IN THE COURT OF COMMON PLEAS
SUMMIT COUNTY, OHIO

MEMBER WILLIAMS, et al., Plaintiffs, v. KISLING, NESTICO & REDICK, LLC, et al., Defendants.	Case No. CV-2016-09-3928 Judge James Brogan **Dr. Sam Ghoubrial's Notice of Filing Affidavit**

Now comes Defendant, Dr. Sam Ghoubrial, by and through his undersigned counsel, and hereby gives notice of filing the Affidavit of Joshua A. Angelotta. The Affidavit is attached hereto as Exhibit A.

Respectfully Submitted,

/s/ Bradley J. Barmen

Bradley J. Barmen (0076515)
LEWIS BRISBOIS BISGAARD & SMITH LLP
1375 East 9th Street, Suite 2250
Cleveland, Ohio 44114
Phone: 216-344-9422
Fax: 216-344-9421
Brad.Barmen@lewisbrisbois.com
Counsel for Defendant Dr. Sam Ghoubrial

CERTIFICATE OF SERVICE

The undersigned certifies that on the 10th day of May, 2019, I electronically field the foregoing with the Clerk of Courts using the CM/ECF system which will send notification of this filing to all attorneys of record.

/s/ Bradley J. Barmen
Bradley J. Barmen
Counsel for Defendant
Sam N. Ghoubrial, M.D.

IN THE COURT OF COMMON PLEAS
SUMMIT COUNTY, OHIO

MEMBER WILLIAMS, et al., Plaintiffs, vs. KISLING, NESTICO, & REDICK, LLC, et al., Defendants.	)	Case No. CV-2016-09-3928 Judge James A. Brogan **AFFIDAVIT OF JOSHUA R. ANGELOTTA**

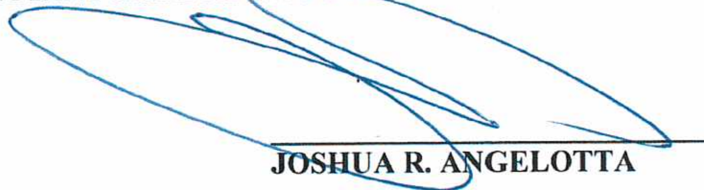
Now comes Affiant, Joshua R. Angelotta, having first been sworn upon his oath, and attests as follows:

1) That I am of legal age, sound mind, and otherwise competent to testify.
2) That this affidavit is based on my personal knowledge.
3) That I am a licensed attorney and was admitted to the Ohio Bar in 2005.
4) That the primary focus of my practice has been and is personal injury law and I have represented defendants and plaintiffs with respect to claims and litigation.
5) I have been employed at Kisling, Nestico & Redick, LLC since 2011 and I am a Senior Partner of the firm.
6) In addition to handling my own caseload of personal injury claims, I am tasked with assisting other attorneys in reviewing and evaluating cases including medical records and bills.
7) Many of my clients have received care for soft tissue injuries to various parts of the body including the back and neck. This treatment frequently includes trigger point injections and the prescription of TENS units, and therefore, I am familiar with the rates charged by various medical providers for these items throughout the state.

8) Attached are explanation of medical benefits extracted from the files of KNR clients (with identifying information redacted) illustrating the cost of trigger point injections and TENS units and the payment of those costs by insurers.

9) That the amount charged by the various health care providers for trigger point injections and TENS units is consistent with the range of charges I see and amounts paid by insurers for these units which I believe is customary.

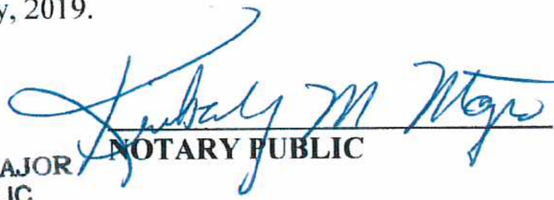
FURTHERMORE AFFIANT SAYETH NAUGHT.



JOSHUA R. ANGELOTTA

STATE OF OHIO)
) SS:
COUNTY OF SUMMIT)

SWORN TO AND SUBSCRIBED in my presence by JOSHUA R. ANGELOTTA this 10 day of May, 2019.



