her home. She refused to complete a Voluntary Statement for the incident and completed a Medical Release. She was escorted to her booth in the Grand Canal Shoppes, collected her belongings, and was escorted to her vehicle in the Team Member Garage on level 8.           </p> <p>             I checked the area of incident and noted that the marble flooring appeared to be flat, even, and dry throughout the area. I did not observe any wet or slick areas and no obstructions were observed. An Accident Scene Check was completed by Facilities Team Member Chavez, Rafael TM#9648 at 1:28pm which found no defects in the area of incident.           </p> <p>             Video coverage is available per Surveillance.           </p> <p>             Risk Management was notified.           </p> <p> <b>Attached Items</b>              1 Scan of the Medical Release              1 Scan of the Accident Scene Check              2 Photographs of Sekera's left arm              2 Photographs of Sekera's shoes (top and bottom)              5 Photographs of the area of incident           </p>		
<b>ADMINISTRATION</b>		
BY OFFICER <b>J. Larson 000025821</b>	DATE/TIME <b>11/04/2016 15:30</b>	APPROVED BY <b>Michael Dean 000041303</b>
OFFICER	UNIT/SHIFT	ASSIGNED TO
		DATE APPROVED <b>11/05/16</b>
		CASE STATUS <b>Closed</b>





VEN 035

EXHIBIT D  
WIT: Sekera  
DATE: 3.14.19  
REPORTER: B. CANO



VEN 036



VEN 037



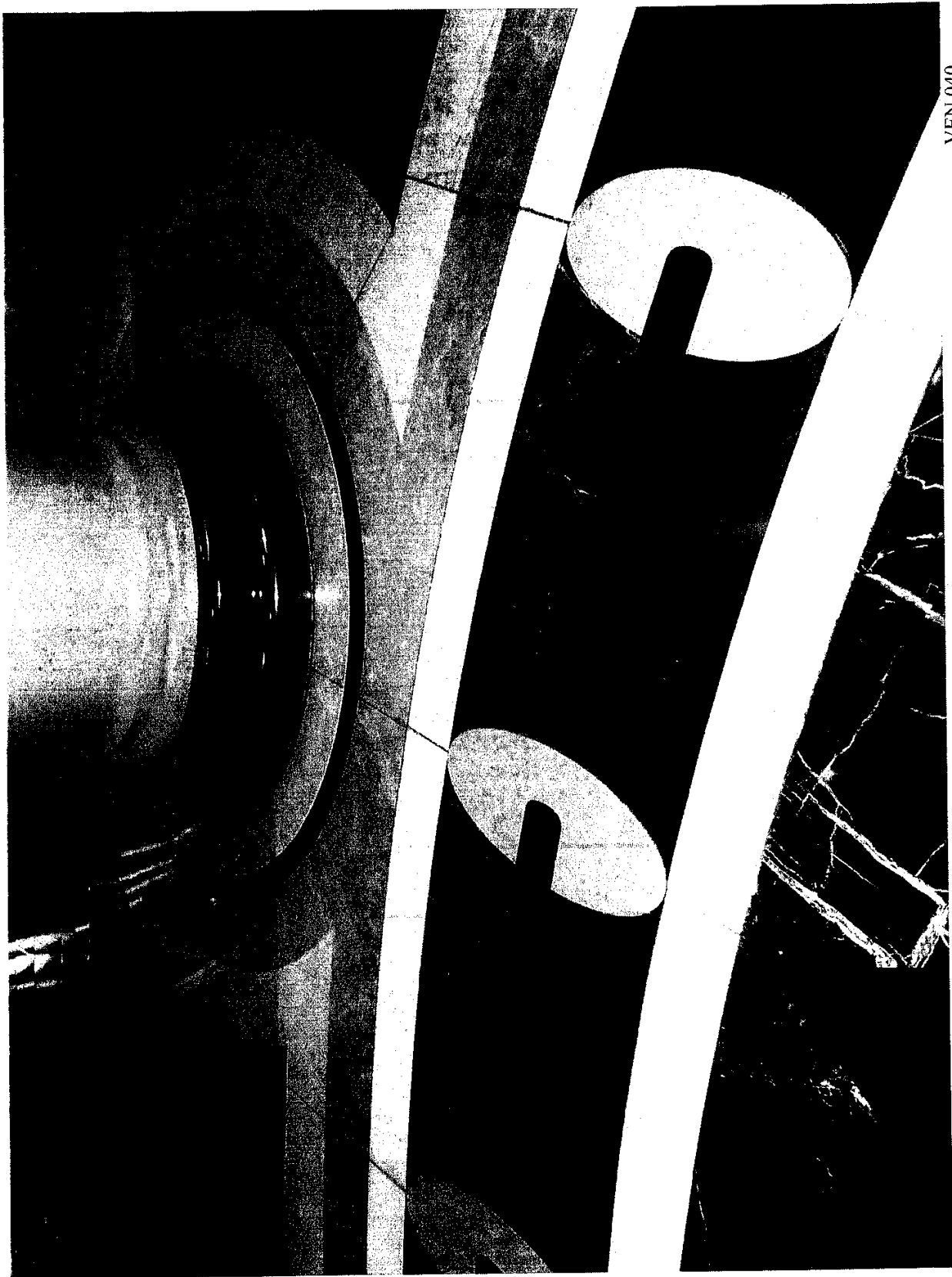


VEN 038

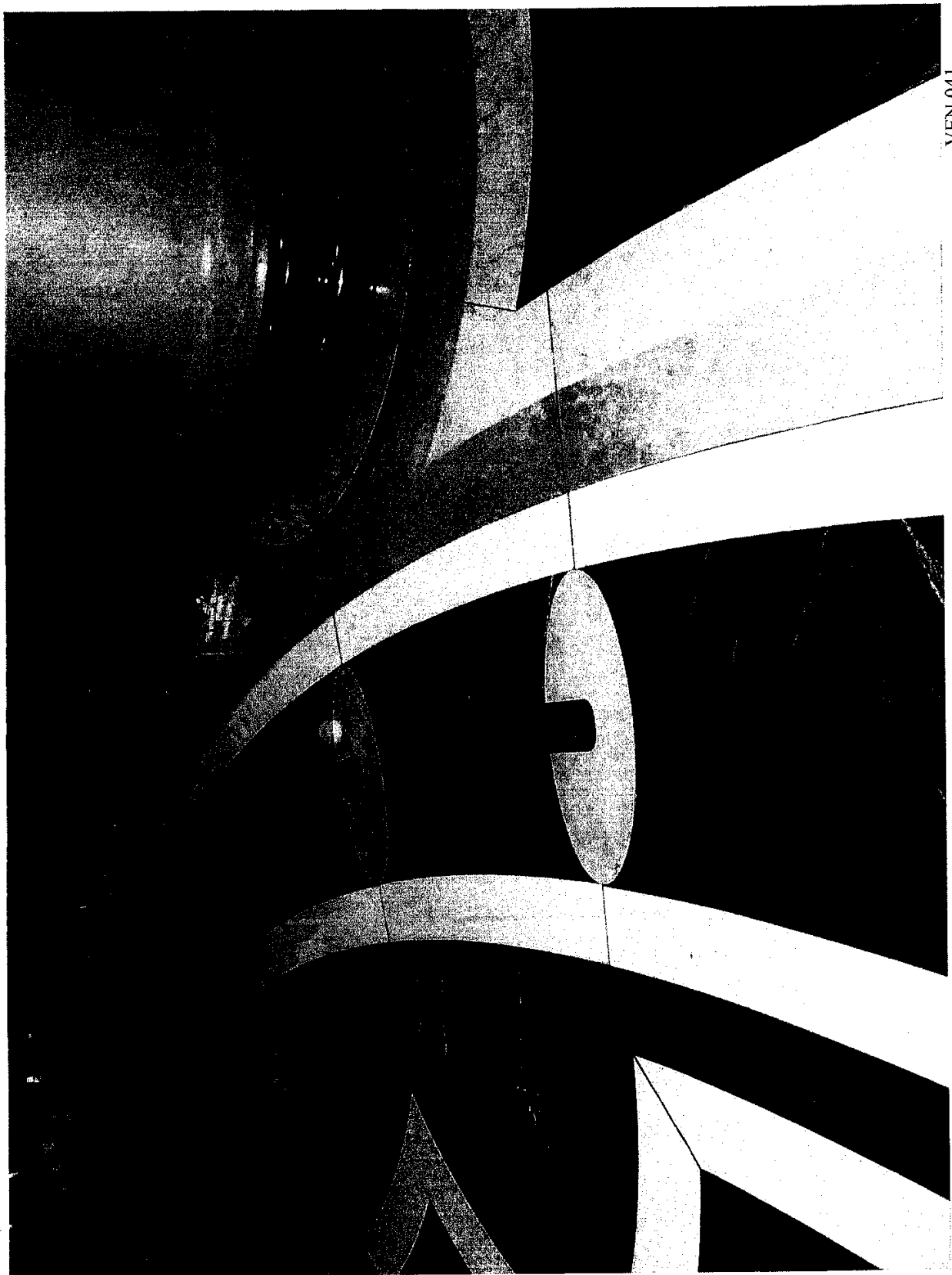


VEN 039

8/14/88



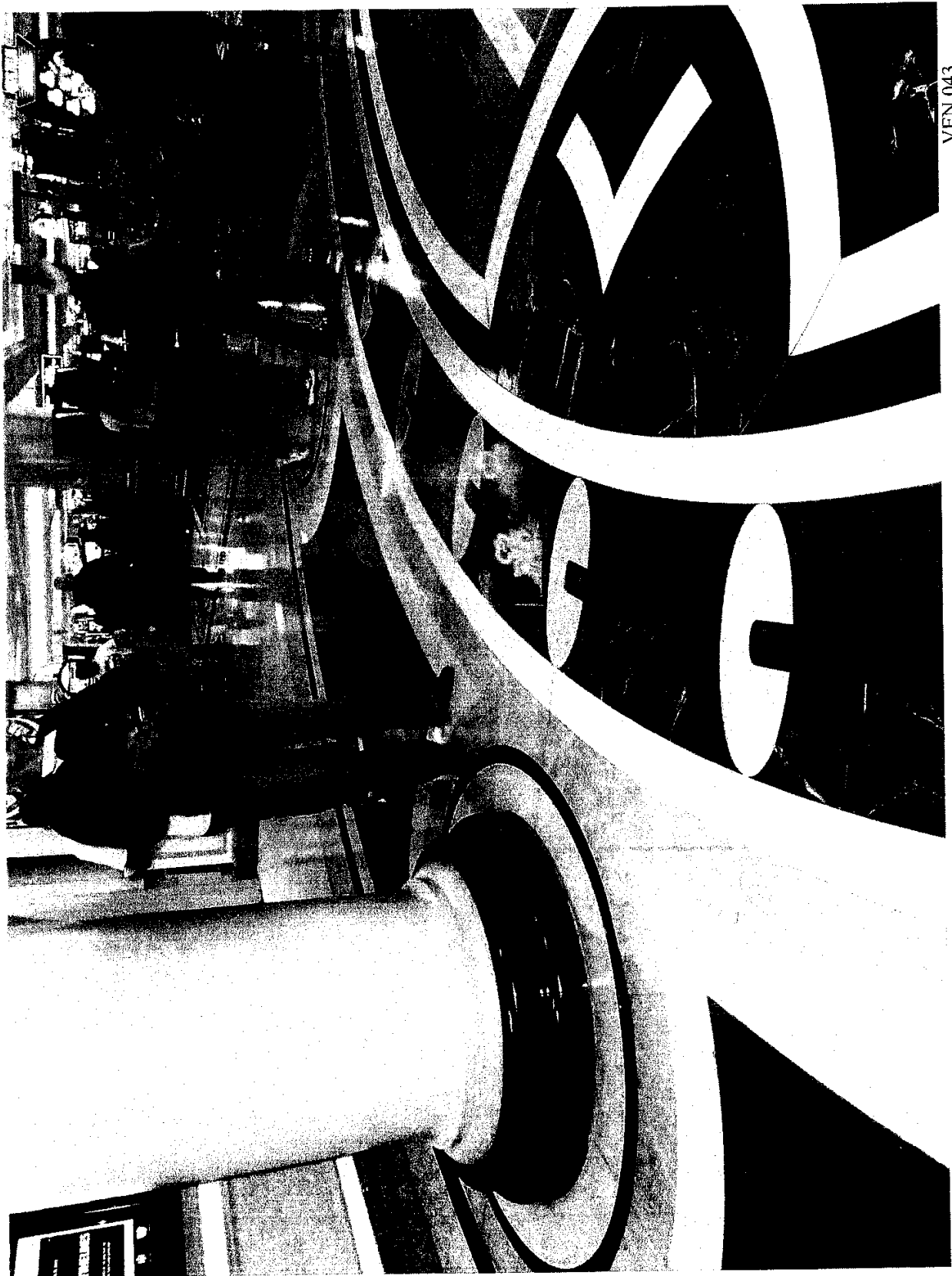
VEN 040



VEN 041



VEN 042



VEN 043



## Acknowledgement of First Aid Assistance & Advice to Seek Medical Care

☒ I (or my guardian) have been informed that only an initial Emergency First Aid treatment and evaluation has been rendered to me by a Venetian or Palazzo Emergency Medical Technician (EMT) who is not a medical doctor and that I (or my guardian) have been advised that I should seek the advice of a physician as soon as possible.

☐ I (or my guardian) refuse treatment by a Venetian or Palazzo Emergency Medical Technician (EMT) and have been advised that I should seek the advice of a physician as soon as possible.

Name (Print): JOYCE SEKERA WFA 5'6" 160 DPO/820  
 Signature: [Signature] (LV TOUR -> GLS)  
 Address: 7810 NESTING PINE PL, LV, NV 89143  
 Date of Birth: 3/22/56 Social Security #: N/A  
 Phone: (702) 467-5457  
 Witness: \_\_\_\_\_  
 Witness: \_\_\_\_\_  
 Date: 11/4/16 Time: 1257  
 Refused to Sign: \_\_\_\_\_  
 Venetian/Palazzo EMT: \_\_\_\_\_ ID#: 25821

S/F, fell backwards onto base of pillar @ LOC, @ H/N/B, @ vent  
 @ elbow -> @ FT, @ ILC  
 @ CMS, tingling in @ PII, PIII; limited ROM due to pain  
 @ axillary pain/soreness  
 @ flank/lateral back pain

@ intro, @ foot slipped 30 min prior to fall  
 X - splint to @ elbow/FA  
 @ CMS -> @ Δ P approx 12 min; @ x

EXHIBIT E  
 WIT: Sekera  
 DATE: 3-14-19  
 REPORTER: B. CANO

VEN 017





CHH- Centennial Hills Hospital Medical Center

Patient: SEKERA, JOYCE  
MRN: CHH7120336  
DOB/Sex: 3/22/1956 / Female  
Attending: ED, Staff Physician

Admit: 11/4/2016  
Disch: 11/4/2016  
FIN: CHH0008005149375

**Emergency Department**

11/4/2016 17:39 PDT  
SERVICE DATE/TIME:  
RESULT STATUS:  
PERFORM INFORMATION:  
SIGN INFORMATION:

ED Physician Record  
11/4/2016 17:39 PDT  
Auth (Verified)  
Taylor, Rachael APRN (11/4/2016 17:53 PDT)  
Del Vecchio MD, Francis X (11/4/2016 18:00 PDT); Taylor,  
Rachael APRN (11/4/2016 17:58 PDT)

**Fall**

Patient: SEKERA, JOYCE MRN: CHH7120336 FIN: CHH0008005149375  
Age: 60 years Sex: Female DOB: 03/22/56  
Associated Diagnoses: None  
Author: Taylor, Rachael APRN

**Basic Information**

Time seen: Date & time 11/04/16 16:33:00, Provider Assignment  
Taylor, Rachael APRN assigned at 11/04/2016 16:25

History source: Patient  
Arrival mode: Private vehicle.  
History limitation: None.

Additional information: Chief Complaint from Nursing Triage Note : Chief Complaint  
11/04/16 14:21 PDT Chief Complaint low back pain and left elbow pain s/p slip and fall .

**History of Present Illness**

The patient presents following fall. The onset was just prior to arrival. The occurrence was single episode. The fall was described as slipped. The location where the incident occurred was at work. Location: Left upper extremity. The character of symptoms is pain, swelling and tingling. The degree at present is minimal. The exacerbating factor is none. The relieving factor is none. Risk factors consist of none. The patient's dominant hand is the right hand. Therapy today: none. A 60-year-old female status post fall at work. Patient was walking and slipped backwards. Patient did not hit her head. No LOC. Patient complains of left elbow pain and left lower back pain. Patient denies any dizziness or shortness of breath. No chest pain. Patient does complain of some paresthesias to her left hand. Patient able to ambulate without difficulty. Patient denies any urine or bowel dysfunction..

**Review of Systems**

Constitutional symptoms: Negative except as documented in HPI.  
Skin symptoms: Negative except as documented in HPI.  
Eye symptoms: Negative except as documented in HPI.  
ENMT symptoms: Negative except as documented in HPI.  
Respiratory symptoms: Negative except as documented in HPI.  
Cardiovascular symptoms: Negative except as documented in HPI.  
Gastrointestinal symptoms: Negative except as documented in HPI.  
Genitourinary symptoms: Negative except as documented in HPI.  
Musculoskeletal symptoms: Back pain, Muscle pain, Reports: Pain to left elbow and left lower lumbar region.  
Neurologic symptoms: Negative except as documented in HPI.  
Psychiatric symptoms: Negative except as documented in HPI.  
Endocrine symptoms: Negative except as documented in HPI.  
Additional review of systems information: All other systems reviewed and otherwise negative.

**Health Status**

**Allergies:**

Allergic Reactions (All)  
No Known Allergies.

Medications: Review/Insert Medication List (Selected)

Print Date/Time 12/14/2016 08:58 PST Medical Record

EXHIBIT F  
WIT: Sekera  
DATE: 3-14-19  
REPORTER: B. CANO

CHH- Centennial Hills Hospital Medical Center

Patient: SEKERA, JOYCE  
MRN: CHH7120336  
DOB/Sex: 3/22/1956 / Female  
Attending: ED, Staff Physician

Admit: 11/4/2016  
Disch: 11/4/2016

FIN: CHH0008005149375

**Emergency Department**

Inpatient Medications

Ordered

Norco 7.5 mg-325 mg oral tablet: 1 Tabs, Oral, q4H, PRN: Pain 4 - 6 (Moderate).

**Past Medical/ Family/ Social History**

**Medical history**

Negative.

**Medical history:** PMH/Problems ST

**Active Problems (1)**

Edema of right upper eyelid

**Surgical history:**

No active procedure history items have been selected or recorded..

**Family history:**

No family history items have been selected or recorded..

**Social history:** Alcohol use: Denies, Tobacco use: Regularly.

**Social history:** Social History ST

**Social & Psychosocial Habits**

**Tobacco**

05/11/2012 Patient Smoked Cigarettes During Last 12 Months: No

11/04/2016 Smoking History: Never smoker.

**Physical Examination**

**Vital Signs**

**Measurements**

11/04/16 14:21 PDT

Height	167.64 cm
Height Method	Stated
Weight	86.18 kg
Daily Weight kg	86.18 kg
Weight Method	Stated
Weight Method	Stated
BSA Measured	2 m2
Body Mass Index Measured	30.67 kg/m2

**Basic Oxygen Information**

11/04/16 14:20 PDT SpO2 95 %

SaO2 95% on room air. Interpretation fair.

**General:** Alert, no acute distress.

**Skin:** Warm, dry, pink.

**Head:** Normocephalic, Not atraumatic,

**Neck:** Trachea midline.

**Eye:** Extraocular movements are intact.

**Ears, nose, mouth and throat:** Oral mucosa moist.

**Cardiovascular:** Regular rate and rhythm, No murmur, Normal peripheral perfusion, No edema, No cardiac rub,

**Respiratory:** Lungs are clear to auscultation, respirations are non-labored, breath sounds are equal, Symmetrical chest wall expansion, No Rales, No Rhonchi, No Wheezing.

**Gastrointestinal:** Soft, Nontender, Non distended, No Masses/Pulsations/Distension.

**Musculoskeletal:** Not normal ROM, Proximal upper extremity: Left, elbow, tenderness.

**Neurological:** Alert and oriented to person, place, time, and situation, No focal neurological deficit observed, CN II-XII Intact, normal speech observed.

Print Date/Time 12/14/2016 08:58 PST

Medical Record

Page 25 of 62

PLF 028

1374

CHH- Centennial Hills Hospital Medical Center

Patient: SEKERA, JOYCE  
MRN: CHH7120336  
DOB/Sex: 3/22/1956 / Female  
Attending: ED, Staff Physician

Admit: 11/4/2016  
Disch: 11/4/2016  
FIN: CHH0008005149375

**Emergency Department**

Psychiatric: Cooperative, appropriate mood & affect.

**Medical Decision Making**

Radiology results: Radiologist's Interpretation: Imaging  
11/04/16 16:35 PDT XR Spine Lumbosacral 2 or 3 Views CHH RADIOLOGY HISTORY: Injury to elbow

COMPARISON: None.

TECHNIQUE: Left , 4 views.

**FINDINGS:**

There is no evidence of fracture. There is no evidence of dislocation or subluxation.  
Bone mineralization is normal. The articular surfaces and joint spaces are well preserved.  
There are no osseous lesions. There are no soft tissue abnormalities.

**IMPRESSION:**

No evidence of acute fracture or dislocation.

Please note that some abnormalities may not be able to be detected with radiographs.  
If clinical symptoms persist, consider cross sectional imaging.

**IMPRESSION:**

Degenerative disk disease most conspicuously at L2-3 where there is endplate osteophyte formation and some endplate sclerosis.. There is slight increased density at the disk space of uncertain etiology possibly related to some calcification. Further assessment with CT or MRI scan can be obtained as clinically warranted.

**Reexamination/ Reevaluation**

Time: 11/04/16 17:46:00.

Notes: Discussed with patients the results of today visits and diagnosis and plan of care. Answered patients questions. Patient agrees to comply with plan of care. Patient requesting to be discharged home..

**Impression and Plan**

Back strain - ICD10-CM S39.012A,  
left elbow pain  
slip and fall  
Plan

Print Date/Time 12/14/2016 08:58 PST

Medical Record

Page 26 of 62

PLF 029

1375

CHH- Centennial Hills Hospital Medical Center

Patient: SEKERA, JOYCE  
MRN: CHH7120336  
DOB/Sex: 3/22/1956 / Female  
Attending: ED, Staff Physician

Admit: 11/4/2016  
Disch: 11/4/2016  
FIN: CHH0008005149375

**Emergency Department**

Condition: Improved.  
Prescriptions: Launch Prescription Writer  
Pharmacy:  
Ibuprofen 600 mg oral tablet (Prescribe): 600 mg, 1 Tabs, Oral, TID, PRN: Pain, 30 Tabs, 0 Refill(s).  
Patient was given the following educational materials: SPRAIN ELBOW, SPRAIN ELBOW, BACK PAIN (Acute or Chronic).  
Follow up with: Pcp No Within 1-2 days; Mark Rosen Within 1-2 days.  
Counseled: Patient, Family, Regarding diagnostic results, Regarding treatment plan, Regarding prescription, Patient Indicated understanding of instructions.  
Disposition: Launch Disposition Order  
Admit/Transfer/Discharge:  
Discharge Request Pending Physician Agreement (Order): 11/04/16 17:51 PDT, Home Routine.

**Addendum**

**Teaching-Supervisory Addendum-Brief**

Notes: I personally interviewed and examined this patient. I discussed the findings, diagnostic studies, interventions and treatment plan with ARNP / PA. I reviewed the clinical notes and test results. I agree with the assessment, management, and disposition as presented by ARNP / PA with exceptions as documented.

Electronically Signed By: Taylor, Rachael  
On: 11.04.2016 17:58 PDT

Electronically Signed On: 11.04.2016 18:00 PDT  
Del Vecchio, Francis MD

11/4/2016 14:49 PDT  
SERVICE DATE/TIME:  
RESULT STATUS:  
PERFORM INFORMATION:  
SIGN INFORMATION:

Triage Note  
11/4/2016 14:49 PDT  
Auth (Verified)  
Vandenberg RN, Emmy L (11/4/2016 14:49 PDT)  
Vandenberg RN, Emmy L (11/4/2016 14:49 PDT)

**ED Abuse/Neglect Adult Entered On: 11/4/2016 14:49 PDT**  
**Performed On: 11/4/2016 14:49 PDT by Vandenberg RN, Emmy L**

**Abuse/Neglect Assessment**

Threatened/Physically Hurt in past year: Yes  
ED DV Harm or Neglect Question: No  
Abuse and Neglect Types: None

Vandenberg RN, Emmy L - 11/4/2016 14:49 PDT

11/4/2016 14:49 PDT  
SERVICE DATE/TIME:  
RESULT STATUS:  
PERFORM INFORMATION:  
SIGN INFORMATION:

Triage Note  
11/4/2016 14:49 PDT  
Auth (Verified)  
Vandenberg RN, Emmy L (11/4/2016 14:49 PDT)  
Vandenberg RN, Emmy L (11/4/2016 14:49 PDT)

Print Date/Time 12/14/2016 08:58 PST

Medical Record

Page 27 of 62

PLF 030

1376



**EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT**  
**FORM C-4**  
**PLEASE TYPE OR PRINT**

Please complete all areas that are highlighted in yellow.

