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

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

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BY MR. ROYAL:

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

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

A. Yes.

Q. It looks like they're all signed by the doctor.

Did the doctor sign these in your presence? Do you remember?

A. Yes.

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

A. Yes.

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

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

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

A. Okay.

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

A. Not to my knowledge.

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

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

A. (Reading document.)

Yes. It looks right.

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

A. Yes.

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

A. Yes.

Q. And tell me about that visit.

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

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

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

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

A. Yes.

Q. And do you remember what you told him?

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

Q. Did you tell him about your neck?

A. Yes, yes.

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

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

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

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

Q. Okay. What was x-rayed?

A. My back, I believe; my neck.

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

A. No.

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

A. Yes.

Q. What can you tell me about that?

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

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

A. Yes.

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

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

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

A. I do not recall.

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

Have you since returned to him?

A. No.

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

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

Q. February 7th, 2019.
A. I want to say March 7th, but I'm not sure.
Q. Are you familiar with a Dr. Schifini? Do you know that name?
A. Yes.
Q. Have you -- how do you know that name?
A. I have a friend that went there.
Q. Okay. Have you presented to Dr. Schifini?
A. No. I won't go there.
Q. Why not?
A. I just won't. It's a personal thing.
Q. Okay. But no one referred you to Dr. Schifini, right, that you know of for injuries associated with that --
A. That would be the workers' comp.
Q. Oh, I see.
A. It has nothing -- yes.
Q. Well, it --
A. What I'm -- yeah.
Q. If they refer you to someone, it's ultimately going to have something to do with this case. So if they refer you to a doctor, it's something I need to know about.
A. Okay.
Q. So have you been referred for more -- strike

that.

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

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

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

A. Yes.

Q. And who is that?

A. Dr. Lee.

Q. Dr. who?

A. Lee.

Q. First name?

A. Daniel.

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

A. Uh-huh.

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

A. Yes.

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

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

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

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

A. Did you say Tao is --

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

EE.

(Exhibit EE was marked.)

BY MR. ROYAL:

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

You know where that is; right?

A. The --

Q. The moving walkway.

A. Yes.

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

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

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

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

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

A. Right here (indicating).

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

A. (Complies.)

Then this right here.

Q. Okay. That's good.

So that would be the first --

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

Q. Where would the next one be?

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

Q. Draw a circle and write "2."

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

Q. Where's the other one?

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

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

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

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

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

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

I would say right here.

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

A. I go to the right.

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

A. The escalators are here, then.

Q. I think the escalators are in the green.

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

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

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

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

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

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

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

A. (Complies.)

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

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

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

A. Okay.

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

A. Okay.

Q. Darken the number 2.

A. Just this one?

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

A. Oh, like this? Bigger?

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

A. (Complies.)

Q. Number 1 looks pretty good.

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

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

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

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

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

Q. Okay. How about if we indicate the elevator.

You've made a circle here?

A. Uh-huh.

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

you recall?

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

Q. It's okay. We don't need to get too technical. Stay off the record for a minute.

(Discussion held off the record.)

MR. ROYAL: Back on the record.

BY MR. ROYAL:

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

A. Name and date?

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

A. (Complies.)

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. Definitely. Oh, yes.

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

A. Yes.

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

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

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

A. That's correct.

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

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

MR. KUNZ: I believe you were on 9.

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

BY MR. ROYAL:

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

Do you see that?

A. Yes.

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

A. No.

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

A. No.

Q. Is there --

A. Just about getting better.

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

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

A. No.

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

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

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

BY MR. ROYAL:

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

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

MR. KUNZ: Same objection.

Go ahead.

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

MR. ROYAL: Yeah.

BY MR. ROYAL:

Q. Did you have a chair at your kiosk?

A. Yes.

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

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

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

A. No.

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

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

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

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

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

A. Possibly. I just don't know.

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

A. No.

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

A. No.

Q. Is that correct?

A. That's correct.

Q. And you have not had any kind of discussion

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

A. No.

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

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

Q. Is it still in a tizzy?

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

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

A. Yes. I will never say never.

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

A. Okay.

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

A. Okay.

MR. ROYAL: Do you have any questions?

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

MR. ROYAL: Okay.

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

THE WITNESS: Okay.

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

THE WITNESS: Okay.

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

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

(The proceedings concluded at 3:49 p.m.)

CERTIFICATE OF DEPONENT

PAGE	LINE	CHANGE	REASON

* * * * *

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.

_____

JOYCE P. SEKERA, Deponent

This ____ day of _____, 2019.

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

Blanca I. Cano, CCR No. 861, RPR

T

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DISTRICT COURT

CLARK COUNTY, NEVADA

JOYCE SEKERA, an Individual, Plaintiff, v. VENETIAN CASINO RESORT, LLC, d/b/a THE VENETIAN LAS VEGAS, a Nevada Limited Liability Company; LAS VEGAS SANDS, LLC d/b/a THE VENETIAN LAS VEGAS, a Nevada Limited Liability Company; YET UNKNOWN EMPLOYEE; DOES I through X, inclusive, Defendants.	CASE NO.: A-18-772761-C DEPT. NO.: 25

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

TO: VENETIAN CASINO RESORT, LLC, Defendant

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

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

Plaintiff, JOYCE SEKERA, by and through her undersigned attorneys, hereby answers Defendants' First Set of Interrogatories as follows:

INTERROGATORY NO. 1:

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

ANSWER NO. 1:

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

INTERROGATORY NO. 2:

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

ANSWER NO. 2:

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

INTERROGATORY NO. 3:

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

ANSWER NO. 3:

Yes.

INTERROGATORY NO. 4:

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

ANSWER NO. 4:

I was walking to the restroom.

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INTERROGATORY NO. 5:

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

ANSWER NO. 5:

Approximately two times a day.

INTERROGATORY NO. 6:

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

ANSWER NO. 6:

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

INTERROGATORY NO. 7:

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

ANSWER NO. 7:

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

INTERROGATORY NO. 8:

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

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ANSWER NO. 8:

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

INTERROGATORY NO. 9:

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

ANSWER NO. 9:

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

INTERROGATORY NO. 10:

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

ANSWER NO. 10:

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

INTERROGATORY NO. 11:

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

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ANSWER NO. 11:

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

INTERROGATORY NO. 12:

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

ANSWER NO. 12:

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

INTERROGATORY NO. 13:

Attached hereto as Exhibit B is a copy of the Narrative portion of the Venetian security report related to the subject incident. A portion of the Narrative reads as Follows: "*She reported that he 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 any head pain, neck pain, back pain, weakens, dizziness, or nausea at that time.*" Please state whether the above quoted portions of the report is an accurate description of information you provided to Defendants' responding security; if not, please provide what you contend to be an accurate statement.

ANSWER NO. 13:

Please see my answer to Interrogatory No. 11.

INTERROGATORY NO. 14:

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

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

ANSWER NO. 14:

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

INTERROGATORY NO. 15:

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

ANSWER NO. 15:

Please see my answer to Interrogatory No. 11.

INTERROGATORY NO. 16:

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

ANSWER NO. 16:

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

INTERROGATORY NO. 17:

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

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ANSWER NO. 17:

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

INTERROGATORY NO. 18:

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

ANSWER NO. 18:

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

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

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

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

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

INTERROGATORY NO. 19:

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

ANSWER NO. 19:

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

Centennial Hills Hospital 6900 N. Durango Drive, LasVegas, Nevada 89149. $4,454.00

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Shadow Emergency Physicians 1000 River Road, Ste. 100, Conshohocken, PA 19428. $1,272.00

Desert Radiologists 2020 Palomino Lane, #100, Las Vegas, Nevada 89106. $77.00

Jason Webber, D.C. CoreRehab 10620 Southern Highlands Pkwy., Ste. 110-329, Las Vegas, Nevada 89141. $10,756.00

Las Vegas Radiology 3201 S. Maryland Parkway, Ste. 102, Las Vegas, Nevada 89109. $848.00

Michelle Hyla, D.O. Southern Nevada Medical Group 1485 E. Flamingo Road, Las Vegas, Nevada 89119. $1,975.00

Russell J. Shah, M.D. Radar Medical Group 10624 S. Eastern Avenue, Henderson, Nevada 89052. $17,613.50

PayLater/WellCare Pharmacy P.O. Box 1200, Las Vegas, Nevada 89125. $282.33

Las Vegas Pharmacy 2600 W. Sahara Avenue, Ste. 120, Las Vegas, Nevada 89102. $1,090.93

Walter M. Kidwell, M.D. Katherine D. Travnicek, M.D. Pain Institute of Nevada 7435 W. Azure Drive, Ste. 190, Las Vegas, Nevada 89130. $16,000.00

Valley View Surgery Center 1330 S. Valley View Blvd., Las Vegas, Nevada 89102. $15,489.48

Steinberg Diagnostic P.O. Box 36900, Las Vegas, Nevada 89133. $1,400.00

Andrew Cash, M.D. Desert Institute of Spine Care 339 W. Sunset Road, Ste. 100, Las Vegas, Nevada 89148. $1,750.00.

William D. Smith, M.D. Western Regional Center for Brain & Spine 3061 S. Maryland Pkwy, Ste. 200, Las Vegas, Nevada 89109.

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INTERROGATORY NO. 20:

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

ANSWER NO. 20:

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

INTERROGATORY NO. 21:

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

ANSWER NO. 21:

None that I can recall.

INTERROGATORY NO. 22:

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

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

ANSWER NO. 22:

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

INTERROGATORY NO. 23:

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

ANSWER NO. 23:

None that I am aware of.

INTERROGATORY NO. 24:

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

ANSWER NO. 24:

Yes. My attorney's office has my shoes.

INTERROGATORY NO. 25:

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

a. Identify the person making the item including name, address and telephone number(s);

b. State the nature and description of the item; and,

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c. State the present location of the item.

ANSWER NO. 25:

None that I am aware of.

INTERROGATORY NO. 26:

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

ANSWER NO. 26:

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

INTERROGATORY NO. 27:

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

ANSWER NO. 27:

Please see my answer to Interrogatory No. 26.

INTERROGATORY NO. 28:

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

ANSWER NO. 28:

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

INTERROGATORY NO. 29:

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

a. Personal/social

b. Employment

c. Family relationships

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d. Other

ANSWER NO. 29:

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

INTERROGATORY NO. 30:

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

ANSWER NO. 30:

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

INTERROGATORY NO. 31:

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

ANSWER NO. 31:

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

INTERROGATORY NO. 32:

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

ANSWER NO. 32:

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

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INTERROGATORY NO. 33:

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

ANSWER NO. 33:

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

INTERROGATORY NO. 34:

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

ANSWER NO. 34:

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

INTERROGATORY NO. 35:

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

ANSWER NO. 35:

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

INTERROGATORY NO. 36:

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

ANSWER NO. 36:

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

INTERROGATORY NO. 37:

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

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ANSWER NO. 37:

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

DATED this 27th day of August, 2018.

THE GALLIHER LAW FIRM

Keith E. Galliher, Jr., Esq.
Nevada Bar No. 220
1850 E. Sahara Avenue, Suite 107
Las Vegas, Nevada 89104
Attorneys for Plaintiff

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VERIFICATION

STATE OF NEVADA)
) **ss.**
COUNTY OF CLARK)

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 21 day of August, 2018.

NOTARY PUBLIC, in and for said
County and State

DEENA P. MOONEY
Notary Public-State of Nevada
Appointment Recorded in Clark County
My Appointment Expires Sept. 21, 2018
98-4745-1

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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)

X 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
Keith E. Galliher, Jr., Esq.
Nevada Bar No. 220
Jeffrey L. Galliher, Esq.
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Attorneys for Plaintiffs

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DISTRICT COURT

CLARK COUNTY, NEVADA

JOYCE SEKERA, an Individual, Plaintiff, v. VENETIAN CASINO RESORT, LLC, d/b/a THE VENETIAN LAS VEGAS, a Nevada Limited Liability Company; LAS VEGAS SANDS, LLC d/b/a THE VENETIAN LAS VEGAS, a Nevada Limited Liability Company; YET UNKNOWN EMPLOYEE; DOES I through X, inclusive, Defendants.	CASE NO.: A-18-772761-C DEPT. NO.: 25

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

TO: VENETIAN CASINO RESORT, LLC, Defendant

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

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

Plaintiff, JOYCE SEKERA, by and through her undersigned attorneys, hereby respondes Defendants' First Set of Request for Admissions as follows:

REQUEST NO. 1:

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

RESPONSE NO. 1:

Admit.

REQUEST NO. 2:

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

RESPONSE NO. 2:

Deny.

REQUEST NO. 3:

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

RESPONSE NO. 3:

Deny.

REQUEST NO. 4:

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

RESPONSE NO. 4:

Deny.

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REQUEST NO. 5:

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

RESPONSE NO. 5:

Admit.

REQUEST NO. 6:

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

RESPONSE NO. 6:

Admit.

REQUEST NO. 7:

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

RESPONSE NO. 7:

Admit.

REQUEST NO. 8:

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

RESPONSE NO. 8:

Deny.

REQUEST NO. 9:

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

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RESPONSE NO. 9:

Deny.

REQUEST NO. 10:

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

RESPONSE NO. 10:

Deny.

REQUEST NO. 11:

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

RESPONSE NO. 11:

Admit.

REQUEST NO. 12:

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

RESPONSE NO. 12:

Admit.

REQUEST NO. 13:

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

RESPONSE NO. 13:

Deny.

REQUEST NO. 14:

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

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RESPONSE NO. 14:

Deny.

REQUEST NO. 15:

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

RESPONSE NO. 15:

Deny.

REQUEST NO. 16:

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

RESPONSE NO. 16:

Deny.

REQUEST NO. 17:

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

RESPONSE NO. 17:

Deny.

REQUEST NO. 18:

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

RESPONSE NO. 18:

Deny.

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REQUEST NO. 19:

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

RESPONSE NO. 19:

Deny.

REQUEST NO. 20:

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

RESPONSE NO. 20:

Admit.

REQUEST NO. 21:

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

RESPONSE NO. 21:

Admit.

REQUEST NO. 22:

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

RESPONSE NO. 22:

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

REQUEST NO. 23:

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

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RESPONSE NO. 23:

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

REQUEST NO. 24:

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

RESPONSE NO. 24:

Admit.