NOTARY PUBLIC

KIMBERLY M. MAJOR
NOTARY PUBLIC
STATE OF OHIO
Recorded in
Portage County
My Comm. Exp. 8/13/22

ALLSTATE INSURANCE COMPANY
PO BOX 440519
KENNESAW GA 30160

EXPLANATION OF MEDICAL BILL PAYMENT

Service Provided For:

3

Date: 09/07/2011
Bill Received Date: 08/25/2011
Claim #:
File Handler: 2Y5
Invoice #: 200748
Injured Person:
Treatment Rendered By: ANALGESIC HEALTHCARE
Provider Specialty:
TIN:
NPI:
CMS ID:

Diagnosis Codes/Present on Admission Indicator
847.2 LUMBAR SPRAIN 728.85 SPASM OF MUSCLE

Date Of Service(s) From	Thru	Procedure/Revenue/NDC Code/Modifier	Description	Units	Billed Amount	Covered Amount	Reason Code(s)
12/05/09	12/05/09	E0730-NU	Transcutaneous electrica	1.00	$ 745.00	$ 745.00	
12/05/09	12/05/09	A4556	Electrodes, (e.g., apnea	16.00	$ 143.28	$ 143.28	
12/05/09	12/05/09	99070	Supplies and materials (	1.00	$ 50.00	$ 0.00	12
01/20/10	01/20/10	A4556	Electrodes, (e.g., apnea	64.00	$ 573.12	$ 573.12	
01/20/10	01/20/10	A4245	Alcohol wipes, per box	3.00	$ 37.50	$ 15.00	41
01/20/10	01/20/10	99002	Handling, conveyance, an	1.00	$ 13.85	$ 13.85	
Total:					$ 1562.75	$ 1490.25	

Eligible Amount Based on 100% of Covered Amount $ 1490.25

Reason Code(s):
12 This CPT/HCPCS code is a "non-specific code." As noted in CPT/HCPCS a description of this procedure must accompany the bill for proper consideration of payment and for verification of proper coding.
41 Dates of Service 5/31/11 and prior, the amount allowed is based on benchmark data provided by Ingenix. As of Dates of Service 6/1/11 and greater, the amount allowed was reviewed using the FH RV Benchmark Database.

Modifier Code(s):
NU New equipment

If you have any questions about this claim, please contact your file handler, JACQUELINE F. JACKSON at (866) 575-4363 ext 5115

Payment for $ 1490.25 was made on 09/07/2011 to:
ANALGESIC HEALTHCARE

Copy(s) of this Explanation of Benefits has been sent to:
, 44333

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER: [X] OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 270725092

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

3. PATIENT'S BIRTH DATE: 02 03 1976 SEX: F [X]

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self [X]

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

CITY: CLEVELAND STATE: OH

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

ZIP CODE: 44102 TELEPHONE (Include Area Code): ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

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

b. AUTO ACCIDENT? [X] YES PLACE (State) OH

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED Signature on file DATE 12/4/2009

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 10 04 2009

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

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI 1861720369

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. 847.2
2. 728.85
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From (MM DD YY)	To (MM DD YY)	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	12 05 09	12 05 09	12		TENS E0730	NU	1,2	745 00	1		NPI	1124044623
2	12 05 09	12 05 09	12		ELECTRODES 2X2 A4556		1,2	143 28	16		NPI	1124044623
3	12 05 09	12 05 09	12		DEVICE SET-UP AND DELIVERY 99070		1,2	50 00	1		NPI	1124044623
4	01 20 10	01 20 10	12		ELECTRODES 2X2 A4556		1,2	573 12	64		NPI	1124044623
5	01 20 10	01 20 10	12		SKIN COTES A4245		1,2	37 50	3		NPI	1124044623
6	01 20 10	01 20 10	12		SHIP/HAND-LRG 99002		1,2	13 85	1		NPI	1124044623

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 593497691 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 200748

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES

28. TOTAL CHARGE: $ 1,562 75

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 1,562 75

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.)

ROY ED[signature] 1/21/2010

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # (813-915-8367

ANALGESIC HEALTHCARE
PO BOX 21021
TAMPA FL 33622-1021

a. 1124044623 b.