First Name <b>JOYCE</b>		Last Name <b>SEKERA</b>		Birthdate <b>3-22-56</b>	Sex <input checked="" type="checkbox"/> F <input type="checkbox"/> M	Claim Number (Insurer's Use Only)
Home Address <b>7840 Nesting Pine Pl</b>		Age <b>60</b>	Height <b>5'6"</b>	Weight <b>180</b>	Social Security Number <b>091-48-5430</b>	
City <b>LAS VEGAS</b>		State <b>NV</b>	Zip <b>89143</b>	Telephone <b>702-467-5457</b>		
Mailing Address <b>7840 Nesting Pine Pl</b>		City <b>LAS VEGAS</b>	State <b>NV</b>	Zip <b>89143</b>	Primary Language Spoken <b>English</b>	
Insurer <b>N/A</b>		Third-Party Administrator <b>N/A</b>		Employee's Occupation (Job Title)/When Injury or Occupational Disease Occurred <b>SALES</b>		
Employer's Name/Company Name <b>BRAND VEGAS</b>		Office Mail Address (Number and Street) <b>N/A</b>		Telephone <b>538-9000</b>		
Date of Injury or Occupational Disease <b>11/4/16</b>	Hour of Injury (if applicable) <b>around 1:00 PM</b>	Date Employer Notified <b>11-4-16</b>	Last Day of Work After Injury or Occupational Disease <b>11-4-16</b>	Supervisor to Whom Injury Reported <b>Robert Church</b>		
Address at Location of Accident (if applicable) <b>Verde Valley Hotel</b>						
What were you doing at the time of the accident? (if applicable) <b>Walking</b>						
How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary.) <b>There was a car on the floor. My feet went out on the floor. I slipped. I fell. My back hurt.</b>						
If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment? <b>N/A</b>					Witnesses to the Accident (if applicable)	
Nature of Injury or Occupational Disease <b>Lower back</b>		Body Part(s) Injured or Affected <b>Lower back</b>		Guesses/Probables <b>Guesses/Probables</b>		
I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INJURANCE AND OCCUPATIONAL DISEASE ACTS AND TO ENSURE THAT I AM NOT DEBARRED FROM ANY OTHER BENEFITS OR COMPENSATION. I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACITITIONER, OR OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS ADMINISTRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE, PERTAINING TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO WORKERS' COMPENSATION AND/OR DISABILITY FOR AID, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST OBTAIN SPECIFIC AUTHORIZATION. A PHOTOGRAPH OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.						
Date <b>11/4/16</b>	Place <b>Centennial Hills Hospital</b>		Employee's Signature <b>[Signature]</b>			
THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT						
Place <b>Emergency Room Department</b>		Name of Facility <b>Centennial Hills Hospital</b>				
Date <b>11/4/16</b>	Diagnosis and Description of Injury or Occupational Disease <b>Lower back strain</b>		Is there evidence that the injured employee was under the influence of alcohol and/or other controlled substances at the time of the accident? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please explain)			
Hour <b>1:20</b>						
Treatment <b>X-ray pain relievers</b>			Have you advised the patient to remain off work five days or more? <input type="checkbox"/> Yes Indicate dates from <b>11/4/16</b> to <b>11/4/16</b> <input checked="" type="checkbox"/> No If no, is the injured employee capable of <input type="checkbox"/> full duty <input checked="" type="checkbox"/> modified duty			
X-Ray Findings <b>B fracture</b>			If modified duty, specify any limitations/restrictions: <b>[Signature]</b>			
From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job related? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
Is additional medical care by a physician indicated? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
Do you know of any previous injury or disease contributing to this condition or occupational disease? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (Explain if yes)						
Date <b>11/4/16</b>	Physician's Name <b>Dr. P. C. [Signature]</b>		I certify that the employer's copy of this form was mailed to the employer on <b>11/4/16</b>			
Address <b>6900 North Durango Drive</b>		City <b>Las Vegas</b>		State <b>Nevada</b>	Zip <b>89149</b>	Telephone <b>702-835-9700</b>
Doctor's Signature <b>[Signature]</b>		Provider's Tax ID Number <b>8805148375-7120336</b>		Degree <b>MD</b>		

ORIGINAL - TREATING PHYSICIAN OR CHIROPRACTOR PAGE 2 - INSURER/TPA PAGE 3 - EMPLOYER PAGE 4 - EMPLOYEE Form C-4 (rev 10/06)

EXHIBIT **G**  
WIT: **Sekera**  
DATE: **3-14-19**  
REPORTER: **B. CANO**





**RIVERMEAD POST-CONCUSSION SYMPTOMS QUESTIONNAIRE (RPQ)**
 Patient Joyce Sekera DOI 11/4/16 Today's Date 11/9/16

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer any of the symptoms listed below. Compare yourself now with how you were before the accident and circle the number closest to your answer.

- 0 = Not experienced at all before or after the accident  
 1 = No more of a problem now than before the accident  
 2 = A mild problem for me now  
 3 = A moderate problem for me now  
 4 = A severe problem for me now

0	1	2	3	4	Headaches
0	1	2	3	4	Dizzy feelings
0	1	2	3	4	Nausea, upset stomach or vomiting
0	1	2	3	4	Noise sensitivity, or easily upset by loud noises
0	1	2	3	4	Sleep disturbance or disruption of sleep patterns
0	1	2	3	4	Fatigue, tiring more easily
0	1	2	3	4	Being irritable, easily annoyed or angered
0	1	2	3	4	Feeling depressed, tearful, crying easily or more emotional
0	1	2	3	4	Getting frustrated easily or being less patient with others
0	1	2	3	4	Poor memory or forgetting things
0	1	2	3	4	Difficulty concentrating
0	1	2	3	4	Taking longer to think
0	1	2	3	4	Blurry vision
0	1	2	3	4	Bright lights irritate or upset me, sensitive to bright lights
0	1	2	3	4	Double vision
0	1	2	3	4	Restlessness, have to move around, can't sit still
0	1	2	3	4	Other

6/12  
JU31/57  
JU
 EXHIBIT H  
 WIT: Sekera  
 DATE: 3-14-19  
 REPORTER: B. CANO

Patient Signature

Doctor Signature

RPQ was originally published in the Journal of Neurology, Neurosurgery and Psychiatry in 1995 by King, Crawford et al from the Oxford Head Injury Service, Rivermead Rehabilitation Centre, Abingdon Road, Oxford, OX1 4XD, United Kingdom

She reported  
 being confused  
 falling out  
 sleep.

PLF 233

1380

## Current Health

- Name and phone number of family doctor: \_\_\_\_\_
- List all CURRENT illnesses or diseases you have been diagnosed with (cancer, tumors, infections, diabetes, aneurysms, etc.): \_\_\_\_\_
- If you are currently taking any prescription or nonprescription medications, please list them below with dosages:  
 Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Medication: \_\_\_\_\_ Dose: \_\_\_\_\_  
 Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Medication: \_\_\_\_\_ Dose: \_\_\_\_\_
- Please list any medications you are allergic to: \_\_\_\_\_
- Please indicate your height and weight 5'2" 190
- Do you have high blood pressure? NO

## Health History

- List any operations, surgeries or medical procedures:  
 Date: \_\_\_\_\_ Procedure: \_\_\_\_\_ Date: \_\_\_\_\_ Procedure: \_\_\_\_\_  
 Date: \_\_\_\_\_ Procedure: \_\_\_\_\_ Date: \_\_\_\_\_ Procedure: \_\_\_\_\_
- If you have ever had in the past or currently have any serious illness or injuries, please list:  
 Date: \_\_\_\_\_ Condition: \_\_\_\_\_ Date: \_\_\_\_\_ Condition: \_\_\_\_\_  
 Date: \_\_\_\_\_ Condition: \_\_\_\_\_ Date: \_\_\_\_\_ Condition: \_\_\_\_\_

Any current loss of bowel or bladder control? YES/NO NOAny current seizures, paralysis, speech, vision problems? YES/NO NOAny unexplained recent weight loss? YES/NO NO Current fever? YES/NO NO

- Please list any significant family illnesses: \_\_\_\_\_
- Have you had any spinal X-Rays or MRI's within the 5 years? If yes, when and where: \_\_\_\_\_
- Do you have a pacemaker? YES/NO NO If yes, please ALERT our doctor and/or chiropractic assistant
- Do you have blood/lymph disorders? YES/NO NO If yes, please list: \_\_\_\_\_
- Do you have osteoporosis or rheumatoid arthritis? YES/NO NO
- Please list any other electrical device that you currently wear: \_\_\_\_\_

Please select one: I have never smoked/ Former smoker/ Current smoker, if so how much  
 \_\_\_\_\_ pk./day 2 pk./wk.Have you ever had chiropractic care YES/NO NO If yes, last date of treatment: \_\_\_\_\_ By whom: \_\_\_\_\_

Similar or different condition: \_\_\_\_\_ Results: \_\_\_\_\_

WOMEN ONLY I hereby declare that to my best of knowledge I AM I AM NOT PREGNANT. If there is a chance that I may be pregnant, I will inform the doctor prior to my examination.Patient Signature Jordan Webber

(Parent/Guardian signature if under 18 years of age)

PLF 234

1381



**Desert Chiropractic & Rehab / Core Rehab**  
7810 West Ann Road #110  
Las Vegas, NV 891495199  
Phone: (702)463-8508  
FAX: (702)463-8772

**Patient Name:** Sekera, Joyce  
**Date of Birth:** 3/22/1956  
**Date of Service:** 11/8/2016

**History of injury:**

Ms. Sekera had a slip and fall injury dated 11/4/16. She stated that she was at work inside the Venetian Hotel. She stated that she was walking on the marble floor when she slipped on something wet when both of her feet slide out from under her and she fell to the ground landing on her back and left elbow. She reported that her neck was thrust back when she fell. She stated that she cannot recall a loss of consciousness, but recalls the first thing she can remember after her fall was people standing over her and feeling dazed.

Ms. Sekera reported that she was evaluated by a paramedic at the scene of her fall and given a sling for her left shoulder. She reported making an incident report and was asked if she wanted an ambulance to take her to the hospital. She stated that she declined the ambulance and drove herself to Centennial Hills Hospital where she had x-rays, was given medications and a new shoulder sling. The patient reported taking the medications which have helped, but not resolve their pain. She also reported using heat packs which have helped some as well. Ms. Sekera cannot recall having prior slip and fall injuries or motor vehicle accidents. The patient stated that she was pain free prior to the above mentioned slip and fall. She reported that she has not returned to her work at this time due to her pain and she is unable to perform her job duties.

**Subjective**

This patient presents with the following problems:

**Headache**

**History of present illness/condition:**

The patient rated the intensity of their pain/symptoms as an 8 on a scale of zero to 10 with zero being complete absence of symptoms and 10 being very severe or unbearable. The mechanism of injury described by the patient involved a slip and fall injury. The symptoms have been present since the date of injury on 11/4/2016. The symptoms have been present 25% to 50% of the day. With associated blurred vision and balance problems. She also reported memory problems and reported that she will go into a room and completely forget what she is doing there. She stated that she is having difficulty sleeping due to her pains. The back of her head is sore and achy.

**Cervicalgia**

**History of present illness/condition:**

The patient rated the intensity of their pain/symptoms as a 7 on a scale of zero to 10 with zero being complete absence of symptoms and 10 being very severe or unbearable. The mechanism of injury described by the patient involved a slip and fall injury. The symptoms have been present since the date of injury on 11/4/2016. The symptoms have been present 100% of the day. The patient describes their pain with the following qualifiers: aching. Upon questioning, they related that the symptoms were aggravated by activities involving movement. With associated numbness and tingling down both arms to her fingers.

**Low back pain**

**History of present illness/condition:**

The patient rated the intensity of their pain/symptoms as a 7 on a scale of zero to 10 with zero being complete absence of symptoms and 10 being very severe or unbearable. The mechanism of injury described by the patient involved a slip and fall injury. The symptoms have been present since the date of injury on 11/4/2016. The symptoms have been present 100% of the day. The patient describes their pain with the following qualifiers: aching. The patient describes their symptoms as radiating bilaterally down the upper leg. Upon questioning, they related that the symptoms were aggravated by activities involving movement. With associated numbness and tingling down both thighs to just below her knees.

**Pain in left shoulder**

**History of present illness/condition:**

The patient rated the intensity of their pain/symptoms as a 6 on a scale of zero to 10 with zero being complete absence of symptoms and 10 being very severe or unbearable. The mechanism of injury described by the patient involved a slip and fall injury. The symptoms have been present since the date of injury on 11/4/2016. The symptoms have been present 100% of the day. The patient describes their pain with the following qualifiers: aching. Upon questioning, they related that the symptoms were aggravated by activities involving movement.

**Pain in left elbow**

**History of present illness/condition:**

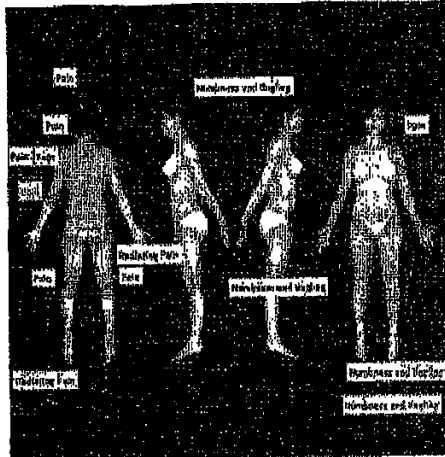
The patient rated the intensity of their pain/symptoms as an 8 on a scale of zero to 10 with zero being complete absence of symptoms and 10 being very severe or unbearable. The mechanism of injury described by the patient involved a slip and fall injury. The symptoms have been present since the date of injury on 11/4/2016. The symptoms have been present 100% of the day. The patient describes their pain with the following qualifiers: aching. Upon questioning, they related that the symptoms were aggravated by activities involving movement.

**Pain in thoracic spine**

**History of present illness/condition:**

EXHIBIT I  
WIT: Sekera  
DATE: 3-14-19  
REPORTER: B. CANO

The patient rated the intensity of their pain/symptoms as a 4 on a scale of zero to 10 with zero being complete absence of symptoms and 10 being very severe or unbearable. The mechanism of injury described by the patient involved a slip and fall injury. The symptoms have been present since the date of injury on 11/4/2016. The symptoms have been present 100% of the day. The patient describes their pain with the following qualifiers: aching. Upon questioning, they related that the symptoms were aggravated by activities involving movement.



## Objective

### Range of motion/joint fixations:

Passive/Active	Joint	Plane of Motion	Degrees	Level of Decrease	With Pain
Active	Cervical	Flex		Moderate	Yes
Active	Cervical	Ext		Moderate	Yes
Active	Cervical	LLF		Moderate	Yes
Active	Cervical	RLF		Mild-Moderate	Yes
Active	Cervical	LR		Mild-Moderate	Yes
Active	Cervical	RR		Mild	No
Active	Left Elbow	Flex		Mild-Moderate	Yes
Active	Left Elbow	Ext		Mild-Moderate	Yes
Active	Left Elbow	Pronation		Mild	Yes
Active	Left Elbow	Supination		Mild	Yes
Active	Left Shoulder	Flex		Moderate-Severe	Yes
Active	Left Shoulder	Ext		Moderate	Yes
Active	Left Shoulder	Abduction		Moderate-Severe	Yes
Active	Left Shoulder	Internal Rot		Normal	No
Active	Left Shoulder	External Rot		Moderate	Yes
Active	Left Shoulder	Adduction		Normal	No

### Palpation/Spasm/Tissue Changes

Region/Area	Anatomy	Finding	Severity	Progress
Cervical, Neck		spasm	moderate to severe	
Thoracic, Mid Back		spasm	moderate to severe	
Lumbar, Lower Back		spasm	moderate to severe	

### Examinations

Type of Exam	Exam/Test/Maneuver	Side	Outcome	Outcome Qualifier	Pain Descriptor	Body Area
Neurological	Muscle strength for C5	Left	graded 4 out of 5			

Comments:	Right S/S.				
Neurological	Muscle strength for C8	Left	graded 4 out of 5		
Comments:	Right S/S.				
Neurological	Muscle strength for C7	Left	graded 4 out of 5		
Comments:	Right S/S.				
Neurological	Muscle strength for C8	Left	graded 4 out of 5		
Comments:	Right S/S.				
Neurological	Muscle strength for L4	Bilateral	graded 5 out of 5		
Neurological	Muscle strength for L6	Bilateral	graded 5 out of 5		
Neurological	Muscle strength for S1	Bilateral	graded 5 out of 5		
Neurological	Muscle strength for T1	Left	graded 4 out of 5		
Comments:	Right S/S.				
Orthopedic	Apley's test	Left	Positive	moderate to severe	Posterior Shoulder Area
Orthopedic	Cervical maximum compression test		Positive	moderate to severe	Neck Area
Orthopedic	Distraction test		Positive	moderate to severe	Neck Area
Orthopedic	Hibb's test		Not performed		
Orthopedic	Kemp's test		Not performed		
Orthopedic	Nachlas test		Not performed		
Orthopedic	O'Donoghue maneuver	Bilateral	Positive	moderate to severe	Neck Area
Orthopedic	Shoulder depression test	Bilateral	Positive	extruding	Neck Area
Orthopedic	Soto-Hall sign		Negative	moderate to severe	
Comments:	(+) for local neck pain, (+) for local mid back pain.				
Orthopedic	Varus / Valgus Stress Test	Left	Negative	moderate	
Comments:	(+) for local elbow pain.				
Orthopedic	Neer's test (lumbar)		Not performed		
Comments:	Due to her wearing a shoulder brace and balance problems range of motion of the lumbar spine was deferred at this time. Orthopedic testing of the lumbar spine was deferred due to pain and spasm at this time.				

Chiropractic Evaluation: Hypomobility and restrictions of the cervical, thoracic, lumbar and sacroiliac regions were noted during an evaluation of the spine.

She was using a left shoulder brace / sling.

## Assessment

### Diagnoses

Number	ICD Code	Description
1	S16.1XXA	Strain of muscle, fascia and tendon at neck level, Init
2	S13.4XXA	Sprain of ligaments of cervical spine, initial encounter
3	M62.83	Muscle spasm
4	S23.3XXA	Sprain of ligaments of thoracic spine, initial encounter
5	M62.830	Muscle spasm of back
6	S29.012A	Strain of muscle and tendon of back wall of thorax, Init
7	S23.5XXA	Sprain of ligaments of lumbar spine, Initial

8	S39.012A	Strain of muscle, fascia and tendon of lower back, Init
9	G44.308	Post-traumatic headache, unspecified, not intractable
10	S06.0X1A	Concussion w LOC of 30 minutes or less, Init
11	S00.03XA	Contusion of scalp, initial encounter
12	F07.81	Postconcussional syndrome
13	H53.8	Other visual disturbances
14	G47.00	Insomnia, unspecified
15	S33.6XXA	Sprain of acromioclavicular joint, initial encounter
16	S43.402A	Unspecified sprain of left shoulder joint, initial encounter
17	M99.07	Segmental and somatic dysfunction of upper extremity
18	S46.012A	Strain of muscle/tendon of the rotator cuff of left shoulder, Init
19	R20.2	Paresthesia of skin
20	M54.16	Radiculopathy, lumbar region
21	S55.409A	Unspecified sprain of unspecified elbow, initial encounter
22	S66.918A	Strain of unsp muscle/fascia/tendon of forearm IV, unsp arm, Init
23	M99.01	Segmental and somatic dysfunction of cervical region
24	M99.02	Segmental and somatic dysfunction of thoracic region
26	M99.03	Segmental and somatic dysfunction of lumbar region
26	M99.04	Segmental and somatic dysfunction of sacral region
27	W01.198A	Fell same lev from slip/trip w strike agnst oth object, Init

**General Assessment:**

Causation: Based on my 11/9/16 physical examination of Ms. Sekera, my discussion with the patient regarding how the accident happened, patient medical history, and the mechanics of her body during the collision, it is my opinion, to a reasonable degree of medical probability, the bodily injury sustained by the patient, as recorded in this report, was caused by the slip and fall dated 11/4/16.

**Complicating Factors:** Age, Severity of Pain

Patient Statements: Felt immediate relief while still in office

Provider Statements: Tolerated treatment well

**Plan****Treatments**

CPT	Mod1	Mod2	Mod3	Mod4	Units	Duration	Description	DxLink...
99203	25				1		Detailed New Patient Exam	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22
98941	25				1		CMT 3-4 Areas	23, 24, 25, 26
97014					1		Electrocut Stimulation	1, 2, 3, 4, 5, 6, 7, 8
97010					1		Ice pack	1, 2, 3, 4, 5, 6, 7, 8
A4558					1		Electrodes	1, 2, 3, 4, 5, 6, 7, 8
99070					1		Home use ice pack	1, 2, 3, 4, 5,

99080				1	Initial report	6, 7, 8, 9 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22
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**Spine Levels Adjusted:**

Instrument adjustment of the cervical spine, thoracic spine, lumbar spine and sacroiliac joints regions.

The patient was given and instructed on the home use of the ice / heat packs today.

**Patient Care Plan**

Informed Consent Obtained:	Yes
Problem:	R51 - Headache, M54.2 - Cervicalgia, M54.5 - Low back pain, M25.512 - Pain in left shoulder, M25.522 - Pain in left elbow, M54.6 - Pain in thoracic spine
Plan Start Date:	11/8/2016
Frequency:	5 times a week, 3 times a week
Duration:	1 week, 3 weeks
Expectation for Recovery:	Guarded at this time
Services:	CMT, Myofascial Release, Electrical Stimulation, Rehabilitation exercises, Intersegmental traction, mechanical massage, chiropractic adjustments, and ice or heat packs
Re-examination Date:	12/8/2016
Home Care Recommendations:	Ice
Short Term Goals:	Reduce pain and restore normal joint function and muscle balance, improve cervical range of motion, improve lumbar range of motion, improve shoulder range of motion
Long Term Goals:	Return patient to pre-accident status
Referral:	Dr. Hyla for medical co-treatment of her injuries.

**Histories****Vital Signs**

Date Reported	Height	Weight	BMI	Pulse	Respiration	Blood Pressure	Temperature	Heart Rate	Pulse Oximetry	Active
11/8/2016	66	180	29	83		161/82				Yes

Signed by Jordan B. Webber D.C.







11/18/2016 10:10AM 7024688772

DR. JORDAN WEBBER

PAGE 01/07



ASSIGNMENT OF PROCEEDS AND/OR LIEN FOR MEDICAL SERVICES  
(“Doctor’s Lien”)

I. Patient and Attorney Information

Patient Name: Joyce Sekera Attorney Name: Keth Gallher  
Patient ID#: CSF1 98 8430 Address: 1839 E Sahara  
Date of Injury: 1/4/16 City: Las Vegas State: NV Zip: 89104  
Note: Phone: 702 735 0204 Fax: 702 735 0204

II. Certification, Authorization and Release in Accordance with HIPAA. Patient and attorney of record (“Attorney”) certify that the information provided herein is correct and complete. Patient understands that, in accordance with Health Information Privacy and Privacy Act of 1996 (“HIPAA”), patient’s medical information relating to this personal injury case may be shared to manage and expedite patient’s medical treatment. Patient authorizes Patient’s Physician, Attorney and any member of the Core Rehab Clinic (“the Clinic”) to review, release, and disclose such medical treatment information with companies and individuals as deemed necessary, and further agrees that examinations, diagnosis, medical treatment, files and reports can be shared with necessary parties involved in patient’s case. Attorney acknowledges that Attorney has obtained a Release of Medical Information from Patient for purposes of communications regarding Patient’s medical information and that the Clinic is governed by said Release.

III. Assignment and/or Lien for Medical Services. Patient and Attorney understand that the medical services, supplies and treatment Patient is receiving as a part of the ongoing personal injury claim may be billed as a Lien and may be authorized by applicable state law and practice. Patient hereby irrevocably authorizes and assigns Attorney, in any capacity to the Clinic, such sums as may be due and owing for the services rendered to Patient by means of the accident from which the claim arose, and by reason of any other bills that accrue in the Clinic, and to withhold such sums from any claim, settlement, judgment or verdict as may be awarded to a subsequently settled and their Patient’s account with the Clinic. By this assignment, Patient gives this “Lien” on Patient’s claim to the Clinic against any and all proceeds of any settlement, judgment or verdict which may be paid to Attorney, or Patient or to another individual on Patient’s behalf that results from the liability of Plaintiff in connection therewith, from which Patient has been treated. In the event another attorney is substituted in this matter, the new attorney shall honor this Lien as it relates to my own, and under of this Lien shall be Patient’s responsibility. This Lien may be signed in person and have the same force and effect as if signed and under in my presence. It is understood and agreed that a copy of this Lien shall have the same force and effect as the original. IV. Release. Inasmuch as this Lien is assigned pursuant to the above, the Clinic shall have the same force and effect as the original. Judgment for release relating to services rendered by the Clinic to the Patient.

V. Payment Responsibility. Patient understands that Patient remains personally responsible to the Clinic for all medical bills submitted for services rendered to Patient and that this assignment is made solely for the Clinic’s protection and in consideration of receiving payment. Patient further understands that such payment is not contingent on any claim, settlement, judgment or verdict by which Patient may eventually recover and that Patient will notify the Clinic of any payment received by Patient for medical services from an insurance company or other source. Payments will be forwarded to the Clinic as requested. Patient further understands and accepts the responsibility for payment of all accounts with the Clinic. Patient understands that the legal settlement may pay all past, present and future medical bills and that Patient is responsible for the complete payment of all accounts. Patient understands that Patient is financially responsible for any amount unpaid by this assignment of proceeds under this Lien, as may be authorized by applicable state law and practice. By signing this Assignment Patient fully understands all provisions set forth in this Assignment.

Patient/Attorney Signature: [Signature] Date: 11/8/16

The undersigned Attorney is responsible for this assignment and does hereby agree to observe all the terms of the above agreement in full and each term from any settlement, judgment or verdict, as may be necessary in order to adequately protect the Clinic. Attorney is expressly directed to withhold Attorney’s direct responsibility such sums from any payment, settlement, judgment, proceeds or other monies received on Patient’s behalf that may be required to adequately protect and pay the bills for services rendered to Patient by the Clinic. Attorney is further directed to pay from Attorney’s office trust account to the Clinic that amount which is due and owing to the Clinic for those medical services examinations, treatments and reports which the Clinic has rendered on Patient’s behalf. Attorney further agrees that in the event Patient assigns other counsel in cooperation with any action instituted by Patient on account of the injuries for which Patient was treated, Attorney shall, to the best of Attorney’s ability, inform such new counsel of this assignment under this.

Attorney’s Signature: [Signature] Date: 11/18/16

Core Rehab Cooperative, LLC  
10620 Southern Highlands Pkwy Ste. 110-300  
Las Vegas, NV 89141  
702-577-1982 Phone  
702-577-1986 Fax

EXHIBIT J  
WIT: Sekera  
DATE: 3-14-19  
REPORTER: B. CANO

PLF 237





Nevada Prescription Monitoring Program  
For assistance using this application, please contact:  
1-855-5NV-4PMP OR pmp@pharmacy.nv.gov.