REQUEST NO. 25:

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

RESPONSE NO. 25:

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

REQUEST NO. 26:

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

RESPONSE NO. 26:

Deny.

REQUEST NO. 27:

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

RESPONSE NO. 27:

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

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REQUEST NO. 28:

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

RESPONSE NO. 28:

Deny.

REQUEST NO. 29:

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

RESPONSE NO. 29:

Admit.

REQUEST NO. 30:

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

RESPONSE NO. 30:

Admit.

REQUEST NO. 31:

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

RESPONSE NO. 31:

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

REQUEST NO. 32:

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

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RESPONSE NO. 32:

Deny.

DATED this 24 day of October, 2018.

THE GALLIHER LAW FIRM

Keith E. Galliher, Jr., Esq.
Nevada Bar No. 220
1850 E. Sahara Avenue, Suite 107
Las Vegas, Nevada 89104
Attorneys for Plaintiff

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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
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Las Vegas, Nevada 89104
702-735-0049 Fax: 702-735-0204

THE GALLIHER LAW FIRM
Keith E. Galliher, Jr., Esq.
Nevada Bar No. 220
Jeffrey L. Galliher, Esq.
Nevada Bar Number 8078
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gkunz@lvlawguy.com
Attorneys for Plaintiffs

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DISTRICT COURT

CLARK COUNTY, NEVADA

JOYCE SEKERA, an Individual, Plaintiff, v. VENETIAN CASINO RESORT, LLC, d/b/a THE VENETIAN LAS VEGAS, a Nevada Limited Liability Company; LAS VEGAS SANDS, LLC d/b/a THE VENETIAN LAS VEGAS, a Nevada Limited Liability Company; YET UNKNOWN EMPLOYEE; DOES I through X, inclusive, Defendants.	CASE NO.: A-18-772761-C DEPT. NO.: 25

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

TO: VENETIAN CASINO RESORT, LLC, Defendant

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

Plaintiff, JOYCE SEKERA, by and through her undersigned attorneys, hereby respondes Defendants' First Set of Request for Admissions as follows:

REQUEST NO. 1:

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

RESPONSE NO. 1:

Admit.

REQUEST NO. 2:

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

RESPONSE NO. 2:

Deny.

REQUEST NO. 3:

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

RESPONSE NO. 3:

Deny.

REQUEST NO. 4:

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

RESPONSE NO. 4:

Deny.

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REQUEST NO. 5:

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

RESPONSE NO. 5:

Admit.

REQUEST NO. 6:

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

RESPONSE NO. 6:

Admit.

REQUEST NO. 7:

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

RESPONSE NO. 7:

Admit.

REQUEST NO. 8:

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

RESPONSE NO. 8:

Deny.

REQUEST NO. 9:

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

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RESPONSE NO. 9:

Deny.

REQUEST NO. 10:

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

RESPONSE NO. 10:

Deny.

REQUEST NO. 11:

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

RESPONSE NO. 11:

Admit.

REQUEST NO. 12:

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

RESPONSE NO. 12:

Admit.

REQUEST NO. 13:

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

RESPONSE NO. 13:

Deny.

REQUEST NO. 14:

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

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RESPONSE NO. 14:

Deny.

REQUEST NO. 15:

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

RESPONSE NO. 15:

Deny.

REQUEST NO. 16:

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

RESPONSE NO. 16:

Deny.

REQUEST NO. 17:

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

RESPONSE NO. 17:

Deny.

REQUEST NO. 18:

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

RESPONSE NO. 18:

Deny.

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REQUEST NO. 19:

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

RESPONSE NO. 19:

Deny.

REQUEST NO. 20:

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

RESPONSE NO. 20:

Admit.

REQUEST NO. 21:

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

RESPONSE NO. 21:

Admit.

REQUEST NO. 22:

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

RESPONSE NO. 22:

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

REQUEST NO. 23:

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

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702-735-0049 Fax: 702-735-0204

RESPONSE NO. 23:

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

REQUEST NO. 24:

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

RESPONSE NO. 24:

Admit.

REQUEST NO. 25:

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

RESPONSE NO. 25:

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

REQUEST NO. 26:

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

RESPONSE NO. 26:

Deny.

REQUEST NO. 27:

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

RESPONSE NO. 27:

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

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702-735-0049 Fax: 702-735-0204

REQUEST NO. 28:

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

RESPONSE NO. 28:

Deny.

REQUEST NO. 29:

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

RESPONSE NO. 29:

Admit.

REQUEST NO. 30:

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

RESPONSE NO. 30:

Admit.

REQUEST NO. 31:

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

RESPONSE NO. 31:

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

REQUEST NO. 32:

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

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Las Vegas, Nevada 89104
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RESPONSE NO. 32:

Deny.

DATED this 24 day of October, 2018.

THE GALLIHER LAW FIRM

Keith E. Galliher, Jr., Esq.
Nevada Bar No. 220
1850 E. Sahara Avenue, Suite 107
Las Vegas, Nevada 89104
Attorneys for Plaintiff

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

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An employee of THE GALLIHER LAW FIRM

Arrest ☐ Crime ☐ Non-Criminal ☒	**Venetian Security** 3355 LAS VEGAS BLVD., S. LAS VEGAS, NV 89109 **Narrative Report**	CASE # 1611V-0880 Page 1 of 2

OFFENSE(S)	OFFENSE(S) cont'd
Protected Health Information	

DATE, TIME AND DAY OF OCCURENCE	TO	DATE AND TIME REPORTED
11/04/16 12:39 Friday	11/04/16 13:31 Friday	11/04/16 12:39

LOCATION OF OCCURENCE	LOCATION NAME	TYPE OF LOCATION	BEAT	SECTOR
	Outside Grand Lux Cafe Restrooms			

NARRATIVE

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.

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.

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

ADMINISTRATION

BY OFFICER	DATE/TIME	APPROVED BY	DATE APPROVED
J. Larson 000025821	11/04/2016 15:30	Michael Dean 000041303	11/05/16
OFFICER	**UNIT/SHIFT**	**ASSIGNED TO**	**CASE STATUS**
			Closed

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

VEN 008

Arrest ☐ Crime ☐ Non-Criminal ☒	***Venetian Security*** 3355 LAS VEGAS BLVD., S. LAS VEGAS, NV 89109 **Narrative Report**	CASE # 1611V-0680 Page 2 of 2

OFFENSE(S)	OFFENSE(S) cont'd
Protected Health Information	

DATE, TIME AND DAY OF OCCURENCE		DATE AND TIME REPORTED
11/04/16 12:39 Friday	TO 11/04/16 13:31 Friday	11/04/16 12:39

LOCATION OF OCCURENCE	LOCATION NAME	TYPE OF LOCATION	BEAT	SECTOR
	Outside Grand Lux Cafe Restrooms			

NARRATIVE

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).

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.

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.

Video coverage is available per Surveillance.

Risk Management was notified.

Attached Items
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

ADMINISTRATION

BY OFFICER	DATE/TIME	APPROVED BY	DATE APPROVED
J. Larson 000025821	11/04/2016 15:30	Michael Dean 000041303	11/05/16
OFFICER	**UNIT/SHIFT**	**ASSIGNED TO**	**CASE STATUS**
			Closed

VEN 035

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

VEN 036

VEN 037

VEN 038

VEN 039

JB 3/14/19

VEN 040

VEN 041

VEN 042

VEN 043

THE VENETIAN THE PALAZZO

1611V-0680

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.

WFA 5'6" 160 PRO/BRO

Name (Print): JOYCE SEKERA (LV TOUR → GCS)

Signature: [signature]

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, ⊖vomit → c/o dizzy

(L) elbow → ⊕T, ⊖IC

⊕CMS, tingling w ⊖PII, PIII; limited ROM due to pain

↑7/10

(L) axillary pain/soreness

(L) flank/lateral back pain

⊕ sitting, ⊖ foot slipped, 30 min prior, no fall prior

Rx - splint to (L) elbow/FA

⊕CMS → ⊖Δ p application; ⊖Rx

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

VEN 017

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 15:33:00, **Provider Assignment**
Taylor, Rachael APRN assigned at 11/04/2016 15:25

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)

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

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.

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 disharged home..

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

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 PrescriptionWriter
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	Triage Note
SERVICE DATE/TIME:	11/4/2016 14:49 PDT
RESULT STATUS:	Auth (Verified)
PERFORM INFORMATION:	Vandenberg RN,Emmy L (11/4/2016 14:49 PDT)
SIGN INFORMATION:	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	Triage Note
SERVICE DATE/TIME:	11/4/2016 14:49 PDT
RESULT STATUS:	Auth (Verified)
PERFORM INFORMATION:	Vandenberg RN,Emmy L (11/4/2016 14:49 PDT)
SIGN INFORMATION:	Vandenberg RN,Emmy L (11/4/2016 14:49 PDT)

PLF 030

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.

EMPLOYEE'S CLAIM – PROVIDE ALL INFORMATION REQUESTED

First Name	MI	Last Name	Birthdate	Sex	Claim Number (Insurer's Use Only)
Joyce	P	Sekera	3-22-56	☐M ☑F	

Home Address		Age	Height	Weight	Social Security Number
7840 Nesting Pine Pl		60	5'6	180	574-54-5430

City	State	Zip	Telephone
Las Vegas	NV	89143	702-467-5457

Mailing Address	City	State	Zip	Primary Language Spoken
7840 Nesting Pine Pl		NV	89143	English

INSURER	THIRD-PARTY ADMINISTRATOR	Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred
N/A	N/A	SALES

Employer's Name/Company Name	Telephone
Boots Vegas	702 538-9000

Office Mail Address (Number and Street)				
N/A	Rainbow Blvd			

Date of Injury or Accident	Hour Injury (if applicable)	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported
11/4/16	17:00 ☑am ☐pm	11-4-16	11-4-16	Warren Church

Address or Location of Accident (if applicable)
Venetian Hotel

What were you doing at the time of the accident? (If applicable)
walking

How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary.)
There was water on the floor. My feet went out from under me. I slipped and fell on my back and arm.

If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?
N/A

Witnesses to the Accident (if applicable)
Guests/workers

Nature of Injury or Occupational Disease
Fall injury, back

Part(s) of Body Injured or Affected
left elbow/back

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 INSURANCE AND OCCUPATIONAL DISEASES ACTS (NRS 616A TO 616D, INCLUSIVE OR CHAPTER 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER, 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, PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO CHIROPRACTIC, TREATMENT AND/OR COUNSELING FOR AIDS, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

Date 11/4/16 Place Centennial Hills Hospital Employee's Signature

THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT

Place Emergency Room Department Name of Facility Centennial Hills Hospital

Date / Hour	Diagnosis and Description of Injury or Occupational Disease	Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident? ☑ No ☐ Yes (If yes, please explain)
11/4/16 17:30	Wrist / back sprain	

Treatment	Have you advised the patient to remain off work five days or more?
X-ray, pain meds	☐ Yes Indicate dates from ____ to ____
X-Ray Findings: no fracture	☑ No If not, is the injured employee capable of ☐ full duty ☑ modified duty
From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? ☑ Yes ☐ No	If modified duty, specify any limitations/restrictions: [illegible] 11.8.
Is additional medical care by a physician indicated? ☑ Yes ☐ No	

Do you know of any previous injury or disease contributing to the condition or occupational disease? ☐ Yes ☑ No (Explain if yes)

Date	Print Doctor's Name	I certify that the employer's copy of this form was mailed to the employer on.
11/4/16	P.V. Del Vecchio	

Address				
6900 North Durango Drive				
City	State	Zip	Provider's Tax I.D. Number	Telephone
Las Vegas	Nevada	89149	20-4993360	702-836-9700
Doctor's Signature			Degree	
FXDEL VECCHIO M.D.			MD	

8005149376-7120336
SEKERA, JOYCE
DOB 03/22/1956 60Y SX F EMR
MRN 7120336 ADM/REG DT 11/04/2016
Centennial Hills Hospital

ORIGINAL – TREATING PHYSICIAN OR CHIROPRACTOR PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYER PAGE 4 – EMPLOYEE

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 disburbance 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 JW

31/57 JW

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

Patient Signature [signature] Doctor Signature [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 JW
Kelly over the phone.

PLF 233

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 5'6" 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)

Any current seizures, paralysis, speech, vision problems? YES/(NO)

Any unexplained recent weight loss? YES/(NO) Current fever? YES/(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) If yes, please ALERT our doctor and/or chiropractic assistant
- Do you have blood/lymph disorders? YES/(NO) If yes, please list _____
- Do you have osteoporosis or rheumatoid arthritis? YES/(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) 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 _____

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

PLF 234

Desert Chiropractic & Rehab / Core Rehab
7810 West Ann Road #110
Las Vegas, NV 891495199
Phone: (702)463-9508
FAX: (702)463-9772

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 dazzled.

Ms. Sekera reported that she was evaulated 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 26% 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 difficuly 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.

