

IN THE COURT OF COMMON PLEAS
SUMMIT COUNTY, OHIO

MEMBER WILLIAMS, et al., Plaintiffs, vs. KISLING, NESTICO & REDICK, LLC, <i>et al.</i> , Defendants.	Case No. CV-2016-09-3928 Judge James A. Brogan Notice of Filing Volume III of Exhibits to the Deposition of Defendant Sam Ghoubrial
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Plaintiffs hereby give notice of filing Volume III of exhibits to the deposition of Defendant Sam Ghoubrial, taken on April 9, 2019.

Respectfully submitted,

/s/ Rachel Hazelet

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Rachel Hazelet (0097855)
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Attorneys for Plaintiffs

Certificate of Service

The foregoing document was filed on May 15, 2019, using the Court's electronic-filing system, which will serve copies on all necessary parties.

/s/ Rachel Hazelet
Attorney for Plaintiffs

7/6/2009

22 PM FROM: Fax TO: 8 1-330-925-9030 P/

006 OF 009

JUN-30-2008 04:13PM FROM: Sam Ghoubril MD

3300259030

T-847 P.011/014 F-884



Sam N. Ghoubril M.D. Inc.



Medical Assignment Form

Re: Patient Michael BookerFirst date of service: 6-10-09

I hereby direct you to pay to Sam N. Ghoubril, M.D. Inc. from the net proceeds of any settlement, claim, judgment, verdict or award, for any and all services rendered as a result of an injury that I received on 6-5-09.

Said amount being fair and reasonable price of medical services provided by Sam N. Ghoubril, M.D. Inc. for me at the direction of my doctor or doctors. I authorize you to withhold said sums from the net proceeds of any settlement, claim, judgment, verdict, or awards as may be necessary to pay Sam N. Ghoubril, M.D. Inc.

I fully understand that I am directly and fully responsible to Sam N. Ghoubril, M.D. Inc. for the aforementioned account submitted to me by Sam N. Ghoubril, M.D. Inc. for services rendered me, and that this agreement is made solely for its additional protection and in consideration of its awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, verdict or award by which I may eventually recover said fee.

Dated: 6-10-09Michael Booker

Patient Signature

The undersigned being attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such claims from the net proceeds of any settlement, claim, judgment, verdict, or award as may be necessary to adequately protect Sam N. Ghoubril, M.D. Inc. provided that said lien is subordinate to attorney's lien herein.

Dated: 7/1/09[Signature]Kisling, Nestico & Redick, LLC
Attorneys at Law

Kisling, Nestico & Redick, LLC
3200 W. Market St., Suite 300
Akron, Ohio 44333
(330) 869-9007
(330) 869-9008 (fax)

2517 Embassy Parkway Fairlawn Ohio 44333 (330) 925-1500

PENGAD 800-631-6883

PLAINTIFF'S
EXHIBIT14

CLIENT: Michael Booker**INSURANCE CO:** JB Hunt Transportation**INSURED:** JB Hunt**ADJUSTER:** Shari Dart**DATE OF LOSS:** 06/05/2009**CLAIM NO:** A0902388

<u>MEDICAL SPECIALS</u>		<u>AMOUNT</u>
<u>PHYSICIANS:</u>		
Dr. Minas Floros, D.C.	(06/08/09 - 08/05/09)	\$ 5,460.00
Dr. Sam Ghoubrial, M.D.	(06/10/09 - 07/01/09)	\$ 1,510.00
<u>OTHER:</u>		
Professional Imaging Consultants, Inc.	(06/24/2009)	\$ 115.00
TOTAL MEDICAL SPECIALS:		\$ 7,085.00

Sam N. Ghoubril M.D., Inc.
3517 Embassy Parkway
Fairlawn, Ohio 44333
330-925-1500
330-925-9030

June 10, 2009
Michael Booker

Michael is a 43-year-old gentleman who was involved in a motor vehicle accident on June 5, 2009. Michael was the restrained passenger in a vehicle that was struck by a truck. Apparently the truck backed into the front end of the vehicle in which he was riding and pulled him forward and then backward. As a result of the impact, Michael states he was jarred around the cabin injuring his back; he states he began to experience pain in his back almost immediately after the accident. He states the pain is approximately 7 on a scale of 10. He notes he has difficulty bending and twisting at the waist. He also complains of some knee pain. He may have struck it on the dashboard as a result of the impact.

Past Medical History: 1. Hypertension.

Social History: Occasional alcohol.

MEDICATIONS: Norvasc, lisinopril, HCTZ.

PHYSICAL EXAM:

INTEGUMENTARY: The skin is without any cyanosis. No evidence of nail fungus, rash or abnormality. Elasticity appears to be WNL.

HEENT: Normocephalic and atraumatic. PERRLA. Mucous membranes are moist. The nose is patent and non-deviated tympanic membranes WNL.

NECK: Soft and supple. Thyroid gland could not be palpated. No evidence of any cervical lymphadenopathy. No JVD is noted.

CARDIOVASCULAR: RRR normal S1 S2, no murmurs rubs or gallops. No carotid bruits could be appreciated.

LUNGS: Clear to auscultation. No wheezes, rales, or rhonchi could be appreciated on exam.

ABDOMEN: Soft and non-tender with positive bowel sounds. No evidence of any ascites or hepatosplenomegaly. No guarding or rebound tenderness. Negative for hernias.

GRASP/MANIPULATION: Pincer movements and fine coordination appear to be WNL.

BACK: No scars are present. He has marked guarding and spasm over the paraspinal musculature of the lumbar spine with decreased range of motion.

Patient Name: Michael Booker

Page Two

UPPER EXTREMITIES: Shoulders, wrists and elbows: demonstrate no scars or gross deformities. +2 radial pulses throughout.

LOWER EXTREMITIES: No venous insufficiency or edema. +2 pulses throughout. Ankles and hips demonstrate no gross abnormalities on exam. He has tenderness of the left knee.

MUSCULOSKELETAL: The patient is able to get on and off the exam table without difficulty. The patient is able to do heel to toe walking. The patient doesn't walk with a cane or walker.

NEUROLOGICAL: The patient is alert and oriented x 3. Cranial nerves II-VII are grossly intact throughout. Reflexes are 2/4 throughout. Tactile sensation is WNL. There is a negative Romberg test. Cerebellar testing is within normal limits. There is a negative straight leg raise and negative bowstring sign.

ASSESSMENT:

1. Lumbosacral strain.

PROCEDURE: I identified two trigger points at the level of L1 and two trigger points at the level of L5. I injected all four trigger points with 1/2 cc of Kenalog and 1 cc of Marcaine under sterile technique. He tolerated the injections well.

PLAN: I prescribed Percocet 5/325 #60, one t.i.d. as needed with no refills. This should help with the pain.



Sam N. Ghoubrial M.D.

INTERNAL MEDICINE CENTER OF RITTMAN

NAME: Michael Booker

DATE	PROGRESS NOTES
6/10/09	MVA New - low back & (L) knee (KW)
6/24/09	A MVA lup (KW)
Michael Booker	June 24 2009
He comes into the office today for a routine followup visit. Michael is doing fairly well. He has some residual guarding and tenderness to his lumbar spine although he is improved. He is still fairly tight.	
PLAN: I prescribed Percocet 5/325 mg, #60, one t.i.d. PRN. In addition, I gave him Soma 350 mg, one pill at night, #14, no refills.	
SNG:rtd Jan M. Reel MD	
7-1-09	MVA - lup (KS)
Michael Booker	July 1, 2009
He is here for a followup visit. He states he is doing very well. He just has a touch of tenderness at the right side of his lumbar spine, particularly on flexion. The C-spine is nice and loose. He has good range of motion.	
IMPRESSION: 1. Lumbar strain.	
PLAN: We can release him.	
SNG:rtd Jan M. Reel MD	

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

KISLING, NESTICO& REDICK LLC
3200 W MARKET ST #300
AKRON, OH 44333

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA <input checked="" type="checkbox"/> (SSN) OTHER <input checked="" type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) BOOKER, MICHAEL E										3. PATIENT'S BIRTH DATE [REDACTED]										4. INSURED'S NAME (Last Name, First Name, Middle Initial) MICHAEL E. BOOKER									
5. PATIENT'S ADDRESS (No., Street) [REDACTED]										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) [REDACTED]									
8. PATIENT STATUS [REDACTED]										9. INSURED'S STATUS [REDACTED]																			
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										11. INSURED'S POLICY GROUP OR FECA NUMBER [REDACTED]																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE SIGNED _____ DATE 08/17/09										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE SIGNED _____																			
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 05/09										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY [REDACTED]																			
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY [REDACTED]										17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY [REDACTED]																			
18. OUTSIDE LAB? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES 0.00										19. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																			
20. PRIOR AUTHORIZATION NUMBER										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Link) 8472																			
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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