Report Prepared: 07/10/2017 Patient Report Date Range: 07/10/2016 - 07/10/2017

JOYCE SEKERA

Linked Records				
Name	DOB	ID	Gender	Address
JOYCE SEKERA	03/22/1956	1	female	7840 NESTING PINE PL LAS VEGAS NV 89143

Report Criteria

First Name: JOYCE, Last Name: SEKERA, DOB: 03/22/1956, ZIP Code: , City: , State: , Phone: , SSN: , DL: ,

Summary

Prescriptions: 1	Pharmacies: 1	Private Pay: 0	Active Daily MME: 0.0
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Prescriptions

Date	ID	Written	Drug	Qty	Days	Prescriber	Pharmacy	Refill	MME/D	Point Type	PMP
11/09/2016	1	11/04/2016	HYDROCODON-ACETAMINOPHEN 5-325	15.0	5	RA TAY	WALGR (0055)	0	15.0	Worker's Comp	NV

\*Pharmacy is created using a combination of pharmacy name and the last four digits of the pharmacy license number.

Prescribers

Name	Address	City	State	Zip	Phone
TAYLOR, RACHAEL A	7842 W SAHARA AVE	LAS VEGAS	NV	89117	7023056339

Dispensers

EXHIBIT K  
WIT: Sekera  
DATE: 3-14-19  
REPORTER: B. CANO



05/18/2017 05:07PM 7024638772  
RECEIVED 12/05/2016 04:11PM 7024638772  
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DR. JORDAN WEBBER  
DR. JORDAN WEBBER  
+ 17024638772

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D2



Patient: Joyce P. Sekera  
Provider: Dr. Michelle Hyla, D.O.

DOB: 03/22/1956  
Visit: 11/21/2016 10:15AM

Sex: F  
Chart: SEJ0000002

**Chief Complaint:** Injuries from Slip and Fall

**CC & History of Present Illness:**

INITIAL EXAMINATION

**CHIEF COMPLAINT(S):**

1. headaches
  2. trouble sleeping
  3. anxiety
  4. cervical pain
  5. thoracic pain
  6. lumbar pain
  7. abdominal pain
  8. right shoulder pain
  9. left shoulder pain
  10. left shoulder joint pain
  11. right upper arm pain
  12. left upper arm pain
  13. left elbow pain
  14. left forearm pain
  15. right hip pain
  16. left hip pain
  17. left hip joint pain
  18. right thigh pain
  19. left thigh pain
  20. right knee pain
  21. left knee pain
  22. right knee joint pain
  23. left knee joint pain
  24. right lower leg pain
  25. left lower leg pain
  26. right calf pain
  27. left calf pain
- **Most Severe Area(s) of Pain:** lumbar pain, cervical pain, left shoulder pain

[Page 1]

E-signed by Dr. Michelle Hyla, D.O. on 11/21/2016 2:40PM

EXHIBIT	L
WIT:	Sekera
DATE:	3-14-19
REPORTER:	B. CANO

12/7/16  
JW

PLF 214

1393

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DR. JORDAN WEBBER  
DR. JORDAN WEBBER  
→ 17024639772

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D3



Patient: Joyce P. Sekera  
Provider: Dr. Michelle Hyla, D.O.

DOB: 09/22/1956  
Visit: 11/21/2016 10:15AM

Sex: F  
Chart: SEJO000002

**ACCIDENT INFORMATION:**

Date of Loss: 11/04/16

**ACCIDENT INFORMATION:**

- Seatbelt: No
- Collision Anticipated: No • Airbag Deployed: No
- Location: N/A
- Time of Accident: 1:00 pm
- Radiating Pain: Left Upper Extremity, Right Upper Extremity, Left Lower Extremity, Right Lower Extremity
- Type of Accident: Slip & Fall
- Contact: Other - Both feet went out from under her, slipped on liquid. Landed on marble floor, on left elbow and back; does not know if she hit head

**CONCUSSION SYMPTOMS: Present**

- Hit Head: Yes
- LOC: Yes
- Contusions: Bruises, Bumps
- Contusions Location: Left elbow

**PREVIOUS ACCIDENT TREATMENT:**

- Previous Evaluation: Hospital
- Primary Care Physician: None
- Date: 11/04/16
- X-Ray: Yes, Lumbar Spine, Elbow (Left), Thoracic Spine, Cervical Spine
- Facility: Centennial Hills
- MRI: No
- CT: No
- Date of First Chiropractic Visit: 11/08/16
- Chiropractor: Jordan Webber

**COMMENTS**

Has already been referred to Dr. Shah

**Med / Fam / Social History:**

[Page 2]

Re-signed by Dr. Michelle Hyla, D.O. on 11/21/2016 2:40PM

PLF 215

1394

05/18/2017 05:07PM 7024 772  
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DR. JORDAN WEBBER  
DR. JORDAN WEBBER  
→ 17024639772

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04



Patient: Joyce P. Sekera  
Provider: Dr. Michelle Hyla, D.O.

DOB: 03/22/1956  
Visit: 11/21/2016 10:16AM

Sex: F  
Chart: SEJ0000002

- Medical Problems: None
- Date of Last Period: In menopause
- Possibility of Current Pregnancy: No
- Hysterectomy: No
- Menopause: Yes
- Previous Injuries: None
- Family Medical Conditions Related to Present Injury: No
- Surgeries: None
- Work: Employed
- Occupation: Sales at Brand Vegas selling show tickets
- Marital Status: Single
- Substance History: Tobacco
- Receiving Disability: No
- Seeing Pain Management: No
- PMP: Yes
- REVIEW OF SYSTEM: Reviewed. Refer to chart for paperwork.

#### Review of Systems:

GENERAL: No fever, no loss of appetite, no night sweats, no unexplained weight loss, no unexplained weight gain, no fatigue.

CARDIOVASCULAR: No chest pain, no syncope/presyncope, no palpitations, no swollen ankles, no dyspnea on exertion.

RESPIRATORY: No dry cough, no productive cough, no wheezing, no shortness of breath.

GASTROINTESTINAL: No abdominal pain.

HEME / LYMPHATIC: No excessive bruising, no bleeding, no lymphadenopathy.

EYES: No blurred vision, no double vision, no eye pain, no eye irritation, no eye discharge, no decrease in visual acuity, no photophobia. Patient complains of blurred vision, denies double vision, denies eye pain, denies eye irritation, denies eye discharge, denies decrease in visual acuity.

EARS, NOSE & THROAT: Patient denies earache, complains of tinnitus, denies of rhinorrhea, denies

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PLF 216

1395



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D5



Patient: Joyce P. Sekera  
Provider: Dr. Michelle Hyla, D.O.

DOB: 03/22/1956  
Visit: 11/21/2016 10:15AM

Sex: F  
Chart: SEJC000002

dysphagia, denies epistaxis, does not use hearing aid.

**MUSCULOSKELETAL:** Patient complains of back pain, denies muscle weakness, denies arthritis, complains of muscle cramping, complains of joint pain, complains of muscle stiffness, complains of neck pain, denies sciatica, complains of myalgia.

**SKIN:** Patient complains of bruising, denies abrasions, denies open wounds, complains of bumps, denies sutures in-place, denies staples in-place

**NEUROLOGIC:** Patient complains of headache, denies limb weakness, complains of numbness, complains of tingling, denies seizures/convulsions, denies syncope, denies tremor

**PSYCHOLOGICAL:** Patient complains of occasional anxiety, denies depression denies suicidal ideations, denies emotional lability.

**Physical Exam:**

Height	Weight	BMI	Temp
66.00 inches	190.00 lbs	30.68	97.10

**CONCUSSION SYMPTOMS:**

- Seizures: No
- Nausea: Yes
- Vomiting: No
- Headache: Yes
- Dizziness: Yes
- Tinnitus: Yes
- Trouble Remembering: Yes
- Drowsiness: Yes
- Balance Problems: Yes
- Sleeping More Than Usual: No
- Sensitivity to Noise: Yes
- Sensitivity to Light: Yes
- Feeling Slowed Down: Yes
- Feeling as if "in a fog": Yes
- Difficulty Concentrating: Yes

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D 6



Patient: Joyce P. Sekera  
Provider: Dr. Michelle Hyla, D.O.

DOB: 03/22/1958  
Visit: 11/21/2016 10:15AM

Sex: F  
Chart: SEJO000002

- Difficulty Remembering: Yes
- Trouble Falling Asleep: Yes
- More Emotional than Usual: Yes
- Irritability: Yes
- Sadness: Yes
- Nervousness: Yes
- Trouble finding your words: Yes

APPEARANCE: In obvious pain.

HEENT: Ears no gross abnormalities. Eyes normal pupils, normal conjunctivae. Nares patent. Mouth/Throat no gross abnormalities.

CV/CHEST: Normal respiratory effort. No audible wheezing. Normal pulses. Grossly normal rhythm.

ABDOMEN: Pain to palpation.

SKIN: bruises, - Elbow (Left)

NEUROLOGICAL: CN II-XII grossly intact. PEERLA EOMI. Symmetric facial movement. DTR's grossly intact. Coordination grossly normal. No nystagmus.

PSYCHOLOGICAL: Appropriate affect. AAOx3.

Cervical Spine

- Cervical spine: Pain to palpation, Hypertonic
- Extension Norm: (70) Decreased
- Flexion Norm: (80) Decreased
- Lt Rot Norm: (80) Decreased
- Rt Rot Norm: (80) Decreased
- Lt Lat Norm: (45) Decreased
- Rt Lat Norm: (45) Decreased

Thoracolumbar Spine

- Thoracic Spine: Decreased
- Lumbar Spine: Decreased

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07



**Patient:** Joyce P. Sekera  
**Provider:** Dr. Michelle Hyla, D.O.

**DOB:** 03/22/1956  
**Visit:** 11/21/2016 10:15AM

**Sex:** F  
**Chart:** SEJ0000002

- Extension Norm: (90) Decreased
- Flexion Norm: (90) Decreased
- Lt Rot Norm: (60) Decreased
- Rt Rot Norm: (60) Decreased
- Lt Lat Norm: (45) Decreased
- Rt Lat Norm: (45) Decreased
- Lumbar spine: Hypertonic, Pain to palpation
- Posture: Asymmetric
- Gait: Abnormal

#### RIGHT UPPER EXTREMITIES

- Right Shoulder: Pain & Tenderness
- Right clavicle: Within Normal Limits
- Right arm: Pain & Tenderness
- Right elbow: Within Normal Limits
- Right forearm: Within Normal Limits
- Right wrist: Within Normal Limits
- Right hand: Within Normal Limits
- Right palm: Within Normal Limits
- Right fingers: Within Normal Limits
- Right thumb: Within Normal Limits

#### LEFT UPPER EXTREMITIES

- Left Shoulder: Decreased range of motion, Pain & Tenderness
- Left clavicle: Within Normal Limits
- Left arm: Pain & Tenderness
- Left elbow: Pain & Tenderness
- Left forearm: Pain & Tenderness
- Left wrist: Within Normal Limits
- Left hand: Within Normal Limits
- Left palm: Within Normal Limits
- Left fingers: Within Normal Limits
- Left thumb: Within Normal Limits

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PLF 219

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Q 8



Patient: Joyce P. Sekera  
 Provider: Dr. Michelle Hyla, D.O.

DOB: 03/22/1958  
 Visit: 11/21/2016 10:15AM

Sex: F  
 Chart: SEJ0000002

**RIGHT LOWER EXTREMITIES**

- Right hip: Pain & Tenderness
- Right thigh: Pain & Tenderness
- Right knee: Decreased range of motion, Pain & Tenderness
- Right leg: Pain & Tenderness
- Right calf: Pain & Tenderness
- Right ankle: Within Normal Limits
- Right foot: Within Normal Limits
- Right heel: Within Normal Limits
- Right toes: Within Normal Limits

**LEFT LOWER EXTREMITIES**

- Left hip: Decreased range of motion, Pain & Tenderness
- Left thigh: Pain & Tenderness
- Left knee: Decreased range of motion, Pain & Tenderness
- Left leg: Pain & Tenderness
- Left calf: Pain & Tenderness
- Left ankle: Within Normal Limits
- Left foot: Within Normal Limits
- Left heel: Within Normal Limits
- Left toes: Within Normal Limits

**Assessment:**

ICD-10-CM Condition	ICD-10-CM Code	Description
ICD-10-CM Condition	W01.0XXA	Fall on same level from slipping, tripping and stumbling without subsequent striking against object, Initial encounter
ICD-10-CM Condition	S13.4XXA	Sprain of ligaments of cervical spine, Initial encounter
ICD-10-CM Condition	S16.1XXA	Strain of muscle, fascia and tendon at neck level, Initial encounter
ICD-10-CM Condition	S23.3XXA	Sprain of ligaments of thoracic spine, Initial encounter
ICD-10-CM Condition	S23.012A	Strain of muscle and tendon of back wall of thorax, Initial encounter
ICD-10-CM Condition	S33.6XXA	Sprain of ligaments of lumbar spine, Initial encounter
ICD-10-CM Condition	S33.012A	Strain of muscle, fascia and tendon of lower back, Initial encounter
ICD-10-CM Condition	M79.521	Pain in right upper arm
ICD-10-CM Condition	M79.522	Pain in left upper arm
ICD-10-CM Condition	M25.522	Pain in left elbow
ICD-10-CM Condition	S63.402A	Unspecified sprain of left elbow, Initial encounter
ICD-10-CM Condition	M79.532	Pain in left forearm

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D9



**SOUTHERN NEVADA**  
 MEDICAL GROUP  
 Health-Optimized. People Flourish.

**Patient:** Joyce P. Sakera  
**Provider:** Dr. Michelle Hyla, D.O.

**DOB:** 03/22/1956  
**Visit:** 11/21/2016 10:15AM

**Sex:** F  
**Chart:** SEJ0000002

ICD-10-CM Condition	ICD-10-CM Code	Description
ICD-10-CM Condition	M25.551	Pain in right hip
ICD-10-CM Condition	M25.552	Pain in left hip
ICD-10-CM Condition	S76.012A	Strain of muscle, fascia and tendon of left hip, initial encounter
ICD-10-CM Condition	S76.011A	Strain of muscle, fascia and tendon of right hip, initial encounter
ICD-10-CM Condition	S78.102A	Unspecified sprain of left hip, initial encounter
ICD-10-CM Condition	M79.651	Pain in right thigh
ICD-10-CM Condition	M79.652	Pain in left thigh
ICD-10-CM Condition	S76.811A	Strain of other specified muscles, fascia and tendons at thigh level, right thigh, initial encounter
ICD-10-CM Condition	S76.812A	Strain of other specified muscles, fascia and tendons at thigh level, left thigh, initial encounter
ICD-10-CM Condition	M25.561	Pain in right knee
ICD-10-CM Condition	M25.562	Pain in left knee
ICD-10-CM Condition	S83.81XA	Sprain of unspecified site of right knee, initial encounter
ICD-10-CM Condition	S83.82XA	Sprain of unspecified site of left knee, initial encounter
ICD-10-CM Condition	S86.212A	Strain of muscle(s) and tendon(s) of anterior muscle group at lower leg level, left leg, initial encounter
ICD-10-CM Condition	S86.211A	Strain of muscle(s) and tendon(s) of anterior muscle group at lower leg level, right leg, initial encounter
ICD-10-CM Condition	S86.112A	Strain of other muscle(s) and tendon(s) of posterior muscle group at lower leg level, left leg, initial encounter
ICD-10-CM Condition	S86.111A	Strain of other muscle(s) and tendon(s) of posterior muscle group at lower leg level, right leg, initial encounter
ICD-10-CM Condition	M79.661	Pain in right lower leg
ICD-10-CM Condition	M79.662	Pain in left lower leg
ICD-10-CM Condition	S39.011A	Strain of muscle, fascia and tendon of abdomen, initial encounter
ICD-10-CM Condition	S08.0X1A	Concussion with loss of consciousness of 30 minutes or less, initial encounter
ICD-10-CM Condition	G44.309	Post-traumatic headache, unspecified, not intractable
ICD-10-CM Condition	F51.9	Sleep disorder not due to a substance or known physiological condition, unspecified
ICD-10-CM Condition	H93.19	Tinnitus, unspecified ear
ICD-10-CM Condition	R11.0	Nausea
ICD-10-CM Condition	R42	Dizziness and giddiness
ICD-10-CM Condition	R41.3	Other amnesia
ICD-10-CM Condition	H81.90	Unspecified disorder of vestibular function, unspecified ear
ICD-10-CM Condition	H93.249	Temporary auditory threshold shift, unspecified ear
ICD-10-CM Condition	H83.149	Visual discomfort, unspecified
ICD-10-CM Condition	R41.89	Other symptoms and signs involving cognitive functions and awareness
ICD-10-CM Condition	R41.840	Attention and concentration deficit
ICD-10-CM Condition	R45.4	Irritability and anger
ICD-10-CM Condition	R45.88	Other symptoms and signs involving emotional state
ICD-10-CM Condition	R46.2	Unhappiness
ICD-10-CM Condition	F43.0	Acute stress reaction

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PLF 221

1400

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D 10



Patient: Joyce P. Sekera  
Provider: Dr. Michelle Hyla, D.O.

DOB: 03/22/1958  
Visit: 11/21/2016 10:15AM

Sex: F  
Chart: SE10000002

ICD-10-CM Condition	ICD-10-CM Code	Description
ICD-10-CM Condition	G47.00	Insomnia, unspecified
ICD-10-CM Condition	R20.9	Unspecified disturbances of skin sensation
ICD-10-CM Condition	M25.511	Pain in right shoulder
ICD-10-CM Condition	M25.512	Pain in left shoulder
ICD-10-CM Condition	S45.912A	Strain of unspecified muscle, fascia and tendon at shoulder and upper arm level, left arm, initial encounter
ICD-10-CM Condition	S45.911A	Strain of unspecified muscle, fascia and tendon at shoulder and upper arm level, right arm, initial encounter
ICD-10-CM Condition	S43.402A	Unspecified sprain of left shoulder joint, initial encounter

#### Medications & Allergies:

Medication	Quantity	Frequency	Location
Norco 5 mg-325 mg oral tablet	0	No	outside office
Ibuprofen 600 mg oral tablet	0	No	outside office

No Known Drug Allergies (NKDA)	NA
--------------------------------	----

#### Plan:

- **Conservative Rehab:** Conservative rehabilitation for 8-12 weeks to include manipulation, passive and active therapy, along with orthopedic modalities.
- **Follow up:** Follow-up in 2-weeks or sooner if needed. May need Psychological counseling.
- **Massage:** May benefit from massage therapy.
- **Orthopedic Evaluation:** May need orthopedic evaluation if not responding to above.
- **Pain Management:** May need pain management consultation if pain not controlled as outlined above.
- **Imaging:** X-rays, MRI may be required pending progress.

#### Causation:

It is my opinion that Joyce P. Sekera's symptoms for which they are being seen today are directly related to the accident described by the patient. It is my opinion that the treatment rendered thus far are of reasonable and necessary frequency and duration. These opinions are stated to a reasonable medical probability. These opinions are based on the facts reported by the patient as well as the patient's history, physical examination, imaging studies, and medical records that are available to me today and reviewed thus far. My opinion could change with additional information provided to me in the future.

#### • Education:

The patient is instructed to increase physical activity as tolerated.

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E-signed by Dr. Michelle Hyla, D.O. on 11/21/2016 2:40PM

PLF 222

1401

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11


**Patient:** Joyce P. Sekera  
**Provider:** Dr. Michelle Hyla, D.O.

**DOB:** 03/22/1958  
**Visit:** 11/21/2016 10:15AM

**Sex:** F  
**Chart:** SEJ0000002

The risks of medications were explained to the patient.  
 The patient understands and agrees to use medications only as prescribed.  
 The patient agrees to obtain pain medications from this practice only.  
 We have fully discussed the potential risk/complications/side effects of the medication with the patient, which include but are not limited to constipation, drowsiness, addiction, impaired judgement, and risk of fatal overdose if not taken as prescribed.  
 We have warned the patient that sharing medications is a felony.  
 We have warned against driving while taking sedating medications.  
 We reminded that the medications should not be crushed, chewed, or broken prior to ingestion.  
 The patient understands that chronic use of pain medications can result in renal and/or hepatic dysfunction, development of tolerance/dependence, and hyperalgesia.  
 The patient should discuss with her primary care physician the fact that these medications are being used and may require regular exams and blood work to monitor for renal and/or hepatic dysfunction.  
 At this point in time, the patient is showing no signs of addiction, abuse, diversion, or suicidal ideations.

CPT	99204	1.00 UN	Office/outpatient visit, new
CPT	99204	1.00 UN	Office/outpatient visit, new
cyclobenzaprine 5 mg oral tablet			
		2 times a day as needed	No
10% Fluoropropen 1% Amitriptyline 6% Gabapentin 2% Lidocaine 2% Prilocaine			
		1 gram(s) transdermal 2 times a day x2 weeks	No

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Signed by Dr. Michelle Hyla, D.O. on 11/21/2016 2:40PM

PLF 223

1402





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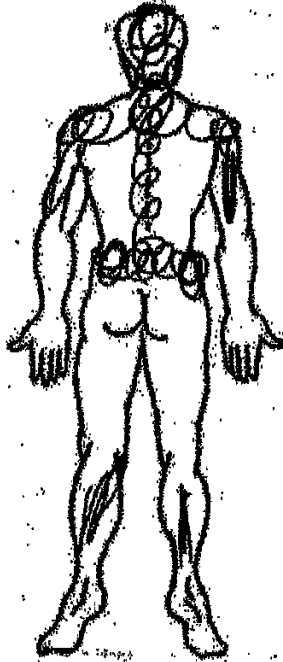
D 12



Patient: Joyce P. Sekera  
Provider: Dr. Michelle Hyla, D.O.

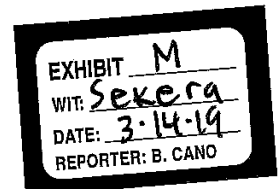
DOB: 03/22/1968  
Visit: 11/21/2018 10:15AM

Sex: F  
Chart: SEJ0000002



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D 13



Patient: Joyce P. Sekera  
Provider: Dr. Michelle Hyla, D.O.

DOB: 03/22/1956  
Visit: 11/21/2016 10:15AM

Sex: F  
Chart: SEJ0000002

PATIENT SIGNATURE

DATE

PHYSICIAN SIGNATURE

DATE

[Page 12]

E-signed by Dr. Michelle Hyla, D.O. on 11/21/2016 2:40PM

PLF 225

1405



# RADAR MEDICAL GROUP, LLP

University Urgent Care

Russell J. Shah, MD  
Neurology and Clinical Neurophysiology

Dipti R. Shah, MD  
Internal Medicine/Nephrology

## NEW PATIENT HEALTH QUESTIONNAIRE CUESTIONARIO DE SALUD DEL PACIENTE NUEVO

Name: SEKERA, JOYCE DOB: 03-22-1956 Today's Date: 12-01-2016  
Nombre: \_\_\_\_\_ Fecha de Nacimiento: \_\_\_\_\_ Fecha de Hoy: \_\_\_\_\_

Reason for initial visit: Headaches, back pain, shoulder  
Motivo de la Visita inicial: \_\_\_\_\_

Please indicate if you are: right handed or left handed  
Escribe usted con la: mano derecha o' mano izquierda

MEDICAL HISTORY: Please circle any medical problems you have (also indicate date of diagnosis):  
Historial Medica: Por favor circule cualquier problema médico que tenga (también indicar la fecha de diagnóstico):

High blood pressure <i>Presion arterial alta</i>	Emphysema <i>Enfisema</i>	Prostate problems <i>Problemas de próstata</i>	Stroke <i>Accidente cerebrovascular</i>
High cholesterol <i>Niveles de colesterol alto</i>	Seizures <i>Convulsiones</i>	Asthma <i>Asma</i>	Diabetes or high blood sugar <i>Diabetes</i>
Liver disease <i>Enfermedad del hígado</i>	Anemia <i>Anemia</i>	Thyroid problems <i>Problemas de la tiroides</i>	Migraine headaches <i>Migrañas</i>
Heart Attack <i>Ataque del corazón</i>	Kidney problems <i>Problemas del riñón</i>	Osteoporosis <i>Osteoporosis</i>	Eye problems <i>Problemas de los ojos</i>
Heart Failure <i>Insuficiencia cardiaca</i>	Stomach ulcers <i>Úlceras gástrica</i>	Depression <i>Depresión</i>	Allergies or sinus problems <i>Alergias o sinusitis</i>
Abnormal heart rhythm <i>Anormal del ritmo cardíaco</i>	Cancer (what type?) <i>Cancer (que tipo?)</i>		

Please list any other medical problems you are aware of (including date of diagnosis):  
Por favor escriba cualquier otro problema médico que está al tanto de (incluyendo la fecha de diagnóstico):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PREVIOUS ACCIDENTS: (Please list all accidents: indicate type and date)  
Accidentes anteriores (indicar tipo de accidente y fecha):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SURGICAL HISTORY: Please list all surgeries (indicate type of surgery and date):  
Antecedentes quirúrgicos: Por favor escriba todas las cirugías (indicar el tipo de cirugía y fecha):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

EXHIBIT N  
WIT: Sekera  
DATE: 3-14-19  
REPORTER: B. CANO

36739

RADAR 385



**RADAR MEDICAL GROUP, LLP dba University Urgent Care**

Russell J. Shah, MD  
Neurology and Clinical Neurophysiology

Dipti R. Shah, MD  
Internal Medicine/Nephrology

Mailing Address: 10624 S. Eastern Avenue, Ste. A-425 Henderson, Nevada 89052  
Office: 702 644-0500 Fax: 702 641-4600 or 702 258-0566

**Sign in Sheet**

Date: 5-2-17

Arrival Time: 9:20 AM

Are you a NEW patient? ☐ Yes ☒ No

Print Name: Joyce Sekern

D.O.B.: 3-22-56

Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

City, State and Zip Code: \_\_\_\_\_

Has your attorney changed? ☐ Yes ☐ No

If yes, who is your attorney?: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

EXHIBIT	<u>0</u>
WIT:	<u>Sekern</u>
DATE:	<u>3-14-19</u>
REPORTER:	B. CANO



# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GALLIHER LAW FIRM  
1850 E SAHARA AVE STE 107  
Las Vegas NV 89104