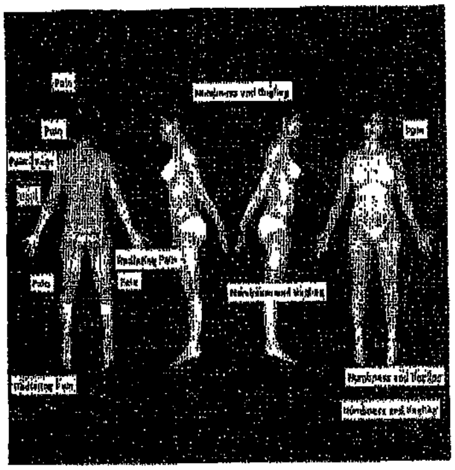
Pain in left elbow
History of present illness/condition:
The patient rated the intensity of their pain/symptoms as an 8 on a scale of zero to 10 with zero being complete absence of symptoms and 10 being very severe or unbearable. The mechanism of injury described by the patient involved a slip and fall 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

PLF 094

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			

PLF 095

1384

Comments:	Right 5/5.					
Neurological	Muscle strength for C6	Left	graded 4 out of 5			
Comments:	Right 5/5.					
Neurological	Muscle strength for C7	Left	graded 4 out of 5			
Comments:	Right 5/5.					
Neurological	Muscle strength for C8	Left	graded 4 out of 5			
Comments:	Right 5/5.					
Neurological	Muscle strength for L4	Bilateral	graded 5 out of 5			
Neurological	Muscle strength for L5	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 5/5.					
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		excruciating	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	Yeoman'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	S33.5XXA	Sprain of ligaments of lumbar spine, initial

		encounter
8	S39.012A	Strain of muscle, fascia and tendon of lowar back, init
9	G44.309	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 sacroiliac 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 musc/tend the rotator cuff of left shoulder, init
19	R20.2	Paresthesia of skin
20	M54.16	Radiculopathy, lumbar region
21	S53.409A	Unspecified sprain of unspecified elbow, initial encounter
22	S56.919A	Strain of unsp musc/fasc/tend at forarm lv, 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	Fall same lev from slip/trip w strike agnst oth object, init

General Assessment:
Causation: Based on my 11/8/16 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	Dx Link
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		Electrical Stimulation	1, 2, 3, 4, 5, 6, 7, 8
97010					1		Ice pack	1, 2, 3, 4, 5, 6, 7, 8
A4556					1		Electrodes	1, 2, 3, 4, 5, 6, 7, 8
99070					1		Home use ice pack	1, 2, 3, 4, 5,

PLF 097

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

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

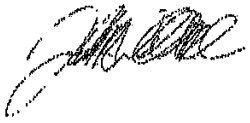
Informed Consent Obtained:	Yes
Problem:	R51 - Headache, M54.2 - Cervicalgia, M54.5 - Low back pain, M25.512 - Pain in left shoulder, M25.522 - Pain in left elbow, M54.6 - Pain in thoracic spine
Plan Start Date:	11/8/2016
Frequency:	5 times a week, 3 times a week
Duration:	1 week, 3 weeks
Expectation for Recovery:	Guarded at this time
Services:	CMT, Myofascial Release, Electrical Stimulation, Rehabilitation exercises, intersegmental traction, mechanical massage, extraspinal 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.



PLF 098

CORE rehab

ASSIGNMENT OF PROCEEDS AND/OR LIEN FOR MEDICAL SERVICES
("Doctor's Lien")

I. Patient and Attorney Information

Patient Name: Joyce Sekera
Patient SSN: 081 98 8930
Date of Injury: 4/4/16
Next Of Kin:

Attorney Name: Keith Galliher
Address: 1850 E Sahara
City: L V State: NV Zip: 89104
Phone: 702 7350049 Fax: 702 7350204

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 Portability and Privacy Act of 1996 ("HIPAA"), patient's medical information relating to this personal injury case may be created or maintained and copied in Patient's medical treatment. Patient authorizes Patient Physician, Attorney and any member of the Core Rehab clinics ("the clinic") to receive, release, and disclose such medical treatment information with companies and individuals as deemed necessary, and further agrees that examinations, diagnostic, medical treatments, films 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 such that the Clinic is covered 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 filed as a Lien and may be authorized by applicable state law and practice. Patient hereby irrevocably authorizes and directs Attorney, in any dispute to the Clinic, such sums as may be due and owing for services rendered to Patient by reason of the accident from which the claim arises, and by reason of any other bills that are due to the Clinic, and to withhold such sums from any claim, settlement, judgment or verdict as may be necessary to adequately protect and cover 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 injuries or illnesses in connection therein, from which Patient has been treated. In the event another attorney is substituted in this matter, the new attorney shall accept this Lien as assistant to my own, and notice of this Lien shall be Patient's responsibility. This Lien may be signed in parts and have the same force and effect as though executed in one document. It is understood and agreed that a copy of this Lien shall have the same force and effect as the original.

IV. Settlement. Payment of this Lien by eighteen percent (18%) per annum, commencing thirty (30) days from the date of payment of settlement, judgment or verdict relating to services rendered by the Clinic to the Patient.

V. Payment Responsibility. Patient understand 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 awaiting payment. Patient further understands that such payment is not contingent on any claim, settlement, judgment or verdict by which Patient may eventually recover said fee. 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 financial responsibility for payment of all amounts with the Clinic. Patient understands that the legal settlement may pay all, part, or none of the Patient's account(s) and that Patient is responsible for complete payment of all account(s). Patient understands that Patient is financially responsible for any amount unpaid by this assignment of proceeds and/or lien, as may be authorized by applicable state law and practice. By signing this document Patient fully understand all provisions set forth in this Agreement.

Patient/Guardian Signature: [signature] Date: 11/8/16

The undersigned attorney of record for in this assignment and does hereby agree to observe all the terms of the aforesaid agreement and to withhold such sums from any settlement, judgment or verdict, as may be necessary in order to adequately protect the Clinic. Attorney is expressly directed to hold in Attorney's client trust account such sums from any payment, settlements, dispositions, proceeds and/or verdicts received on Patient's behalf as may be required to adequately protect and pay the above my services rendered on Patient's behalf by the Clinic. Attorney is further directed to pay from Attorney's client trust account to the Clinic that amount which is the said owing to the Clinic for those medical services, examinations, treatments and reports which the clinic has had prepared on Patient's behalf. Attorney further agrees that in the event Patient executes other counsel in connection with any matter 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 and/or lien.

Attorney's Signature: [signature] Date: 11/18/16

Core Rehab Cooperative, LLC
10620 Southern Highlands Pkwy Ste. 110-329
Las Vegas, NV 89141
702-577-1982 Phone
702-577-1916 Fax

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

PLF 237

Nevada PRESCRIPTION MONITORING PROGRAM

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

Prescriptions

Filled	ID	Written	Drug	QTY	Days	Prescriber	Rx #	Pharmacy*	Refills	MME/D	Pymt Type	PMP
11/09/2016	1	11/04/2016	HYDROCODON-ACETAMINOPHEN 5-325	15.0	5	RA TAY	1460267	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

SOUTHERN NEVADA
MEDICAL GROUP

Patient: Joyce P. Sekera **DOB:** 03/22/1956 **Sex:** F
Provider: Dr. Michelle Hyla, D.O. **Visit:** 11/21/2016 10:15AM **Chart:** SEJC000002

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

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

SOUTHERN NEVADA
MEDICAL GROUP

Patient: Joyce P. Sekera **DOB:** 03/22/1956 **Sex:** F
Provider: Dr. Michelle Hyla, D.O. **Visit:** 11/21/2016 10:15AM **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:

PLF 215

SOUTHERN NEVADA MEDICAL GROUP

Patient: Joyce P. Sekera **DOB:** 03/22/1956 **Sex:** F
Provider: Dr. Michelle Hyla, D.O. **Visit:** 11/21/2016 10:15AM **Chart:** SEJO000002

- **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 shortes 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 rhinnorhea , denies

PLF 216

SOUTHERN NEVADA MEDICAL GROUP

Patient: Joyce P. Sekera **DOB:** 08/22/1956 **Sex:** F
Provider: Dr. Michelle Hyla, D.O. **Visit:** 11/21/2016 10:15AM **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:

66.00 Inches	190.00 lbs	30.66	9/10

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

 E-signed by Dr. Michelle Hyla, D.O. on 11/21/2016 2:10PM

PLF 217

SOUTHERN NEVADA MEDICAL GROUP

Patient: Joyce P. Sekera **DOB:** 03/22/1956 **Sex:** F
Provider: Dr. Michelle Hyla, D.O. **Visit:** 11/21/2016 10:15AM **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

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

PLF 218

SOUTHERN NEVADA MEDICAL GROUP

Patient: Joyce P. Sekera **DOB:** 03/22/1956 **Sex:** F
Provider: Dr. Michelle Hyla, D.O. **Visit:** 11/21/2016 10:15AM **Chart:** SEJO000002

- **Extension Norm:** (30) 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:** Hypertonia, 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

SOUTHERN NEVADA MEDICAL GROUP

Patient: Joyce P. Sekera **DOB:** 03/22/1956 **Sex:** F
Provider: Dr. Michelle Hyta, D.O. **Visit:** 11/21/2016 10:15AM **Chart:** SEJO000002

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:

Type	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	S29.012A	Strain of muscle and tendon of back wall of thorax, initial encounter
ICD-10-CM Condition	S33.5XXA	Sprain of ligaments of lumbar spine, initial encounter
ICD-10-CM Condition	S39.012A	Strain of muscle, fascia and tendon of lower back, initial encounter
ICD-10-CM Condition	M79.621	Pain in right upper arm
ICD-10-CM Condition	M79.622	Pain in left upper arm
ICD-10-CM Condition	M25.522	Pain in left elbow
ICD-10-CM Condition	S53.402A	Unspecified sprain of left elbow, initial encounter
ICD-10-CM Condition	M79.632	Pain in left forearm

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

PLF 220

SOUTHERN NEVADA MEDICAL GROUP

Patient: Joyce P. Sekera **DOB:** 03/22/1956 **Sex:** F
Provider: Dr. Michelle Hyla, D.O. **Visit:** 11/21/2016 10:15AM **Chart:** SEJC000002

	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	S83.91XA	Sprain of unspecified site of right knee, initial encounter
ICD-10-CM Condition	S83.92XA	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	S06.0X1A	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	F51.5	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	H53.149	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	R45.89	Other symptoms and signs involving emotional state
ICD-10-CM Condition	R46.2	Unhappiness
ICD-10-CM Condition	F43.0	Acute stress reaction

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

PLF 221

1400

SOUTHERN NEVADA MEDICAL GROUP

Patient: Joyce P. Sekera **DOB:** 03/22/1956 **Sex:** F
Provider: Dr. Michelle Hyta, D.O. **Visit:** 11/21/2016 10:15AM **Chart:** SEJO000002

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	S46.912A	Strain of unspecified muscle, fascia and tendon at shoulder and upper arm level, left arm, initial encounter
ICD-10-CM Condition	S46.911A	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:

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)	N/A

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.

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

PLF 222

SOUTHERN NEVADA MEDICAL GROUP

Patient: Joyce P. Sekera **DOB:** 03/22/1956 **Sex:** F
Provider: Dr. Michelle Hyla, D.O. **Visit:** 11/21/2016 10:15AM **Chart:** SEJO000002

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.

Type	CPT	Modifier	Quantity	Description
CPT	99204		1.00 UN	Office/outpatient visit, new
CPT	99204		1.00 UN	Office/outpatient visit, new

Medication	Sig	PRN?	Notes
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	

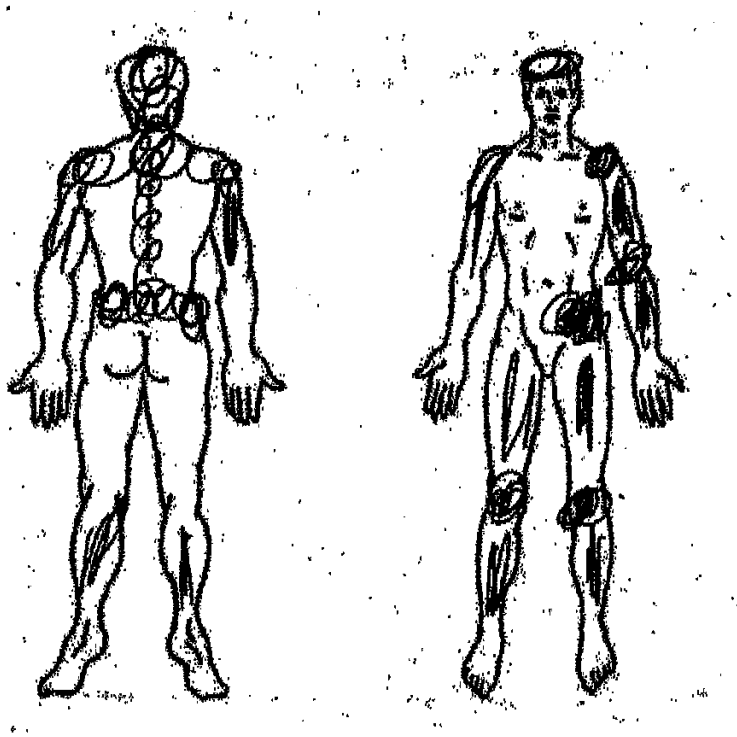
 E-signed by Dr. Michelle Hyla, D.O. on 11/21/2016 2:40PM

PLF 223

1402

SOUTHERN NEVADA
MEDICAL GROUP

Patient: Joyce P. Sekera **DOB:** 03/22/1956 **Sex:** F
Provider: Dr. Michelle Hyla,D.O. **Visit:** 11/21/2016 10:15AM **Chart:** SEJC000002



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

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

PLF 224

SOUTHERN NEVADA
MEDICAL GROUP

Patient: Joyce P. Sekera **DOB:** 03/22/1956 **Sex:** F
Provider: Dr. Michelle Hyla, D.O. **Visit:** 11/21/2016 10:15AM **Chart:** SEJO000002

PATIENT SIGNATURE: DATE: 11/21/16

PHYSICIAN SIGNATURE: DATE: 11/21/16

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

PLF 225

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 *Nombre* DOB: 03-22-1956 *Fecha de Nacimiento* Today's Date: 12-01-2016 *Fecha de Hoy*

Reason for initial visit: Headaches, back pain, shoulders
Motivo de la Visita inicial

Please indicate if you are: *Escribe usted con la:* right handed ~~*mano derecha*~~ or *o'* left handed *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 *Presion arterial alta*	Emphysema *Enfisema*	Prostate problems *Problemas de próstata*	Stroke *Accidente cerebrovascular*
High cholesterol *Niveles de cholesterol alto*	Seizures *Convulsiones*	Asthma *Asma*	Diabetes or high blood sugar *Diabetes*
Liver disease *Enfermedad del higado*	Anemia *Anemia*	Thyroid problems *Problemas de la tiroides*	Migraine headaches *Migrañas*
Heart Attack *Ataque del corazon*	Kidney problems *Problemas del riñón*	Osteoporosis *Osteoporosis*	Eye problems *Problemas de los ojos*
Heart Failure *Insuficiencia cardiaca*	Stomach ulcers *Ulceras gastrica*	Depression *Depresion*	Allergies or sinus problems *Alergias o sinusitis*
Abnormal heart rhythm *Anormal del ritmo cardiaco*	Cancer (what type?) *Cancer (que tipo?)* _____		

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 cirugias (indicar el tipo de cirugia y fecha):

_____ _____ _____
_____ _____ _____

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

36739

RADAR 388

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: 9:20AM.