KISLING, NESTICO& REDICK LLC
3200 W MARKET ST #300
AKRON, OH 44333

PICA										PICA									
1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input checked="" type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) [REDACTED]									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) BOOKER, MICHAEL E										3. PATIENT'S BIRTH DATE [REDACTED] SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F									
5. PATIENT'S ADDRESS (No., Street) [REDACTED]										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY [REDACTED] STATE [REDACTED]										4. INSURED'S NAME (Last Name, First Name, Middle Initial) MICHAEL E. BOOKER									
ZIP CODE [REDACTED] TELEPHONE (Include Area Code) [REDACTED]										7. INSURED'S ADDRESS (No., Street) [REDACTED]									
CITY [REDACTED] STATE [REDACTED]										CITY [REDACTED] STATE [REDACTED]									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) OH									
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE									
11. INSURED'S POLICY GROUP OR FECA NUMBER										a. INSURED'S DATE OF BIRTH [REDACTED] MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
b. EMPLOYER'S NAME OR SCHOOL NAME										b. INSURED'S DATE OF BIRTH [REDACTED] MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
c. INSURANCE PLAN NAME OR PROGRAM NAME KISLING, NESTICO& REDICK										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE SIGNED [REDACTED] DATE 08/17/09										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE SIGNED [REDACTED]									
14. DATE OF CURRENT: 05/09 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (I MP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES 0.00									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 8472 2. 71946 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 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1001. 1002. 1003. 1004. 1005. 1006. 1007. 1008. 1009. 1010. 1011. 1012. 1013. 1014. 1015. 1016. 1017. 1018. 1019. 1020. 1021. 1022. 1023. 1024. 1025. 1026. 1027. 1028. 1029. 1030. 1031. 1032. 1033. 1034. 1035. 1036. 1037. 1038. 1039. 1040. 1041. 1042. 1043. 1044. 1045. 1046. 1047. 1048. 1049. 1050. 1051. 1052. 1053. 1054. 1055. 1056. 1057. 1058. 1059. 1060. 1061. 1062. 1063. 1064. 1065. 1066. 1067. 1068. 1069. 1070. 1071. 1072. 1073. 1074. 1075. 1076. 1077. 1078. 1079. 1080. 1081. 1082. 1083. 1084. 1085. 1086. 1087. 1088. 1089. 1090. 1091. 1092. 1093. 1094. 1095. 1096. 1097. 1098. 1099. 1100. 1101. 1102. 1103. 1104. 1105. 1106. 1107. 1108. 1109. 1110. 1111. 1112. 1113. 1114. 1115. 1116. 1117. 1118. 1119. 1120. 1121. 1122. 1123. 1124. 1125. 1126. 1127. 1128. 1129. 1130. 1131. 1132. 1133. 1134. 1135. 1136. 1137. 1138. 1139. 1140. 1141. 1142. 1143. 1144. 1145. 1146. 1147. 1148. 1149. 1150. 1151. 1152. 1153. 1154. 1155. 1156. 1157. 1158. 1159. 1160. 1161. 1162. 1163. 1164. 1165. 1166. 1167. 1168. 1169. 1170. 1171. 1172. 1173. 1174. 1175. 1176. 1177. 1178. 1179. 1180. 1181. 1182. 1183. 1184. 1185. 1186. 1187. 1188. 1189. 1190. 1191. 1192. 1193. 1194. 1195. 1196. 1197. 1198. 1199. 1200. 1201. 1202. 1203. 1204. 1205. 1206. 1207. 1208. 1209. 1210. 1211. 1212. 1213. 1214. 1215. 1216. 1217. 1218. 1219. 1220. 1221. 1222. 1223. 1224. 1225. 1226. 1227. 1228. 1229. 1230. 1231. 1232. 1233. 1234. 1235. 1236. 1237. 1238. 1239. 1240. 1241. 1242. 1243. 1244. 1245. 1246. 1247. 1248. 1249. 1250. 1251. 1252. 1253. 1254. 1255. 1256. 1257. 1258. 1259. 1260. 1261. 1262. 1263. 1264. 1265. 1266. 1267. 1268. 1269. 1270. 1271. 1272. 1273. 1274. 1275. 1276. 1277. 1278. 1279. 1280. 1281. 1282. 1283. 1284. 1285. 1286. 1287. 1288. 1289. 1290. 1291. 1292. 1293. 1294. 1295. 1296. 1297. 1298. 1299. 1300. 1301. 1302. 1303. 1304. 1305. 1306. 1307. 1308. 1309. 1310. 1311. 1312. 1313. 1314. 1315. 1316. 1317. 1318. 1319. 1320. 1321. 1322. 1323. 1324. 1325. 1326. 1327. 1328. 1329. 1330. 1331. 1332. 1333. 1334. 1335. 1336. 1337. 1338. 1339. 1340. 1341. 1342. 1343. 1344. 1345. 1346. 1347. 1348. 1349. 1350. 1351. 1352. 1353. 1354. 1355. 1356. 1357. 1358. 1359. 1360. 1361. 1362. 1363. 1364. 1365. 1366. 1367. 1368. 1369. 1370. 1371. 1372. 1373. 1374. 1375. 1376. 1377. 1378. 1379. 1380. 1381. 1382. 1383. 1384. 1385. 1386. 1387. 1388. 1389. 1390. 1391. 1392. 1393. 1394. 1395. 1396. 1397. 1398. 1399. 1400. 1401. 1402. 1403. 1404. 1405. 1406. 1407. 1408. 1409. 1410. 1411. 1412. 1413. 1414. 1415. 1416. 1417. 1418. 1419. 1420. 1421. 1422. 1423. 1424. 1425. 1426. 1427. 1428. 1429. 1430. 1431. 1432. 1433. 1434. 1435. 1436. 1437. 1438. 1439. 1440. 1441. 1442. 1443. 1444. 1445. 1446. 1447. 14																			



Sam N. Ghoubril M.D., Inc.
Internal Medicine Center of Rittman

Sam N. Ghoubril, M.D.
Richard H. Gunning, M.D.
25 South Main Street
Rittman, Ohio 44270
Telephone: (330) 925-1500
Fax: (330) 925-9030

Invoice for Medical Services

August 17, 2009

Re: Michael Booker
Date of Accident: 06/05/2009
Date of Birth: [REDACTED]

Medical services for the above-named client.		AMOUNT
06/10/09	see detailed HCFA 1500	\$960.00
06/10/09—07/01/09	see detailed HCFA 1500	\$550.00
08/17/09	Documentation preparation fee	\$50.00
Total amount due:		\$1560.00

Please make checks payable to:

Sam N. Ghoubril, M.D. Inc.
25 South Main Street
Rittman, Ohio 44270

Tax ID# 34-1843255

Akron Square Chiropractic
1419 South Arlington Rd.
Akron, OH 44306
(330)773-3882

Tax I.D.31-1528200

Statement Date

9/2/2009

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Michael Booker
% KISLING, NESTICO & REDICK
3200 WEST MARKET STREET
SUITE 300
AKRON, OH 44333

Diagnosis

847.2
847.1
847.0
844.9

Chart Number

BOOMI006

Date	Description	Procedure Code	Amount
Date of Loss: 6/5/2009	Previous Balance		0.00
Patient: Michael Booker	Chart #: BOOMI006	Case Description: mva	
6/8/2009	TEN POINT EXAM	10 PT	0.00
6/8/2009	X-ray Lumbosacral, complete, bending	72114	160.00
6/8/2009	Electrical Muscle Stimulation	97014	30.00
6/8/2009	Hot/Cold Packs to one or more areas	97010	20.00
6/9/2009	Established Patient Office Visit - Inter	99213	40.00
6/9/2009	Electrical Muscle Stimulation	97014	30.00
6/9/2009	Hot/Cold Packs to one or more areas	97010	20.00
6/9/2009	Traction, Mechanical	97012	25.00
6/9/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00
6/10/2009	Spinal Manipulation 1-2 regions	98940	65.00
6/10/2009	Electrical Muscle Stimulation	97014	30.00
6/10/2009	Hot/Cold Packs to one or more areas	97010	20.00
6/10/2009	Traction, Mechanical	97012	25.00
6/10/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00
6/11/2009	Spinal Manipulation 1-2 regions	98940	65.00
6/11/2009	Electrical Muscle Stimulation	97014	30.00
6/11/2009	Hot/Cold Packs to one or more areas	97010	20.00
6/11/2009	Traction, Mechanical	97012	25.00
6/11/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00
6/12/2009	Spinal Manipulation 1-2 regions	98940	65.00
6/12/2009	Electrical Muscle Stimulation	97014	30.00

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

Akron Square Chiropractic
1419 South Arlington Rd.
Akron, OH 44306
(330)773-3882

Tax I.D.31-1528200

Statement Date

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Michael Booker
 % KISLING, NESTICO & REDICK
 3200 WEST MARKET STREET
 SUITE 300
 AKRON, OH 44333

Diagnosis

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 844.9

Chart Number

BOOMI006

Date	Description	Procedure Code	Amount
6/12/2009	Hot/Cold Packs to one or more areas	97010	20.00
6/12/2009	Traction, Mechanical	97012	25.00
6/12/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00
6/15/2009	Spinal Manipulation 1-2 regions	98940	65.00
6/15/2009	Electrical Muscle Stimulation	97014	30.00
6/15/2009	Hot/Cold Packs to one or more areas	97010	20.00
6/15/2009	Traction, Mechanical	97012	25.00
6/15/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00
6/16/2009	Spinal Manipulation 1-2 regions	98940	65.00
6/16/2009	Electrical Muscle Stimulation	97014	30.00
6/16/2009	Hot/Cold Packs to one or more areas	97010	20.00
6/16/2009	Traction, Mechanical	97012	25.00
6/16/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00
6/17/2009	Spinal Manipulation 1-2 regions	98940	65.00
6/17/2009	Electrical Muscle Stimulation	97014	30.00
6/17/2009	Hot/Cold Packs to one or more areas	97010	20.00
6/17/2009	Traction, Mechanical	97012	25.00
6/17/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00
6/18/2009	Spinal Manipulation 1-2 regions	98940	65.00
6/18/2009	Electrical Muscle Stimulation	97014	30.00
6/18/2009	Hot/Cold Packs to one or more areas	97010	20.00
6/18/2009	Traction, Mechanical	97012	25.00
6/18/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00

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

Akron Square Chiropractic
1419 South Arlington Rd.
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Statement Date

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Diagnosis

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844.9

Chart Number

BOOMI006

Date	Description	Procedure Code	Amount
6/22/2009	Spinal Manipulation 1-2 regions	98940	65.00
6/22/2009	Electrical Muscle Stimulation	97014	30.00
6/22/2009	Hot/Cold Packs to one or more areas	97010	20.00
6/22/2009	Traction, Mechanical	97012	25.00
6/22/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00
6/23/2009	Spinal Manipulation 1-2 regions	98940	65.00
6/23/2009	Electrical Muscle Stimulation	97014	30.00
6/23/2009	Hot/Cold Packs to one or more areas	97010	20.00
6/23/2009	Traction, Mechanical	97012	25.00
6/23/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00
6/24/2009	Spinal Manipulation 1-2 regions	98940	65.00
6/24/2009	Electrical Muscle Stimulation	97014	30.00
6/24/2009	Hot/Cold Packs to one or more areas	97010	20.00
6/24/2009	Traction, Mechanical	97012	25.00
6/24/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00
6/25/2009	Spinal Manipulation 1-2 regions	98940	65.00
6/25/2009	Electrical Muscle Stimulation	97014	30.00
6/25/2009	Hot/Cold Packs to one or more areas	97010	20.00
6/25/2009	Traction, Mechanical	97012	25.00
6/25/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00
6/29/2009	Spinal Manipulation 1-2 regions	98940	65.00
6/29/2009	Electrical Muscle Stimulation	97014	30.00
6/29/2009	Hot/Cold Packs to one or more areas	97010	20.00

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

Akron Square Chiropractic
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Michael Booker
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Diagnosis