PI

PICA ☐

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input checked="" type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>SEKERA, JOYCE</b>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street) <b>7840 NESTING PINE PL</b>		7. INSURED'S ADDRESS (No., Street)	
CITY <b>LAS VEGAS</b>		CITY	
STATE <b>NV</b>		STATE	
ZIP CODE <b>89143-4469</b>		ZIP CODE	
TELEPHONE (Include Area Code) <b>(702) 4675457</b>		TELEPHONE (Include Area Code)	
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER <b>DOT110416</b>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>	
b. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
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.) <b>SIGNED SIGNATURE ON FILE</b>		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) <b>SIGNED SIGNATURE ON FILE</b>	
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY <b>11042016</b> QUAL <b>431</b>		15. OTHER DATE MM DD YY <b>11042016</b>	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. <b>0</b>		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>NO PURCH. SVC.</b>	
A. <b>FQ781</b> B. <b>LS161XXD</b> C. <b>M5011</b> D. <b>G43909</b>		22. RESUBMISSION CODE ORIGINAL REF. NO.	
E. <b>S39012D</b> F. <b>WQ10XXD</b> G. <b>L</b> H. <b>L</b>		23. PRIOR AUTHORIZATION NUMBER	
I. <b>L</b> J. <b>L</b>		F. <b>\$ CHARGES</b> G. <b>DAYS OR UNITS</b> H. <b>EPSDT FAMILY PLOD</b> I. <b>ID. QUAL</b> J. <b>RENDERING PROVIDER ID. #</b>	
24. A. DATES(S) OF SERVICE FROM MM DD YY TO MM DD YY B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER		F. <b>350.00</b> G. <b>1</b> H. <b>NPI</b> I. <b>1346324092</b>	
FOLLOW UP EVALUATION 04112017 04112017 1 99213 ABCD			
25. FEDERAL TAX I.D. NUMBER SSN EIN <b>260209037</b> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. <b>36739</b>	
27. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <b>MD RUSSELL J SHAH</b> 04182017		28. TOTAL CHARGE \$ <b>350.00</b> 29. AMOUNT PAID \$ <b>0.00</b>	
31. SERVICE FACILITY LOCATION INFORMATION <b>CHARLESTON OFFICE</b> <b>2628 W CHARLESTON BLVD</b> <b>Las Vegas NV 89102</b> <b>*1881888956</b>		30. Rsvd for NUCC Use	
32. BILLING PROVIDER INFO & PH # <b>702 6440500</b>		33. BILLING PROVIDER INFO & PH # <b>702 6440500</b>	
34. BILLING PROVIDER INFO & PH # <b>1881888956</b>		35. BILLING PROVIDER INFO & PH # <b>1881888956</b>	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-838-1197 form 1500 (02-12)

RADAR 059

1410

<b>RUSSELL J. SHAH , MD</b>				<b>DATE:</b> 04-11-2017	
<b>ACCT#</b> 36739		<b>DATE OF BIRTH #</b> 03-22-1956		<b>S.S.#</b>	
<b>LAST NAME</b> SEKERA			<b>FIRST NAME</b> JOYCE		
<b>INSURANCE COMPANY NAME</b> GALLIHER LAW FIRM			<b>REFERRING DOCTOR</b> WEBBER		
<b>OFFICE VISITS</b>				<b>EMG</b>	
<b>NEW PATIENT (NON CONSULTATIVE)</b>				95860 SINGLE EXTREMITY EMG	
99203 DETAILED H & P				95861 TWO EXTREMITY EMG	
99204 COMPREHENSIVE H & P				95863 THREE EXTREMITY EMG	
99205 MORE COMPREHENSIVE H & P				95864 FOUR EXTREMITY EMG	
<b>ESTABLISHED PATIENT</b>				95886 MUSC TEST DONE W/N TEST COMP X	
99212 PROBLEM FOCUSED				<b>NCV</b>	
X 99213 EXPANDED				95900 MOTOR NCV X	
99214 DETAILED				95904 SENSORY NCV X	
99215 DETAILED				95903 MOTOR NERVE W/F WAVE X	
<b>OFFICE CONSULTATIONS</b>				95907 NRV CNDJ TST 1-2 STUDIES	
99243 DETAILED H & P				95908 NRV CNDJ TST 3-4 STUDIES	
99244 COMPREHENSIVE H & P				95909 NRV CNDJ TST 5-6 STUDIES	
99245 MORE COMP H & P				95910 NRV CNDJ TST 7-8 STUDIES	
<b>MISCELLANEOUS</b>				95911 NRV CNDJ TST 9-10 STUDIES	
99080 X 99354 X				95912 NRV CNDJ TST 11-12 STUDIES	
99358 X 99355 X				95913 NRV CNDJ TST 13+ STUDIES	
99373 X				95934 H FLEX X	
MODIFIER .93 FOR INTERPRETATION				95937 REPETITIVE NERVE STIMULATION X	
<b>OFFICE PROCEDURES</b>					
95816 STANDARD EEG				95925 SSEP UE X	
95819 SLEEP EEG				95926 SSEP LE X	
95957 DIGITAL SPIKE ANALYSIS				96116 NEUROBEHAVIORAL	
93042 SINGLE LEAD EKG				93386 TCD COMPLETE INTRACRANIAL	
92585 BAER				93888 TCD LIMITED INTRACRANIAL	
				93892 TCD EMBOLI	
<b>NEUROLOGY DIAGNOSIS</b>				<b>ICD-10</b>	
ANXIETY				F41.1	
BRAIN INJURY W/LOC -30MINS INTERACRANIAL INJURY				S06.891	
BRAIN INJURY NO LOC INTERACRANIAL INJURY				S06.890	
BACK PAIN - SPINE				M54.9	
CARPAL TUNNEL SYNDROME				G56.00	
CEREBROVASCULAR ISCHEMIC DISORDER				I63.50	
CERVICAL RADICULOPATHY				M50.11	
CERVICAL / CERVICOTHORACIC STRAIN				S161XX	
COGNITIVE IMPAIRMENT				G31.84	
CONCUSSION W/LOC				S06.0X1	
CONCUSSION NO LOC				S06.0X0	
DIZZINESS / VERTIGO				R42	
EPILEPSY				G40.909	
GAIT DISTURBANCE				R26.9	
HEADACHES				R51	
HEAD INJURY / TRAUMA NO LOC				S09.90X	
HEAD INJURY /TRAUMA WITH LOC				S09.91X	
INSOMNIA				G47.00	
LOW BACK PAIN				M54.5	
LUMBAR RADICULOPATHY				M54.16	
LUMBAR STRAIN				S39.012	
				MEMORY LOSS R41.3	
				MOOD SWINGS F31.8	
				MIGRAINES G43.909	
				MUSCLE SPASMS M62.838	
				NEUROPATHY G62.9	
				NUMBNESS / PARESTHESIAS R20.0 R20.2	
				OCCIPITAL NEURALGIA M54.81	
				PAIN CERVICAL / NECK M54.2	
				PAIN LIMB UNSPECIFIED M79.609	
				POST TRAUMATIC BRAIN SYNDROME F07.81	
				POST CONCUSSIONAL SYNDROME F07.81	
				SLEEP DISTURBANCE IMPAIRMENT G47.9	
				STROKE I63.9	
				SYNCOPE R55	
				RESTLESSNESS R45.1	
				SENSORY PROBLEMS LIMBS R20.2	
				SHOULDER STRAIN S46.911 S46.912	
				THORACIC STRAIN S29.012	
				TREMOR ESSENTIAL G25.0	
				WEAKNESS, LIMB R53.1	
				WEAKNESS, GENERALIZED M62.81	

PHYSICIAN SIGNATURE: \_\_\_\_\_

RUSSELL J. SHAH MD

EDWIN FAVIS APRN



**Name:** SEKERA, JOYCE  
**DOE:** 04-11-2017

## **RADAR MEDICAL GROUP, LLP**

Mailing address: 10624 South Eastern Avenue, Suite A-425, Henderson, NV 89052  
Phone (702) 644-0500 Fax (702) 641-4600

**MD**

/Neurophysiology

**Russell J. Shah**

Neurology

### **NEUROLOGY Follow Up**

JORDAN WEBBER D.C.  
2425 N Lamb Blvd  
Ste #100  
Las Vegas, NV 89115

**PATIENT NAME:** SEKERA, JOYCE  
**DOB:** 03-22-1956  
**Gender:** F  
**Date of Injury:** 11-04-2016  
**Date of Evaluation:** 04-11-2017

Dear Dr. JORDAN WEBBER:

JOYCE SEKERA was seen on 04-11-2017 for a neurologic follow up evaluation.

#### **HISTORY OF INJURY**

Date of Injury: 11-04-2016

#### **MEDICATIONS/ MEDICATION ALLERGY**

Medications:

Page: 1

RADAR 061

**1412**

**Name:** SEKERA, JOYCE  
**DOE:** 04-11-2017

NAME	DOSAGE	SIG	DISCONTINUE DATE
ZPAK		AS DIRECTED	

#### REVIEW OF SYSTEMS

**Constitutional** Normal appetite, normal steady weight, no malaise, no generalized weakness, no diaphoresis, no unexplained weight loss

**ENMT** Negative unless documented in the HPI and/or Present complaints. No sore throat, no painful swallowing, no change of speech, (-) slurred speech, no tongue numbness, no perioral numbness

**Cardiac:** Negative unless documented in the HPI and/or Present complaints. No palpitations, no chest pain, no shortness of breath during activities is present. No syncope

**Respiratory:** Negative unless documented in the HPI and/or Present complaints. No asthma, no bronchitis, no fever, no chills, no coughing and no shortness of breath is present.

**GI:** Negative unless documented in the HPI and/or Present complaints. (+) nausea, no vomiting, no diarrhea and no constipation is present. No blood in the stool

**GU:** Negative unless documented in the HPI and/or Present complaints. No bowel urgency, (+) bladder urgency, no bowel incontinence, no bladder incontinence, no painful urination, and no blood in the urine

**Visual:** Negative unless documented in the HPI and/or Present complaints. (-) double vision, (+) blurred vision and (+) eye pain is present.

**Neurologic:** Negative unless documented in the HPI and/or Present complaints. (+) headache, (+) neck pain, (+) mid back pain, (+) low back pain, (+) weakness in the arms, (+) weakness in the hands, (+) weakness in the legs, (+) weakness on walking, (+) numbness or tingling in the arms, (+) numbness or tingling in the legs.

**Psychiatric:** Negative unless documented in the HPI and/or Present complaints. (+) depression, (+) anxiety, (+) restlessness, no sleep onset difficulties, no active or recent suicidal ideation, thought, attempt or plan.

#### RECORD REVIEW

chart

#### PRESENT COMPLAINT

Page: 2

RADAR 062

1413

**Name:** SEKERA, JOYCE  
**DOE:** 04-11-2017

She is better and not crying and much less emotional

She is better in her memory and less forgetful and notes improvement and stopped all medications due to pain shots

She is with less neck pain and the numbness in the hands is much better

She had injections 2-3 weeks ago and then subsequently had a cough and cold illness which she is recovering from and has delayed her pain shot treatment with Dr. Kidwell's group

She is with low back pain

She has stiffness and ache in the shoulder blades

She is not working now and was in sales.

She is unable to work due to the injury

She is on zpack antibiotics completion today and inhaler

She is off medication as she just had injections and was ill

She has stiffness and achiness in the legs

She had an mri of the cervical and lumbar at LV Radiology at Durango

She has noted less hand numbness

#### EXAMINATION

##### Vital Signs:

TEMP	PULSE	RESP	HT	WT	BMI	BP SYST	BP DIAST	COMMENT
98	61	16	66	207	33	148	76	AG

##### General:

The patient is awake, alert appropriate and non-toxic appearing

The patient appears to be in mild distress.

The patient has a clear sensorium.

The patient is a fair historian

No pausing during conversation, fair eye contact, fair vocal prosody, no psychomotor retardation, masked face or decrease eye contact. Attentive throughout

Name: SEKERA, JOYCE  
DOE: 04-11-2017

**Musculoskeletal:**

There is mild lumbar paraspinal muscle tenderness.  
There is no lumbar sacral spinous processes tenderness.  
There is tightness and/or spasm of the lumbar paraspinal muscles  
There is no florid muscle spasm of the lumbar paraspinal muscles

**Lumbar range:** Lumbar range of motion was limited on extension, No SLR, no Tinel's at the fibular head or tarsal tunnel

Obesity

**Cranial Nerves:** EOMI  
No nystagmus.  
Anicteric  
Hearing was intact.  
The smile is symmetric.

**Motor :**

**Lower:**

Normal power of 5  
Able to heel and toe stance  
Reflexes 2

**Coordination:** Unremarkable

**Gait:** Nonwide based gait which is symmetric.

Romberg was performed and demonstrated with no sway.

**IMPRESSION from 11/4/2016 Trauma**

1. Post traumatic brain syndrome

- will reinstitute aricept after the illness recovers

2. Cervical strain/headaches

- f/u pain management - hold any procedures till she recovers from the recent illness. She was told that injections/procedures and/or steroids may lower her immune system and will notify pain management

Page: 4

RADAR 064

1415

Name: SEKERA, JOYCE  
DOE: 04-11-2017

3. Migraines secondary to #1/2
4. Secondary insomnia due to #1,2, and #5
5. Lumbar strain with leg pain/ache
  - neurodiagnostic lowers
6. Carpal tunnel syndrome
  - wrist splint to continue

Sincerely,



Russell J. Shah, MD

Page: 5

RADAR 065

1416

## In House Scheduling and Information Request

Date 04-11-2017 Patient Name SEKERA, JOYCE DOB: 03-22-1956

Diagnosis/symptoms/indication: \_\_\_\_\_

☒ Follow up    1 day    2 days    3 days    1 wk    2 wk    3 wk  
                          1 month    2 mo    ☒ 3 mo    4 mo    6 mo    12 mo  
 \_\_\_ ReEvaluation    \_\_\_ 1wk    \_\_\_ 2wk    \_\_\_ 1mo    \_\_\_ 2mo    \_\_\_ 3mo    \_\_\_ 6mo    \_\_\_ 12mo

☒ EMG/NCV    \_\_\_ upper    ☒ lower    \_\_\_ upper+lower    \_\_\_ with follow up same day  
 \_\_\_ EMG    \_\_\_ upper    \_\_\_ lower    \_\_\_ upper+lower    \_\_\_ with follow up same day  
 \_\_\_ NCV    \_\_\_ upper    \_\_\_ lower    \_\_\_ upper+lower    \_\_\_ with follow up 30 minutes

\_\_\_ NCV    4/11/2017 11:23:16 AM  
 \_\_\_ NCV    LV office  
 \_\_\_ NCV    Pt: SEKERA, JOYCE  
 \_\_\_ SSEP    DOB: 3/22/1956  
 \_\_\_ EEG Awake    F/U APPT JULY 10 @1PM, EMG SCH FOR  
 \_\_\_ Ambulatory EEG    5/2/17 @10AM.....CM

Cranial

protocol

\_\_\_ BAER  
 \_\_\_ VER  
 \_\_\_ TCD    \_\_\_ TCD 30 minute emboli detection    \_\_\_ TCD emboli bubble study(with MD)

\_\_\_ Carotid ultrasound

\_\_\_ Carotid duplex

\_\_\_ 2 D Echo

\_\_\_ 2 D Echo with bubble study

\_\_\_ 12 lead EKG

\_\_\_ Cardiac stress test Evaluation

\_\_\_ Vascular ultrasound : \_\_\_\_\_

\_\_\_ ABI – ankle brachial index

\_\_\_ X-rays: \_\_\_\_\_

\_\_\_ Request Information of \_\_\_\_\_

\_\_\_ Obtain \_\_\_ MRI report, \_\_\_ MRI films, \_\_\_ CT's, \_\_\_ ER/hospital records, \_\_\_ notes of refer source  
 Location: \_\_\_\_\_

\_\_\_ Obtain \_\_\_\_\_

\_\_\_ Notify \_\_\_\_\_

\_\_\_ Send all treating doctor(s) \_\_\_ MRI's, \_\_\_ consults/f/u, \_\_\_ recent f/u, \_\_\_ test results, \_\_\_ labs

\_\_\_ No Show Appt-contact patient to reschedule and send letter to patient for them to reschedule

\_\_\_ D/c to Primary treating physician for further care

\_\_\_ D/c to Primary care physician for further care

\_\_\_ D/c from clinic (patient informed)

\_\_\_ Contact WC insurance adjustor/notify of current status/authorizations

\_\_\_ Resubmit authorizations already pending/denied/awaiting in the past for procedures requested

(702)467-5457

**RADAR MEDICAL GROUP LLP****Russell J. Shah MD****Neurology and Clinical Neurophysiology**

Mailing Address: 10624 South Eastern Avenue, Suite A-425, Henderson, NV 89052

Phone: (702) 644-0500 Fax: (702) 641-4600

**PRESCRIPTION – In house Medication Dispensing**Date 04-11-2017Patient Name SEKERA, JOYCE DOB: 03-22-1956Phone # (702)467-5457 Secondary Phone #: \_\_\_\_\_Primary Insurance and/or Payor: GALLIHER LAW FIRM

Diagnosis/symptoms/indication: \_\_\_\_\_

Medication Dispense (In house only dispense at only time of check-out per policy)

<input type="checkbox"/> Gabapentin 300 mg # 30	<input type="checkbox"/> Gabapentin 300 mg # 90	
<input type="checkbox"/> Amitryptline 10 mg # 30	<input type="checkbox"/> Amitryptline 25 mg # 30	
<input type="checkbox"/> Flexeril 10 mg # 30	<input type="checkbox"/> Flexeril 10 mg # 90	
<input type="checkbox"/> Soma 350 mg # 30	<input type="checkbox"/> Soma 350 mg # 60	
<input type="checkbox"/> Norco # 30	<input type="checkbox"/> Norco # 60	
<input type="checkbox"/> Hydrocodone 5/325 # 30	<input type="checkbox"/> Hydrocodone 5/325 # 60	
<input type="checkbox"/> Hydrocodone 7.5/325 # 30	<input type="checkbox"/> Hydrocodone 7.5/325 # 60	
<input type="checkbox"/> Lyrica 50 mg # 30	<input type="checkbox"/> Lyrica 50 mg # 90	
<input type="checkbox"/> Prilosec 20 mg # 30	<input type="checkbox"/> Prilosec 20 mg # 60	
<input type="checkbox"/> Paxil 10 mg # 30	<input type="checkbox"/> Paxil 20 mg # 30	<input type="checkbox"/> Paxil 40 mg #30
<input type="checkbox"/> Cymbalta 20 mg # 30		
<input type="checkbox"/> Depakote 250 mg # 30	<input type="checkbox"/> Depakote 250 mg # 60	
<input type="checkbox"/> Topiramate 25 mg # 25	<input type="checkbox"/> Topiramate 25 mg # 60	
<input type="checkbox"/> Fiorcet # 30	<input type="checkbox"/> Fiorcet # 60	
<input type="checkbox"/> Prevacid 20 mg # 30		

Other: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

# RADAR MEDICAL GROUP LLP

36739

**Russell J. Shah MD****Neurology and Clinical Neurophysiology**

Mailing Address: 10624 South Eastern Avenue, Suite A-425, Henderson, NV 89052

Phone: (702) 644-0500 Fax: (702) 641-4600

## PRESCRIPTION

Date 04-11-2017Patient Name SEKERA, JOYCE DOB: 03-22-1956Phone # (702)467-5457 Secondary Phone #: \_\_\_\_\_Primary Insurance and/or Payor: GALLIHER LAW FIRM

Diagnosis/symptoms/indication: \_\_\_\_\_

☐ Carotid U/S, ☐ Echo-2D, ☐ Transesophageal Echo, ☐ Echo w/ bubble study, ☐ EKG☐ CT Scan of \_\_\_\_\_ without contrast☐ MRI of \_\_\_\_\_ without contrast☐ MRI brain 3 tesla with SWI and DTI \_\_\_\_\_☐ MRA of \_\_\_\_\_ with / without contrast ☐ MRV of Brain☐ Upright MRI flexion/extension/lateral bending ☐ cervical ☐ lumbar☐ SPECT brain ☐ PET brain ☐ Fluoroscopic guided Lumbar Puncture ☐ Sleep Study☐ Digital x-ray: \_\_\_\_\_☐ Other: \_\_\_\_\_☐ LABS: ☐ CBC ☐ CMP ☐ TSH ☐ T4 ☐ HgbA1C ☐ RPR ☐ ESR☐ ANA ☐ Serum heavy metals ☐ Urine heavy metals 24 hr ☐ ACE☐ Fasting lipid profile ☐ Cholesterol profile ☐ AM cortisol level☐ Other: \_\_\_\_\_☐ Physical therapy evaluation ☐ with treatment 3 x week for 4 weeks☐ Occupational therapy evaluation ☐ with treatment 3 x week for 4 weeks☐ Balance therapy evaluation☐ Consult Internal Medicine for medication management☐ Consult ☐ Pain management ☐ Spine Orthopedic surgeon ☐ Orthopedic☐ Neurosurgery ☐ Neuropsychology ☐ Psychiatry☐ Primary care ☐ Cardiology ☐ Endocrinology☐ Ophthalmology ☐ Urology ☐ Podiatry☐ Consult \_\_\_\_\_☐ F/u ☐ 1 week ☐ 4 weeks ☐ 12 weeks☐ Re-eval ☐ 1 week ☐ 4 weeks ☐ 12 weeks ☐ 6 months ☐ 1 yr

Physician Signature: \_\_\_\_\_

\*Please fax all results to (702) 641-4600 \*For abnormal results, please call Dr. Russell J. Shah at (702) 644-0500

RADAR 049





Dec. 2, 2016 9:21AM

No. 0039 P. 1

**RADAR MEDICAL GROUP, LLP dba University Urgent Care****Russell J. Shah, MD****Dipti R. Shah, MD****Neurology and Clinical Neurophysiology****Internal Medicine/Nephrology**

Mailing address: 10624 S. Eastern Avenue, Ste. A-425, Henderson Nevada 89052

Office: (702) 644-0500 Fax: (702) 258-0566 or (702) 641-4600

**ATTORNEY LIEN****ATTORNEY: GALLIHER LAW FIRM****RADAR MEDICAL GROUP, LLP**

1850 E. SAHARA AVE, STE 107

Dba University Urgent Care

LAS VEGAS, NV 89104

Russell J. Shah, MD

T:702-735-0049 F:702-735-0204

Dipti R. Shah, MD

**RE: MEDICAL RECORDS AND DOCTOR'S LIEN****PATIENT NAME: SEKERA, JOYCE**DOI: 11-4-16  
(DATE OF INJURY)

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bill that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney or myself as the result of injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and full responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Date

12-1-16

Patient signature

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above named.

Date

12-2-16

Attorney signature

Dear Attorney; Please date, sign and return one copy to our office upon receipt

36739

EXHIBIT P  
WIT: Sekera  
DATE: 3-14-19  
REPORTER: B. CANO

RADAR 149

1421



## PAIN CHART

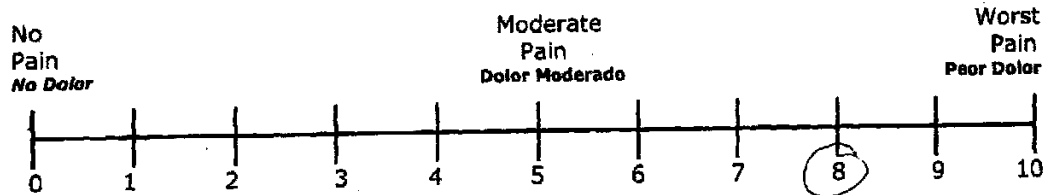
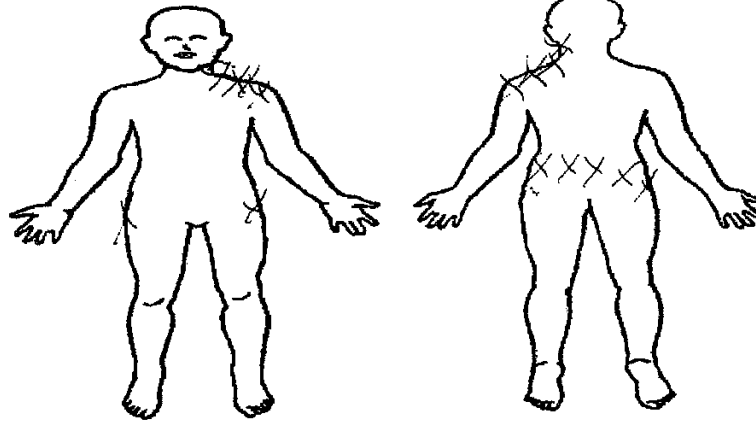
Name: SEKERA, JOYCE DOB: 03-22-1956 DOS: 12-01-2016

Where is your pain?  
*Donde esta su dolor?*

Please mark on the drawings below the areas where you feel your pain.  
*Porfavor marque las partes del cuerpo donde siente dolor.*

FRONT/FRENTE

BACK/ATRAS



Is your pain: **BETTER** **SAME** **WORSE** from your last visit.  
*Su dolor esta: MEJOR IGUAL PEOR de su ultima visita.*

(Please circle one)  
(Porfavor circule uno)

Patient Signature/firma de paciente

Reviewed by Physician/Revisado por doctor

EXHIBIT	<u>Q</u>
WIT:	<u>Sekera</u>
DATE:	<u>3-14-19</u>
REPORTER:	<u>B. CANO</u>

36739

Name: **SEKERA, JOYCE**

DOB: **03-22-1956**

DOS: **12-01-2016**

**Numbness**  
(Adormecimiento)

-----  
-----  
-----

**Pins & Needles**  
(Piquetes)

○ ○ ○ ○ ○ ○ ○  
○ ○ ○ ○ ○ ○ ○  
○ ○ ○ ○ ○ ○ ○

**Burning**  
(Ardor)

△ △ △ △ △ △  
△ △ △ △ △ △  
△ △ △ △ △ △

**Aching**  
(Adolorido)

X X X X X X  
X X X X X X  
X X X X X X

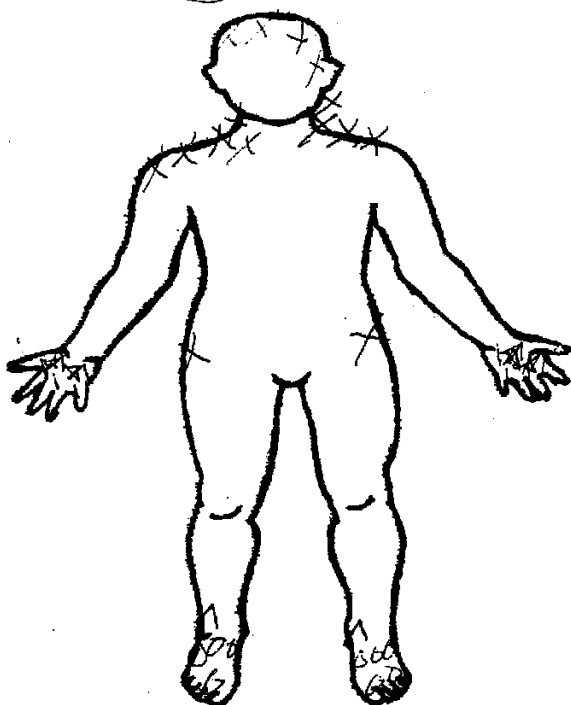
**Stabbing**  
(Punzadas)

⊗ ⊗ ⊗ ⊗ ⊗ ⊗  
⊗ ⊗ ⊗ ⊗ ⊗ ⊗  
⊗ ⊗ ⊗ ⊗ ⊗ ⊗

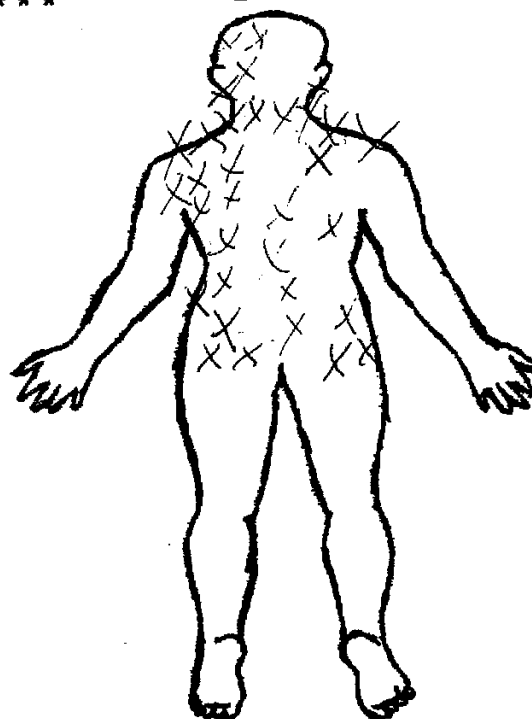
**Tinging**  
(Hormigueo)

\* \* \* \* \*  
\* \* \* \* \*  
\* \* \* \* \*

**FRONT/ FRENTE**



**BACK/ ATRAS**



\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Reviewed by Physician

**36739**

RADAR 386

**1424**



**Patient:** Joyce P. Sekera**DOB:** 03/22/1956**Sex:** F**Provider:** Dr. Michelle Hyla, D.O.**Visit:** 12/05/2016 10:15AM**Chart:** SEJO000002**Chief Complaint:** Injuries from Slip and Fall**Re-Examination:**

Patient is being re-evaluated today in relation to injuries sustained in a(n) motor vehicle accident. The patient is currently undergoing chiropractic and physical therapy for treatment of the injuries related to the accident.