NUCC Instruction Manual available at: www.nucc.org

NM0398342- EOBID -De

On Your Side*
Ohio

EXPLANATION OF REVIEW

Provider Copy

Receive Date : 10/15/2012
Service Provider : JONES, JOSHUA M
27-0845852

1134 BROWN ST
AKRON OH 44301

Claim Number :
Adjuster :
Date Of Loss :

Billing Provider : CLEARWATER BILLING SERVICES
PO BOX 1243
BATH OH 44210

Patient :

Patient Account # : 3648
Carrier : NATIONWIDE INS - AFFILIATED CO
ALLIED INS - AFFILIATED CO
TITAN INS - AFFILIATED CO
PO BOX 26005
DAPHNE AL 36526

Provider Title : MD
Provider Specialty :

Dates Of Service : 09/18/2012 to 10/03/2012

DIAGNOSTIC CODES	DESCRIPTION
719.41	ICD-9 - Pain in joint, shoulder region
847.0	ICD-9 - Neck sprain and strain
847.1	ICD-9 - Thoracic sprain and strain
847.2	ICD-9 - Lumbar sprain and strain

LINE	DOS	PROC. CODE	MOD	DESCRIPTION	UNITS	CHARGE	*PEN REDUCTION	PROVIDER REIMBURSE	EXPLANATION
1	9/18/12	99204		Office/outpatient visit, new	1	350.00	0.00	350.00	
2	9/18/12	20553		Inject trigger points, =/> 3	1	800.00	0.00	800.00	

"If payment is due, check will be mailed under separate cover. Cashing this check will not forfeit your appeal rights. The amount shown should be considered full payment for service dates indicated, unless additional information is requested. The submitted claim, resulting in this explanation of review, reimbursement or benefit, was processed in accordance with the regulatory requirements (statutes, regulations or administrative codes) of the jurisdiction in which the claim was submitted. WARNING: OHIO Codes, Section 3999.21 states: "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud." APPEAL PROCESS: Please submit the following to the address listed below: 1. A copy of this Explanation of Reimbursement , 2. The reasons that you disagree with the reimbursement, 3. A copy of all supporting medical documentation concerning this appeal."

If you have any questions regarding payment, please contact your insurance carrier.
If you have question regarding this Explanation of Review, please contact our Customer Service Department at 877-444-8763.

PO BOX 26005, DAPHNE, AL 36526
877.444.8763

Printed On –
17-Oct-2012 7:44 pm

Claim Number —

Total Charges — $ 1,880.00

NM0398342- EOBID -De
Provider Copy

Billing Provider — CLEARWATER BILLING SERVICES

Total Reimbursement — $ 1,880.00

Service Provider — JONES, JOSHUA M

Patient Name —

Dates Of Service — 09/18/2012 - 10/03/2012

3	9/18/12	J1040	Inj methylprdnisolone actat 80 mg	1	80.00	0.00	80.00
4	10/03/12	99213	Office/outpatient visit, est	1	150.00	0.00	150.00
5	10/03/12	E0730	Tens device 4/> leads mx nerve stim	1	500.00	0.00	500.00
Total Lines :		5			1880.00	0.00	1880.00

Reimbursement Amount :	1,880.00
Apportionment % :	
Subtotal :	1,880.00
Less Deductible :	0.00
Limited Benefits/Copay :	0.00
Collateral Source/Healthcare Carrier Payment :	0.00
Plus Interest :	0.00
EOR Check Amount :	1,880.00
Allocated PIP Payment :	0.00
Allocated MedPay Payment :	1,880.00

EXPLANATION	EXPLANATION FOR THE REVIEW AMOUNT	REF DOC_ID	REF LINE NUMBER

"If payment is due, check will be mailed under separate cover. Cashing this check will not forfeit your appeal rights. The amount shown should be considered full payment for service dates indicated, unless additional information is requested. The submitted claim, resulting in this explanation of review, reimbursement or benefit, was processed in accordance with the regulatory requirements (statutes, regulations or administrative codes) of the jurisdiction in which the claim was submitted. WARNING: OHIO Codes, Section 3999.21 states: "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud." APPEAL PROCESS: Please submit the following to the address listed below: 1. A copy of this Explanation of Reimbursement , 2. The reasons that you disagree with the reimbursement, 3. A copy of all supporting medical documentation concerning this appeal."