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847.1
847.0
844.9

Chart Number

BOOMI006

Date	Description	Procedure Code	Amount
6/29/2009	Traction, Mechanical	97012	25.00
6/29/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00
6/30/2009	Spinal Manipulation 1-2 regions	98940	65.00
6/30/2009	Electrical Muscle Stimulation	97014	30.00
6/30/2009	Hot/Cold Packs to one or more areas	97010	20.00
6/30/2009	Traction, Mechanical	97012	25.00
6/30/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00
7/1/2009	Spinal Manipulation 1-2 regions	98940	65.00
7/1/2009	Electrical Muscle Stimulation	97014	30.00
7/1/2009	Hot/Cold Packs to one or more areas	97010	20.00
7/1/2009	Traction, Mechanical	97012	25.00
7/1/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00
7/2/2009	Spinal Manipulation 1-2 regions	98940	65.00
7/2/2009	Electrical Muscle Stimulation	97014	30.00
7/2/2009	Traction, Mechanical	97012	25.00
7/2/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00
7/6/2009	Spinal Manipulation 1-2 regions	98940	65.00
7/6/2009	Electrical Muscle Stimulation	97014	30.00
7/6/2009	Traction, Mechanical	97012	25.00
7/6/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00
7/7/2009	Spinal Manipulation 1-2 regions	98940	65.00
7/7/2009	Electrical Muscle Stimulation	97014	30.00
7/7/2009	Traction, Mechanical	97012	25.00

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

Akron Square Chiropractic
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Diagnosis

847.2
 847.1
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 844.9

Chart Number

BOOMI006

Date	Description	Procedure Code	Amount
7/7/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00
7/8/2009	Spinal Manipulation 1-2 regions	98940	65.00
7/8/2009	Electrical Muscle Stimulation	97014	30.00
7/8/2009	Traction, Mechanical	97012	25.00
7/8/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00
7/9/2009	Spinal Manipulation 1-2 regions	98940	65.00
7/9/2009	Electrical Muscle Stimulation	97014	30.00
7/9/2009	Traction, Mechanical	97012	25.00
7/9/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00
7/13/2009	Spinal Manipulation 1-2 regions	98940	65.00
7/13/2009	Electrical Muscle Stimulation	97014	30.00
7/13/2009	Traction, Mechanical	97012	25.00
7/13/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00
7/15/2009	Spinal Manipulation 1-2 regions	98940	65.00
7/15/2009	Electrical Muscle Stimulation	97014	30.00
7/15/2009	Traction, Mechanical	97012	25.00
7/15/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00
7/16/2009	Spinal Manipulation 1-2 regions	98940	65.00
7/16/2009	Electrical Muscle Stimulation	97014	30.00
7/16/2009	Traction, Mechanical	97012	25.00
7/16/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00
7/20/2009	Spinal Manipulation 1-2 regions	98940	65.00
7/20/2009	Electrical Muscle Stimulation	97014	30.00

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

Akron Square Chiropractic
1419 South Arlington Rd.
Akron, OH 44306
(330)773-3882

Tax I.D.31-1528200

Statement Date

9/2/2009

Page

6

Michael Booker
% KISLING, NESTICO & REDICK
3200 WEST MARKET STREET
SUITE 300
AKRON, OH 44333

Diagnosis

847.2
847.1
847.0
844.9

Chart Number

BOOMI006

Date	Description	Procedure Code	Amount
7/20/2009	Traction, Mechanical	97012	25.00
7/20/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00
7/21/2009	Spinal Manipulation 1-2 regions	98940	65.00
7/21/2009	Electrical Muscle Stimulation	97014	30.00
7/21/2009	Traction, Mechanical	97012	25.00
7/21/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00
7/22/2009	Spinal Manipulation 1-2 regions	98940	65.00
7/22/2009	Electrical Muscle Stimulation	97014	30.00
7/22/2009	Traction, Mechanical	97012	25.00
7/22/2009	Massage/Trigger Point-Distinct Procedure	97124-59	50.00
7/27/2009	Spinal Manipulation 1-2 regions	98940	65.00
7/27/2009	Electrical Muscle Stimulation	97014	30.00
7/27/2009	Traction, Mechanical	97012	25.00
7/28/2009	Spinal Manipulation 1-2 regions	98940	65.00
7/28/2009	Electrical Muscle Stimulation	97014	30.00
7/28/2009	Traction, Mechanical	97012	25.00
7/29/2009	Spinal Manipulation 1-2 regions	98940	65.00
7/29/2009	Electrical Muscle Stimulation	97014	30.00
7/29/2009	Traction, Mechanical	97012	25.00
8/3/2009	Spinal Manipulation 1-2 regions	98940	65.00
8/4/2009	Spinal Manipulation 1-2 regions	98940	65.00
8/5/2009	Spinal Manipulation 1-2 regions	98940	65.00

Total Charges	Total Payments	Total Adjustments	Balance Due
\$5460.00	\$0.00	\$0.00	5,460.00

11/23/2009 09:38 AM

Page 1 of 1

209285 / Booker, Mr. Michael**Settlement Memorandum****Recovery:**

REC	JB Hunt Transportation	\$ 9,000.00
		<hr/>
		\$ 9,000.00

DEDUCT AND RETAIN TO PAY:**Kisling Legal Group**

AMC Investigations; case 209285/investigation	\$ 30.00
Floros, Dr. Minas; case 209285/fee for narrative	\$ 200.00
Ghoubrial, Dr. Sam N.; case 209285/fee for records	\$ 50.00

Total due Kisling Legal Group	<hr/>	\$ 280.00
--------------------------------------	-------	------------------

DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron Square Chiropractic	\$ 3,000.00
Ghoubrial, M.D., Dr. Sam N.	\$ 1,200.00
Kisling, Nestico & Redick, LLC	\$ 1,867.50
Preferred Capital Funding-Ohio, LLC	\$ 597.50
Professional Imaging Consultants	\$ 55.00

Total due Others	<hr/>	<u>\$ 6,720.00</u>
-------------------------	-------	---------------------------

Total Deductions	<u>\$ 7,000.00</u>
-------------------------	---------------------------

Total Amount Due To Client	\$ 2,000.00
-----------------------------------	--------------------

Less Previously Paid To Client	<u>\$ 0.00</u>
---------------------------------------	-----------------------

Net Amount Due Client	<u>\$ 2,000.00</u>
------------------------------	---------------------------

I hereby approve the above settlement and distribution of proceeds. I have reviewed the above information and I acknowledge that it accurately reflects all outstanding expenses associated with my injury claim. I further understand that the itemized bills listed above will be deducted and paid from the gross amount of my settlement except as otherwise indicated. Finally, I understand that any bills not listed above are my responsibility and not the responsibility of the Kisling, Nestico & Redick, LLC.

Date: _____ Name: _____

11/9/2009 09:57 AM

Page 1 of 1

209285 / Booker, Mr. Michael

Settlement Memorandum**Recovery:**

REC JB Hunt Transportation

\$ 9,000.00

\$ 9,000.00**DEDUCT AND RETAIN TO PAY:****Kisling Legal Group**

AMC Investigations; case 209285/investigation \$ 30.00

Floros, Dr. Minas; case 209285/fee for narrative \$ 200.00

Ghoubrial, Dr. Sam N.; case 209285/fee for records \$ 50.00

Total due Kisling Legal Group

\$ 280.00**DEDUCT AND RETAIN TO PAY TO OTHERS:**

Akron Square Chiropractic \$ 5,460.00

Ghoubrial, M.D., Dr. Sam N. \$ 1,510.00

Kisling, Nestico & Redick, LLC \$ 3,000.00

Preferred Capital Funding-Ohio, LLC \$ 597.50

Professional Imaging Consultants \$ 55.00

Total due Others

\$ 10,622.50**Total Deductions**

\$ 10,902.50

Total Amount Due To Client

\$ -1,902.50

Less Previously Paid To Client

\$ 0.00

Net Amount Due Client

\$ -1,902.50

I hereby approve the above settlement and distribution of proceeds. I have reviewed the above information and I acknowledge that it accurately reflects all outstanding expenses associated with my injury claim. I further understand that the itemized bills listed above will be deducted and paid from the gross amount of my settlement except as otherwise indicated. Finally, I understand that any bills not listed above are my responsibility and not the responsibility of the Kisling, Nestico & Redick, LLC.

Date: _____ Name: _____



209,285 / Michael Booker

Settlement MemorandumRecovery:

REC	JB Hunt Transportation	\$ 9,000.00
-----	------------------------	-------------

\$ 9,000.00

DEDUCT AND RETAIN TO PAY:

Kisling, Nestico & Redick, LLC		
Floros, Dr. Minas; case 209285/fee for narrative		\$ 200.00
Ghoubrial, Dr. Sam N.; case 209285/fee for records		\$ 50.00
AMC Investigations; case 209285/investigation		\$ 30.00
Total Due		<hr/> \$ 280.00

DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron Square Chiropractic		\$ 3,000.00
Ghoubrial, M.D., Dr. Sam N.		\$ 1,200.00
Kisling, Nestico & Redick, LLC	(\$3,000.00)	\$ 1,867.50
Preferred Capital Funding-Ohio, LLC		\$ 597.50
Professional Imaging Consultants		\$ 55.00
Total Due Others		<hr/> \$ 6,720.00

Total Deductions	\$ 7,000.00
Total Amount Due to Client	\$ 2,000.00
Less Previously Paid to Client	\$ 0.00
Net Amount Due to Client	\$ 2,000.00

I hereby approve the above settlement and distribution of proceeds. I have reviewed the above information and I acknowledge that it accurately reflects all outstanding expenses associated with my injury claim. I further understand that the itemized bills listed above will be deducted and paid from the gross amount of my settlement except as otherwise indicated. Finally, I understand that any bills not listed above and/or those not listed by me to indicate that they are not being paid from the settlement are my responsibility and not the responsibility of Kisling, Nestico & Redick, LLC.

Date:

10/23/09

Name:

Michael Booker

Firm:

Kisling, Nestico & Redick, LLC



Sam N. Ghoubril M.D.
Richard H. Gunning M.D.
Lisa M. Esterle D.O.
MEDICAL LIEN

Re: Patient Chetoi B. Asley
First date of service: 11-08-17

I hereby direct you to pay to Clearwater Billing Services, LLC from the net proceeds of any settlement, claim, judgment, verdict or award, for any and all medical services rendered as a result of an injury that I received on 11-3-17.

Said amount being fair and reasonable price of medical services provided by our medical providers for me at the direction of my doctor or doctors. I authorize you to withhold said sums from the net proceeds of any settlement, claim, judgment, verdict, or awards as may be necessary to pay Clearwater Billing Services, LLC. Furthermore, I also request that you forward all my records and bills to my attorney.