Are you a NEW patient? ☐ Yes ☑ No

Print Name: Joyce Sekera 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 O
WIT: Sekera
DATE: 3-14-19
REPORTER: B. CANO

RADAR 058

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 ☐ (Medicare#)	MEDICAID ☐ (Medicaid#)	TRICARE ☐ (ID#/DoB#)	CHAMPVA ☐ (Member ID#)	GROUP HEALTH PLAN ☐ (ID#)	FECA BLK LUNG ☐ (ID#)	OTHER ☒ (ID#)	
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTHDATE MM DD YY	SEX		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)		
SEKERA, JOYCE		03221956	M ☐ F ☒				
5 PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED			4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
7840 NESTING PINE PL		Self ☐ Spouse ☐ Child ☐ Other ☒					
CITY	STATE	8. RESERVED FOR NUCC USE			7. INSURED'S ADDRESS (No, Street)		
LAS VEGAS	NV				CITY	STATE	
ZIP CODE	TELEPHONE (Include Area Code)				ZIP CODE	TELEPHONE (Include Area Code)	
89143-4469	(7024675457					( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER		
					DOI110416		
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO			a. INSURED'S DATE OF BIRTH MM DD YY	SEX M ☐ F ☐	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT PLACE (State) ☐ YES ☒ NO			b. OTHER CLAIM ID (Designated by NUCC)		
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? ☒ YES ☐ NO			c. INSURANCE PLAN NAME OR PROGRAM NAME		
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.		

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

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

SIGNED SIGNATURE ON FILE DATE 04182017

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
11042016 QUAL. 431	484 11042016		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ☐ YES ☒ NO	$ CHARGES NO PURCH. SVC.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0		22. RESUBMISSION CODE	ORIGINAL REF. NO.
A. F0781 B. S161XXD C. M5011 D. G43909 E. S39012D F. W010XXD G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER	

24. A. DATE(S) OF SERVICE FROM MM DD YY TO MM DD YY	B. PLACE OF SERV.	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 FOLLOW UP EVALUATION 04112017 04112017	11		99213		ABCD	350 00	1		NPI	1346324092
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
260209037 ☒	36739	☒ YES ☐ NO	$ 350 00	$ 0 00	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (702 6440500
MD RUSSELL J SHAH 04182017	CHARLESTON OFFICE 2628 W CHARLESTON BLVD Las Vegas NV 89102 a 1881888956 b	RADAR MED GRP LLP 10624 S EASTERN AVE A425 Henderson NV 89052 a 1881888956 b
SIGNED DATE		

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 form 1500 (02-12)

RADAR 059

39504

RUSSELL J. SHAH , MD

DATE: 04-11-2017

ACCT# 36739 | DATE OF BIRTH # 03-22-1956 | S.S#

LAST NAME: SEKERA | FIRST NAME: JOYCE

INSURANCE COMPANY NAME: GALLIHER LAW FIRM | REFERRING DOCTOR: WEBBER

OFFICE VISITS				**EMG**	
NEW PATIENT (NON CONSULTATIVE)				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
ESTABLISHED PATIENT				95886	MUSC TEST DONE W/N TEST COMP X_____
	99212	PROBLEM FOCUSED		**NCV**	
X	99213	EXPANDED		95900	MOTOR NCV X_____
	99214	DETAILED		95904	SENSORY NCV X_____
	99215	DETAILED		95903	MOTOR NERVE W/F WAVE X_____
OFFICE CONSULTATIONS				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
MISCELLANEOUS				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_____
OFFICE PROCEDURES					
	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

NEUROLOGY DIAGNOSIS	ICD-10			ICD-10
ANXIETY	F41.1	MEMORY LOSS		R41.3
BRAIN INJURY W/LOC -30MINS INTERACRANIAL INJURY	S06.891_	MOOD SWINGS		F34.8
BRAIN INJURY NO LOC INTERACRANIAL INJURY	S06.890_	MIGRAINES		G43.909
BACK PAIN - SPINE	M54.9	MUSCLE SPASMS		M62.838
CARPAL TUNNEL SYNDROME	G56.00	NEUROPATHY		G62.9
CEREBROVASCULAR ISCHEMIC DISORDER	I63.50	NUMBNESS / PARESTHESIAS	R20.0	R20.2
CERVICAL RADICULOPATHY	M50.11	OCCIPITAL NEURALGIA		M54.81
CERVICAL / CERVICOTHORACIC STRAIN	S161XX_	PAIN CERVICAL / NECK		M54.2
COGNITIVE IMPAIRMENT	G31.84	PAIN LIMB UNSPECIFIED		M79.609
CONCUSSION W/LOC	S06.0X1_	POST TRAUMATIC BRAIN SYNDROME		F07.81
CONCUSSION NO LOC	S06.0X0_	POST CONCUSSIONAL SYNDROME		F07.81
DIZZINESS / VERTIGO	R42	SLEEP DISTURBANCE IMPAIRMENT		G47.9
EPILEPSY	G40.909	STROKE		I63.9
GAIT DISTRUBANCE	R26.9	SYNCOPE		R55
HEADACHES	R51	RESTLESSNESS		R45.1
HEAD INJURY / TRAUMA NO LOC	S09.90X_	SENSORY PROBLEMS LIMBS		R20.2
HEAD INJURY /TRAUMA WITH LOC	S09.91X_	SHOULDER STRAIN	S46.911_	S46.912_
INSOMNIA	G47.00	THORACIC STRAIN		S29.012_
LOW BACK PAIN	M54.5	TREMOR ESSENTIAL		G25.0
LUMBAR RADICULOPATHY	M54.16	WEAKNESS, LIMB		R53.1
LUMBAR STRAIN	S39.012_	WEAKNESS, GENERALIZED		M62.81

PHYSICIAN SIGNATURE: _____ **RUSSELL J. SHAH MD** **EDWIN FAVIS APRN**

RADAR 060

RADAR MEDICAL GROUP, LLP

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

Russell J. Shah

MD

Neurology

/Neurophysiology

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:

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

She is better and not crying andmuch 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 int he 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. Kidwells'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 stifness 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

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 florrid muscle spasm of the lumbar paraspinal muscles

Lumbar range: Lumbar range of motion was limited on extension, No SLR, no Tinels 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 reinitiate 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

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

Russell J. Shah, MD

In House Scheduling and Information Request

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

Diagnosis/symptoms/indication: _____

X Follow up ___1 day ___2 days ___3 days ___1 wk ___2 wk ___3 wk
___1 month ___2 mo X 3 mo ___4 mo ___6 mo ___12 mo
___ReEvaluation ___1wk ___2wk ___1mo ___2mo ___3mo ___6mo ___12mo

X EMG/NCV ___upper X 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
___NCV
___NCV
___SSEP Cranial
___EEG Awake
___Ambulatory EEG
___Neurobehavioral protocol
___Neurofeedback th
___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

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

(702)467-5457

RADAR 066

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 04-11-2017

Patient Name SEKERA, JOYCE **DOB:** 03-22-1956

Phone # (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)

____Gabapentin 300 mg	# 30	____Gabapentin 300 mg	# 90		
____Amitryptline 10 mg	# 30	____Amitryptline 25 mg	# 30		
____Flexeril 10 mg	# 30	____Flexeril 10 mg	# 90		
____Soma 350 mg	# 30	____ Soma 350 mg	# 60		
____Norco	# 30	____ Norco	# 60		
____ Hydrocodone 5/325	# 30	____ Hydrocodone 5/325	# 60		
____ Hydrocodone 7.5/325	# 30	____ Hydrocodone 7.5/325	# 60		
____ Lyrica 50 mg	# 30	____ Lyrica 50 mg	# 90		
____ Prilosec 20 mg	# 30	____ Prilosec 20 mg	# 60		
____ Paxil 10 mg	# 30	____ Paxil 20 mg	# 30	____ Paxil 40 mg	#30
____ Cymbalta 20 mg	# 30				
____ Depakote 250 mg	# 30	____ Depakote 250 mg	# 60		
____ Topiramate 25 mg	# 25	____ Topiramate 25 mg	# 60		
____ Fiorcet	# 30	____ Fiorcet	# 60		
____ Prevacid 20 mg	# 30				

____Other: _____

Physician Signature: _____

RADAR 067

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

Date 04-11-2017

Patient Name SEKERA, JOYCE DOB: 03-22-1956

Phone # (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
___Opthalmology ___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 1658

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) 258-0566 or (702) 641-4600

ATTORNEY LIEN

ATTORNEY: GALLIHER LAW FIRM
1850 E. SAHARA AVE, STE 107
LAS VEGAS, NV 89104
T:702-735-0049 F:702-735-0204

RADAR MEDICAL GROUP, LLP
Dba University Urgent Care
Russell J. Shah, MD
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.

12-1-16
Date

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.

12-2-16
Date

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 1-09

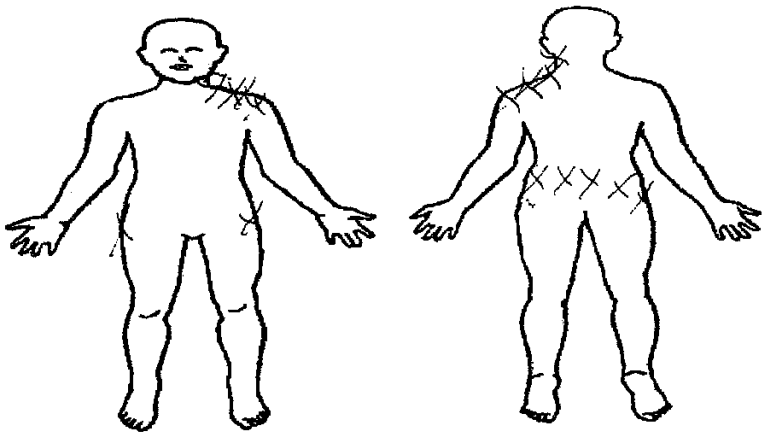
PAIN CHART

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*



No Pain ***No Dolor*** Moderate Pain **Dolor Moderado** Worst Pain **Peor Dolor**

0 1 2 3 4 5 6 7 8 9 10

0 2 4 6 8 10

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

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

36739

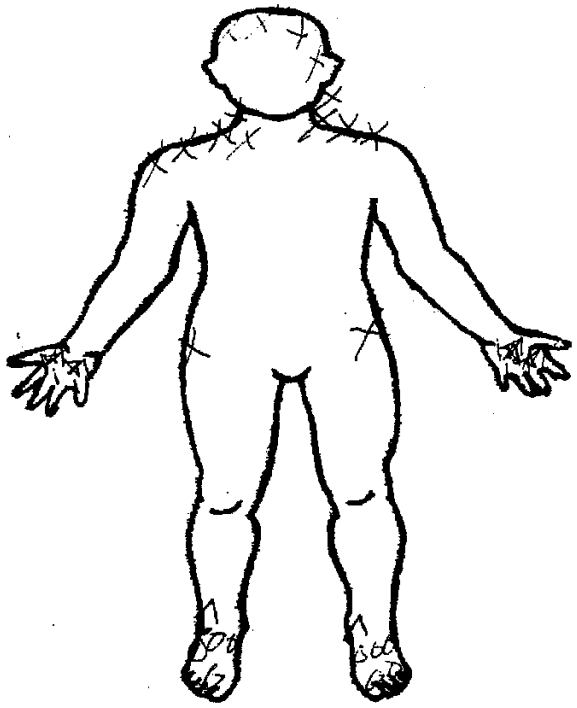
RADAR 385

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

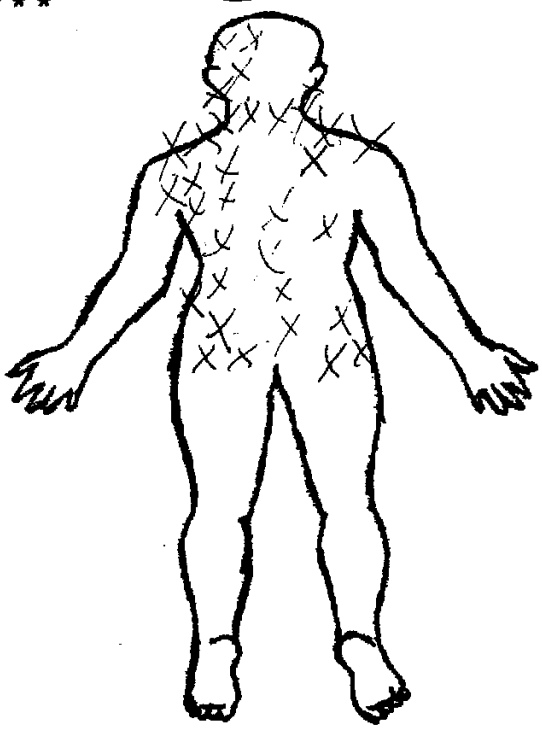
Numbness (Adormecimiento)	Pins & Needles (Piquetes)	Burning (Ardor)	Aching (Adolorido)	Stabbing (Punzadas)
---------	○ ○ ○ ○ ○ ○ ○	^ ^ ^ ^ ^ ^	X X X X X X	⊗ ⊗ ⊗ ⊗ ⊗ ⊗
---------	○ ○ ○ ○ ○ ○ ○	^ ^ ^ ^ ^ ^	X X X X X X	⊗ ⊗ ⊗ ⊗ ⊗ ⊗
---------	○ ○ ○ ○ ○ ○ ○	^ ^ ^ ^ ^ ^	X X X X X X	⊗ ⊗ ⊗ ⊗ ⊗ ⊗

Tinging
(Hormigueo)
* * * * * *
* * * * * *
* * * * * *

FRONT / FRENTE



BACK / ATRAS



Patient signature

Reviewed by Physician

36739

RADAR 386

SOUTHERN NEVADA
MEDICAL GROUP
Health Centered. Patient Focused.

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)

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

SOUTHERN NEVADA
MEDICAL GROUP
Health Centered, Patient Focused.