**COMMENTS:** Saw Dr. Shah has ordered MRI which is scheduled for 12/07/16, left shoulder improved still, with some weakness to it, left elbow is better, left hip has improved walking much better, knees are still the same, no weakness or locking or popping

- **Outside Provider Records Reviewed:** Yes
- **Changes to Med/Fam/Soc Hx:** No

**SUBJECTIVE**

Overall improved

**Radiating Pain:** Left Lower Extremity, Right Lower Extremity, Left Upper Extremity, Right Upper Extremity

**New complaints:** None

**Worst Area of Pain:** cervical pain, lumbar pain, left shoulder pain, headaches

**Highest Pain Scale in 72-Hour Period:** 9/10

**Activities that Aggravate Pain:** Sitting, Standing, Laying Down, Walking, Bending, Repetitive Movements

**REVIEW OF SYSTEMS:**

**MUSCULOSKELETAL:** Patient complains of back pain, denies muscle weakness, denies arthritis, complains of muscle cramping, complains of joint pain, complains of muscle stiffness, complains of neck pain, denies sciatica, complains of myalgia.

**NEUROLOGIC:** Patient complains of headache, denies limb weakness, complains of numbness, complains of tingling, denies seizures/convulsions, denies syncope, denies tremor

**PSYCHOLOGICAL:** Patient complains of occasional anxiety, denies depression denies suicidal ideations, denies emotional lability.

**PLAN**

- **Specialists:** F/U - Neurology • **Other:** Dr. Shah has ordered MRI and EEG
- **X-rays:** Reviewed, Cervical Spine, Thoracic Spine, Lumbar Spine, Elbow (Left), Hip (Left)

[Page 1]

E-signed by Dr. Michelle Hyla, D.O. on 12/05/2016 1:34PM

EXHIBIT	R
WIT:	Sekera
DATE:	3-14-19
REPORTER:	B. CANO

SOUTHERN 014

1426

**Patient:** Joyce P. Sekera**DOB:** 03/22/1956**Sex:** F**Provider:** Dr. Michelle Hyla, D.O.**Visit:** 12/05/2016 10:15AM**Chart:** SEJO000002

- **MRI:** Pending
- **CT:** None

**Medication Refill:** No**Medication Side Effects:** None**PMP:** Reviewed

The patient is advised to continue therapy 3 times per week, and follow up with me in 2 weeks.

Patient is advised to return to all current care providers for continued therapy and assessment. Patient has been advised of the importance of continued therapy for maximum recovery. Patient will be re-evaluated again in two to three weeks. Patient has been counseled on the importance of exercise and good sleep hygiene.

**Physical Exam:**

Pain
6/10

**CONCUSSION SYMPTOMS:**

- **Nausea:** Yes - Unchanged
- **Headache:** Yes - Aggravated
- **Dizziness:** Yes - Aggravated
- **Tinnitus:** Yes - Resolved
- **Trouble Remembering:** Yes - Aggravated
- **Drowsiness:** Yes - Aggravated
- **Balance Problems:** Yes - Unchanged, Aggravated
- **Sensitivity to Noise:** Yes - Unchanged
- **Sensitivity to Light:** Yes - Unchanged
- **Feeling Slowed Down:** Yes - Aggravated
- **Feeling as if "in a fog":** Yes - Aggravated
- **Difficulty Concentrating:** Yes - Aggravated
- **Difficulty Remembering:** Yes - Aggravated
- **Trouble Falling Asleep:** Yes - Aggravated
- **More Emotional than Usual:** Yes - Aggravated
- **Irritability:** Yes - Aggravated
- **Sadness:** Yes - Aggravated





**Patient:** Joyce P. Sekera

**DOB:** 03/22/1956

**Sex:** F

**Provider:** Dr. Michelle Hyla, D.O.

**Visit:** 12/05/2016 10:16AM

**Chart:** SEJO000002

- **Nervousness:** Yes - Aggravated
- **Trouble finding your words:** Yes - Aggravated

**APPEARANCE:** AAOX3.

**ABDOMEN:** Unchanged.

**SKIN:** Resolved, bruises. - Elbow (Left)

**Cervical Spine**

- **Cervical spine:** Unchanged

**Thoracolumbar Spine**

- **Thoracic spine:** Unchanged
- **Lumbar spine:** Unchanged

**RIGHT UPPER EXTREMITIES**

- **Right Shoulder:** Unchanged
- **Right arm:** Improved

**LEFT UPPER EXTREMITIES**

- **Left Shoulder:** Unchanged
- **Left arm:** Improved
- **Left elbow:** Improved
- **Left forearm:** Unchanged

**RIGHT LOWER EXTREMITIES**

- **Right hip:** Improved
- **Right thigh:** Improved
- **Right knee:** Unchanged
- **Right leg:** Aggravated
- **Right calf:** Aggravated

**LEFT LOWER EXTREMITIES**

[Page 3]

E-signed by Dr. Michelle Hyla, D.O. on 12/05/2016 1:34PM

SOUTHERN 016

1428

**Patient:** Joyce P. Sekera**DOB:** 03/22/1956**Sex:** F**Provider:** Dr. Michelle Hyla, D.O.**Visit:** 12/05/2016 10:15AM**Chart:** SEJ0000002

- Left hip: Improved
- Left thigh: Unchanged
- Left knee: Unchanged
- Left leg: Unchanged
- Left calf: Unchanged

**Assessment:**

Type	Code	Description
ICD-10-CM Condition	S29.012D	Strain of muscle and tendon of back wall of thorax, subsequent encounter
ICD-10-CM Condition	S33.5XXD	Sprain of ligaments of lumbar spine, subsequent encounter
ICD-10-CM Condition	S39.012D	Strain of muscle, fascia and tendon of lower back, subsequent encounter
ICD-10-CM Condition	S63.402D	Unspecified sprain of left elbow, subsequent encounter
ICD-10-CM Condition	S76.012D	Strain of muscle, fascia and tendon of left hip, subsequent encounter
ICD-10-CM Condition	S76.011D	Strain of muscle, fascia and tendon of right hip, subsequent encounter
ICD-10-CM Condition	S43.402D	Unspecified sprain of left shoulder joint, subsequent encounter
ICD-10-CM Condition	S46.911D	Strain of unspecified muscle, fascia and tendon at shoulder and upper arm level, right arm, subsequent encounter
ICD-10-CM Condition	S46.912D	Strain of unspecified muscle, fascia and tendon at shoulder and upper arm level, left arm, subsequent encounter
ICD-10-CM Condition	S06.0X0D	Concussion without loss of consciousness, subsequent encounter
ICD-10-CM Condition	S39.011D	Strain of muscle, fascia and tendon of abdomen, subsequent encounter
ICD-10-CM Condition	S88.111D	Strain of other muscle(s) and tendon(s) of posterior muscle group at lower leg level, right leg, subsequent encounter
ICD-10-CM Condition	S86.211D	Strain of muscle(s) and tendon(s) of anterior muscle group at lower leg level, right leg, subsequent encounter
ICD-10-CM Condition	S86.212D	Strain of muscle(s) and tendon(s) of anterior muscle group at lower leg level, left leg, subsequent encounter
ICD-10-CM Condition	S73.102D	Unspecified sprain of left hip, subsequent encounter
ICD-10-CM Condition	S76.812D	Strain of other specified muscles, fascia and tendons at thigh level, left thigh, subsequent encounter
ICD-10-CM Condition	S76.811D	Strain of other specified muscles, fascia and tendons at thigh level, right thigh, subsequent encounter
ICD-10-CM Condition	S83.91XD	Sprain of unspecified site of right knee, subsequent encounter
ICD-10-CM Condition	S83.92XD	Sprain of unspecified site of left knee, subsequent encounter
ICD-10-CM Condition	S86.112D	Strain of other muscle(s) and tendon(s) of posterior muscle group at lower leg level, left leg, subsequent encounter
ICD-10-CM Condition	W01.0XXD	Fall on same level from slipping, tripping and stumbling without subsequent striking against object, subsequent encounter
ICD-10-CM Condition	S13.4XXD	Sprain of ligaments of cervical spine, subsequent encounter
ICD-10-CM Condition	S16.1XXD	Strain of muscle, fascia and tendon at neck level, subsequent encounter
ICD-10-CM Condition	S23.3XXD	Sprain of ligaments of thoracic spine, subsequent encounter

**Patient:** Joyce P. Sekera**DOB:** 03/22/1956**Sex:** F**Provider:** Dr. Michelle Hyla, D.O.**Visit:** 12/05/2016 10:15AM**Chart:** SEJO000002**Medications & Allergies:**

Current Medication & Dosage	Sig	PRN?	Indication
cyclobenzaprine 5 mg oral tablet	2 times a day as needed	No	
10% Flurbuprofen 1% Amitriptyline 6% Gabapentin 2% Lidocaine 2% Prilocaine	1 gram(s) transdermal 2 times a day x2 weeks	No	
Norco 5 mg-325 mg oral tablet	0	No	outside office
ibuprofen 600 mg oral tablet	0	No	outside office

Allergy	Reaction
No Known Drug Allergies (NKDA)	N/A

**Plan:**

Type	Code	Modifiers	Quantity	Description
CPT	99213		1.00 UN	Office/outpatient visit, est
CPT	99213		1.00 UN	Office/outpatient visit, est



# HEAD INJURY FOLLOW UP QUESTIONNAIRE (HIF)

Patient Joyce Sekera Date of Injury 11-4-16 Today's Date 12-9-16

We would like to know if your brain concussion symptoms are improving, staying the same or getting worse. Please mark the box for each symptom to tell us how you are doing.

Symptom	Getting Worse	Staying Same	Getting Better	100% Well	Never Had
Anxiety, nervousness or worry		<input checked="" type="checkbox"/>			
Depression, crying or more emotional			<input checked="" type="checkbox"/>		
Irritable or getting angry easily		<input checked="" type="checkbox"/>			
Difficulty finding simple words when talking		<input checked="" type="checkbox"/>			
Difficulty concentrating or thinking slowly		<input checked="" type="checkbox"/>			
Memory problems or forgetting things	<input checked="" type="checkbox"/>				
Understanding what people say to me		<input checked="" type="checkbox"/>			
Sleep disturbance or disruption of sleep patterns	<input checked="" type="checkbox"/>				
Fatigue, tiring more easily or low energy	<input checked="" type="checkbox"/>				
The overall level of my physical pain(s)		<input checked="" type="checkbox"/>			
Feeling behind, never caught up or overwhelmed		<input checked="" type="checkbox"/>			
Relationship with my partner or family			<input checked="" type="checkbox"/>		
Ability to enjoy my hobbies or leisure activities			<input checked="" type="checkbox"/>		
Ability to exercise or play sports I enjoy			<input checked="" type="checkbox"/>		
The quality or quantity of how much work I can do	<input checked="" type="checkbox"/>				
How much I enjoy life				<input checked="" type="checkbox"/>	
Loud noises, noisy rooms or crowds bother me		<input checked="" type="checkbox"/>			
Bright lights bother me or I have to wear sunglasses		<input checked="" type="checkbox"/>			
Feeling like I want to socialize with friends or family	<input checked="" type="checkbox"/>				
Other					

Would you like a referral to a specialist for mental or emotional issues? ☐ Yes ☒ No  
 Would you like a referral to a specialist for help with physical pain? ☐ Yes ☒ No

Patient Signature

*Joyce Sekera*

Doctor Signature

*Jordan Webber*

EXHIBIT	<u>S</u>
WIT:	<u>Sekera</u>
DATE:	<u>3-14-19</u>
REPORTER:	B. CANO

PLF 146





# History Questionnaire Advanced Head Imaging

Patient Information  
First Name Joyce Last Name Sekera Patient Number 790179.0  
Age 68

Reason for your Exam (please describe in detail)  
Headaches Dizziness vision T  
nausea memory loss  
S/P Fall hitting head on floor on 11/4/16

TECH NOTES: (for internal use only)  
Contrast \_\_\_\_\_  
Sedation \_\_\_\_\_  
Notes \_\_\_\_\_

## Head (Circle all that Apply)

Stroke Memory Loss Tremor Dizziness  
Seizures MS Hemorrhage

## Headaches (circle one)

Acute Chronic Severe Due to Trauma

Migraines (circle one) Acute Chronic

Vision Loss (circle one) Right Left Both

Hearing Loss (circle one) Right Left Both

Numbness/Tingling Where hands

History of head trauma? YES NO

## Sinus (circle all that apply)

Sinus Infections Headaches Facial Pain  
Congestion Runny Nose Frequent Colds  
Sore Throats Toothaches Chronic Cough  
Post Nasal Drip Nose Bleeds Deviated Nasal Septum  
Nasal Polyps Snoring Sleep Apnea  
Previous Nasal Fracture

Please list any other related symptoms

Previous sinus surgery? YES NO

If yes, procedure description and date:

Is your problem related to an injury? NO YES ✓ (if yes continue)

Date of Injury 11-4-16 How were you injured (circle one) Car Accident Work Other

Describe Injury (please be specific) slip on salt liquid on floor

Have you ever been diagnosed with cancer? NO ✓ YES (if yes continue)

What type of cancer \_\_\_\_\_ Location \_\_\_\_\_ Date Diagnosed \_\_\_\_\_

Current Status (please circle one) Newly Diagnosed Recurrence Remission

Treatment (please circle all that apply) Surgery Radiation ChemoTherapy

Date of last Treatment \_\_\_\_\_

Has it spread? NO YES If Yes, Where \_\_\_\_\_

Is your visit today related to this cancer diagnosis NO YES

Previous surgeries or imaging studies related to the affected area you are being seen for today.  
(please list specifically, what and when)

Procedure Description \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

EXHIBIT T  
WIT: Sekera  
DATE: 3-14-19  
REPORTER: B. CANO

SD 030

1434



Intake Questionnaire  
ADVANCED IMAGING

Please answer all questions below and notify the technologist of any metal inside or on your body. For MRI's, please remove all removable metal from your body such as hearing aides, hairpins, jewelry, dentures, partial plates, etc. SDMI IS NOT RESPONSIBLE FOR HEARING AIDS BROUGHT INTO THE EXAM ROOM.

**Patient Information**  
First Name Joyce Last Name SEKERA Patient Number 790179.0  
Age 60

**DO YOU HAVE? (circle yes or no for all)**  
Pacemaker / Wires / Cardiac Defibrillator? YES ☐ NO ☒ Brand: \_\_\_\_\_  
Brain Aneurysm Clips / Coils? YES ☐ NO ☒  
Neurostimulator / Wires? YES ☐ NO ☒ Where: \_\_\_\_\_  
Bone Stimulator / Wires? YES ☐ NO ☒ Where: \_\_\_\_\_  
Cochlear Implant / Ear Implant? YES ☐ NO ☒  
Breast Tissue Expander? YES ☐ NO ☒  
Metallic Foreign Body in Eye? YES ☐ NO ☒  
If you circled yes to ANY of the above you must verbally NOTIFY the tech before your exam.

Metal in the body (joints, rods, screws, clips)? YES ☐ NO ☒ Where: \_\_\_\_\_  
Stents or Filters? YES ☐ NO ☒ Where: 2 implants - Bottom Denture  
Shunt Valves Programmable? YES ☐ NO ☒  
Shunt Valves Non-Programmable? YES ☐ NO ☒  
Surgically Implanted Device? YES ☐ NO ☒ Where: \_\_\_\_\_  
Medication Patch? YES ☐ NO ☒  
Hearing Aid? YES ☐ NO ☒ If Yes, you must leave outside of room  
Tattoos or Permanent Makeup? YES ☐ NO ☒ Where: \_\_\_\_\_  
Any clothing containing Metal? YES ☐ NO ☒ If Yes/Unsure you will need to change into a gown  
Recent Barium Enema/UGI? YES ☐ NO ☒  
IV Dye (MRI or CT) in last 48 hours? YES ☐ NO ☒

**History (circle yes or no for all)**  
Are you pregnant / breastfeeding? YES ☐ NO ☒  
Have you ever had Renal Failure / Dialysis? YES ☐ NO ☒  
If Yes, when: \_\_\_\_\_  
Do you have Hypertension? YES ☐ NO ☒  
Do you have Diabetes? YES ☐ NO ☒  
If Yes: (circle one) Insulin Oral Medication  
COPD YES ☐ NO ☒  
Cardiac Disease YES ☐ NO ☒  
**History Continued (circle all that apply)**  
Are you a smoker? ☒ Current ☐ Past ☐ Never  
If yes, how many years? 25 yrs  
Allergies (list all, medications)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Signature: Joyce Sekera Today's Date: \_\_\_\_\_

**TECH NOTES: (for internal use only)**  
Notes \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_







Intake Questionnaire  
ADVANCED IMAGING

Please answer all questions below and notify the technologist of any metal inside or on your body. For MRI's, please remove all removable metal from your body such as hearing aides, hairpins, jewelry, dentures, partial plates, etc. SDMI IS NOT RESPONSIBLE FOR HEARING AIDS BROUGHT INTO THE EXAM ROOM.

Patient Information

First Name Joyce Last Name SEKERA Patient Number 790179.0 to be filled in by tech  
Age 68

DO YOU HAVE? (circle yes or no for all)

Pacemaker / Wires / Cardiac Defibrillator? YES ☒ NO Brand: \_\_\_\_\_  
Brain Aneurysm Clips / Coils? YES ☒ NO Where: \_\_\_\_\_  
Neurostimulator / Wires? YES ☒ NO Where: \_\_\_\_\_  
Bone Stimulator / Wires? YES ☒ NO Where: \_\_\_\_\_  
Cochlear Implant / Ear Implant? YES ☒ NO  
Breast Tissue Expander? YES ☒ NO  
Metallic Foreign Body in Eye? YES ☒ NO

If you circled yes to ANY of the above you must verbally NOTIFY the tech before your exam.

Metal in the body (Joints, rods, screws, clips)? YES ☒ NO Where: \_\_\_\_\_  
Stents or Filters? YES ☒ NO Where: \_\_\_\_\_  
Shunt Valves Programmable? YES ☒ NO  
Shunt Valves Non-Programmable? YES ☒ NO  
Surgically Implanted Device? YES ☒ NO Where: \_\_\_\_\_  
Medication Patch? YES ☒ NO  
Hearing Aid YES ☒ NO If Yes, you must leave outside of room  
Tattoos or Permanent Makeup YES ☒ NO Where: \_\_\_\_\_  
Any clothing containing Metal YES ☒ NO If Yes/Unsure you will need to change into a gown  
Recent Barium Enema/UGI YES ☒ NO  
IV Dye (MRI or CT) in last 48 hours YES ☒ NO

History (circle yes or no for all)

Are you pregnant / breastfeeding? YES ☒ NO  
Have you ever had Renal Failure / Dialysis? YES ☒ NO  
If Yes, when: \_\_\_\_\_  
Do you have High Blood Pressure? YES ☒ NO  
Do you have Diabetes? YES ☒ NO  
If Yes: (circle one) Insulin Oral Medication  
COPD YES ☒ NO  
Cardiac Disease YES ☒ NO

History Continued (circle all that apply)

Are you a smoker? ☒ Current ☐ Past ☐ Never  
If yes, how many years? 25

Allergies (list all, medications)

Patient Signature: Joyce Sekera

Today's Date: 12-20-16

TECH NOTES (for internal use only)

Notes \_\_\_\_\_

EXHIBIT U  
WIT: Sekera  
DATE: 3-14-19  
REPORTER: B. CANO

SD 024

1437



# History Questionnaire Advanced Spine Imaging

## Patient Information

First Name Joyce

Last Name Sekera

Patient Number 790179.0

Age 60

## Reason for your Exam (please describe in detail)

Pain in lower back/neck

Surgey

## TECH NOTES: (for internal use only)

Contrast \_\_\_\_\_

Sedation \_\_\_\_\_

Notes \_\_\_\_\_

## SYMPTOMS, Body (circle all that apply)

Neck Pain Acute Chronic Due to Trauma  
Mid Back Pain Acute Chronic Due to Trauma  
Low Back Pain Acute Chronic Due to Trauma  
Face Numbness Right Left Bilateral  
Face Weakness Right Left Bilateral  
Body Numbness Right Left Bilateral  
Body Pain Right Left Bilateral

How long have you had the above symptoms:

Nov 4/2016

## SYMPTOMS, Extremities (circle all that apply)

### Radiculopathy

Arm Numbness Right Left Bilateral  
Arm Pain Right Left Bilateral  
Leg Numbness Right Left Bilateral  
Leg Pain Right Left Bilateral

### Myelopathy

Arm Weakness Right Left Bilateral  
Leg Weakness Right Left Bilateral

Limited Range of Motion? NO YES L

If YES, list exact location: \_\_\_\_\_

Is your problem related to an injury? NO YES ✓ (if yes continue)

Date of Injury 11/4/16 How were you injured (circle one) Car Accident Work Other \_\_\_\_\_

Describe Injury (please be specific) Slip on Fall (Liquid on Floor)

Have you ever been diagnosed with cancer? NO ✓ YES \_\_\_\_\_ (if yes continue)

What type of cancer \_\_\_\_\_ Location \_\_\_\_\_ Date Diagnosed \_\_\_\_\_

Current Status (please circle one) Newly Diagnosed Recurrence Remission

Treatment (please circle all that apply) Surgery Radiation ChemoTherapy

Date of last Treatment \_\_\_\_\_

Has it spread? NO YES \_\_\_\_\_ If Yes, Where \_\_\_\_\_

Is your visit today related to this cancer diagnosis NO YES \_\_\_\_\_

Previous surgeries or imaging studies related to the affected area you are being seen for today.  
(please list specifically, what and when)

Procedure Description

Date

SD 025

1438





## Pain Institute of Nevada

Walter M. Kidwell, M.D. Katherine D. Travnicek MD.  
 Gregory Jarrett, D. C. Gina M. Nguyen, PA-C  
 7435 W Azure Dr., Suite 190 Las Vegas, NV 89130  
 (702) 878-8252 (phone) (702) 628-5098 (fax)

## MEDICAL LIEN

I, the undersigned patient (or legal guardian of a minor), grant to Pain Institute of Nevada (hereafter "medical facility") a lien upon the recovery of any and all proceeds from any source obtained through settlement, judgment, for any medical services rendered to me or the minor, for treatment of injuries sustained or the exacerbation of any medical condition(s) (hereafter "treatment") that I or the minor have indicated, believe or did in fact arise out of an incident that occurred on or about the date set forth below (hereafter "incident"). I further authorize the medical facility to furnish my attorney with a full report of the examinations, diagnoses, treatments, prognoses, as well as billings for treatment from this incident. I hereby notify and authorize you, my attorney, to pay directly to the medical facility the unpaid amount due for services rendered.

I understand that apart from this lien, I am directly and fully responsible to the medical facility for all medical bills submitted by it for services rendered, even for bills incurred for the minor (as indicated below) who may reach the age of majority, for which I may be required to make a lump sum or periodic payments, at the election of the medical facility. This lien is made solely for said medical facility's additional protection, and in consideration of its awaiting payment. Except as otherwise provided below, I intend for this lien to continue until all charges have been satisfied. I agree that the statute of limitations of my obligation to pay is tolled and does not begin to run while the medical facility is awaiting payment by way of this lien. I further understand that the payment of services is not contingent upon any settlement, judgment, or verdict that the minor or I may eventually recover.