I fully understand that I am directly/fully responsible and guarantee payment to Clearwater Billing Services, LLC for the aforementioned account submitted to me by Clearwater Billing Services, LLC for services rendered me, and that this agreement is made solely for its additional protection and in consideration of its awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, verdict or award by which I may eventually recover said fee.

Dated: 11-07-17

The undersigned being attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such claims from the net proceeds of any settlement, claim, judgment, verdict, or award as may be necessary to adequately protect Clearwater Billing Services, LLC provided that said lien is subordinate to attorney's lien herein.

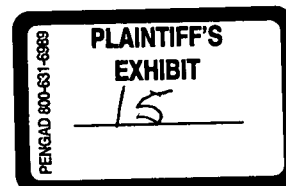
Dated: 11/10/17

Kisling, Nestico & Redick, LLC
Attorneys at Law

Kisling, Nestico & Redick, LLC
3412 W. Market St.
Akron, Ohio 44333
(330) 869-9007
(330) 869-9008 (fax)

1419 South Arlington Street, Akron, Ohio 44306
Phone: (330) 331-7207 Fax: (330) 331-7567

Revised June 2017



Sam N. Ghoubrial, M.D.
PHONE 330-331-7207
FAX 330-331-7567

November 8, 2017

Chetoiri Beasley

The patient is a 45-year-old very pleasant woman involved in a motor vehicle accident on November 3, 2017. She was the restrained front seat passenger of a vehicle that was struck by a car attempting to make a right hand turn from the left lane. Unfortunately, the patient was hit on the passenger side where she sat. She continues to have pain in her neck and back. On a scale of 1 to 10, her pain is 10. She has difficulty twisting, turning and bending. She has difficulty performing her activities of daily living. She went to the emergency room at Akron General where she was treated and released. Unfortunately, she continues to have pain. Most of her pain is in her neck and back.

Past Medical History: Unremarkable.

Past Surgical History: 1. Disc surgery in lower back in 2017. Her back is actually worse.

Social History: No history of illicit drug use. Occasional alcohol and tobacco.

MEDICATIONS: None.

ALLERGIES: NKDA.

PHYSICAL EXAM:

HEENT: Normocephalic and atraumatic. PERRLA. Mucous membranes are moist. The nose is patent and non-deviated.

NECK: Thyroid gland could not be palpated. No evidence of any cervical lymphadenopathy. No JVD is noted.

SPINE/BACK: She has severe guarding and spasm of the cervical trapezius complex. There is a scar on the lower lumbar spine consistent with previous surgery. She has loss of lordosis of the lumbar spine with pain on range of motion, guarding and spasm.

GRASP/MANIPULATION: Pincer movements and fine coordination appear to be WNL.

UPPER EXTREMITIES: Shoulders, wrists and elbows: demonstrate no scars or gross deformities. +2 radial pulses throughout.

LOWER EXTREMITIES: No venous insufficiency or edema. +2 pulses throughout. Ankles and hips demonstrate no gross abnormalities on exam.

Patient Name: Chetoiri Beasley
Page Two

MUSCULOSKELETAL: The patient is able to get on and off the exam table without difficulty. The patient is able to do heel to toe walking. The patient doesn't walk with a cane or walker.

NEUROLOGICAL: The patient is alert and oriented x 3. Cranial nerves II-XII are grossly intact throughout. Reflexes are 2/4 throughout. Tactile sensation is WNL. There is a negative Romberg test. Cerebellar testing is within normal limits. There is a negative straight leg raise and negative bowstring sign.

ASSESSMENT:

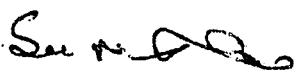
1. Cervical, thoracic and lumbar strain.

PROCEDURE: I identified four trigger points, two at C7 and two at T2. I injected a total of 1 cc methylprednisolone and 3 cc of Marcaine.

PLAN: I prescribed Percocet 5/325 mg, #21, one PO b.i.d. Given her history of recent back surgery, I think this is appropriate. I also prescribed Zanaflex 4 mg, #30, one at night; and Mobic 15 mg, #30, one a day. I will see her back in one week.

SPECIAL NOTE: I provided the patient with an Ultima 3t TENS unit. I gave instructions on its use and recommended the normal mode setting (30 microseconds pulse width and 2 Hz pulse rate) for 30 minutes twice a day.

I want the patient to continue therapy. The patient understands he/she needs to participate in therapy, and is actively participating in therapy.



Sam N. Ghoubril M.D./rtd

Progress Notes

Name: _____

Chetoiri Beasley

11-1-17	9 Chetoiri Beasley	I was treated in a polite and courteous manner and I am satisfied with the care I received today.
	Initial visit. (NS)	<input checked="" type="radio"/> Yes <input type="radio"/> No
		clb
11/15/17	10 Chetoiri Beasley	
	Follow Up (am)	
	Chetoiri Beasley	November 15, 2017
	The patient is here for a follow-up visit. I reviewed her OARRS report.	
	EXAM: The patient still has some guarding and tenderness of the lumbar spine with reproducible pain. The trigger point injections in her neck have helped.	
	PLAN: I prescribed Percocet 5/325 mg, #30, one PO twice a day. I will see her back in two weeks. Hopefully this will help her. She is participating in therapy. She has had back surgery. Her OARRS report is relatively benign. She understands that I can only give her one more prescription. She is starting to feel better with the cortisone shots.	
	Addendum: The pharmacy called us back regarding the reason for filling the prescription. Apparently the patient had been exhibiting some very strange drug-seeking behavior. She was very agitated. The pharmacist concluded, along with me, that it is probably not in her best interest and that Pain Management would be more suited for her. She only received one prescription in total from us. Hopefully the trigger point injections will be benefitting her.	
	SNG/rtd	
	See re-...	
11-21-17	sent referral to CPM. They call the pt to schedule. (NS)	

Progress Notes

Name: _____

Chetoiri Beasley

11/15/17

15

Chetoiri Beasley

FOLLOW UP. (NS)

Chetoiri Beasley

November 29, 2017

She came in and I told her she would need to go to Pain Management. She is okay with this. She was somewhat abrupt in her visit and rude. I told her this was the best option for her. She seems to understand.

SNG/rtd



Clearwater Billing Services, LLC

Sam N. Ghoubrial M.D.
Richard H. Gunning M.D.
Joshua M. Jones M.D.
Lisa M. Esterle D.O.

Re: Tens Unit Instruction & Confirmation

I, Chetairi Beasley, was issued an Ultima 3t Unit on 11-8-17 and instructed how to use this device and given a manual on a 3t Ultima Lot No. 170323. At the time of instruction, I can confirm that the Tens Unit I was instructed on and received was in great working order. I can affirm that this unit was tested in front of me at my visit and that the unit turned on after the battery was placed in the unit with the setting functions properly working during instruction. In addition, I was directed to use my manual or contact the medical office at (330) 331-7207, if you have any questions related to this Tens Unit.

Chetairi Beasley
Patients Signature

11/8/17
Date

Chetairi Beasley
Please print name

[Signature]
Authorized Representative for Clearwater Billing Services, LLC

CLIENT: Chetoiri Beasley**INSURANCE CO:** Erie Insurance Company***DEFENDANT:** Margaret Perduyn**ADJUSTER:** Danielle Klausner**DATE OF LOSS:** 11/3/2017**CLAIM NO:** A00000583521

<u>HOSPITALS:</u>	<u>MEDICAL SPECIALS</u>	<u>AMOUNT</u>
Akron General Medical Center	(11/04/2017 - 11/04/2017)	\$ 7,626.60
Clinical Medical Services	(11/04/2017 - 11/04/2017)	\$ 823.00
Akron General Health System	(01/29/2018 - 01/29/2018)	\$ 2,967.00
Clinical Medical Services	(01/29/2018 - 01/29/2018)	\$ 446.00
<u>PHYSICIANS:</u>		
Akron Square Chiropractic	(11/07/2017 - 01/19/2018)	\$ 4,010.00
Clearwater Billing Services, LLC	(11/08/2017 - 11/29/2017)	\$ 2,150.00
Akron General Orthopedics	(01/19/2018 - 02/02/2018)	\$ 246.00
<u>DIAGNOSTIC SERVICES:</u>		
National Diagnostic Imaging Consultants	(12/05/2017 - 12/05/2017)	\$ 200.00
TOTAL MEDICAL SPECIALS:		\$ 18,468.60



CHETOIRI BEASLEY

HEALTH INSURANCE CLAIM FORM

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

PICA		PICA	
1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input checked="" type="checkbox"/>		1a. INSURED'S ID NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) BEASLEY, CHETOIRI		4. INSURED'S NAME (Last Name, First Name, Middle Initial) BEASLEY, CHETOIRI	
5. PATIENT'S ADDRESS (No., Street) [REDACTED]		7. INSURED'S ADDRESS (No., Street) [REDACTED]	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
11. INSURED'S POLICY GROUP OR FECA NUMBER		11. INSURED'S DATE OF BIRTH [REDACTED] M <input type="checkbox"/> D <input type="checkbox"/> Y <input checked="" type="checkbox"/> F <input type="checkbox"/>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE 12 06 2017		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 11 08 17 QUAL 431		15. OTHER DATE 11 03 17	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES 0.00	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. S16.1XXA B. S23.3XXA C. S39.012A ICD Ind. S16.1XXD E. S23.3XXD F. S39.012D G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EP301 Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #		23. PRIOR AUTHORIZATION NUMBER	
1 11 08 17 11 08 17 11 99203 A,B,C 300.00 1 1003892217			
2 11 08 17 11 08 17 11 E0730 A,B,C 500.00 1 1003892217			
3 11 08 17 11 08 17 11 20553 A,B,C 1000.00 1 1003892217			
4 11 08 17 11 08 17 11 J1030 A,B,C 50.00 1 1003892217			
5 11 15 17 11 15 17 11 99213 D,E,F 150.00 1 1003892217			
6 11 29 17 11 29 17 11 99213 D,E,F 150.00 1 1003892217			
25. FEDERAL TAX ID NUMBER SSN EIN 270796590		26. PATIENT'S ACCOUNT NO. [REDACTED]	
27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 2150.00	
29. AMOUNT PAID \$ 0.00		30. Rsvd for NUCC Use	
NATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. PHYSICIAN OR SUPPLIER ADDRESS	
SAM N. GHOUBRIAL, MD 12 06 17 1669702841		33. PHYSICIAN OR SUPPLIER PHONE	
SIGNED DATE		a. b.	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Invoice for Medical Services