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

SOUTHERN NEVADA
MEDICAL GROUP
Health Centered. Patient Focused.

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

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

SOUTHERN 016

SOUTHERN NEVADA
MEDICAL GROUP
Health Centered. Patient Focused.

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

- **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	S86.111D	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

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

SOUTHERN 017

1429

SOUTHERN NEVADA
MEDICAL GROUP
Health Obsessed, Patient Focused.

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

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

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		✓			
Depression, crying or more emotional			✓		
Irritable or getting angry easily		✓			
Difficulty finding simple words when talking		✓			
Difficulty concentrating or thinking slowly		✓			
Memory problems or forgetting things	✓				
Understanding what people say to me		✓			
Sleep disturbance or disruption of sleep patterns	✓				
Fatigue, tiring more easily or low energy	✓				
The overall level of my physical pain(s)		✓			
Feeling behind, never caught up or overwhelmed		✓			
Relationship with my partner or family				✓	
Ability to enjoy my hobbies or leisure activities			✓		
Ability to exercise or play sports I enjoy			✓		
The quality or quantity of how much work I can do	✓				
How much I enjoy life				✓	
Loud noises, noisy rooms or crowds bother me		✓			
Bright lights bother me or I have to wear sunglasses		✓			
Feeling like I want to socialize with friends or family	✓				
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

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

PLF 146

SDMI STEINBERG DIAGNOSTIC

History Questionnaire
Advanced Head Imaging

Patient Information
First Name Joyce Last Name Sekera Patient Number 790179.0 (to be filled in by tech) Age 60

Reason for your Exam *(please describe in detail)*
Headaches, Dizziness, Vision &
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 n 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

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

SD 030

SDMI STEINBERG DIAGNOSTIC

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 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: 2 Implants - Bottom Denture
Stents or Filters?	YES	(NO)	
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 **Todays Date:**

TECH NOTES: *(for Internal use only)*

Notes

SD 031

SDMI STEINBERG DIAGNOSTIC

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 Patient Number 790179.0 (to be filled in by tech)

First Name Joyce Last Name SeKeRA 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:
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 Pemanent 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 Todays Date: 12-20-16

TECH NOTES: *(for internal use only)*

Notes

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

SD 024

SDMI STEINBERG DIAGNOSTIC

History Questionnaire
Advanced Spine Imaging

Patient Information
First Name Joyce Last Name Sekera Patient Number 790179.0 (to be filled in by tech) Age 60

Reason for your Exam *(please describe in detail)*
pain in Lower back/Neck
(-) Surgery

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:
About 4/2016

SYMPTOMS, Extremeties *(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 ✓
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 & 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

PAIN INSTITUTE OF NEVADA

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 additional to pay accrued interest. If your account will accrue at the interest at annual rate of 18 (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 the 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.

Keith Galliher
Attorney Name

Attorney Signature

702 735-0049
Attorney Phone Number

1850 E Sahara Ave #107 Las Vegas NV 89104
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

Pain Institute of Nevada
7435 W Azure Dr., Ste. 190
Las Vegas, NV 89130

Ph: (702) 878-8252
Fax: (702) 878-8098
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:

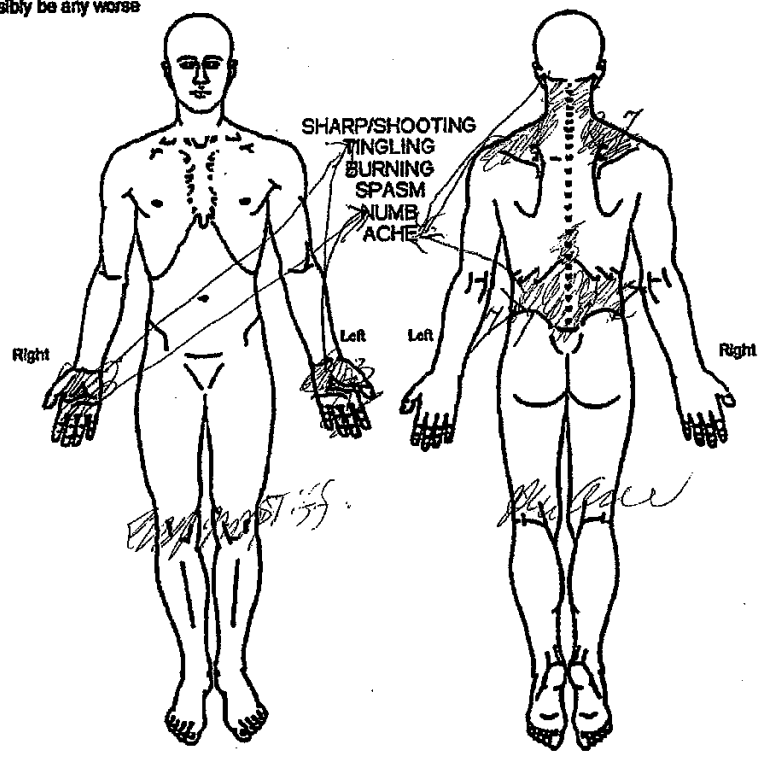
How far can you walk? _____

How long can you sit? _____

How long can you stand? 10 min

Are you working? NO

Are you able to work? NO



Name: Joyce Sekera

Date: 1-9-17

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

Revised February 24, 2016

PAIN057

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
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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? Tires easily

How long can you sit? _____

How long can you stand? _____

Are you working? NO

Are you able to work? NO

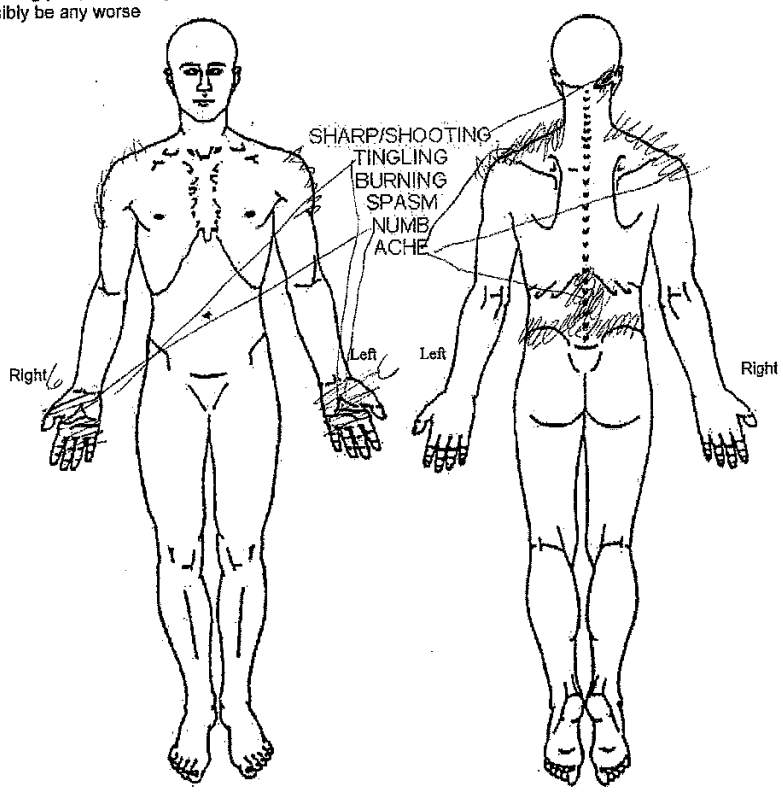

EXHIBIT X
WIT: Sekera
DATE: 3-14-19
REPORTER: B. CANO

Name: Joyce Sekera
Joyce Sekera

Date: 1-30-17

PAIN088

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
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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:

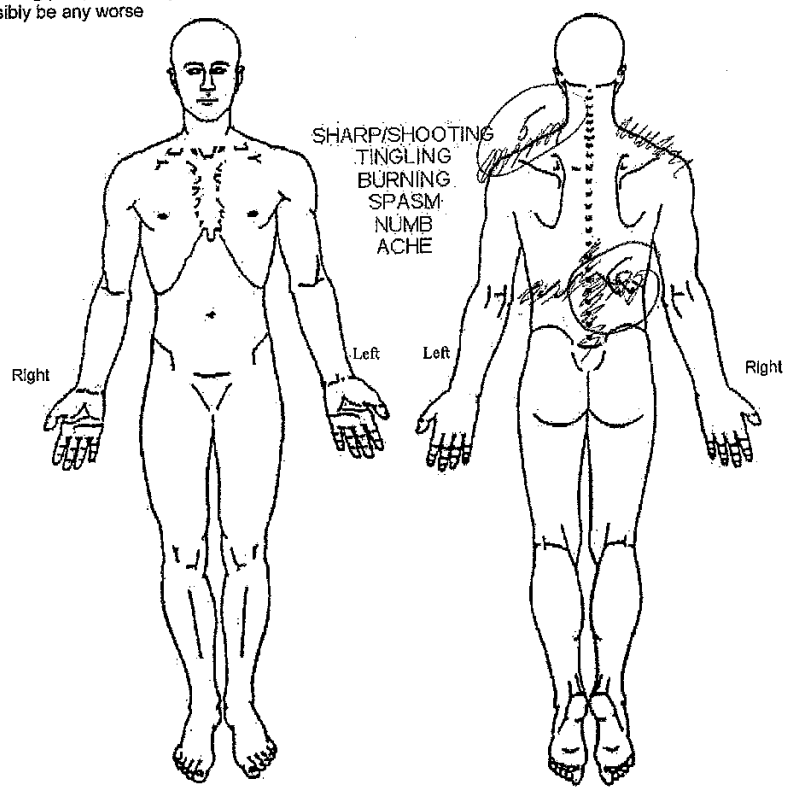
How far can you walk? 15 min's

How long can you sit? 15 min's

How long can you stand? 15 min's

Are you working? NO

Are you able to work? NO



Name: Joyce Sekera

Date: 2/20/17

PAIN084

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

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3 /10: Mild pain, Minimal impact of daily activities
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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:

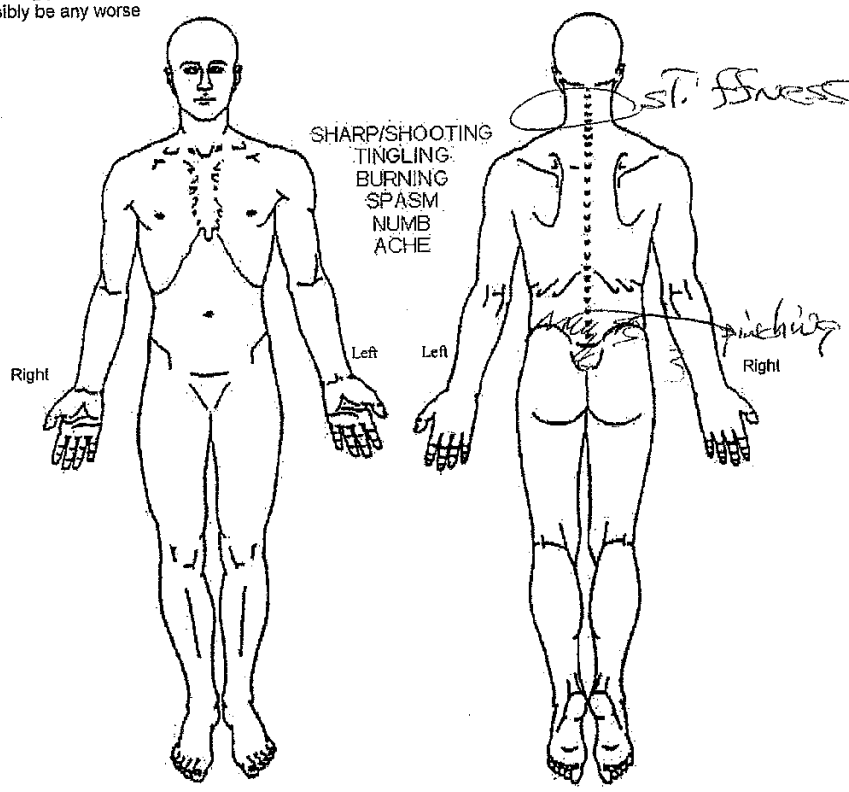
How far can you walk? _____

How long can you sit? _____

How long can you stand? _____

Are you working? _____

Are you able to work? _____



Name: _____ Date: 5/11/17

PAIN077

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:

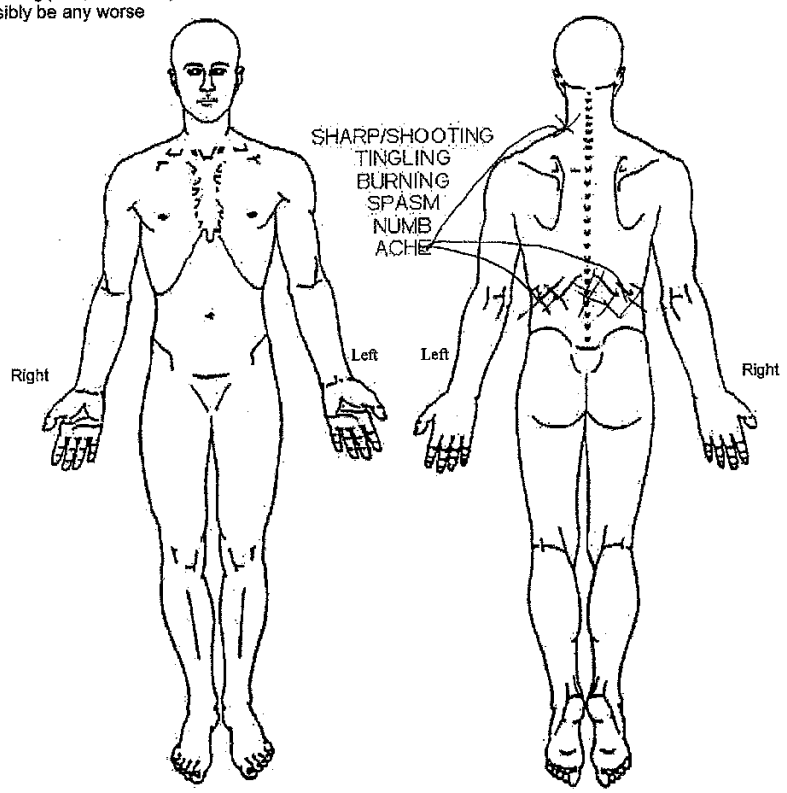
How far can you walk? 10 min

How long can you sit? 10 min

How long can you stand? 10 min

Are you working? N/A

Are you able to work? No



Name: Joyce Sokol

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:

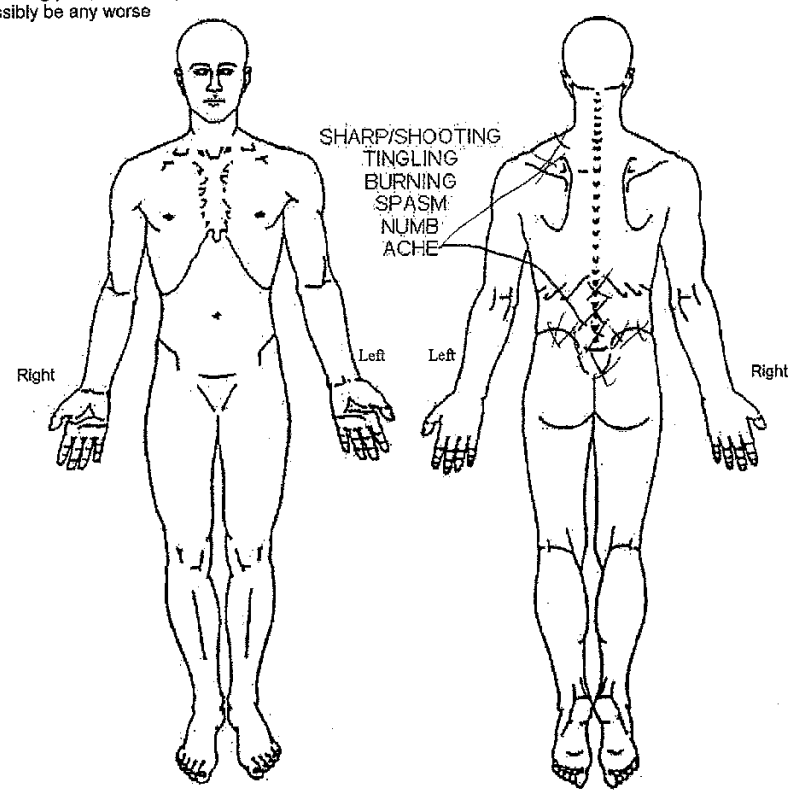
How far can you walk? _____

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

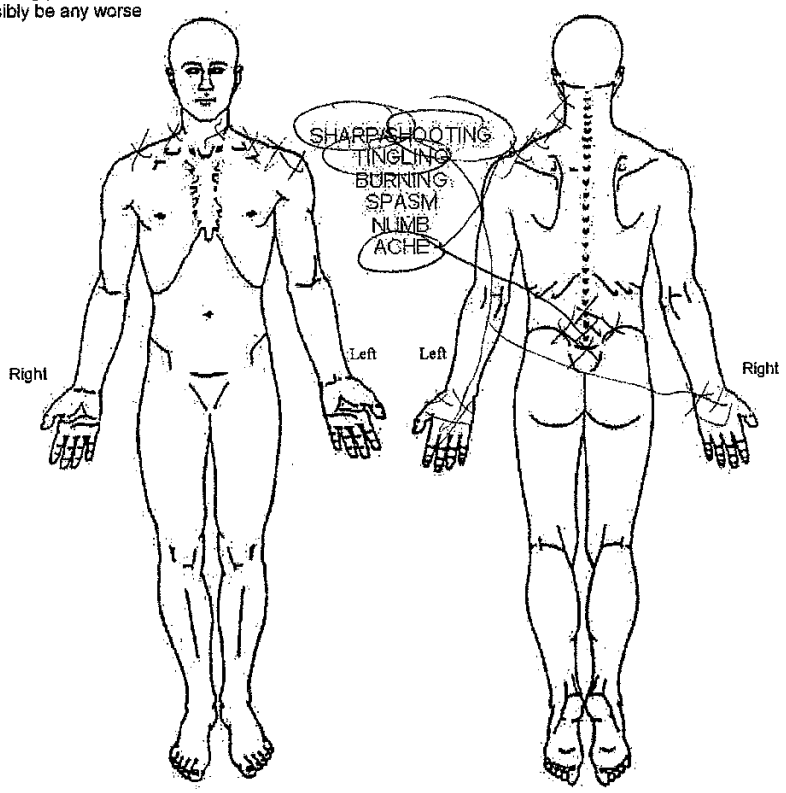
In regards to your pain in the last week:

- 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? Ø
Are you able to work? Ø



Name: Joyce Sekera

Date: 10/23/17

Joyce Sekera

PAIN072

Pain Institute of Nevada
7435 W. Azure Dr. Ste 190
Las Vegas, NV 89130

Ph: (702) 878-8252
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Pain Diagram

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Pain Scale
0 /10: No Pain
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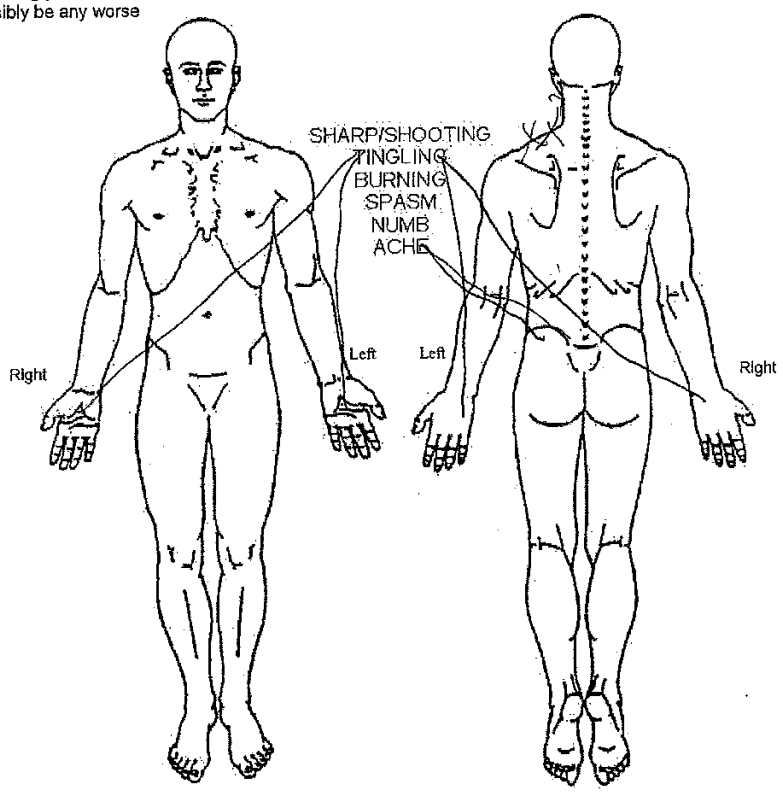
3 /10: Mild pain, Minimal impact of daily activities
4 /10: Moderate pain, Minimal limitations of daily activities
5 /10: Moderate pain, Some limitations of daily activities
6 /10: Moderate pain, Moderate limitations of daily activities
7 /10: Moderate/Severe pain, Very limited daily activities
8 /10: 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? 10min
Are you working? no
Are you able to work? no



Name: Joykera
Joyce Sekera

Date: 12/7/17

PAIN069

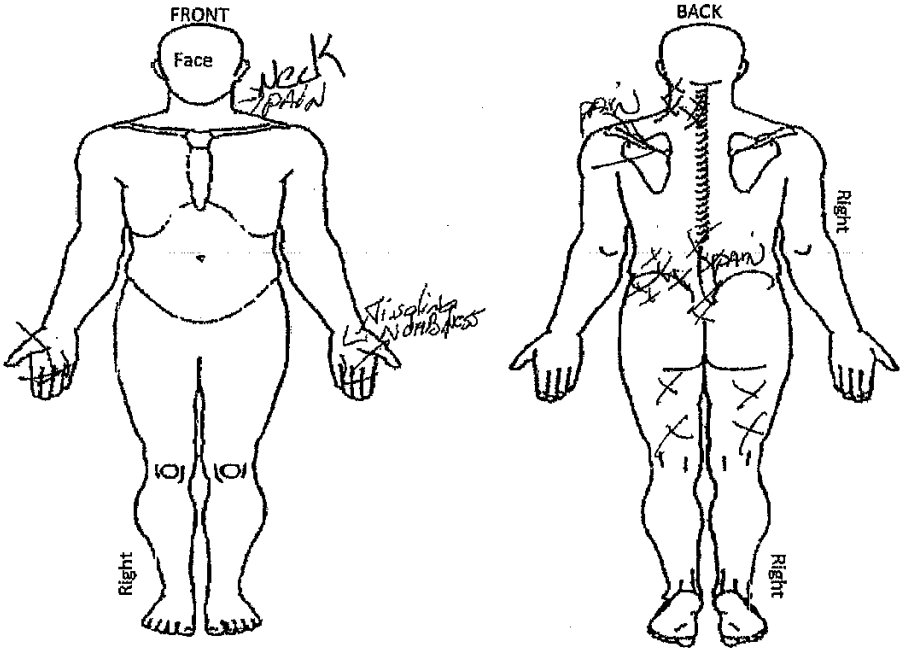
DISC

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 This The Floor Very hard. My Feet were up and Front and I fell on my left Side elbow & Back.

OTHER:

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

DISC 007

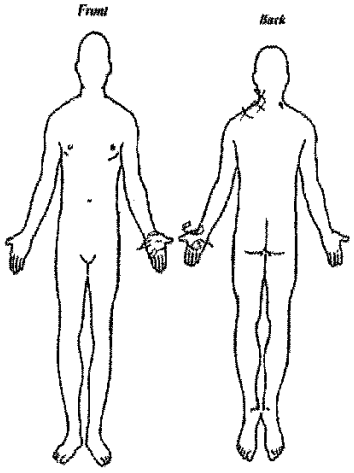
Pain Diagram

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
Burning	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

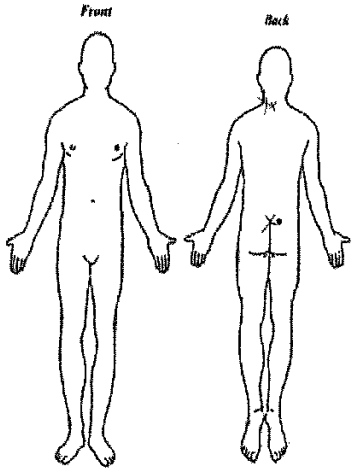
NONE ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ UNBEARABLE

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

HISTORY HISTORIAL	Yes Si	No
22. **Home oxygen** Usa oxigeno en el hogar	☐	☑
23. **Hepatitis** Hepatitis **If Yes /** En caso que si Type ☐ A ☐ B ☐ C	☐	☑
24. **Hiatal Hernia** Hernia Hiatal	☐	☑
25. **Previous Colonoscopy?** ¿Colonsocopy anterior? **If Yes, when?** 8/16 ¿En caso afirmativo, cuándo? _____	☑	☐
26. **Rheumatic Fever** Fiebre Reumática	☐	☑
27. **Ulcers** Ulceras	☐	☑
28. **Stroke** Derrame Cerebral	☐	☑
29. **Seizures** Convulsiones	☐	☑
30. **Parkinson disease** Enfermedad de Parkinsons	☐	☑
31. **Blackouts** Desmayos	☐	☑
32. **Sleep Apnea Bipap / C-pap** Deja de respirar durante la noche	☐	☑
33. **Back / Neck Problems** Problemas de cuello / espalda	☑	☐
34. **Osteoporosis** Osteoporosis	☐	☑
35. **Muscle Diseases** Enfermedad Muscular	☐	☑
36. **Arthritis** Artritis	☑	☐
37. **Diabetes** Diabetes	☑	☐
38. **Thyroid Problems** Problemas de la Tiroides	☐	☑
39. **Hemophilia** Hemofilia / Desorden de sangrado	☐	☑
40. **Sickle Cell Anemia** Anemia de Celulas falciformes	☐	☑
41. **Blood Transfusion** Transfusión de sangre	☐	☑
42. **Kidney Disease** Enfermedad de Riñones	☐	☑
43. **Dialysis patient?** ¿Paciente de diálisis? **If yes, date of last dialysis?** _____ ¿En caso que Si, fecha de ultimo tratamiento?	☐	☑

HISTORY HISTORIAL	Yes Si	No
44. **Aids / HIV Positive** Sida / VIH Positivo	☐	☑
45. **MVP (Mitral Valve Prolapse)** Prolapso de la valvula Mitral	☐	☑
46. **Metal Implants** Inplantes Metálicos dentures	☑	☐
47. **Cancer** **If Yes, Where** _____ Cancer En caso que Si, en donde _____	☐	☑
48. **Drug resistant infection** **Methicillin resistant Staph Aureus (MRSA)**	☐	☑
49. **Long term antibiotic treatment** Tratamiento de antibioticos a largo plazo	☐	☑
50. **Draining wound** Herida abierta	☐	☑
51. **Have you or your family had a high or unexplained fever (hyperthermia) during or after surgery?** ¿Usted o su familiar a tenido fiebre inexplicable durante o despues de cirugia?	☐	☑
52. **Have you traveled outside of country in the past 6 months?** ¿Has viajado afuera de el país en los ultimo 6 meses?	☐	☑

Any additional information you want to communicate?
Alguna otra información que desea comunicar:

_____

_____

_____

_____

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

_____
Signature (Patient/ or Person filling out form)
(If other than patient, relationship : _____)

Joyce Sekera
_____
Firma (Paciente/representante)
(relación al paciente: _____)

11/30/17
Date/Fecha

_____ 11/30/17
Signature of Pre Op Nurse — Date

☐ = Fall risk

JS495

Valley View Surgery Center

Pre-Anesthesia Record
(Adult, age 18 and over)
M:\FORMS\Clinical forms\Pre Anesthesia Record 01.2017.doc

Patient Lar
NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 11/30/17 SEX: F

Western Regional Center for Brain & Spine Surgery
Comprehensive Neurosurgical Care

William D. Smith, MD
Jason E. Garber, MD, FACS
Stuart S. Kaplan, MD, FACS
Gregory L. Douds, MD

Medical History Form

www.wrcbss.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)*: N/A
☐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	✓		81	Good
Father		✓		
Sister/Brother *(circle one)*	✓		56	Good
Sister/Brother *(circle one)*	✓		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)? _____
Do you live alone? ☐Yes ☑No Who lives with you? Mother
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 wk.
If 'No', specify: ☐Never smoked ☐Quit 0-6 months ago ☐Quit 6-12 month 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.