Except as provided below, I agree never to rescind this lien, and I do not grant any attorney that may represent the minor or me the right to rescind it. However, if my first attorney does not promptly sign, acknowledge and return this lien to the medical facility within 10 (ten) days of receipt of this lien, or if the first attorney for any reason (e.g., withdraws, resigns, is released by me, or substituted by another attorney) no longer represents me or the minor child for injuries arising from this incident, then the Irrevocable Assignment of Proceeds that I have signed with this medical facility supersedes this lien and takes immediate effect. Alternatively, if an attorney modifies this lien in any way, then the Assignment of Proceeds supersedes this lien and takes immediate effect when the modification occurs. I agree to promptly notify medical facility of any change of my address or change or addition of attorney(s).

In the event that you/the responsible parties, or your attorney fails to pay the balance owed or fails to make any satisfactory arrangement for payment or otherwise arrangement for payment and are forced to turn over the unpaid balance to a collection agency. A \$25.00 charge will be assessed to all collection accounts, in addition to pay accrued interest. If your account will accrue at the interest at annual rate of 1% (eighteen) percent until or until the account is assigned to a collection agency. In addition, you will be responsible for collection costs, attorney's fees, court costs, services fees and associated miscellaneous fees and costs.

To my attorney: Please acknowledge this medical lien by signing below and returning it to the medical facility's office.

Date of Incident: 11-4-16

Print Name

Joyce Sekera

Date: 1-9-17

Signature of Patient or Legal Guardian of Minor

I, the undersigned attorney, state that I am the attorney of record for this patient; I acknowledge that I am in receipt of this lien; and I agree to observe its terms by withholding the sums from any settlement, judgment or verdict that are owed to the medical facility, for their compensation or benefit. I also agree to promptly (1) notify the medical facility if I discontinue representation of this patient/client, and to (2) provide any subsequent attorney of the patient for this incident a copy of this lien, along with all of the medical facility's records and billings in my or my law firm's possession. In the event this lien is litigated, the prevailing party will be awarded attorney's fees and costs.

Attorney Name

Keith Gallher  
702 735-0049

Attorney Phone Number

Attorney Signature

1850 E Sahara Ave  
Las Vegas, NV 89107

Attorney Address

Please sign, date and return one copy to medical facility's office within 10 days after receipt. Also keep one for your records

EXHIBIT V  
 WIT: Sekera  
 DATE: 3-14-19  
 REPORTER: B. CANO

PAIN142

1440



### Pain Diagram

In regards to your pain in the last week:

- Please shade in the areas that best represent your pain.
- Draw a line from the pain description to the area of your pain.
- Indicate your current pain score 0/10 - 10/10 for each area of your pain.

**Pain Scale**

- 0/10: No Pain  
1/10: Minimal pain  
2/10: Mild pain, No impact on daily activities  
3/10: Mild pain, Minimal impact of daily activities  
4/10: Moderate pain, Minimal limitations of daily activities  
5/10: Moderate pain, Some limitations of daily activities  
6/10: Moderate pain, Moderate limitations of daily activities  
7/10: Moderate/Severe pain, Very limited daily activities  
8/10: Moderate/Severe pain, Very difficult to perform daily activities  
9/10: Severe Pain, Severely limited ability to perform daily activities  
10/10: Severe Disabling pain, essentially unable to do any activities whatsoever, cannot possibly be any worse

Please answer the following questions:

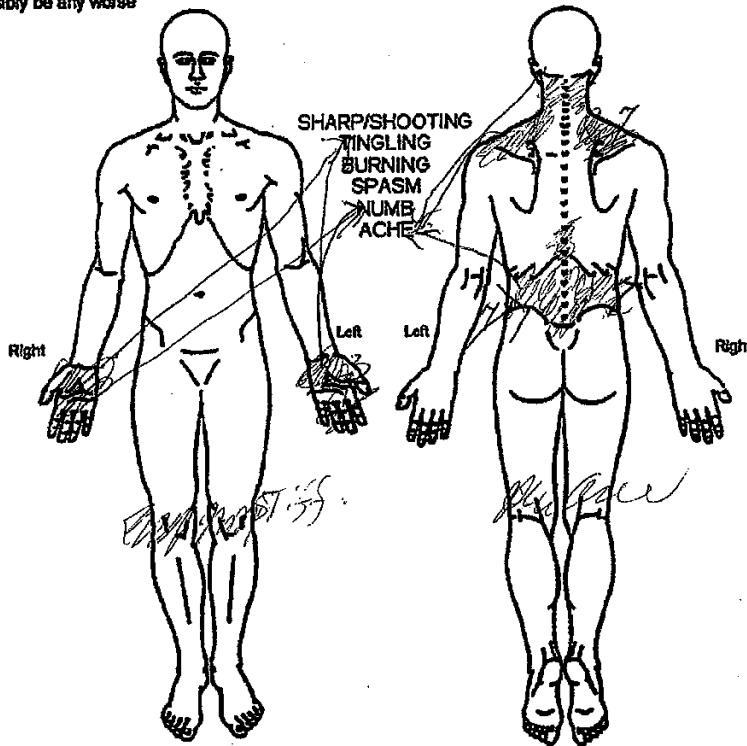
How far can you walk? \_\_\_\_\_

How long can you sit? \_\_\_\_\_

How long can you stand? 10 Min

Are you working? NO

Are you able to work? NO



Name: Joyce Sekera

Date: 1-9-17

EXHIBIT	<u>W</u>
WIT:	<u>Sekera</u>
DATE:	<u>3-14-19</u>
REPORTER:	<u>B. CANO</u>





# Pain Institute of Nevada

7435 W. Azure Dr. Ste 190  
Las Vegas, NV 89130

Ph: (702) 878-8252  
Fax: (702) 878-9096  
www.paininstitute.com

## Pain Diagram

In regards to your pain in the last week:

- Please shade in the areas that best represent your pain.
- Draw a line from the pain description to the area of your pain.
- Indicate your current pain score 0/10 - 10/10 for each area of your pain.

### Pain Scale

- 0/10: No Pain  
1/10: Minimal pain  
2/10: Mild pain, No impact on daily activities  
3/10: Mild pain, Minimal impact of daily activities  
4/10: Moderate pain, Minimal limitations of daily activities  
5/10: Moderate pain, Some limitations of daily activities  
6/10: Moderate pain, Moderate limitations of daily activities  
7/10: Moderate/Severe pain, Very limited daily activities  
8/10: Moderate/Severe pain, Very difficult to perform daily activities  
9/10: Severe Pain, Severely limited ability to perform daily activities  
10/10: Severe Disabling pain, essentially unable to do any activities whatsoever, cannot possibly be any worse

Please answer the following questions:

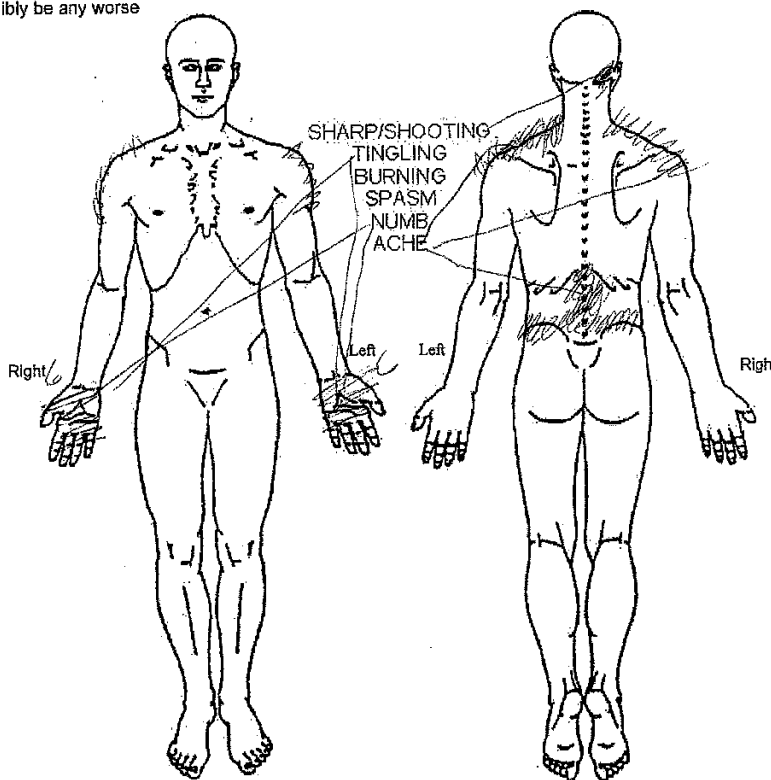
How far can you walk? Two easily

How long can you sit? \_\_\_\_\_

How long can you stand? \_\_\_\_\_

Are you working? NO

Are you able to work? NO



Name: Joyce Sekera

Joyce Sekera

Date: 1-30-17

EXHIBIT	X
WIT:	Sekera
DATE:	3-14-19
REPORTER:	B. CANO

PAIN088

## Pain Diagram

In regards to your pain in the last week:

- Please shade in the areas that best represent your pain.
- Draw a line from the pain description to the area of your pain.
- Indicate your current pain score 0/10 - 10/10 for each area of your pain.

### **Pain Scale**

- 0/10: No Pain  
1/10: Minimal pain  
2/10: Mild pain, No impact on daily activities  
3/10: Mild pain, Minimal impact of daily activities  
4/10: Moderate pain, Minimal limitations of daily activities  
5/10: Moderate pain, Some limitations of daily activities  
6/10: Moderate pain, Moderate limitations of daily activities  
7/10: Moderate/Severe pain, Very limited daily activities  
8/10: Moderate/Severe pain, Very difficult to perform daily activities  
9/10: Severe Pain, Severely limited ability to perform daily activities  
10/10: Severe Disabling pain, essentially unable to do any activities whatsoever, cannot possibly be any worse

Please answer the following questions:

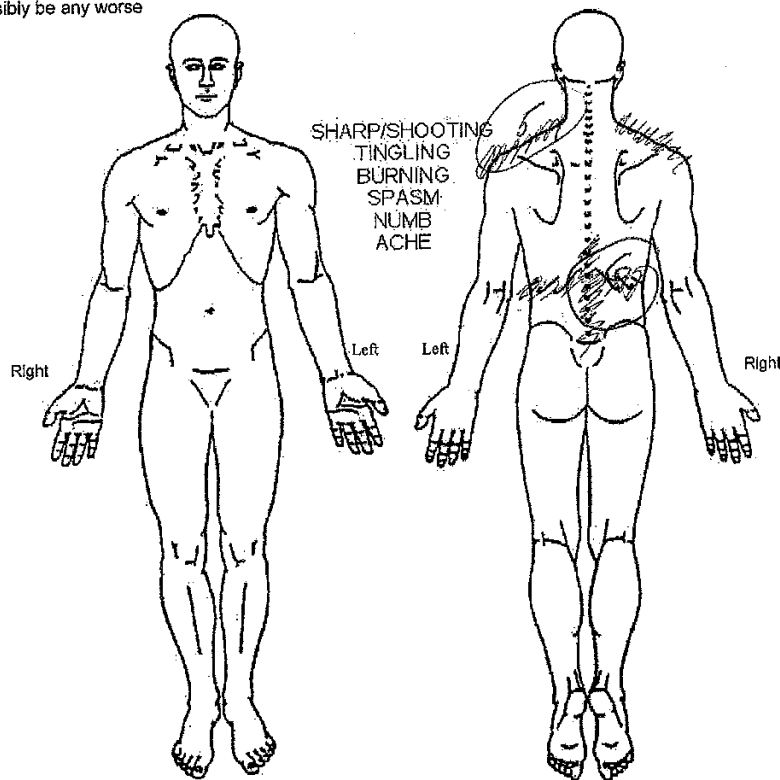
How far can you walk? 15 min

How long can you sit? 15 min

How long can you stand? 15 min

Are you working? NO

Are you able to work? NO



Name: Joyce Sckera

Date: 2/20/17

PAIN084

## Pain Diagram

In regards to your pain in the last week:

- Please shade in the areas that best represent your pain.
- Draw a line from the pain description to the area of your pain.
- Indicate your current pain score 0/10 - 10/10 for each area of your pain.

### **Pain Scale**

0 /10: No Pain

1 /10: Minimal pain

2 /10: Mild pain, No impact on daily activities

3 /10: Mild pain, Minimal impact of daily activities

4 /10: Moderate pain, Minimal limitations of daily activities

5 /10: Moderate pain, Some limitations of daily activities

6 /10: Moderate pain, Moderate limitations of daily activities

7 /10: Moderate/Severe pain, Very limited daily activities

8 /10: Moderate/Severe pain, Very difficult to perform daily activities

9 /10: Severe Pain, Severely limited ability to perform daily activities

10/10: Severe Disabling pain, essentially unable to do any activities whatsoever, cannot possibly be any worse

Please answer the following questions:

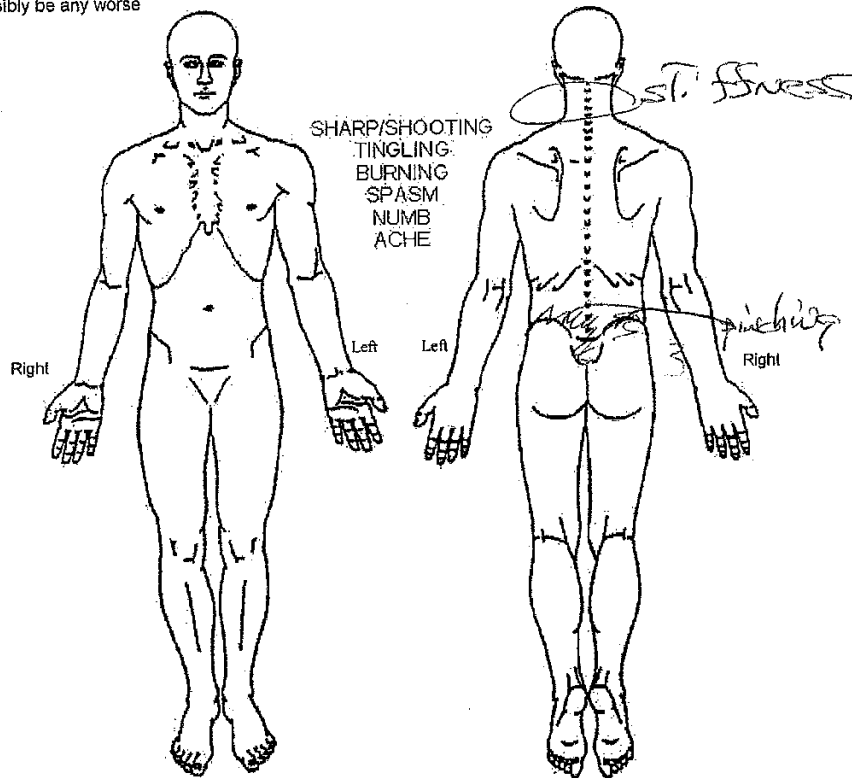
How far can you walk? \_\_\_\_\_

How long can you sit? \_\_\_\_\_

How long can you stand? \_\_\_\_\_

Are you working? \_\_\_\_\_

Are you able to work? \_\_\_\_\_



Name: Jane Zekia

Date: 5/11/17

PAIN077

## Pain Diagram

In regards to your pain in the last week:

- Please shade in the areas that best represent your pain.
- Draw a line from the pain description to the area of your pain.
- Indicate your current pain score 0/10 - 10/10 for each area of your pain.

### **Pain Scale**

- 0/10: No Pain  
1/10: Minimal pain  
2/10: Mild pain, No impact on daily activities  
3/10: Mild pain, Minimal impact of daily activities  
4/10: Moderate pain, Minimal limitations of daily activities  
5/10: Moderate pain, Some limitations of daily activities  
6/10: Moderate pain, Moderate limitations of daily activities  
7/10: Moderate/Severe pain, Very limited daily activities  
8/10: Moderate/Severe pain, Very difficult to perform daily activities  
9/10: Severe Pain, Severely limited ability to perform daily activities  
10/10: Severe Disabling pain, essentially unable to do any activities whatsoever, cannot possibly be any worse

Please answer the following questions:

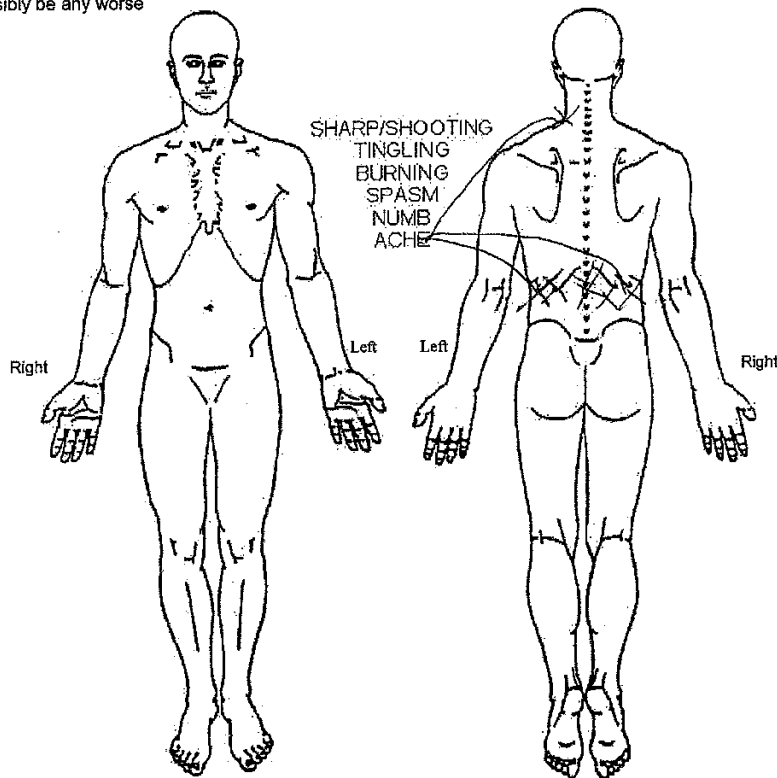
How far can you walk? 10 min

How long can you sit? 10 min

How long can you stand? 10 min

Are you working? N/A

Are you able to work? Nb



Name: Joyce Saker

Date: 6-26-17

PAIN075

## Pain Institute of Nevada

7435 W. Azure Dr. Ste 190  
Las Vegas, NV 89130

Ph: (702) 878-8252  
Fax: (702) 878-9096  
www.paininstitute.com

### Pain Diagram

In regards to your pain in the last week:

- Please shade in the areas that best represent your pain.
- Draw a line from the pain description to the area of your pain.
- Indicate your current pain score 0/10 - 10/10 for each area of your pain.

#### Pain Scale

- 0/10: No Pain  
1/10: Minimal pain  
2/10: Mild pain, No impact on daily activities  
3/10: Mild pain, Minimal impact of daily activities  
4/10: Moderate pain, Minimal limitations of daily activities  
5/10: Moderate pain, Some limitations of daily activities  
6/10: Moderate pain, Moderate limitations of daily activities  
7/10: Moderate/Severe pain, Very limited daily activities  
8/10: Moderate/Severe pain, Very difficult to perform daily activities  
9/10: Severe Pain, Severely limited ability to perform daily activities  
10/10: Severe Disabling pain, essentially unable to do any activities whatsoever, cannot possibly be any worse

Please answer the following questions:

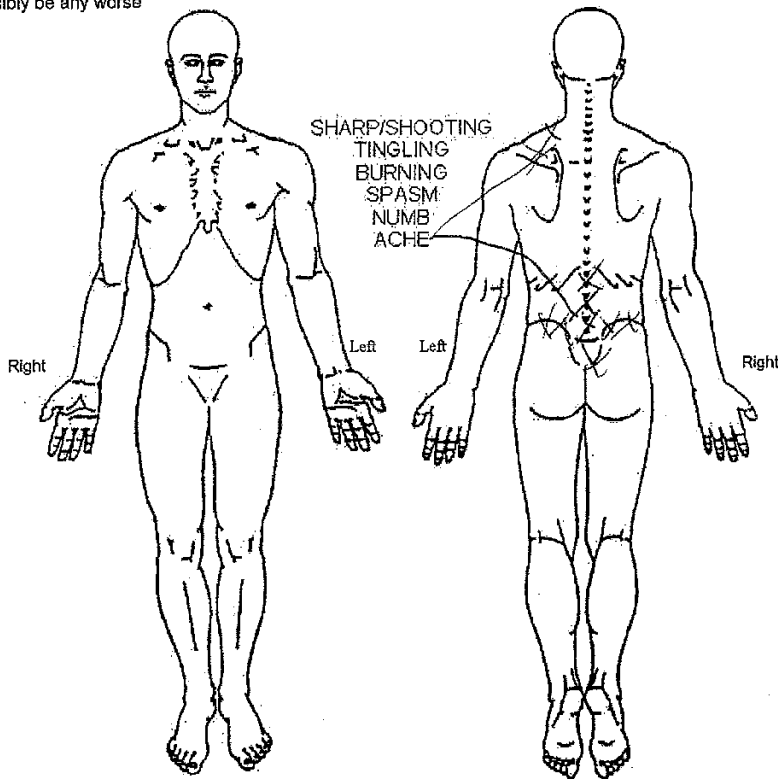
How far can you walk? \_\_\_\_\_

How long can you sit? \_\_\_\_\_

How long can you stand? \_\_\_\_\_

Are you working? \_\_\_\_\_

Are you able to work? \_\_\_\_\_



Name: Joyce Sekera

Date: 7-10-17

PAIN074

## Pain Institute of Nevada

7435 W. Azure Dr. Ste 190  
Las Vegas, NV 89130

Ph: (702) 878-8252  
Fax: (702) 878-9096  
www.paininstitute.com

### Pain Diagram

In regards to your pain in the last week:

- Please shade in the areas that best represent your pain.
- Draw a line from the pain description to the area of your pain.
- Indicate your current pain score 0/10 - 10/10 for each area of your pain.

#### Pain Scale

- 0/10: No Pain  
1/10: Minimal pain  
2/10: Mild pain, No impact on daily activities  
3/10: Mild pain, Minimal impact of daily activities  
4/10: Moderate pain, Minimal limitations of daily activities  
5/10: Moderate pain, Some limitations of daily activities  
~~6/10~~: Moderate pain, Moderate limitations of daily activities  
7/10: Moderate/Severe pain, Very limited daily activities  
8/10: Moderate/Severe pain, Very difficult to perform daily activities  
9/10: Severe Pain, Severely limited ability to perform daily activities  
10/10: Severe Disabling pain, essentially unable to do any activities whatsoever, cannot possibly be any worse

Please answer the following questions:

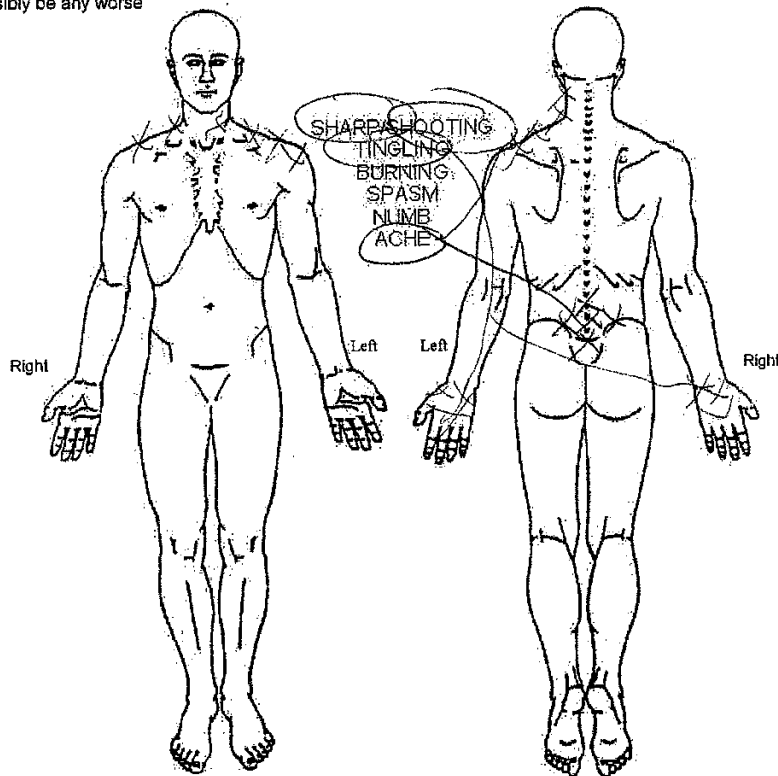
How far can you walk? 5min

How long can you sit? 5min

How long can you stand? 5min

Are you working? 0

Are you able to work? 0



Name: Hoyce Sekera

Date: 10/23/17

PAIN072

## Pain Institute of Nevada

7435 W. Azure Dr. Ste 190  
Las Vegas, NV 89130

Ph: (702) 878-8252  
Fax: (702) 878-9096  
www.paininstitute.com

### Pain Diagram

In regards to your pain in the last week:

- Please shade in the areas that best represent your pain.
- Draw a line from the pain description to the area of your pain.
- Indicate your current pain score 0/10 - 10/10 for each area of your pain.