Re: Chetoiri Beasley
Date of Accident: 11/3/17
Date of Birth: [REDACTED]

Medical services for the above- named client.		Amount
11/8/17	See detailed HCFA 1500	\$2150.00
12/7/17	Document preparation fee	\$50.00
Total amount due:		\$2200.00

Please make checks payable to:

Clearwater Billing Service, LLC
P.O. Box 1243
Bath, Ohio 44210-1243

Tax ID: 27-0796590

Sandra Kurt, Summit County Clerk of Courts

Page 2 Patient: CHETOIRI BEASLEY

Date	Description	Amount
12/06/17	97140 59, 52 MANUAL THERAPY, EACH 15 MIN	\$ 55.00
12/07/17	98940 (CMT); SPINAL, 1-2 REGIONS	\$ 95.00
12/07/17	97012 TRACTION, MECHANICAL TO 1+ AREAS;	\$ 70.00
12/07/17	97140 59, 52 MANUAL THERAPY, EACH 15 MIN	\$ 55.00
12/15/17	98940 (CMT); SPINAL, 1-2 REGIONS	\$ 95.00
12/15/17	97012 TRACTION, MECHANICAL TO 1+ AREAS;	\$ 70.00
12/15/17	97140 59, 52 MANUAL THERAPY, EACH 15 MIN	\$ 55.00
12/21/17	98940 (CMT); SPINAL, 1-2 REGIONS	\$ 95.00
12/21/17	97012 TRACTION, MECHANICAL TO 1+ AREAS;	\$ 70.00
12/21/17	97140 59, 52 MANUAL THERAPY, EACH 15 MIN	\$ 55.00
01/02/18	98940 (CMT); SPINAL, 1-2 REGIONS	\$ 95.00
01/02/18	97012 TRACTION, MECHANICAL TO 1+ AREAS;	\$ 70.00
01/02/18	97140 59, 52 MANUAL THERAPY, EACH 15 MIN	\$ 55.00
01/05/18	98940 (CMT); SPINAL, 1-2 REGIONS	\$ 95.00
01/05/18	97012 TRACTION, MECHANICAL TO 1+ AREAS;	\$ 70.00
01/05/18	97140 59, 52 MANUAL THERAPY, EACH 15 MIN	\$ 55.00
01/05/18	97014 ELECTRIC STIMULATION THERAPY	\$ 55.00
01/10/18	98940 (CMT); SPINAL, 1-2 REGIONS	\$ 95.00
01/10/18	97012 TRACTION, MECHANICAL TO 1+ AREAS;	\$ 70.00
01/10/18	97140 59, 52 MANUAL THERAPY, EACH 15 MIN	\$ 55.00
01/10/18	97014 ELECTRIC STIMULATION THERAPY	\$ 55.00
01/15/18	98940 (CMT); SPINAL, 1-2 REGIONS	\$ 95.00
01/15/18	97012 TRACTION, MECHANICAL TO 1+ AREAS;	\$ 70.00
01/15/18	97140 59, 52 MANUAL THERAPY, EACH 15 MIN	\$ 55.00
01/15/18	97014 ELECTRIC STIMULATION THERAPY	\$ 55.00
01/19/18	98940 (CMT); SPINAL, 1-2 REGIONS	\$ 95.00
01/19/18	97140 59, 52 MANUAL THERAPY, EACH 15 MIN	\$ 55.00

Total Sales Tax	: \$	0.00
Total Late Charges	: \$	0.00
Total Interest Charges	: \$	0.00
Patients-Cash Rcvd	: \$	0.00
Patients-Chks Rcvd	: \$	0.00
Patients-Crdt Crd	: \$	0.00
Per Payments	: \$	0.00

Total Charges	: \$	4010.00
Total Received	: \$	0.00
Total Adjustment	: \$	0.00
Balance (based on search)	: \$	4010.00

4/23/2018 08:52 AM

Page 1 of 1

Summary of Check Requests

Party Name Memo Payee Address	Case Number Debit Account Requestor	Value Code	Amount From To Report?
Beasley, Ms. Chetoiri JRA atty fees Kisling, Nestico & Redick 3412 West Market Street, Akron, OH 44333	275579 Cost Account LNORMAN	ATT	\$ 9,000.00 Us Provider No
Beasley, Ms. Chetoiri cost reimbursement Kisling, Nestico & Redick 3412 West Market Street, Akron, OH 44333	275579 Cost Account LNORMAN	CAR	\$ 381.86 Us Provider No
Beasley, Ms. Chetoiri Clearwater Billing Services, LLC P.O. Box 1243, Bath, OH 44210-1243	275579 Cost Account LNORMAN	DR.	\$ 1,500.00 Us Provider No
Beasley, Ms. Chetoiri Akron Square Chiropractic 1419 S. Arlington St., Akron, OH 44306	275579 Cost Account LNORMAN	DR.	\$ 3,200.00 Us Provider No
Beasley, Ms. Chetoiri Final PI proceeds Beasley, Ms. Chetoiri [REDACTED]	275579 Cost Account LNORMAN	PIP	\$ 7,458.14 Us Provider No
Beasley, Ms. Chetoiri 005165 National Diagnostic Imaging Consultants 3414 West Tuscarawas Street, Canton, OH 44708	275579 Cost Account LNORMAN	RAD	\$ 100.00 Us Provider No
Beasley, Ms. Chetoiri Loan#2 good until 09/08/2018 Oasis Legal Finance 9525 W. Bryn Mawr Ave, Suite 900, Rosemont, IL 60018	275579 Cost Account LNORMAN	SLN	\$ 2,260.00 Us Provider No

4/16/2018 02:51 PM

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275579 / Beasley, Ms. Chetoiri

Settlement MemorandumRecovery:


PSF	Oasis Legal Finance	\$ 500.00
PSF	Oasis Legal Finance	\$ 350.00
PSF	Oasis Legal Finance	\$ 750.00
REC	Erie Insurance	\$ 26,100.00
		<hr/>
		\$ 27,700.00

DEDUCT AND RETAIN TO PAY:Kisling Legal Group

Akron General Medical Center***; 85663636/TTT	\$ 42.17
Akron General Medical Center***; 85663636/TTT	\$ 21.69
AMC Investigations;	\$ 50.00
Clearwater Billing Services, LLC; TTT	\$ 50.00
Floros, Dr. Minas; Narrative/TTT	\$ 150.00
Kisling, Nestico & Redick; chartswap rad bill	\$ 21.00
Kisling, Nestico & Redick; chartswap rad bill	\$ 21.00
Kisling, Nestico & Redick; medinform invc# 41606	\$ 6.50
Kisling, Nestico & Redick; medinform invc# 47242	\$ 6.50
Kisling, Nestico & Redick; Medinform invc# 51607	\$ 6.50


Total due Kisling Legal Group\$ 375.36DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron General Health System <i>ELC on DOL and MRA 11/3/17</i>	\$ 2,967.00 - <i>61P</i>
Akron Square Chiropractic <i>11/7 - 1/17</i>	\$ 4,010.00 <i>3200</i>
Clearwater Billing Services, LLC	\$ 2,150.00 <i>1500</i>
Clinical Medical Services*	\$ 1,269.00 <i>61P</i>
Kisling, Nestico & Redick	\$ 8,700.00
National Diagnostic Imaging Consultants	\$ 200.00 <i>100</i>
Oasis Legal Finance	\$ 2,260.00
Ohio Tort Recovery Unit*	\$ 3,500.00

Total due Others\$ 25,056.00Total DeductionsTotal Amount Due To ClientLess Previously Paid To ClientNet Amount Due Client

KWR to CWR

8724.64
- 2260
8464.64

\$ 25,431.36
\$ 2,268.64
\$ 850.00
\$ 1,418.64

I hereby approve the above settlement and distribution of proceeds. I have reviewed the above information and I acknowledge that it accurately reflects all outstanding expenses associated with my injury claim. I further understand that the itemized bills listed above will be deducted and paid from the gross amount of my settlement except as otherwise

4/19/2018 09:30 AM

Page 1 of 3

275579 / Beasley, Ms. Chetoiri

Settlement MemorandumRecovery:

PSF	Oasis Legal Finance	\$ 500.00
PSF	Oasis Legal Finance	\$ 350.00
PSF	Oasis Legal Finance	\$ 750.00
REC	Erie Insurance	\$ 26,100.00
		<hr/>
		\$ 27,700.00

DEDUCT AND RETAIN TO PAY:Kisling Legal Group

Akron General Medical Center***; 85663636/TTT	\$ 42.17
Akron General Medical Center***; 85663636/TTT	\$ 21.69
AMC Investigations;	\$ 50.00
Clearwater Billing Services, LLC; TTT	\$ 50.00
Floros, Dr. Minas; Narrative/TTT	\$ 150.00
Kisling, Nestico & Redick; chartswap rad bill	\$ 21.00
Kisling, Nestico & Redick; chartswap rad bill	\$ 21.00
Kisling, Nestico & Redick; MEDINFORM INV# 54404	\$ 6.50
Kisling, Nestico & Redick; medinform invc# 41606	\$ 6.50
Kisling, Nestico & Redick; medinform invc# 47242	\$ 6.50
Kisling, Nestico & Redick; Medinform invc# 51607	\$ 6.50

Total due Kisling Legal Group

\$ 381.86DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron Square Chiropractic	\$ 4,010.00
Clearwater Billing Services, LLC	\$ 2,150.00
Kisling, Nestico & Redick	\$ 8,700.00
National Diagnostic Imaging Consultants	\$ 200.00
Oasis Legal Finance	\$ 2,260.00
Ohio Tort Recovery Unit*	\$ 2,900.00

Total due Others

\$ 20,220.00Total DeductionsTotal Amount Due To ClientLess Previously Paid To ClientNet Amount Due Client

\$ 20,601.86

\$ 7,098.14

\$ 850.00

\$ 6,248.14

I hereby approve the above settlement and distribution of proceeds. I have reviewed the above information and I acknowledge that it accurately reflects all outstanding expenses associated with my injury claim. I further understand that the itemized bills listed above will be deducted and paid from the gross amount of my settlement except as otherwise

275579 / Chetoiri Beasley

Settlement MemorandumRecovery:

PSF	Oasis Legal Finance	\$ 350.00
REC	Erie Insurance	\$ 27,000.00
PSF	Oasis Legal Finance	\$ 750.00
PSF	Oasis Legal Finance	\$ 500.00
		\$ 28,600.00