Joyce Sekera 2-22-18

Patient Signature **Date**

I have reviewed the above information with the patient.

Physician Signature **Date**

SDMI STEINBERG DIAGNOSTIC

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 (to be filled in by tech) 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/UG I	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? I actually may be

Allergies *(list all, medications)*

Patient Signature: [signature] **Todays Date:** 4/27/18

TECH NOTES: *(for internal use only)*

Notes

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

SD 017

SDMI STEINBERG DIAGNOSTIC

History Questionnaire
Advanced Musculoskeletal Imaging

Patient Information
First Name Joyce Last Name Sekera Patient Number 790179.0 (to be filled in by staff)
Age 61

Reason for your Exam *(please describe in detail)*
RT Knee pain (DJD)
Pain on medial side of knee
Swelling RT

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

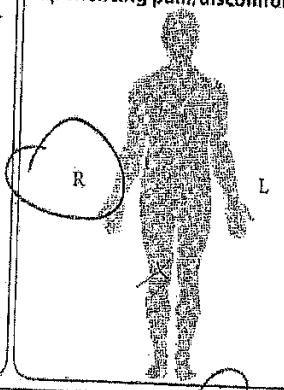
SYMPTOMS, Extremeties *(circle all that apply)*

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		

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

Please mark where you are experiencing pain/discomfort



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 over 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

SD 018

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

Numbness (Adormecimiento)	Pins & Needles (Piquetes)	Burning (Ardor)	Aching (Adolorido)	Stabbing (Punzadas)
- - - - - - - - -	O O O O O O O	^ ^ ^ ^ ^ ^ ^	X X X X X X	⊗ ⊗ ⊗ ⊗ ⊗ ⊗
- - - - - - - - -	O O O O O O O	^ ^ ^ ^ ^ ^ ^	X X X X X X	⊗ ⊗ ⊗ ⊗ ⊗ ⊗
- - - - - - - - -	O O O O O O O	^ ^ ^ ^ ^ ^ ^	X X X X X X	⊗ ⊗ ⊗ ⊗ ⊗ ⊗

Tinging
(Hormigueo)
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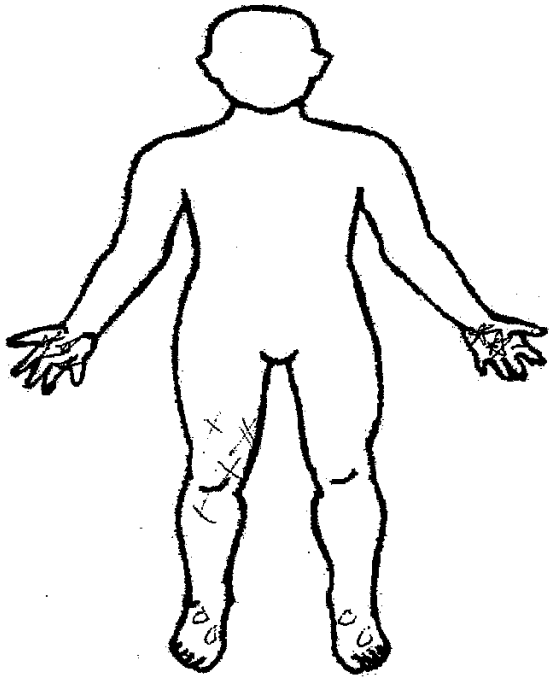
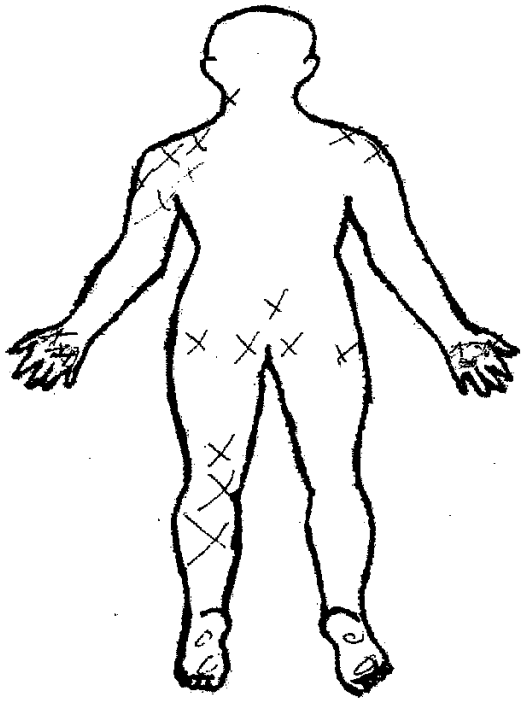
FRONT / FRENTE



BACK / ATRAS



Patient signature

Reviewed by Physician

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

36739

RADAR 074

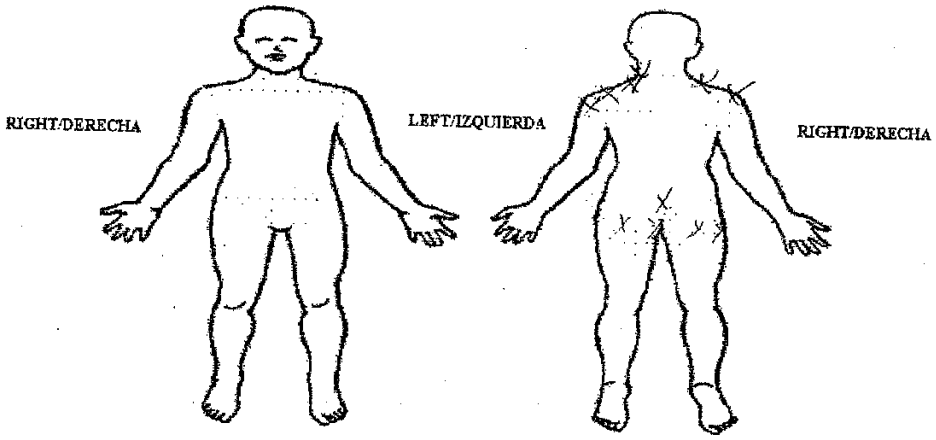
PAIN CHART

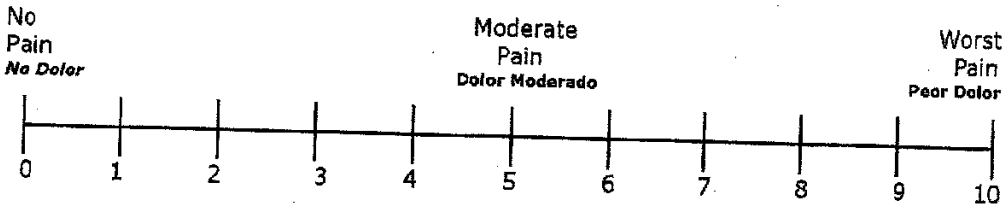
Name: SEKERA, JOYCE DOB: 03-22-1956 DOS: 04-11-2017

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.

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

RADAR 075

Name: SEKERA, JOYCE DOB: 03-22-1956 DOS: 05-02-2017

Numbness (Adormecimiento)	Pins & Needles (Piquetes)	Burning (Ardor)	Aching (Adolorido)	Stabbing (Punzadas)
- - - - - - - - -	O O O O O O O	^ ^ ^ ^ ^ ^ ^	X X X X X X X	⊗ ⊗ ⊗ ⊗ ⊗ ⊗ ⊗
- - - - - - - - -	O O O O O O O	^ ^ ^ ^ ^ ^ ^	X X X X X X X	⊗ ⊗ ⊗ ⊗ ⊗ ⊗ ⊗
- - - - - - - - -	O O O O O O O	^ ^ ^ ^ ^ ^ ^	X X X X X X X	⊗ ⊗ ⊗ ⊗ ⊗ ⊗ ⊗

Tingling (Hormigueo)

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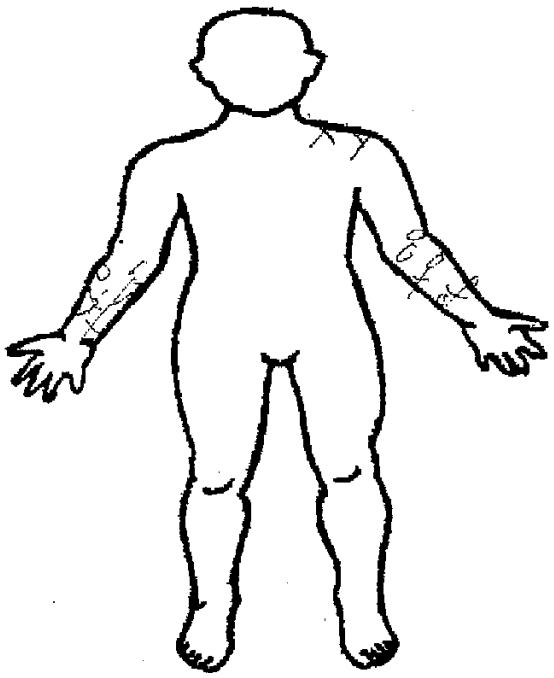
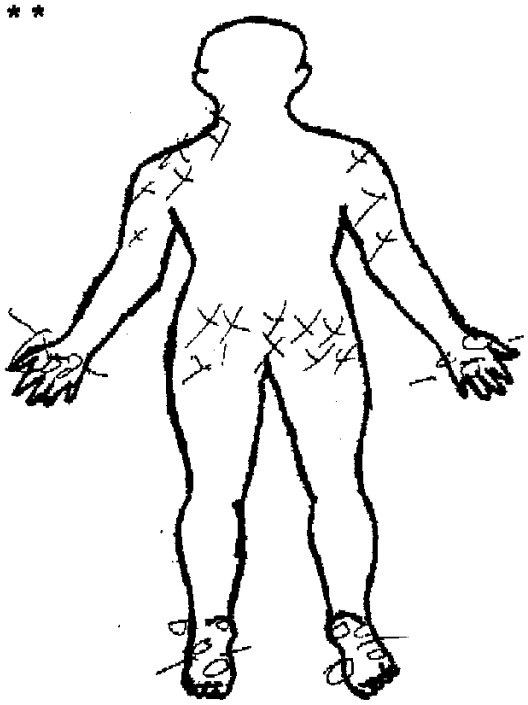
FRONT / FRENTE



BACK / ATRAS



Patient signature

Reviewed by Physician

36739

RADAR 041

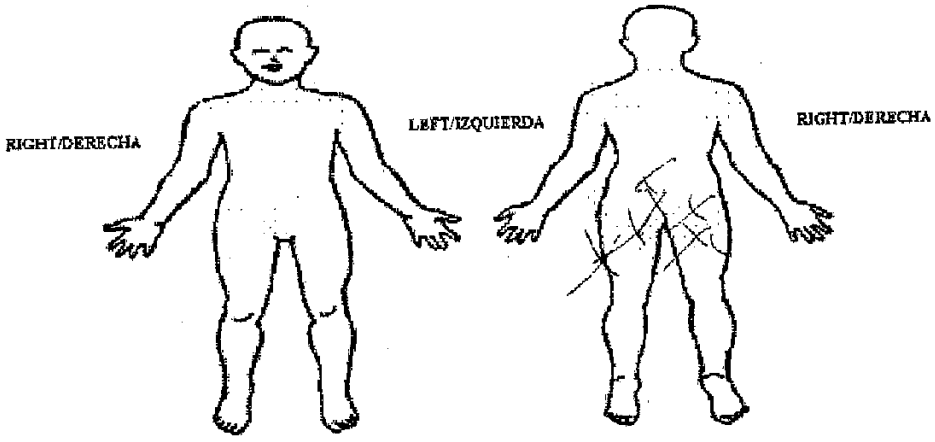
PAIN CHART

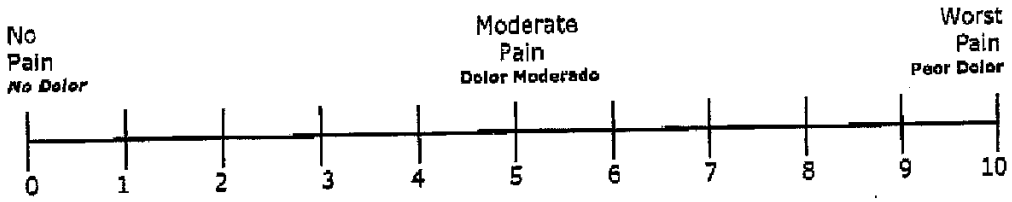
Name: SEKERA, JOYCE DOB: 03-22-1956 DOS: 05-02-2017

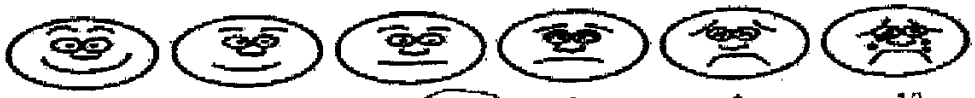
Where is your pain?
Donde esta su dolor?