#### Pain Scale

0 /10: No Pain

1 /10: Minimal pain

2 /10: Mild pain, No impact on daily activities

3 /10: Mild pain, Minimal impact of daily activities

4 /10: Moderate pain, Minimal limitations of daily activities

5 /10: Moderate pain, Some limitations of daily activities

6 /10: Moderate pain, Moderate limitations of daily activities

7 /10: Moderate/Severe pain, Very limited daily activities

8 /10: Moderate/Severe pain, Very difficult to perform daily activities

9 /10: Severe Pain, Severely limited ability to perform daily activities

10/10: Severe Disabling pain, essentially unable to do any activities whatsoever, cannot possibly be any worse

Please answer the following questions:

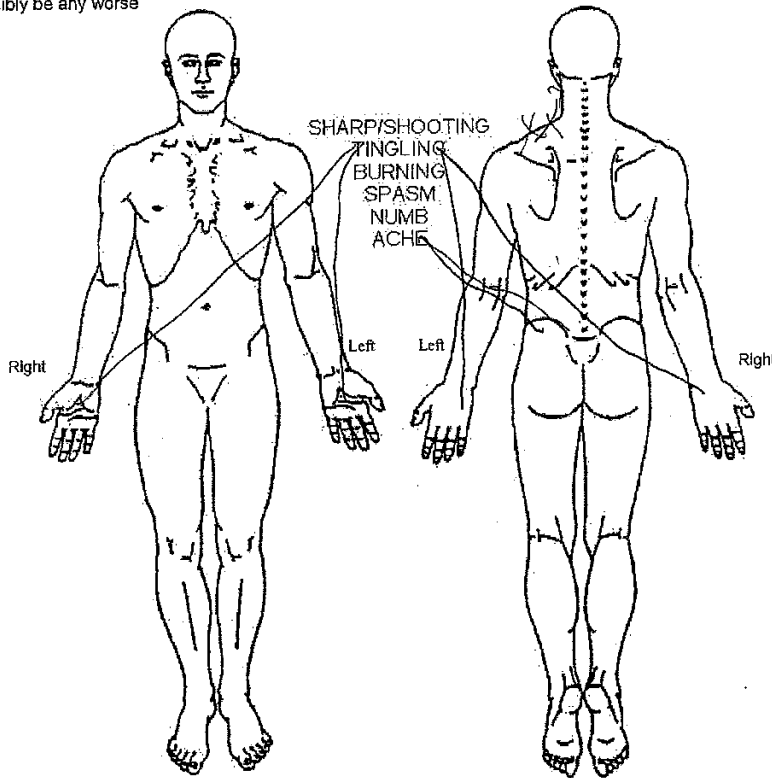
How far can you walk? 5 min

How long can you sit? 5 min

How long can you stand? 10 min

Are you working? no

Are you able to work? no



Name: Joyce Sekera

Date: 12/7/17

PAIN069







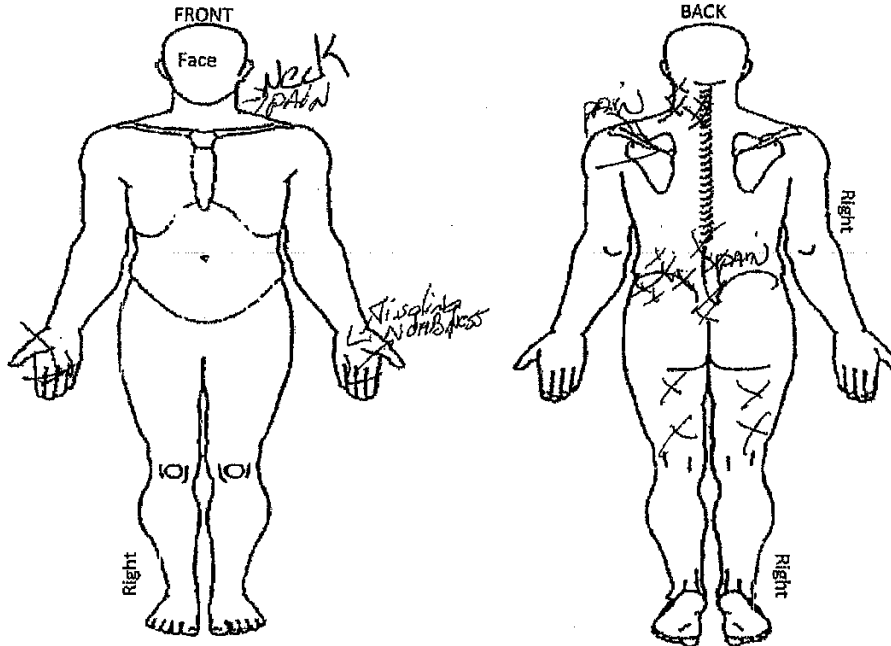
Phone: 702-630-3472  
Fax: 702-946-5115

Height: 5'6

Weight: \_\_\_\_\_

What is your chief complaint? Lower Back/Neck/Arm Pain/Leg Pain

Mark on the body diagram below where you are experiencing any pain, numbness or tingling. Please try to stay within the body lines. Pay attention to front/back and right/left:



IF YOUR INJURY RESULTED FROM MOTOR VEHICLE ACCIDENT: Date of accident/injury: \_\_\_\_/\_\_\_\_/\_\_\_\_  
How did impact happen? Please provide ALL details. - \_\_\_\_\_

IF YOUR INJURY RESULTED FROM A SLIP, TRIP or FALL: Date of accident/injury: 11/4/2016  
Describe what happened... Be specific. What did you slip/trip on? What body parts did you land on? Did you collide with anything during the fall? I slipped on liquid that was on the floor at the Venetian. I fell back. I just remember that the floor was very hard. My feet were up in front of me. I fell on my left side elbow & back.

OTHER: \_\_\_\_\_

Page | 4

EXHIBIT Y  
WIT: Sekera  
DATE: 3-14-19  
REPORTER: B. CANO

DISC 007

1452



# Pain Diagram

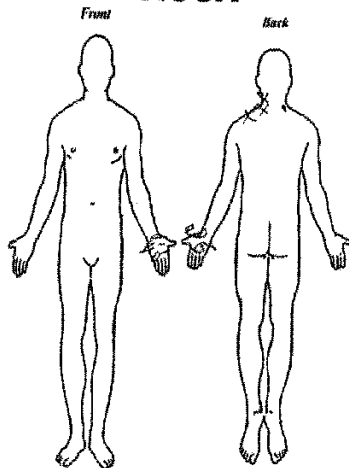
Name: Joyce Sekera

Date: 2/22/18

Please be sure to fill this pain evaluation out extremely accurately.  
Mark the areas on your body where you feel the described sensation(s).  
Using the appropriate symbols:

Numbness -----  
 Pins & Needles o o o o o o o o  
 Burning x x x x x x x x  
 Stabbing / / / / / / / /  
 Aching ( ( ( ( ( ( ( (

## Neck



Please mark the pain level (0 ~ 10) that most accurately represents your pain for each indicated area:

### Neck

NONE ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ UNBEARABLE

### Left Arm

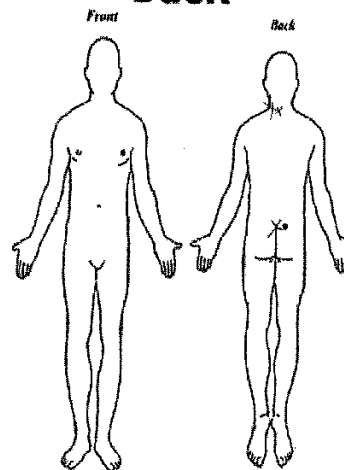
NONE ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ UNBEARABLE

### Right Arm

NONE ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ UNBEARABLE

☐ I do not have neck or upper extremity pain.

## Back



Please mark the pain level (0 ~ 10) that most accurately represents your pain for each indicated area:

### Back

NONE ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ UNBEARABLE

### Left Leg

NONE ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ UNBEARABLE

### Right Leg

NONE ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ UNBEARABLE

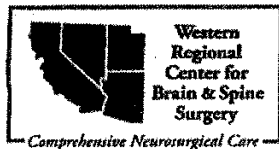
☐ I do not have back or lower extremity pain.

EXHIBIT Z  
 WIT: Sekera  
 DATE: 3-14-19  
 REPORTER: B. CANO



## 1456





William D. Smith, MD  
Jason E. Garber, MD, FACS  
Stuart S. Kaplan, MD, FACS  
Gregory L. Douda, MD

### Medical History Form

www.wrchss.com

Patient Name First: Joyce MI: P Last: Sekera  
Date of Birth: 3-22-56 Age: 61 Height: 5'6" Weight: 200 Email: JoyceSekera@yahoo.com  
Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Reason for today's visit: ☐ Brain tumor ☐ Carpal tunnel syndrome ☐ Cauda equina syndrome ☐ Cerebral palsy ☐ Chronic pain  
☐ Dizziness ☐ Headache ☐ Herniated disc ☐ Low back pain ☐ Neck pain ☐ Leg pain ☐ Arm pain ☐ Numbness & tingling  
☐ Weakness in limbs, etc. ☐ Scoliosis ☐ Spondylolisthesis ☐ Subarachnoid hemorrhage ☐ Follow up visit ☐ Postoperative visit  
☐ Scheduled postop visit ☐ Non-routine postop visit ☐ Work-related health problem ☐ Independent Medical Examination  
☐ Other: \_\_\_\_\_

Symptoms (specific problems): examination

How long have you had symptoms? \_\_\_\_\_

Is your current problem a result of an accident? ☐ Yes ☐ No

If 'Yes', mark all that apply: ☐ Car accident ☐ Work accident ☐ Accident Other: \_\_\_\_\_

### Past Medical Problems

Major illnesses and/or injuries (Mark all that apply below):

#### Cardiovascular

If you have experienced chest pain or angina, what was the date of your last EKG? \_\_\_\_\_

☐ Myocardial infarction ☐ Congestive heart failure ☐ Peripheral vascular disease  
☐ Cerebrovascular disease ☐ Hypertension (high blood pressure)  
☐ Other: \_\_\_\_\_

#### Respiratory

Date of last chest x-ray: \_\_\_\_\_

☐ Chronic pulmonary disease ☐ Asthma ☐ Emphysema  
☐ Bronchitis ☐ Pneumonia ☐ Lung cancer  
☐ Other: \_\_\_\_\_

#### Gastrointestinal

☐ Liver disease ☐ Colon cancer ☐ Ulcers ☐ Gastritis  
☐ Other: \_\_\_\_\_

#### Genitourinary

☐ Renal/Kidney disease ☐ Kidney stone(s) ☐ Prostate cancer (males)  
☐ Endometriosis ☐ Uterine ☐ Uterine cancer (females)  
☐ Cervical cancer (females)  
☐ Other: \_\_\_\_\_

#### Musculoskeletal

☐ Arthritis ☐ Fractures (specify): \_\_\_\_\_  
☐ Cervical spine disease ☐ Thoracic spine disease ☐ Lumbar spine disease  
☐ Other: \_\_\_\_\_

EXHIBIT BB  
WIT: Sekera  
DATE: 3-14-19  
REPORTER: B. CANO

**Past Medical Problems (continued)**

**Skin/Breast**

☐ Connective tissue disease

Date of last mammogram: \_\_\_\_\_ Result of mammogram: \_\_\_\_\_

☐ Other: \_\_\_\_\_

**Psychiatric**

☐ Depression

☐ Other psychiatric disorder: \_\_\_\_\_

**Endocrine**

☐ Diabetes

☐ Diabetes with end organ damage

☐ Thyroid disease

☐ Other: \_\_\_\_\_

**Hematology/Lymphatic**

☐ Anemia

☐ Hemophilia

☐ Blood clotting

☐ Blood transfusion (If checked, when?): \_\_\_\_\_

☐ Other: \_\_\_\_\_

**Immunologic**

☐ AIDS

☐ HIV positive

☐ Autoimmune disease

☐ Other immunological disorder: \_\_\_\_\_

**Other**

☐ Dementia

☐ Hemiplegia

☐ Any tumor

☐ Leukemia

☐ Lymphoma

☐ Metastatic solid tumor

☐ NONE OF THE ABOVE

**Allergies**

Allergy to latex: ☐ Yes ☒ No

Allergy to iodinated contrast: ☐ Yes ☐ No

Allergies to medications (specify): \_\_\_\_\_

☐ Food allergies (specify): \_\_\_\_\_

☐ Contact allergies (specify): \_\_\_\_\_

☐ Environmental allergies (specify): \_\_\_\_\_

☐ Other (specify): \_\_\_\_\_

☐ NONE OF THE ABOVE

**Family History**

Family Member	Alive	Deceased	Age	Health Status/Cause of Death
Mother	<input checked="" type="checkbox"/>	<input type="checkbox"/>	81	Good
Father	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Sister/Brother (circle one)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	86	Good
Sister/Brother (circle one)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	62	Good

**Social History**

What is your occupation? \_\_\_\_\_

What is your current work status? (specify below)

☐ Currently working (Full time)

☐ Currently working (Part time)

☐ Homemaker

☒ Retired (due to ill health)

☐ Retired (voluntarily)

☐ Full-time student

☐ Unpaid leave

☐ Medical disability - short term

☐ Medical disability - long term

☐ Unemployed

☐ No response

If "Currently working," indicate your work's physical demands: (specify below)

☐ Sedentary - little or no lifting, seated most of the time

☐ Light/moderate - light to moderate lifting, on feet part or most of the time

☐ Heavy - heavy lifting, stairs, ladders, squatting, etc.

If "Currently working," has your spine condition impacted your work status and/or the amount of physical work you can perform? ☐ Yes ☐ No ☐ N/A Indicate date last worked: \_\_\_\_\_



**Social History (continued)**

Marital Status: ☒ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Do you have children? ☒ Yes ☐ No Number of Adult (age 18 and over)? 1 Number of Child (age 0-17)? 0

Do you live alone? ☐ Yes ☒ No Who lives with you? None

Do you currently smoke or chew tobacco? ☒ Yes ☐ No

If 'Yes', how much do you smoke? ☐ less than 1 pack per day ☐ 1 pack per day ☐ 2 packs per day ☐ more than 2 packs per day

☐ N/A, currently use chewing tobacco 1 or 2 cigarettes a day

If 'No', specify: ☐ Never smoked ☐ Quit 0-6 months ago ☐ Quit 6-12 months ago

☐ Quit more than 1 year ago, less than 2 years ago ☐ Quit more than 2 years ago

Do you drink alcohol? ☒ No, never ☐ Occasionally ☐ 1 glass/day (light) ☐ 2-4 glass/day (moderate) ☐ 5 or more (heavy)

Do you use illicit drugs? ☒ Never ☐ Rarely ☐ Once a month ☐ Once a week ☐ Once or more per day

Are you at risk for HIV? (e.g. drug abuse, previous blood transfusion)

☒ No ☐ Yes, please explain: \_\_\_\_\_

**Spine Specific**

Indicate the highest recreational level you engaged in just prior to your spine condition. (Mark one below)

☐ Contact sports ☐ Non-contact sports ☐ Light recreational ☐ Sedentary ☐ N/A - Disabled ☐ No response

Is your recreation level affected by your spine condition? ☒ Yes ☐ No

**Medications**

Are you taking pain medications? (Mark all that apply below)

☒ No ☐ Yes, over-the-counter pain medications ☐ Yes, prescribed pain medication

If 'Yes', how often do you take pain medications?

☐ One dose/week as needed ☐ 1 dose every 2 days ☐ 1 or 2 doses per day ☐ 3 or more doses per day

List your Current Medications	Dose	Frequency

**Surgical History**

Have you ever had problems with anesthesia? ☐ Yes ☒ No If yes, please specify: \_\_\_\_\_

Have you had prior spine surgery? ☐ Yes ☒ No Specify: \_\_\_\_\_

Surgeries	Month/Day/Year	Surgeon	Complications

**Diagnostic Studies**

Indicate if you have undergone any of the following therapies for your back/neck and/or leg/arm before today? (Mark all that apply)

☐ None ☐ Bed rest ☐ Anti-depressant ☐ Acupuncture ☐ Behavior therapy ☐ Bracing/immobilization ☒ Chiropractic

☐ Epidural steroid injections Date: \_\_\_\_\_ Physician who performed injection? \_\_\_\_\_

☐ Medications ☐ EMG biofeedback ☒ Exercise therapy ☐ Physical therapy ☐ TENS ☐ Traction

☐ Bone density study ☐ MRI brain ☐ MRI cervical spine ☐ MRI thoracic spine

☒ MRI lumbar spine ☐ CT brain ☐ CT cervical spine ☐ CT thoracic spine

☐ CT lumbar spine ☐ CT pelvis ☐ X-ray cervical spine ☐ X-ray thoracic spine

☒ X-ray lumbar spine ☐ Hip x-ray ☐ Other (specify) \_\_\_\_\_

# **Review of Systems**

**Do you currently have the following problems? (Mark all that apply below)**

## **General**

- ☐ Fever
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats
- ☐ Excessive fatigue

## **Head, Ears, Eyes, Nose, Throat**

- ☐ Wears glasses/contact lenses
- ☐ Eye infection
- ☐ Eye injury
- ☐ Glaucoma
- ☐ Cataracts

- ☐ Hearing loss
- ☐ Wears hearing aids
- ☐ Ear pain

- ☐ Ear infection
- ☐ Ringing in the ears

- ☐ Balance disturbance
- ☐ Vertigo
- ☐ Spinning sensation
- ☐ Nose bleed
- ☐ Nasal congestion

- ☐ Nasal drainage
- ☐ Inability to smell
- ☐ Sinus problems
- ☐ Sinus headaches

## **Respiratory**

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bloody sputum
- ☐ Asthma

## **Breast**

- ☐ Breast pain
- ☐ Breast tenderness
- ☐ Breast swelling
- ☐ Nipple discharge

## **Cardiovascular**

- ☐ High blood pressure
- ☐ Irregular pulse
- ☐ Heart murmur
- ☐ High cholesterol
- ☐ Swelling of extremities
- ☒ Leg pain and/or swelling

## **Gastrointestinal**

- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Jaundice

- ☐ Abdominal pain
- ☐ Change in bowel habits

- ☐ Blood in urine

- ☐ Urinary frequency
- ☐ Painful urination
- ☐ Urinary urgency
- ☐ Incontinence

## **Musculoskeletal**

- ☒ Neck pain
- ☒ Arm pain
- ☐ Arm weakness
- ☒ Back pain

- ☒ Leg pain

- ☐ Leg weakness
- ☐ Joint pain
- ☒ Joint swelling
- ☐ Decreased range of motion

## **Neurological**

- ☐ Fainting spells
- ☐ Blacking out
- ☐ Seizures
- ☐ Problems with memory
- ☐ Disorientation
- ☐ Difficulty with speech
- ☐ Inability to concentrate
- ☐ Double vision
- ☐ Blurred vision
- ☐ Face weakness
- ☐ Incoordination
- ☐ Headaches

## **Psychiatric**

- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

## **Endocrine**

- ☐ Appetite changes
- ☐ Thyroid problems
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Excessive sweating
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Hair changes

## **Hematology**

- ☐ Easy bruising
- ☐ Excessive bleeding
- ☐ Gland problems
- ☐ Anemia

The above information is accurate to the best of my knowledge.

Patient Signature

Date

I have reviewed the above information with the patient.

Physician Signature

Date





Intake Questionnaire  
ADVANCED IMAGING

Please answer all questions below and notify the technologist of any metal inside or on your body. For MRI's, please remove all removable metal from your body such as hearing aides, hairpins, jewelry, dentures, partial plates, etc. SDMI IS NOT RESPONSIBLE FOR HEARING AIDS BROUGHT INTO THE EXAM ROOM

Patient Information

First Name Joyce Last Name SEKERA Patient Number 790179  
Age 62

DO YOU HAVE? (circle yes or no for all)

Pacemaker / Wires / Cardiac Defibrillator? YES ☒ NO ☐ Brand: \_\_\_\_\_  
Brain Aneurysm Clips / Coils? YES ☒ NO ☐  
Neurostimulator / Wires? YES ☒ NO ☐ Where: \_\_\_\_\_  
Bone Stimulator / Wires? YES ☒ NO ☐ Where: \_\_\_\_\_  
Cochlear Implant / Ear Implant? YES ☒ NO ☐  
Breast Tissue Expander? YES ☒ NO ☐  
Metallic Foreign Body In Eye? YES ☒ NO ☐

If you circled yes to ANY of the above you must verbally NOTIFY the tech before your exam.

Metal In the body (joints, rods, screws, clips)? YES ☒ NO ☐ Where: \_\_\_\_\_  
Stents or Filters? YES ☒ NO ☐ Where: \_\_\_\_\_  
Shunt Valves Programmable? YES ☒ NO ☐  
Shunt Valves Non-Programmable? YES ☒ NO ☐  
Surgically Implanted Device? YES ☒ NO ☐ Where: \_\_\_\_\_  
Medication Patch? YES ☒ NO ☐  
Hearing Aid? YES ☒ NO ☐ If Yes, you must leave outside of room  
Tattoos or Permanent Makeup? YES ☒ NO ☐ Where: \_\_\_\_\_  
Any clothing containing metal? YES ☒ NO ☐  
Recent Barium Enema/UGI? YES ☒ NO ☐  
IV Dye (MRI or CT) in last 48 hours? YES ☒ NO ☐

History (circle yes or no for all)

Are you pregnant / breastfeeding? YES ☒ NO ☐  
Have you ever had Renal Failure / Dialysis? YES ☒ NO ☐  
If Yes, when: \_\_\_\_\_  
Do you have Hypertension? YES ☒ NO ☐  
Do you have Diabetes? YES ☒ NO ☐  
If Yes: (circle one) Insulin Oral Medication  
COPD YES ☒ NO ☐  
Cardiac Disease YES ☒ NO ☐

History Continued (circle all that apply)

Are you a smoker? Current ☒ Past ☐ Never ☐  
If yes, how many years? 1 day MAY 18

Allergies (list all, medications)

Patient Signature: Joyce Sekera

Todays Date: 4/27/18

TECH NOTES: (for internal use only)

Notes \_\_\_\_\_

EXHIBIT 66  
WIT: Sekera  
DATE: 3-14-19  
REPORTER: B. CANO

SD 017

1463



# History Questionnaire Advanced Musculoskeletal Imaging

**Patient Information**  
 First Name Joyce Last Name Sekera Patient Number 140799  
 Age 62

**Reason for your Exam** (please describe in detail)  
RT knee pain  
pain on medial side of knee  
swelling

**TECH NOTES:** (for internal use only)  
 Contrast             
 Sedation             
 Notes           

**SYMPTOMS, Extremities** (circle all that apply)  
 Previous Joint Injections YES            NO            Where Spine  
 Joint Pain            Acute Chronic Right Left  
 Arthritis            Acute Chronic Right Left  
Stiffness            Acute Chronic Right Left  
 Weakness            Acute Chronic Right Left  
 Loss of Range of Motion Acute Chronic Right Left  
 Mass            Acute Chronic Right Left  
 Infection            Acute Chronic Right Left

**Please mark where you are experiencing pain/discomfort**

What is the exact location of your symptoms:  
 Have you ever been diagnosed with Diabetes? YES            NO             
 Have you ever had Renal Failure / Dialysis? YES when:            NO           

**Is your problem related to an injury?** NO            YES            (if yes continue)  
 Date of Injury 1/2 week How were you injured (circle one) Car Accident Work Other             
 Describe Injury (please be specific) fell off bed

**Have you ever been diagnosed with cancer?** NO            YES            (if yes continue)  
 What type of cancer            Location            Date Diagnosed             
 Current Status (please circle one) Newly Diagnosed Recurrence Remission  
 Treatment (please circle all that apply) Surgery Radiation ChemoTherapy  
 Date of last Treatment             
 Has it spread? NO            YES            If Yes, Where             
 Is your visit today related to this cancer diagnosis NO            YES           

**Previous surgeries related to the affected area you are being seen for today.** (Please list specifically, what and when. Use back if extra space needed.)

Procedure Description	Date

**Previous imaging studies related to the affected area you are being seen for today.** (Please list specifically, what and when. Use back if extra space needed.)

Procedure Description	Date



Name: SEKERA, JOYCE

DOB: 03-22-1956 DOS: 04-11-2017

**Numbness**  
(Adormecimiento)

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-----  
-----

**Pins & Needles**  
(Piquetes)

○ ○ ○ ○ ○ ○ ○  
○ ○ ○ ○ ○ ○ ○  
○ ○ ○ ○ ○ ○ ○

**Burning**  
(Ardor)

△ △ △ △ △ △  
△ △ △ △ △ △  
△ △ △ △ △ △

**Aching**  
(Adolorido)

× × × × × ×  
× × × × × ×  
× × × × × ×

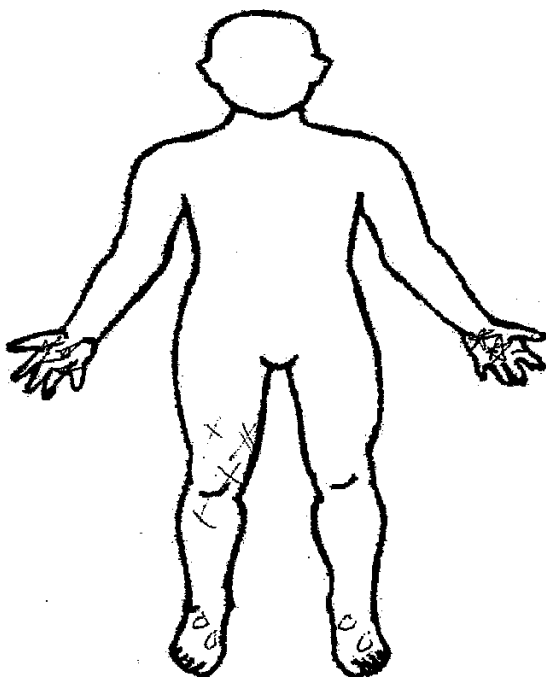
**Stabbing**  
(Punzadas)

⊗ ⊗ ⊗ ⊗ ⊗ ⊗  
⊗ ⊗ ⊗ ⊗ ⊗ ⊗  
⊗ ⊗ ⊗ ⊗ ⊗ ⊗

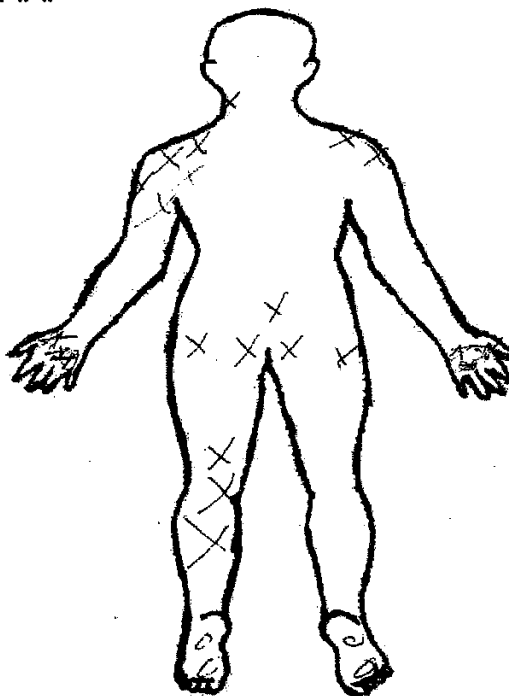
**Tinging**  
(Hormigueo)

\* \* \* \* \*  
\* \* \* \* \*  
\* \* \* \* \*

FRONT / FRENTE



BACK / ATRAS



  
Patient signature

  
Reviewed by Physician

EXHIBIT DD  
WIT: Sekera  
DATE: 3-14-19  
REPORTER: B. CANO

36739

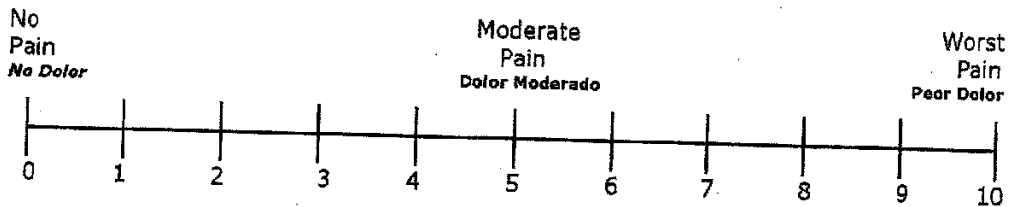
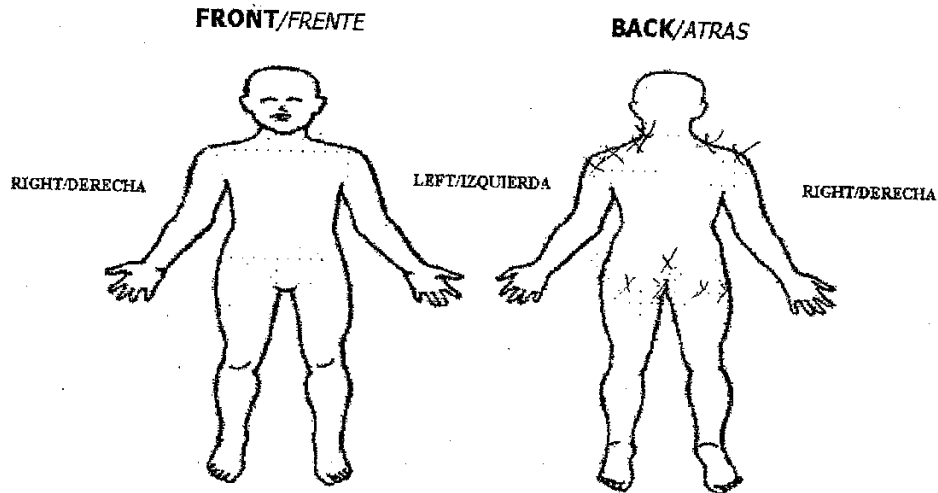
RADAR 074

# PAIN CHART

Name: SEKERA, JOYCE DOB: 03-22-1956 DOS: 04-11-2017

**Where is your pain?**  
*Donde esta su dolor?*

**Please mark on the drawings below the areas where you feel your pain.**  
*Porfavor marque las partes del cuerpo donde siente dolor.*



Is your pain: **BETTER** **SAME** **WORSE** from your last visit.  
 Su dolor esta: **MEJOR** **IGUAL** **PEOR** de su ultima visita.