DEDUCT AND RETAIN TO PAY:

Kisling, Nestico & Redick

AMC Investigations;	\$ 50.00
Clearwater Billing Services, LLC	\$ 50.00
Floros, Dr. Minas	\$ 150.00
Chartswap	\$ 42.00
Medinform	\$ 26.00
Akron General Medical Center	\$ 63.86

Total Due**\$ 381.86**DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron Square Chiropractic	(\$4,010.00) \$ 3,200.00
Clearwater Billing Services, LLC	(\$2,150.00) \$ 1,500.00
Kisling, Nestico & Redick	\$ 9,000.00
National Diagnostic Imaging Consultants	(\$200.00) \$ 100.00
Oasis Legal Finance	\$ 2,260.00
Ohio Tort Recovery Unit	\$ 3,100.00
Total Due Others	\$ 19,160.00

Total Deductions \$ 19,541.86

Total Amount Due to Client \$ 9,058.14

Less Previously Paid to Client \$ 1,600.00

Net Amount Due to Client \$ 7,458.14

I hereby approve the above settlement and distribution of proceeds. I have reviewed the above information and attorney's fees with Kisling, Nestico & Redick. I acknowledge that it accurately reflects all costs, including but not limited to, the investigation fee, and all outstanding expenses associated with my injury claim. I further understand that the itemized bills listed above will be deducted and paid from the gross amount of my settlement except as otherwise indicated. If any amount was withheld from the settlement for potential subrogation interests, any balance due after the subrogation interest is satisfied may be subject to Attorney Fees not to exceed the contractually agreed amount. Finally, I understand that any bills not listed above, including but not limited to Health Insurance or Medical Payments Subrogation and/or those initiated by me to indicate that they are not being paid from the settlement are my responsibility and not the responsibility of Kisling, Nestico & Redick.

Date: 4-20-18Name: 

Chetoiri Beasley

Firm: 

Kisling, Nestico & Redick



Sam N. Ghoubrial M.D.
Richard H. Gunning M.D.
Joshua M. Jones M.D.
Lisa M. Esterle D.O.
MEDICAL LIEN

Re: Patient Chetoni Brasler
First date of service: 1-14-15

I hereby direct you to pay to Clearwater Billing Services, LLC from the net proceeds of any settlement, claim, judgment, verdict or award, for any and all services rendered as a result of an injury that I received on 1-11-15.

Said amount being fair and reasonable price of medical services provided by Hancrist, LLC for me at the direction of my doctor or doctors. I authorize you to withhold said sums from the net proceeds of any settlement, claim, judgment, verdict, or awards as may be necessary to pay Clearwater Billing Services, LLC

I fully understand that I am directly and fully responsible to Clearwater Billing Services, LLC for the aforementioned account submitted to me by Clearwater Billing Services, LLC for services rendered me, and that this agreement is made solely for its additional protection and in consideration of its awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, verdict or award by which I may eventually recover said fee.

Dated: 1-14-15 [Signature]

The undersigned being attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such claims from the net proceeds of any settlement, claim, judgment, verdict, or award as may be necessary to adequately protect Clearwater Billing Services, LLC provided that said lien is subordinate to attorney's lien herein.

Dated: 1-19-15 [Signature]

Kisling, Nestico & Redick, LLC
Attorneys at Law

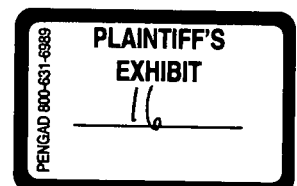
Kisling, Nestico & Redick, LLC
3412 W. Market St.
Akron, Ohio 44333
(330) 869-9007
(330) 869-9008 (fax)

② 1-16-15 DS

215 East Waterloo Road, Suite 12, Akron, Ohio 44319

Phone: (330) 331-7207

Fax: (330) 331-7567



Sam N. Ghoubril M.D., Inc.
PHONE 330-331-7207
FAX 330-331-7567

January 14, 2015
Chetoiri Beasley

Chetoiri is a 43-year-old very pleasant lady who was involved in a motor vehicle accident on January 11, 2015. She was the restrained front seat passenger of a vehicle that was T-boned by a car that ran a stop sign, striking her on the passenger side where she was sitting. As a result of that, Chetoiri injured her neck and back. On a scale of 1 to 10, her pain is 10 out of 10. She has difficulty twisting, turning and bending, and trouble sleeping. She has difficulty performing her activities of daily living. She has difficulty with headaches, back pain and neck pain. She has problems standing up straight and when bending. She has headaches.

Past Medical History: Unremarkable.

Past Surgical History: Unremarkable.

Social History: No history of illicit drug use. Unremarkable.

MEDICATIONS: None.

ALLERGIES: NKDA.

PHYSICAL EXAM:

INTEGUMENTARY: The skin is without any cyanosis. No evidence of nail fungus, rash or abnormality. Elasticity appears to be WNL.

HEENT: Normocephalic and atraumatic. PERRLA. Mucous membranes are moist. The nose is patent and non-deviated.

NECK: Thyroid gland could not be palpated. No evidence of any cervical lymphadenopathy. No JVD is noted.

SPINE/BACK: No scars are present. She has guarding and tenderness of the thoracolumbar junction, right side. She has reproducible pain with flexion of the cervical and upper thoracic spine, right greater than left.

CARDIOVASCULAR: RRR normal S1 S2, no murmurs rubs or gallops. No carotid bruits could be appreciated.

LUNGS: Clear to auscultation. No wheezes, rales, or rhonchi could be appreciated on exam.

Patient Name: Chetoiri Beasley
Page Two

ABDOMEN: Soft and non-tender with positive bowel sounds. No evidence of any ascites or hepatosplenomegaly. No guarding or rebound tenderness. Negative for hernias.

GRASP/MANIPULATION: Pincer movements and fine coordination appear to be WNL.

UPPER EXTREMITIES: Shoulders, wrists and elbows: demonstrate no scars or gross deformities. +2 radial pulses throughout.

LOWER EXTREMITIES: No venous insufficiency or edema. +2 pulses throughout. Ankles and hips demonstrate no gross abnormalities on exam.

MUSCULOSKELETAL: The patient is able to get on and off the exam table without difficulty. The patient is able to do heel to toe walking. The patient doesn't walk with a cane or walker.

NEUROLOGICAL: The patient is alert and oriented x 3. Cranial nerves II-XII are grossly intact throughout. Reflexes are 2/4 throughout. Tactile sensation is WNL. There is a negative Romberg test. Cerebellar testing is within normal limits. There is a negative straight leg raise and negative bowstring sign.

ASSESSMENT:

1. Cervical, thoracic and lumbar strain.

PROCEDURE: I identified six trigger points, one at C7, one at T2, one at T4, one at T10, one at L1, and one at L2, right side. I injected each with 1/2 cc of methylprednisolone and Marcaine mixture under sterile technique.

SPECIAL NOTE: I provided her with a Lux TENS unit. I gave instructions on its use.

PLAN: I prescribed Percocet 5/325 mg, one PO b.i.d.; Flexeril 10 mg, #60, one b.i.d.; and Motrin 800 mg, #60, one b.i.d. I will see the patient back in two weeks.

I want the patient to continue therapy. The patient understands he/she needs to participate in therapy, and is actively participating in therapy.



Sam N. Ghoumbrial M.D./rtd

Name: Chetwiri Beasley

10	Historic Baseline	11:14				
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1/14/15	Initial visit - (E)
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10	Chesler, Braden					
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1/28/15 Follow up (ml)

January 28, 2015

EXAM: She still has residual tenderness in the right side of her neck.

PLAN: I refilled Percocet 5/325 mg, #30, one PO b.i.d. I want her to take one Percocet and one Motrin twice a day. She will see me back again in two weeks.

SNG/rtd

Summa

3	Chetoni Beale					
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2/11/15	Follow Up (mc)
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February 11, 2015

EXAM: The patient has residual discomfort in the right lower lumbar spine.

PLAN: I want her to use the TENS unit. I prescribed Percocet 5/325 mg, #10, one b.i.d. No refills. Hopefully this will get her through the rest of therapy. I will check on her in two weeks.

SNG/rtd

C. W. C.

Progress NotesName: Chetairi Beasley131 Chetairi Beasley2/18/15 Follow Up (ck)

Chetairi Beasley

February 18, 2015

The patient is here for a follow-up visit. She said the trigger point injections were beneficial. She is still active in therapy.

EXAM: The patient has pain on range of motion of the lumbar spine.

PLAN: 1 refilled Percocet 5/325 mg, #14, one PO b.i.d.

SNG/rtd

*See me*3/4/15 No Show (mc)



CHETOIRI BEASLEY

ALTH INSURANCE CLAIM FORM

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

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BOX LUNG (N/A) <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (N/A)		1a. INSURED'S ID NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last, first, middle initial) BEASLEY, CHETOIRI		3. PATIENT'S BIRTH DATE <input type="checkbox"/> SEX <input checked="" type="checkbox"/>	
4. PATIENT'S ADDRESS (No. Street) CITY STATE OH		5. INSURED'S ADDRESS (No. Street) CITY STATE OH	
6. PATIENT'S RELATIONSHIP TO INSURED Spouse <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No. Street) CITY STATE OH	
8. RESERVED FOR NUCC USE		9. RESERVED FOR NUCC USE	
10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO OH c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER	
12. OTHER INSURED'S POLICY OR GROUP NUMBER		13. INSURED'S DATE OF BIRTH <input type="checkbox"/> SEX <input checked="" type="checkbox"/>	
14. RESERVED FOR NUCC USE		15. OTHER CLAIM ID (Designated by NUCC)	
16. RESERVED FOR NUCC USE		17. INSURANCE PLAN NAME OR PROGRAM NAME CHETOIRI BEASLEY	
18. INSURANCE PLAN NAME OR PROGRAM NAME		19. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 18, 19a, and 19b	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 20. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of my medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the entity who accepts assignment on my behalf.) SIGNED: CHETOIRI BEASLEY DATE: 03 10 2015		21. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED: CHETOIRI BEASLEY	
22. DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (MM/DD/YY) 01/11/15 QUAL 431		23. OTHER DATE (MM/DD/YY) 01/11/15 QUAL 439	
24. NAME OF REFERRING PROVIDER OR OTHER SOURCE (17a) CHETOIRI BEASLEY (17b) NPI		25. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM/DD/YY TO MM/DD/YY	
26. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		27. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM/DD/YY TO MM/DD/YY	
28. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (ICD-9) 847.0 847.1 847.2 ICD-9 9		29. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 0.00	
30. RESUBMISSION CODE ORIGINAL REF. NO.		31. PRIOR AUTHORIZATION NUMBER	
32. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		33. PROCEDURE, SERVICE, OR SUPPLY (ICD-9-CM, CPT, HCPCS, or other code) MODIFIER	
34. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		35. DIAGNOSIS PORTER	
36. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		37. S. CHARGES 350.00	
38. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		39. DAYS OF REST 1	
40. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		41. N. PROVIDER ID 1003892217	
42. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		43. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.	
44. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		45. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.	
46. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		47. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.	
48. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		49. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.	
50. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		51. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.	
52. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		53. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.	
54. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		55. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.	
56. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		57. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.	
58. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		59. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.	
60. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		61. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.	
62. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		63. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.	
64. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		65. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.	
66. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		67. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.	
68. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		69. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.	
70. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		71. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.	
72. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		73. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.	
74. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		75. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.	
76. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		77. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.	
78. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		79. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.	
80. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		81. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.	
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CHETOIRI BEASLEY