If you have any questions regarding payment, please contact your insurance carrier.
If you have question regarding this Explanation of Review, please contact our Customer Service Department at 877-444-8763.

PO BOX 26005, DAPHNE, AL 36526
877.444.8763

Printed On —
17-Oct-2012 7:44 pm

10/20/2015 9:04AM (GMT-04:00)

Alok Bhaiji M.D.
7255 Old Oak Blvd. C-111
Middleburg, Ohio 44130

Invoice

MAKE CHECKS PAYABLE TO THE HURT DOCTORS
Bill To

Invoice Date -	3/21/2015
Invoice #	

Please return this portion of statement with payment

Location	DIAGNOSIS	ATTORNEY
EO	844.9	KNR

Service Date	Item Code	Quantity	Description	Price Each	Amount
3/19/2015	99205	1	FIRST COMPREHENSIVE VISIT	575.00	575.00
3/19/2015	97010	1	HOT/COLD PACKS	30.00	30.00
3/19/2015	97032	1	E-STIM ATTENDED	40.00	40.00
3/19/2015	97035	1	ULTRASOUND THERAPY	35.00	35.00
3/19/2015	97535	1	ACTIVITIES OF DAILY LIVING	100.00	100.00
3/24/2015	97010	1	HOT/COLD PACKS	30.00	30.00
3/24/2015	97032	1	E-STIM ATTENDED	40.00	40.00
3/24/2015	97035	1	ULTRASOUND THERAPY	35.00	35.00
3/24/2015	97535	1	ACTIVITIES OF DAILY LIVING	100.00	100.00
3/26/2015	97010	1	HOT/COLD PACKS	30.00	30.00
3/26/2015	97032	1	E-STIM ATTENDED	40.00	40.00
3/26/2015	97035	1	ULTRASOUND THERAPY	35.00	35.00
3/31/2015	97010	1	HOT/COLD PACKS	30.00	30.00
3/31/2015	97032	1	E-STIM ATTENDED	40.00	40.00
3/31/2015	97035	1	ULTRASOUND THERAPY	35.00	35.00
4/2/2015	99213	1	OFFICE VISIT/ESTABLISHED PATIENT	275.00	275.00
4/2/2015	20553	6	TRIGGER POINT INJECTIONS	110.00	660.00
4/2/2015	97535	1	ACTIVITIES OF DAILY LIVING	100.00	100.00
4/2/2015	E0730-NU	1	TENS	500.00	500.00
4/7/2015	97010	1	HOT/COLD PACKS	30.00	30.00
4/7/2015	97032	1	E-STIM ATTENDED	40.00	40.00
4/7/2015	97035	1	ULTRASOUND THERAPY	35.00	35.00
4/9/2015	99213	1	OFFICE VISIT/ESTABLISHED PATIENT	275.00	275.00
4/9/2015	20553	6	TRIGGER POINT INJECTIONS	110.00	660.00
4/9/2015	97010	1	HOT/COLD PACKS	30.00	30.00
4/9/2015	97032	1	E-STIM ATTENDED	40.00	40.00
4/9/2015	97035	1	ULTRASOUND THERAPY	35.00	35.00
4/9/2015	97535	1	ACTIVITIES OF DAILY LIVING	100.00	100.00
4/14/2015	99213	1	OFFICE VISIT/ESTABLISHED PATIENT	275.00	275.00
4/14/2015	20553	4	TRIGGER POINT INJECTIONS	110.00	440.00
4/14/2015	97010	1	HOT/COLD PACKS	30.00	30.00
4/14/2015	97032	1	E-STIM ATTENDED	40.00	40.00
4/14/2015	97035	1	ULTRASOUND THERAPY	35.00	35.00

For Assistance please call (440) 816-2556

Total

10/20/2015 15:17 Dr. Bhaiji, M.D. Inc (FAX)14408162557 P.002/013

AUCK CHIROPRACTIC SERVICES, INC.