Please mark on the drawings below the areas where you feel your pain.
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

RADAR 042

Name: SEKERA, JOYCE DOB: 03-22-1956 DOS: 07-10-2017

Numbness (Adormecimiento)	Pins & Needles (Piquetes)	Burning (Ardor)	Aching (Adolorido)	Stabbing (Punzadas)
- - - - - - - - -	○ ○ ○ ○ ○ ○ ○	^ ^ ^ ^ ^ ^	X X X X X X	⊗ ⊗ ⊗ ⊗ ⊗ ⊗
- - - - - - - - -	○ ○ ○ ○ ○ ○ ○	^ ^ ^ ^ ^ ^	X X X X X X	⊗ ⊗ ⊗ ⊗ ⊗ ⊗
- - - - - - - - -	○ ○ ○ ○ ○ ○ ○	^ ^ ^ ^ ^ ^	X X X X X X	⊗ ⊗ ⊗ ⊗ ⊗ ⊗

Tinging
(Hormigueo)
* * * * * *
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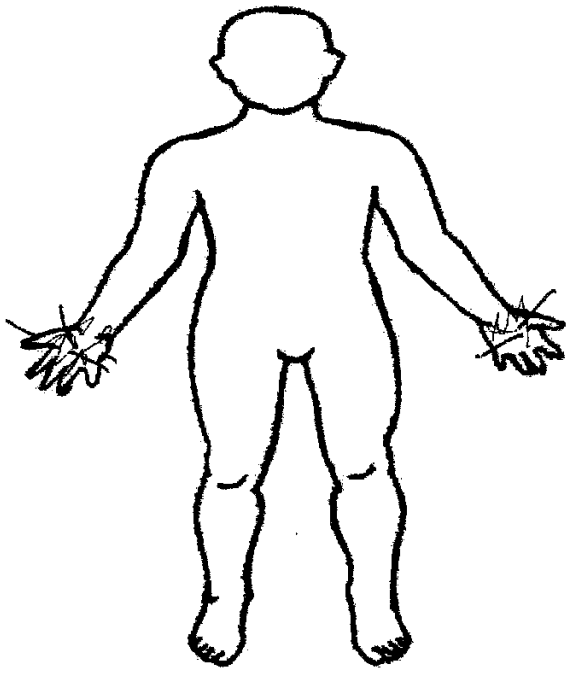
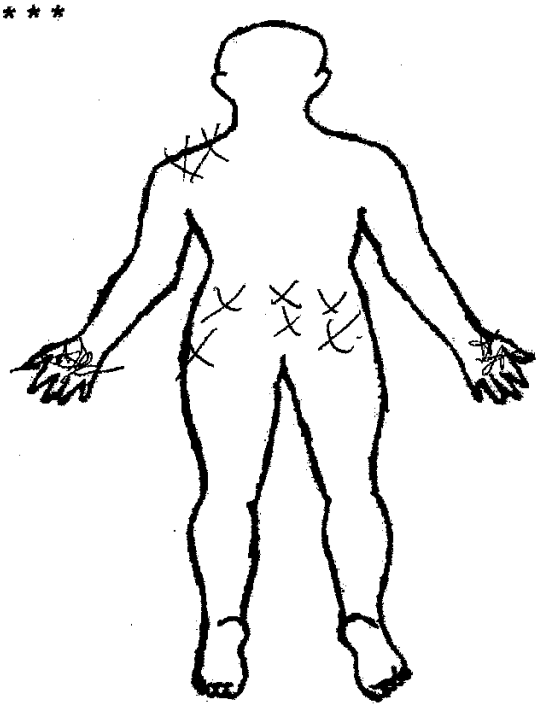
* * * * * *

FRONT / FRENTE



BACK / ATRAS



Patient signature

Reviewed by Physician

36739

RADAR 035

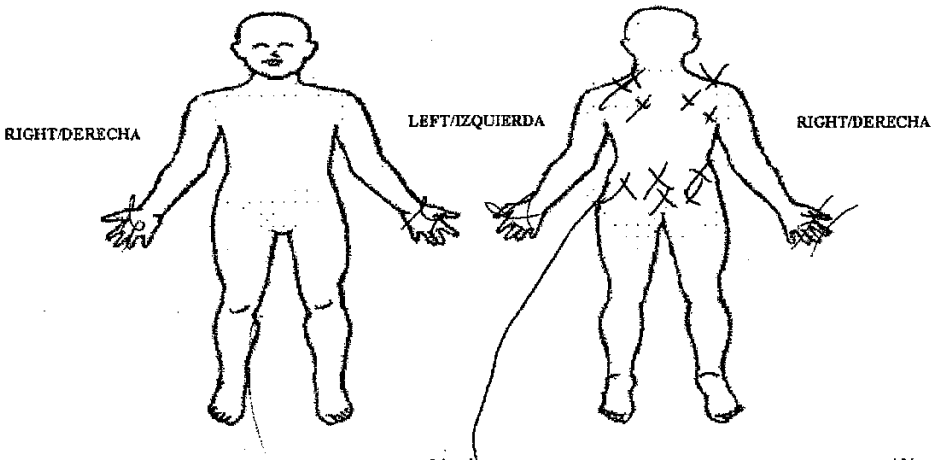
PAIN CHART

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*



No Pain
No Dolor

Moderate Pain
Dolor Moderado

Worst Pain
Peor Dolor

0 2 4 6 8 10

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

RADAR 036

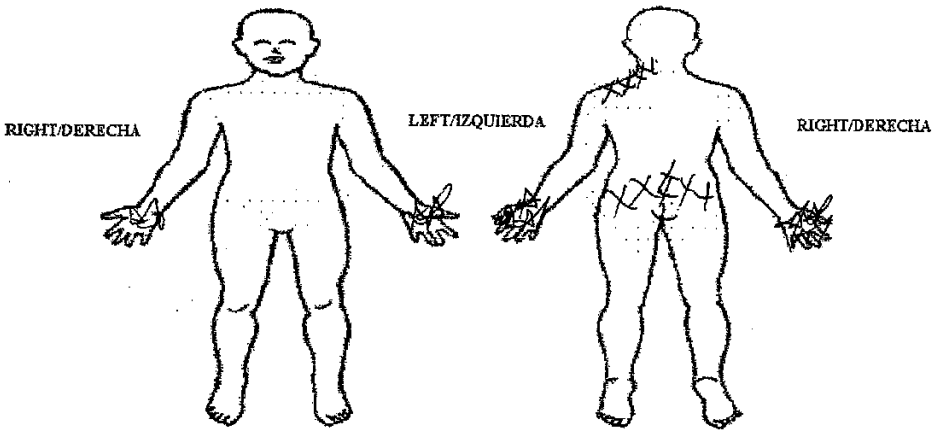
PAIN CHART

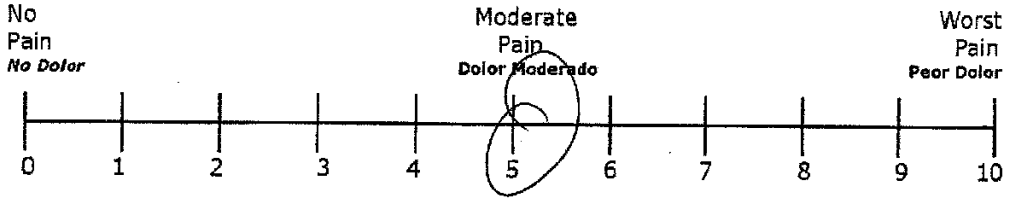
Name: SEKERA, JOYCE DOB: 03-22-1956 DOS: 10-23-2017

Where is your pain?
Donde esta su dolor?

Please mark on the drawings below the areas where you feel your pain.
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

RADAR 019

Name: SEKERA, JOYCE DOB: 03-22-1956 DOS: 10-23-2017

Numbness (Adormecimiento)	Pins & Needles (Piquetes)	Burning (Ardor)	Aching (Adolorido)	Stabbing (Punzadas)
- - - - - - - - -	O O O O O O O	^ ^ ^ ^ ^ ^ ^	X X X X X X	⊗ ⊗ ⊗ ⊗ ⊗ ⊗
- - - - - - - - -	O O O O O O O	^ ^ ^ ^ ^ ^ ^	X X X X X X	⊗ ⊗ ⊗ ⊗ ⊗ ⊗
- - - - - - - - -	O O O O O O O	^ ^ ^ ^ ^ ^ ^	X X X X X X	⊗ ⊗ ⊗ ⊗ ⊗ ⊗

Tinging
(Hormigueo)
* * * * * *
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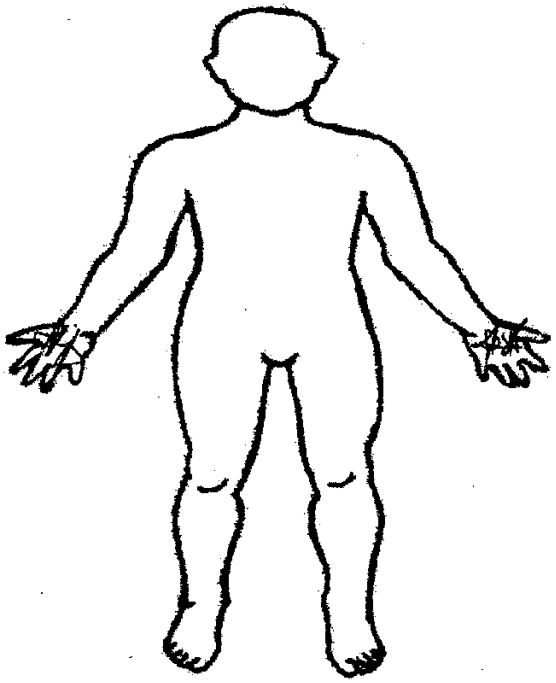
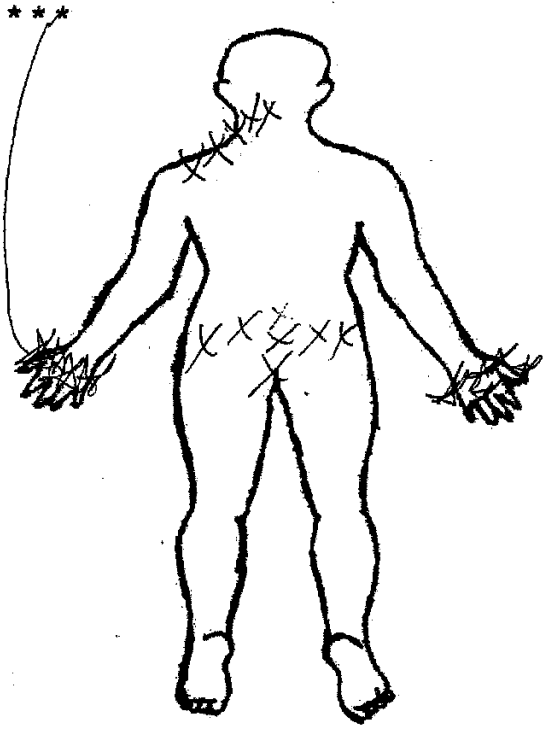
FRONT / FRENTE



BACK / ATRAS



Patient signature

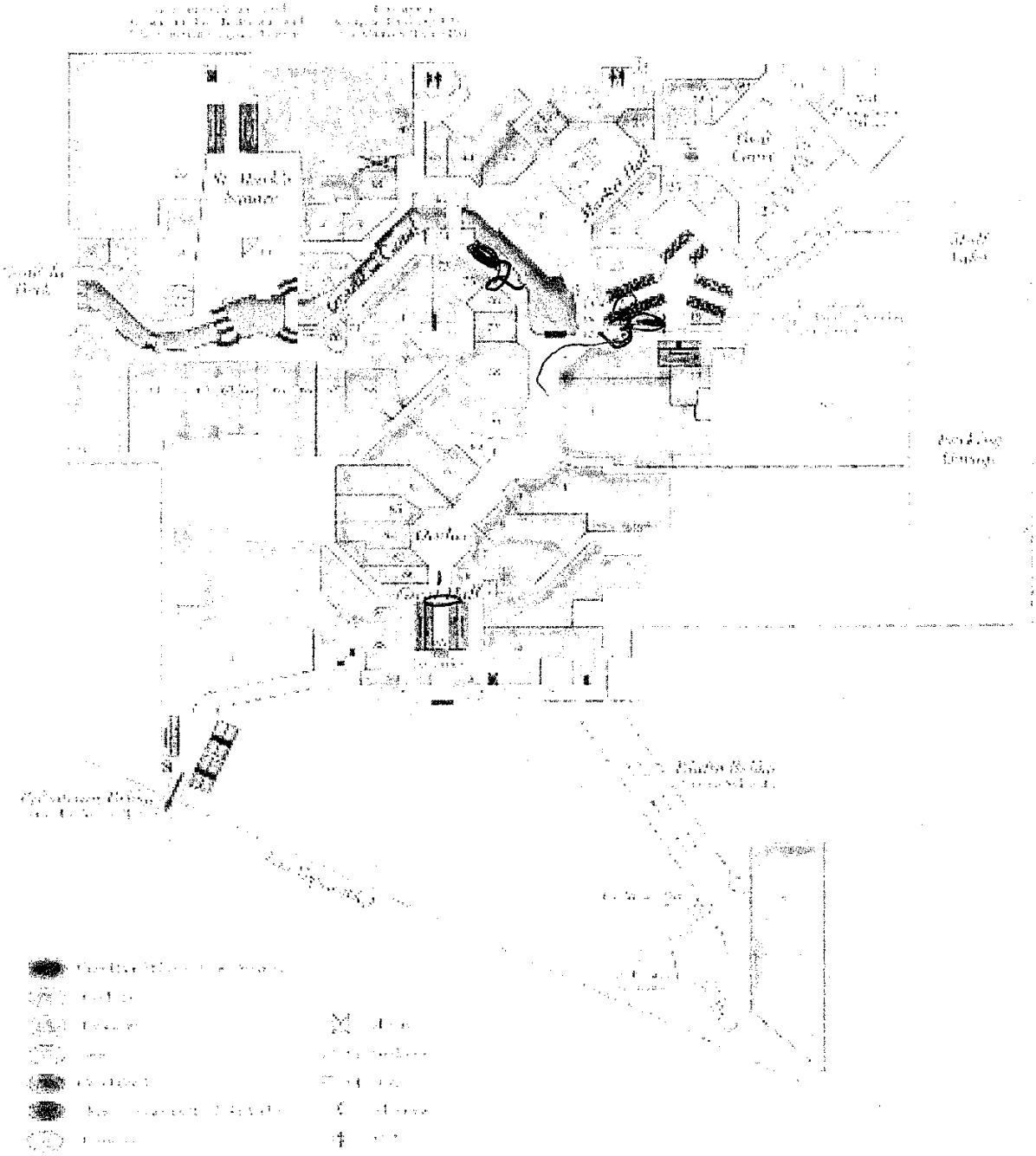
Reviewed by Physician

36739

RADAR 020

The Grand Canal Shoppes

SECOND LEVEL



3/14/19

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