HEALTH INSURANCE CLAIM FORM

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

MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA (FICA) <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S ID NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) BEASLEY, CHETOIRI		4. INSURED'S NAME (Last Name, First Name, Middle Initial) BEASLEY, CHETOIRI	
3. PATIENT'S BIRTH DATE [REDACTED]		7. INSURED'S ADDRESS (No. Street) [REDACTED]	
5. PATIENT'S ADDRESS (No. Street) [REDACTED]		8. RESERVED FOR NUCC USE	
6. PATIENT RELATIONSHIP TO INSURED Spouse <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		9. RESERVED FOR NUCC USE	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO OR c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER	
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 authorize payment of government benefits either to myself or to the party who receives assignment of claim.) SIGNED: [REDACTED] DATE: 03 10 2015		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: [REDACTED]	
14. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 01 11 15 01 11 15		15. OTHER DATE QUAL 433 01 11 15	
16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE [REDACTED]	
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		19. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES 0.00	
20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please fill in boxes A through H) A 847.0 B 847.1 C 847.2 D [REDACTED] E [REDACTED] F [REDACTED] G [REDACTED] H [REDACTED]		21. PRIOR AUTHORIZATION NUMBER	
22. FEDERAL TAX ID NUMBER 270796590		23. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
24. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials) [REDACTED]		25. SERVICE FACILITY LOCATION INFORMATION HANCHRIST LLC 215 E WATERLOO #12 AKRON, OH 44319	
26. TOTAL CHARGE \$ 1260.00		27. AMOUNT PAID \$ 0.00	
28. BILLING PROVIDER INFO A PH # (330) 331 7207 CLEARWATER BILLING SERVICES LLC P.O. BOX 1243 BATH, OH 44210		29. Filed by NUCC Use	

Invoice for Medical Services

Re: Chetoiri Beasley
Date of Accident: 1/11/15
Date of Birth: [REDACTED]

Medical services for the above- named client.		Amount
1/14/15-1/28/15	See detailed HCFA 1500	\$2680.00
1/28/15-2/18/15	See detailed HCFA 1500	\$1260.00
3/10/15	Document preparation fee	\$50.00
Total amount due:		\$3990.00

Please make checks payable to:

Clearwater Billing Service, LLC
P.O. Box 1243
Bath, Ohio 44210-1243

Tax ID: 27-0796590

PO Box 1243 • Bath, Ohio 44210 • Phone: (330) 331-7207 Ext. 106 • Fax: (330) 331-7567
• Clearwaterbilling@yahoo.com

CLIENT: Chetoiri Beasley**INSURANCE CO:** Pekin Insurance Co.**DEFENDANT:** Raymond Schillinger**ADJUSTER:** Keith Brady**DATE OF LOSS:** 1/11/2015**CLAIM NO:** Z21088

<u>PHYSICIANS:</u>	<u>MEDICAL SPECIALS</u>	<u>AMOUNT</u>
Akron Square Chiropractic	(01/12/2015 - 02/25/2015)	\$ 3,880.00
Sam Ghoubrial, M.D.	(01/14/2015 - 02/18/2015)	\$ 3,940.00
 <u>HOSPITALS:</u>		
Summa Akron City Hospital	(01/17/2015)	\$ 1,922.50
Summa Emergency Associates, Inc	(01/17/2015)	\$ 316.00
Akron Radiology *supplemented	(01/17/2015)	\$ 75.00
 <u>OTHERS:</u>		
National Diagnostic Imaging	(01/22/2015)	\$ 110.00
 TOTAL MEDICAL SPECIALS:		 \$ 10,243.50

FOR ATTORNEY EYES ONLY - CONFIDENTIAL SUBJECT TO PROTECTIVE ORDER

Invoice for Medical Services

Re: Chetoiri Beasley
Date of Accident: 1/11/15
Date of Birth: [REDACTED]

Medical services for the above- named client.	Amount
1/14/15-1/28/15 . See detailed HCFA 1500	\$2680.00
1/28/15-2/18/15 See detailed HCFA 1500	\$1260.00
3/10/15 Document preparation fee	\$50.00
Total amount due:	\$3990.00

Please make checks payable to:

Clearwater Billing Service, LLC
P.O. Box 1243
Bath, Ohio 44210-1243

Tax ID: 27-0796590

PO Box 1243 • Bath, Ohio 44210 • Phone: (330) 331-7207 Ext. 106 • Fax: (330) 331-7567
• Clearwaterbilling@yahoo.com

Ghoubrial - 000476

Akron Square Chiropractic
 1419 South Arlington Rd.
 Akron, OH 44306
 330-773-3882
 ID#: 31-1528200
 Minas Flores DC NPI#: 1306928650
 Monday March 16, 2015

Patient : CHETOIRI BEASLEY #468
 Itemized Statement: - 03/16/2015
 DOB :
 Onset date : 01/11/2015

Mail to:
 CHETOIRI BEASLEY

Insured

Insurance Carrier (primary)

DOB:
 Policy#:

Attorney
 KISLING, NESTICO, AND REDICK
 3412 W. MARKET ST
 AKRON OH 44333

Employer

Current Diagnosis
 847 0 SPRAIN/STRAIN OF NECK
 84 SPRAIN/STRAIN THORACIC REGION
 84 SPRAIN/STRAIN LUMBAR REGION
 728.85 SPASM OF MUSCLE
 729.1 UNS MYALGIA/MYOSITIS

Date	Description	Amount
01/12/15	72040 X-RAY, SPINE, CERVICAL; 2 OR 3 VIEWS	\$ 120.00
01/12/15	72100 X-RAY, SPINE, LUMBOSACRAL; 2 OR 3 VIEWS	\$ 80.00
01/12/15	97014 ELECTRIC STIMULATION THERAPY	\$ 45.00
01/12/15	97010 APPLICATION, AREAS; HOT/COLD PACKS	\$ 30.00
01/14/15	97014 ELECTRIC STIMULATION THERAPY	\$ 45.00
01/14/15	97010 APPLICATION, AREAS; HOT/COLD PACKS	\$ 30.00
01/19/15	97014 ELECTRIC STIMULATION THERAPY	\$ 45.00
01/19/15	97010 APPLICATION, AREAS; HOT/COLD PACKS	\$ 30.00
01/19/15	98940 (CMT); SPINAL, 1-2 REGIONS	\$ 85.00
01/19/15	97124 52 THERAPEUTIC PROC, EACH 15 MIN	\$ 55.00
01/20/15	97014 ELECTRIC STIMULATION THERAPY	\$ 45.00
01/20/15	97010 APPLICATION, AREAS; HOT/COLD PACKS	\$ 30.00
01/20/15	98940 (CMT); SPINAL, 1-2 REGIONS	\$ 85.00
01/20/15	97124 52 THERAPEUTIC PROC, EACH 15 MIN	\$ 55.00
01/22/15	98940 (CMT); SPINAL, 1-2 REGIONS	\$ 85.00
01/22/15	97014 ELECTRIC STIMULATION THERAPY	\$ 45.00
01/22/15	97039 UNLISTED MODALITY (SPECIFY TYPE & TIME)	\$ 50.00
01/22/15	97124 52 THERAPEUTIC PROC, EACH 15 MIN	\$ 55.00
01/26/15	98940 (CMT); SPINAL, 1-2 REGIONS	\$ 85.00
01/26/15	97014 ELECTRIC STIMULATION THERAPY	\$ 45.00
01/26/15	97039 UNLISTED MODALITY (SPECIFY TYPE & TIME)	\$ 50.00
01/26/15	97124 52 THERAPEUTIC PROC, EACH 15 MIN	\$ 55.00
01/28/15	98940 (CMT); SPINAL, 1-2 REGIONS	\$ 85.00
01/28/15	97014 ELECTRIC STIMULATION THERAPY	\$ 45.00
01/28/15	97012 TRACTION, MECHANICAL TO 1+ AREAS;	\$ 55.00
01/28/15	97124 52 THERAPEUTIC PROC, EACH 15 MIN	\$ 55.00
02/03/15	98940 (CMT); SPINAL, 1-2 REGIONS	\$ 85.00
02/03/15	97014 ELECTRIC STIMULATION THERAPY	\$ 45.00
02/03/15	97012 TRACTION, MECHANICAL TO 1+ AREAS;	\$ 55.00
02 /15	97124 52 THERAPEUTIC PROC, EACH 15 MIN	\$ 55.00
02 /15	98940 (CMT); SPINAL, 1-2 REGIONS	\$ 85.00
02/04/15	97014 ELECTRIC STIMULATION THERAPY	\$ 45.00
02/04/15	97012 TRACTION, MECHANICAL TO 1+ AREAS;	\$ 55.00
02/04/15	97124 52 THERAPEUTIC PROC, EACH 15 MIN	\$ 55.00