ACHIEVE OPTIMAL HEALTH THROUGH CHIROPRACTIC

PRACTICE RELIEF ♦ CONSULTING ♦ PRODUCT SALES

INVOICE

Tax ID #: 36-4559102

DATE: 08/24/2016

Insurance:
Founders Insurance
P.O. Box 5100
Des Plaines, IL 60017
Adj. Paula Barr

Attorney:
KNR
4790 Market St.
Boardman, OH 44512
330-729-1090

For:
[redacted]
Youngstown, Ohio 44506
330-951-2683

Diagnosis Codes:
S13.4xxA, S23.3xxA,S33 5xxA, G44.319
E812.0

DOB:
11/23/1964

DOI:
08/06/2016

Claim #:
1000127409

DESCRIPTION	AMOUNT
2-Lead TENS Unit for localized nerve stimulation Code: E0720	$500.00
Includes instruction, follow-up, and four packs of TENS pads (for daily home use 1-5x/day)	
DOS: 08/24/2016	
Make check payable to: Auck Chiropractic Services, Inc. 111 Jennette Drive, Boardman, OH 44512	
TOTAL:	$500.00

05-05-15;07:16AM; ; # 6/ 8

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) / MEDICAID (Medicaid#) / TRICARE (ID#/DoD#) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (ID#) / FECA BLK LUNG (ID#) / OTHER [X] (ID#)

1a. INSURED'S I.D. NUMBER: FXZ049A24617

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

3. PATIENT'S BIRTH DATE: MM DD YY 05 07 66 — SEX: M [ ] F [X]

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

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

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

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

CITY: PERRYSBURG — STATE: OH

8. RESERVED FOR NUCC USE

ZIP CODE: 43551 — TELEPHONE (Include Area Code)

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
c. OTHER ACCIDENT? YES [ ] NO [X]

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER: 174092MCAF

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

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME: BCBS OH

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

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 QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DK ANN MURAWSKI

17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind. 9

A. 723.4 B. 723.1 C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL.	J. RENDERING PROVIDER ID. #
1 04 02 14		12		E0730	NU	12	795 00	1		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 411310335 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 5410066-20494942

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

28. TOTAL CHARGE: $ 795 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

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.)

SIGNATURE ON FILE

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH #

EMPI, INC
599 CARDIGAN RD
SHOREVIEW MN 55126-3965

a. 1174574032 b.

CARRIER → PATIENT AND INSURED INFORMATION → PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual Available at: www.nucc.org

APPROVED OMB-0938-1197 FORM 1500 (02/12)

Sandra Kurt, Summit County Clerk of Courts 05/05/2015 8:20AM (GMT-04:00)

S.A. MAHER
P.O. BOX 38306
OLMSTED FALLS, OHIO 44138
440-777-5544
FAX:440-777-5094

July 25, 2014

Kimberly Lubrani
Attorney at Law
3412 West Market St.
Akron, OH 44333
330-869-9007
330-669-9008 fax

Re:

Dear Attorney Rosenberg:

Services provided to your client by S. A. Maher, Inc. are as follows:

Date	Service rendered	Billed charges	Insurance payment
3/3/2011	Tens unit	$695.00	$32.24
4/3/2011	rental payment		$32.24
5/3/2011	rental payment		$32.24
6/3/2011	rental payment		$32.24
7/3/2011	rental payment		$32.24
7/7/2011	electrode	$25.80	$25.00
8/3/2011	rental payment		$32.24
8/7/2011	electrode	$25.80	$25.00
9/3/2011	rental payment		$32.24
9/7/2011	electrode	$25.80	$25.00
10/3/2011	rental payment		$32.24
10/7/2011	electrode	$25.80	$25.00
11/3/2011	rental payment		$32.24
11/7/2011	electrode	$25.80	$25.00
12/3/2011	rental payment		$32.24
12/7/2011	electrode	$25.80	$25.00
1/7/2012	electrode	$25.80	$25.00
2/7/2012	electrode	$25.80	$25.00
3/7/2012	electrode	$25.80	$25.00
4/7/2012	electrodes	$61.90	$61.90
5/7/2012	electrodes	$61.90	$61.90
6/7/2012	electrodes	$61.90	$61.90
7/7/2012	electrodes	$61.90	$61.90
8/7/2012	electrodes	61.*90	$61.90
9/7/2012	electrodes	$61.90	$61.90
10/7/2012	electrodes	$61.90	$61.90

The patient's insurance company will pay ten rentals for the TENS unit. We will send statements as charges and payments occur. We do accept assignment with Medicare and Medicaid. All payments are considered . paid in full. This statement is to show what has been paid by the patient's health insurance.