*(Please circle one)*  
*(Porfavor circule uno)*

*[Signature]*  
 Patient Signature/firma de paciente

*[Signature]*  
 Reviewed by Physician/firma de doctor

36739

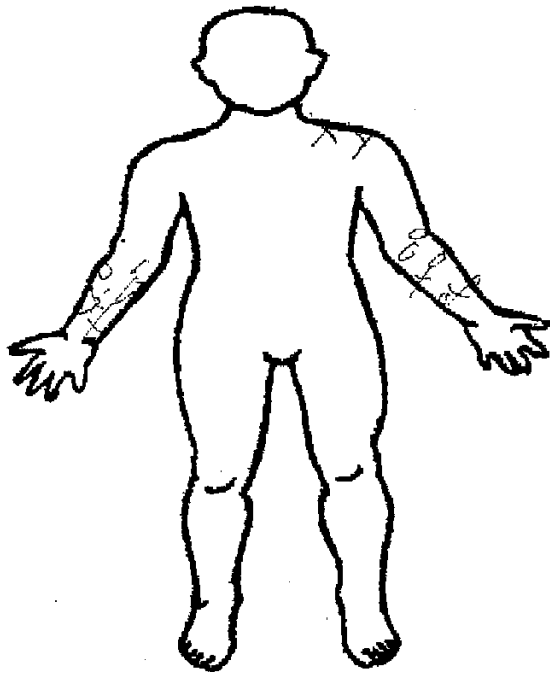


Name: SEKERA, JOYCE DOB: 03-22-1956 DOS: 05-02-2017

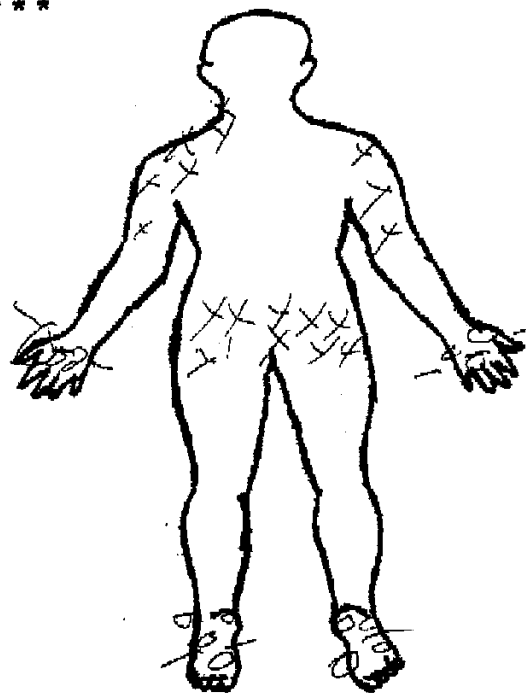
<b>Numbness</b> (Adormecimiento)	<b>Pins &amp; Needles</b> (Piquetas)	<b>Burning</b> (Ardor)	<b>Aching</b> (Dolorido)	<b>Stabbing</b> (Punzadas)
.....	○ ○ ○ ○ ○ ○ ○ ○	△ △ △ △ △ △ △ △	× × × × × ×	⊗ ⊗ ⊗ ⊗ ⊗ ⊗
.....	○ ○ ○ ○ ○ ○ ○ ○	△ △ △ △ △ △ △ △	× × × × × ×	⊗ ⊗ ⊗ ⊗ ⊗ ⊗
.....	○ ○ ○ ○ ○ ○ ○ ○	△ △ △ △ △ △ △ △	× × × × × ×	⊗ ⊗ ⊗ ⊗ ⊗ ⊗

**Tinging**  
(Hormigueo)  
\* \* \* \* \*  
\* \* \* \* \*  
\* \* \* \* \*

FRONT / FRENTE



BACK / ATRAS



  
\_\_\_\_\_  
Patient signature

  
\_\_\_\_\_  
Reviewed by Physician

36739

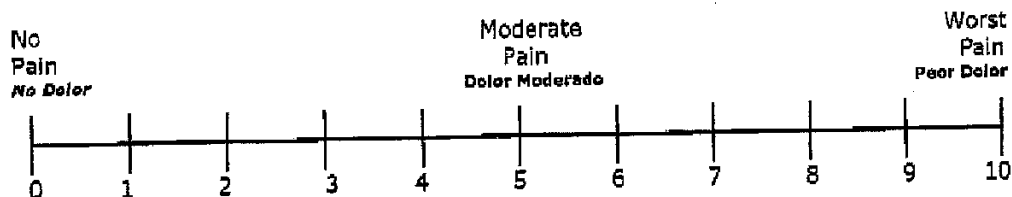
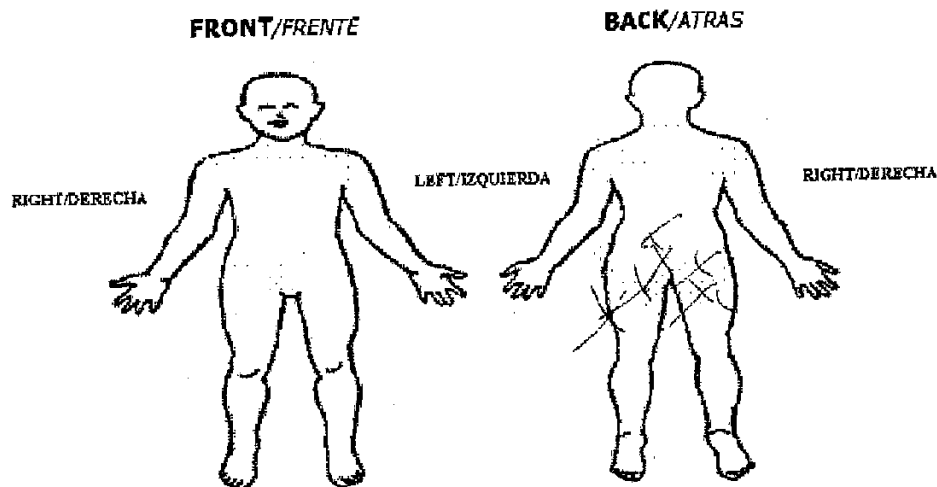
RADAR 041

# PAIN CHART

Name: SEKERA, JOYCE DOB: 03-22-1956 DOS: 05-02-2017

**Where is your pain?**  
*Donde esta su dolor?*

**Please mark on the drawings below the areas where you feel your pain.**  
*Por favor marque las partes del cuerpo donde siente dolor.*



Is your pain: **BETTER** **SAME** **WORSE** from your last visit.  
 Su dolor esta: **MEJOR** **IGUAL** **PEOR** de su ultima visita.

*(Please circle one)*  
*(Por favor circule uno)*

*[Signature]*  
 Patient Signature/firma de paciente

*[Signature]*  
 Reviewed by Physician/firma de doctor

36739

Name: SEKERA, JOYCE

DOB: 03-22-1956 DOS: 07-10-2017

**Numbness**  
(Adormecimiento)

.....  
.....  
.....

**Pins & Needles**  
(Piquetes)

○ ○ ○ ○ ○ ○ ○  
○ ○ ○ ○ ○ ○ ○  
○ ○ ○ ○ ○ ○ ○

**Burning**  
(Ardor)

△ △ △ △ △ △  
△ △ △ △ △ △  
△ △ △ △ △ △

**Aching**  
(Dolorido)

x x x x x x  
x x x x x x  
x x x x x x

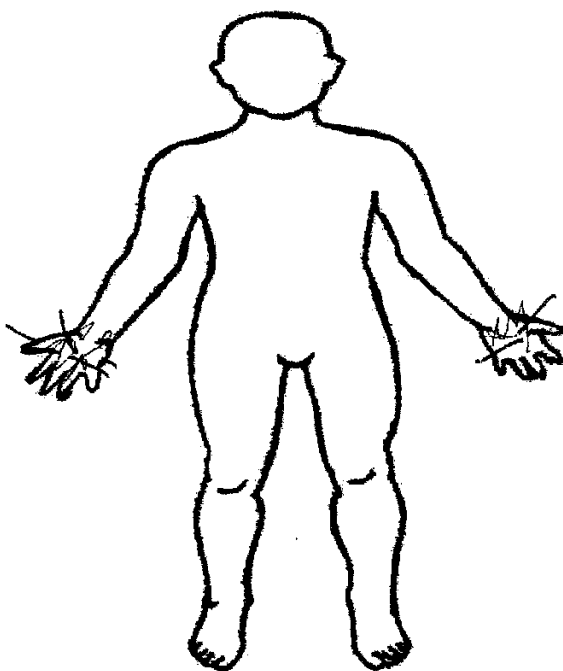
**Stabbing**  
(Punzadas)

⊗ ⊗ ⊗ ⊗ ⊗  
⊗ ⊗ ⊗ ⊗ ⊗  
⊗ ⊗ ⊗ ⊗ ⊗

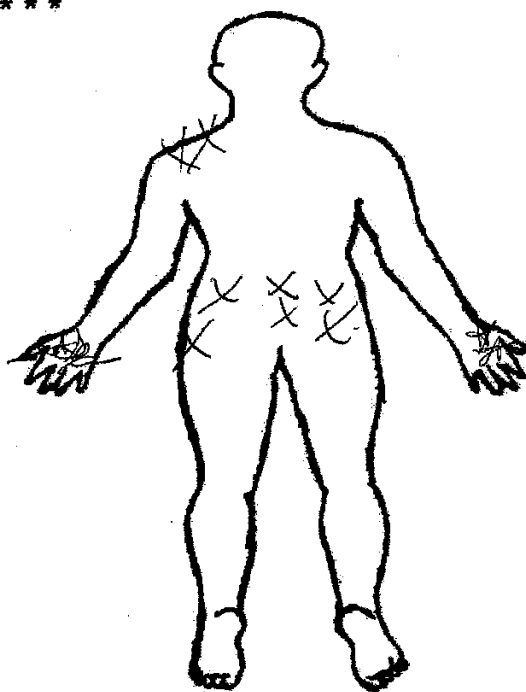
**Tinging**  
(Hormigueo)


\* \* \* \* \*  
\* \* \* \* \*  
\* \* \* \* \*


FRONT / FRENTE



BACK / ATRAS



  
Patient signature

  
Reviewed by Physician

36739

# PAIN CHART

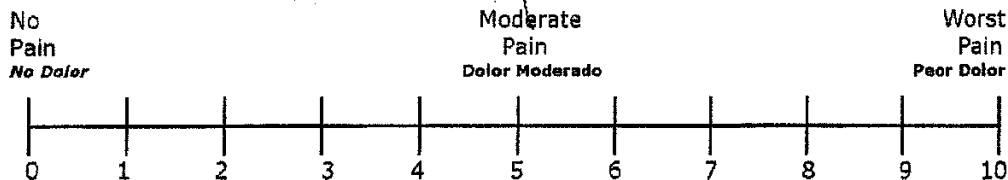
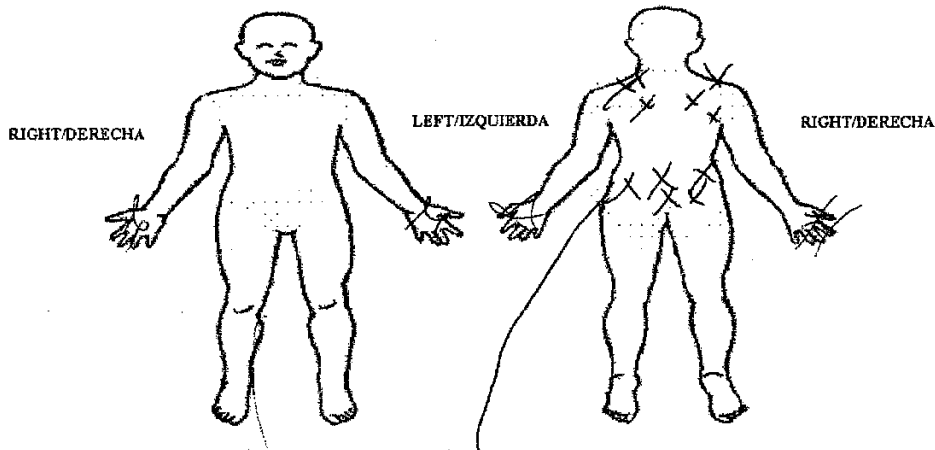
Name: SEKERA, JOYCE DOB: 03-22-1956 DOS: 07-10-2017

**Where is your pain?**  
*Donde esta su dolor?*

**Please mark on the drawings below the areas where you feel your pain.**  
*Porfavor marque las partes del cuerpo donde siente dolor.*

**FRONT/FRENTE**

**BACK/ATRAS**



Is your pain: **BETTER** **SAME** **WORSE** from your last visit.  
*Su dolor esta: MEJOR IGUAL PEOR de su ultima visita.*

*(Please circle one)*  
*(Porfavor circule uno)*

Patient Signature/firma de paciente

Reviewed by Physician/firma de doctor

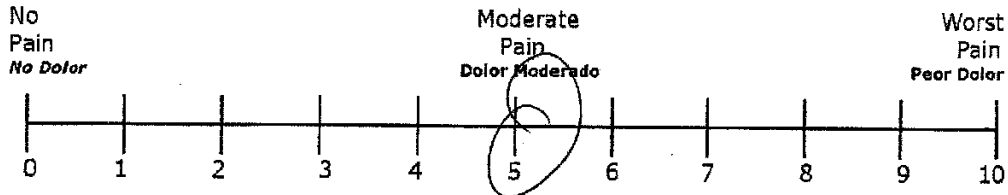
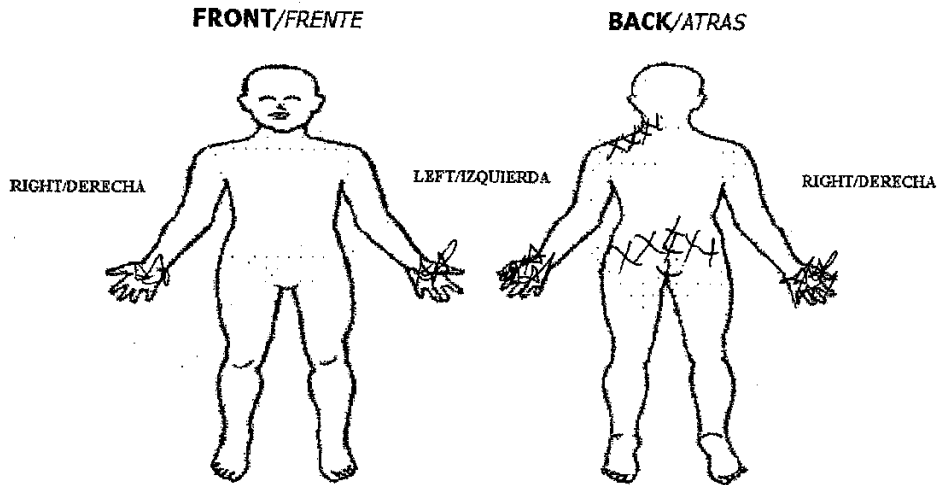
36739

# PAIN CHART

Name: SEKERA, JOYCE DOB: 03-22-1956 DOS: 10-23-2017

**Where is your pain?**  
*Donde esta su dolor?*

**Please mark on the drawings below the areas where you feel your pain.**  
*Por favor marque las partes del cuerpo donde siente dolor.*



**Is your pain: BETTER SAME WORSE from your last visit.**  
*Su dolor esta: MEJOR IGUAL PEOR de su ultima visita.*

*(Please circle one)*  
*(Por favor circule uno)*

Patient Signature/firma de paciente

Reviewed by Physician/firma de doctor

36739

Name: SEKERA, JOYCE

DOB: 03-22-1956 DOS: 10-23-2017

**Numbness**  
(Adormecimiento)

.....  
.....  
.....

**Pins & Needles**  
(Piquetes)

○ ○ ○ ○ ○ ○ ○  
○ ○ ○ ○ ○ ○ ○  
○ ○ ○ ○ ○ ○ ○

**Burning**  
(Ardor)

△ △ △ △ △ △  
△ △ △ △ △ △  
△ △ △ △ △ △

**Aching**  
(Adolorido)

× × × × × ×  
× × × × × ×  
× × × × × ×

**Stabbing**  
(Punzadas)

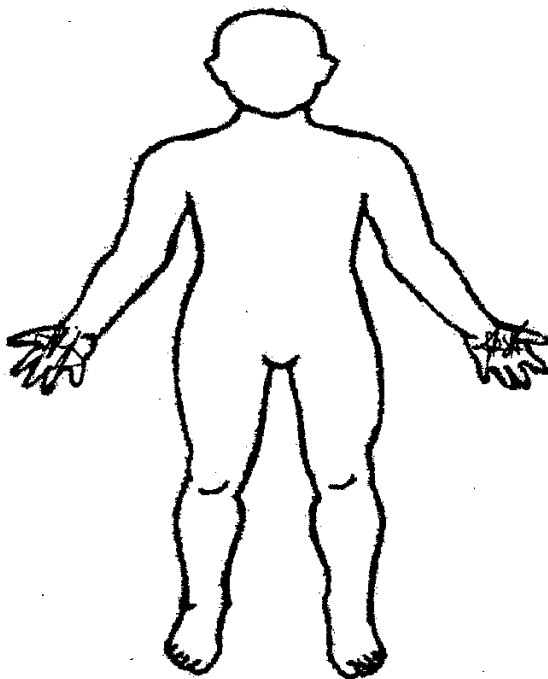
⊗ ⊗ ⊗ ⊗ ⊗ ⊗  
⊗ ⊗ ⊗ ⊗ ⊗ ⊗  
⊗ ⊗ ⊗ ⊗ ⊗ ⊗

**Tinging**

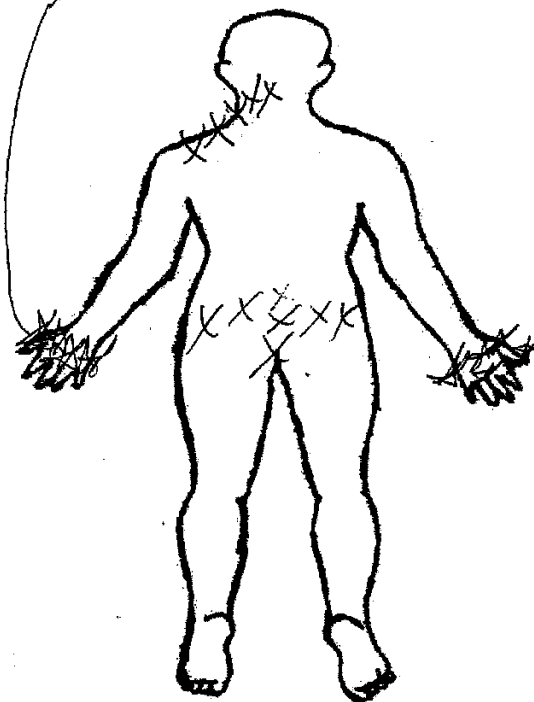
(Hormigueo)

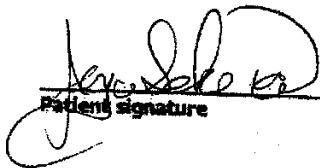
\* \* \* \* \*  
\* \* \* \* \*  
\* \* \* \* \*

FRONT / FRENTE



BACK / ATRAS



  
Patient signature

  
Reviewed by Physician

36739

RADAR 020



## SECOND L E N I E N T

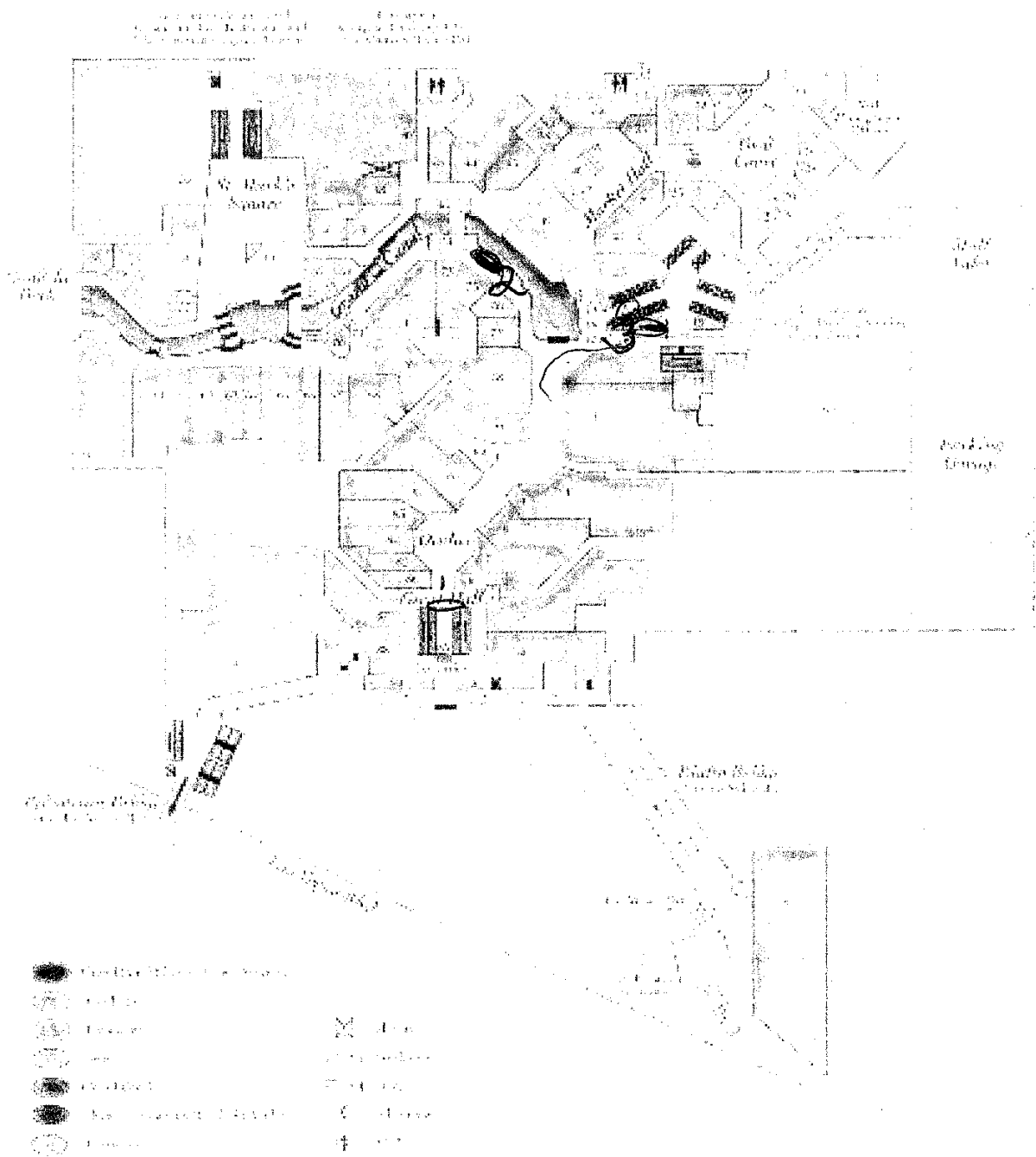


EXHIBIT EE  
WIT: Sekera  
DATE: 3-14-19  
REPORTER: B. CANO