BECKY GREBOW
5410066
SALES/RENTAL 21995567

419 874-4569 05 07

12343 ROOSEVELT PERRYSBURG, OH 43551

3 6 6 6 2 0 4 9 4

X

6488518 ST LUKES HOSP PAIN CLINIC 419 893-5986

5759 MONCLOVA RD MAUMEE, OH 43537

1N DAVID NOWARD
2786

MONTHLY
RENTAL

1 199584-001 SELECT TENS KIT 1831275 125.00 795.0
193068-100 QTY = 2 86905220 QTY = 2
200048-001 QTY = 1
* Supplies, Tax & Freight Additional *

04-02-14 07:11 21990375 25978717

Ohio Institute of Pain Management

2048 N. River Road NE
Warren , OH 44483-2543
Phone: 330-372-5550 Fax: 330-372-5551

Superbill

Superbill Date: 07/25/2016 **Service** 3/1/2016 thru 7/25/2016

Patient Information

Account: 20105
Date of birth: 6/10/1953
Employer:

Payor Information
Kisling, Nestico & Redick, LLC
4790 Market Street
Boardman, OH 44512

Insurance Phone: 330-729-1090
Insured ID:
Insurance Policy Group:
Insurance Plan Name:

Dx: (M54.2) Cervicalgia, (M54.5) Low back pain, (M79.1) Myalgia, (M25.519) Pain in unspecified shoulder, (M54.12) Radiculopathy, cervical reg, (M25.511) Pain in RT shoulder, (M54.6) Pain in thoracic spine

Date	Type	Code	Mod	Units	Description	Date of injury	POS	Tax	Amount
03/21/2016	CSV	99203		1	NP Detailed		11	0.00	150.00
03/24/2016	CSV	20552		1	Trigger Point Injection 1-2 Muscles		11	0.00	160.00
03/28/2016	CSV	20552		1	Trigger Point Injection 1-2 Muscles		11	0.00	160.00
03/31/2016	CSV	20552		1	Trigger Point Injection 1-2 Muscles		11	0.00	160.00
04/04/2016	CSV	20552		1	Trigger Point Injection 1-2 Muscles		11	0.00	160.00
04/07/2016	CSV	20552		1	Trigger Point Injection 1-2 Muscles		11	0.00	160.00
04/18/2016	CSV	20552		1	Trigger Point Injection 1-2 Muscles		11	0.00	160.00
04/21/2016	CSV	20552		1	Trigger Point Injection 1-2 Muscles		11	0.00	160.00
04/21/2016	CSV	99213	25	1	EP Expanded		11	0.00	100.00
04/28/2016	CSV	20552		1	Trigger Point Injection 1-2 Muscles		11	0.00	160.00
05/05/2016	CSV	20552		1	Trigger Point Injection 1-2 Muscles		11	0.00	160.00
05/12/2016	CSV	20552		1	Trigger Point Injection 1-2 Muscles		11	0.00	160.00
05/23/2016	CSV	20552		1	Trigger Point Injection 1-2 Muscles		11	0.00	160.00
05/26/2016	CSV	20552		1	Trigger Point Injection 1-2 Muscles		11	0.00	160.00
06/16/2016	CSV	99212	25	1	EP Problem Focus		11	0.00	75.00

Provider Information
Name: Sara Dorris CNP
License: COA.16193-NP/OHIO
Tax ID: 20-1752165
NPI: 1174930986

Total Charges	$2,245.00
Total Taxes	$0.00
Total	$2,245.00

Printed: 7/25/2016 11:24:52 AM