Page 2 Patient: CHETOIRI BEASLEY

Dr	Description	Amount
02/06/15	98940 (CMT); SPINAL, 1-2 REGIONS	\$ 85.00
02/06/15	97014 ELECTRIC STIMULATION THERAPY	\$ 45.00
02/06/15	97012 TRACTION, MECHANICAL TO 1+ AREAS;	\$ 55.00
02/06/15	97124 52 THERAPEUTIC PROC, EACH 15 MIN	\$ 55.00
02/10/15	98940 (CMT); SPINAL, 1-2 REGIONS	\$ 85.00
02/10/15	97014 ELECTRIC STIMULATION THERAPY	\$ 45.00
02/10/15	97012 TRACTION, MECHANICAL TO 1+ AREAS;	\$ 55.00
02/10/15	97124 52 THERAPEUTIC PROC, EACH 15 MIN	\$ 55.00
02/11/15	98940 (CMT); SPINAL, 1-2 REGIONS	\$ 85.00
02/11/15	97014 ELECTRIC STIMULATION THERAPY	\$ 45.00
02/11/15	97012 TRACTION, MECHANICAL TO 1+ AREAS;	\$ 55.00
02/11/15	97124 52 THERAPEUTIC PROC, EACH 15 MIN	\$ 55.00
02/18/15	98940 (CMT); SPINAL, 1-2 REGIONS	\$ 85.00
02/18/15	97014 ELECTRIC STIMULATION THERAPY	\$ 45.00
02/18/15	97012 TRACTION, MECHANICAL TO 1+ AREAS;	\$ 55.00
02/18/15	97124 52 THERAPEUTIC PROC, EACH 15 MIN	\$ 55.00
02/20/15	98940 (CMT); SPINAL, 1-2 REGIONS	\$ 85.00
02/20/15	97014 ELECTRIC STIMULATION THERAPY	\$ 45.00
02/20/15	97039 UNLISTED MODALITY (SPECIFY TYPE & TIME)	\$ 50.00
02/20/15	97124 52 THERAPEUTIC PROC, EACH 15 MIN	\$ 55.00
02/23/15	98940 (CMT); SPINAL, 1-2 REGIONS	\$ 85.00
02/23/15	97014 ELECTRIC STIMULATION THERAPY	\$ 45.00
02/23/15	97039 UNLISTED MODALITY (SPECIFY TYPE & TIME)	\$ 50.00
02/23/15	97124 52 THERAPEUTIC PROC, EACH 15 MIN	\$ 55.00
02/24/15	98940 (CMT); SPINAL, 1-2 REGIONS	\$ 85.00
02/24/15	97014 ELECTRIC STIMULATION THERAPY	\$ 45.00
02/24/15	97124 52 THERAPEUTIC PROC, EACH 15 MIN	\$ 55.00
02/24/15	97012 TRACTION, MECHANICAL TO 1+ AREAS;	\$ 55.00
02/25/15	98940 (CMT); SPINAL, 1-2 REGIONS	\$ 85.00
02/25/15	97014 ELECTRIC STIMULATION THERAPY	\$ 45.00
02/25/15	97124 52 THERAPEUTIC PROC, EACH 15 MIN	\$ 55.00
02/25/15	97012 TRACTION, MECHANICAL TO 1+ AREAS;	\$ 55.00

To Sales Tax	:	\$ 0.00
To Late Charges	:	\$ 0.00
Total Interest Charges	:	\$ 0.00
Patients-Cash Rcvd	:	\$ 0.00
Patients-Chks Rcvd	:	\$ 0.00
Patients-Crdt Crd	:	\$ 0.00
Payer Payments	:	\$ 0.00

Total Charges	:	\$ 3880.00
Total Received	:	\$ 0.00
Total Adjustment	:	\$ 0.00
Balance (based on search)	:	\$ 3880.00

4/14/2015 10:38 AM

Page 1 of 1

247295 / Beasley, Ms. Chetoiri**Settlement Memorandum****Recovery:**

PSF	Preferred Capital Funding-Ohio, LLC	\$ 500.00
REC	Pekin Insurance Company	\$ 20,500.00
		<u>\$ 21,000.00</u>

Ken

DEDUCT AND RETAIN TO PAY:**Kisling Legal Group**

Clearwater Billing Services, LLC; doc fee	\$ 50.00
Floros, Dr. Minas; narr fee	\$ 150.00
MRS Investigations, Inc.;	\$ 50.00
Summa Health System*; bill 6458780 /pjs	\$ 22.47
Summa Health System; recs 1502-000105 /pjs	\$ 39.20

Total due Kisling Legal Group

\$ 311.67

DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron Square Chiropractic	\$ 3,880.00
Clearwater Billing Services, LLC	\$ 3,940.00
Kisling, Nestico & Redick, LLC	\$ 6,838.33
National Diagnostic Imaging Consultants	\$ 110.00
Ohio Tort Recovery Unit*	\$ 400.00
Preferred Capital Funding-Ohio, LLC	\$ 622.50

3200
6075**Total due Others**\$ 15,785.83**Total Deductions**\$ 16,097.50**Total Amount Due To Client**

\$ 4,902.50

Less Previously Paid To Client\$ 500.00**Net Amount Due Client**\$ 4,402.50OK
6100.00

I hereby approve the above settlement and distribution of proceeds. I have reviewed the above information and I acknowledge that it accurately reflects all outstanding expenses associated with my injury claim. I further understand that the itemized bills listed above will be deducted and paid from the gross amount of my settlement except as otherwise indicated. Finally, I understand that any bills not listed above, including but not limited to Health Insurance or Medical Payments Subrogation and/or those initiated by me to indicate that they are not being paid from the settlement are my responsibility and not the responsibility of Kisling, Nestico & Redick, LLC.

Date: _____

Name: _____

Ref by ASC

[Signature]

247295 / Chetoiri Beasley

Settlement MemorandumRecovery:

REC Pekin Insurance Company
 PSF Preferred Capital Funding-Ohio, LLC

\$ 20,500.00

\$ 500.00

\$ 21,000.00

DEDUCT AND RETAIN TO PAY:

Kisling, Nestico & Redick, LLC

Floros, Dr. Minas; narr fee

MRS Investigations, Inc.

Summa Health System

Summa Health System

Clearwater Billing Services, LLC

Total Due

\$ 150.00

\$ 50.00

\$ 22.47

\$ 39.20

\$ 50.00

\$ 311.67

DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron Square Chiropractic

Clearwater Billing Services, LLC

Kisling, Nestico & Redick, LLC

National Diagnostic Imaging Consultants

Ohio Tort Recovery Unit

Preferred Capital Funding-Ohio, LLC

Total Due Others

\$ 3,880.00

\$ 3,000.00

(\$6,833.33) \$ 6,075.00

\$ 110.00

\$ 400.00

\$ 622.50

\$ 14,087.50

\$ 3,000 / KMZ

Total Deductions

\$ 14,399.17

Total Amount Due to Client

\$ 6,600.83

Less Previously Paid to Client

\$ 500.00

Net Amount Due to Client\$ 6,100.83

I hereby approve the above settlement and distribution of proceeds. I have reviewed the above information and I acknowledge that it accurately reflects all outstanding expenses associated with my injury claim. I further understand that the itemized bills listed above will be deducted and paid from the gross amount of my settlement except as otherwise indicated. Finally, I understand that any bills not listed above, including but not limited to Health Insurance or Medical Payments Subrogation and/or those initialed by me to indicate that they are not being paid from the settlement are my responsibility and not the responsibility of Kisling, Nestico & Redick, LLC.

\$1
 + 880
 \$16,980.83

Date:

4-20-15

Name:

Chetoiri Beasley

Firm:

Kisling, Nestico & Redick, LLC

247295 / Chetori Beasley

Settlement MemorandumRecovery:

REC Pekin Insurance Company
 PSF Preferred Capital Funding-Ohio, LLC

\$ 20,500.00

~~\$ 500.00~~

\$ 21,000.00

DEDUCT AND RETAIN TO PAY:

Kisling, Nestico & Redick, LLC
 Floros, Dr. Minas; narr fee
 MRS Investigations, Inc.
 Summa Health System
 Summa Health System
 Clearwater Billing Services, LLC
 Total Due

\$ 150.00
 \$ 50.00
 \$ 22.47
 \$ 39.20
 \$ 50.00
 \$ 311.67

DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron Square Chiropractic
 Clearwater Billing Services, LLC
 Kisling, Nestico & Redick, LLC
 National Diagnostic Imaging Consultants
 Ohio Tort Recovery Unit
 Preferred Capital Funding-Ohio, LLC
 Total Due Others

\$ 3,890.00
 \$ 3,000.00
 (\$6,833.33) \$ 6,075.00
 \$ 110.00
 \$ 400.00
 \$ 622.50
 \$ 14,087.50

org fee

\$ 3,000 / FM2

+ \$105.21

Final is

\$189.57

Total Deductions

\$ 14,399.17

Total Amount Due to Client

\$ 6,600.83

Less Previously Paid to Client

\$ 500.00

Net Amount Due to Client

\$ 6,100.83

+ \$105.21

I hereby approve the above settlement and distribution of proceeds. I have reviewed the above information and I acknowledge that it accurately reflects all outstanding expenses associated with my injury claim. I further understand that the itemized bills listed above will be deducted and paid from the gross amount of my settlement except as otherwise indicated. Finally, I understand that any bills not listed above, including but not limited to Health Insurance or Medical Payments Subrogation and/or those initiated by me to indicate that they are not being paid from the settlement are my responsibility and not the responsibility of Kisling, Nestico & Redick, LLC.

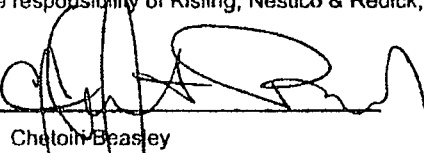
+ \$88.12

\$16,980.12

Date:

4-20-15

Name:


 Chetori Beasley
 Firm:
 Kisling, Nestico & Redick, LLC

Shannon S.

4/17/2015 12:04 PM

Page 1 of 1

247295 / Beasley, Ms. Chetoiri**Settlement Memorandum****Recovery:**

PSF	Preferred Capital Funding-Ohio, LLC	\$ 500.00
REC	Pekin Insurance Company	\$ 20,500.00
		<hr/>
		\$ 21,000.00

DEDUCT AND RETAIN TO PAY:**Kisling Legal Group**

Clearwater Billing Services, LLC; doc fee	\$ 50.00
Floros, Dr. Minas; narr fee	\$ 150.00
MRS Investigations, Inc.;	\$ 50.00
Summa Health System*; bill 6458780 /pjs	\$ 22.47
Summa Health System; recs 1502-000105 /pjs	\$ 39.20

Total due Kisling Legal Group

\$ 311.67**DEDUCT AND RETAIN TO PAY TO OTHERS:**

Akron Square Chiropractic	\$ 3,880.00
Clearwater Billing Services, LLC	\$ 3,000.00
Kisling, Nestico & Redick, LLC	\$ 6,075.00
National Diagnostic Imaging Consultants	\$ 110.00
Ohio Tort Recovery Unit*	\$ 400.00
Preferred Capital Funding-Ohio, LLC	\$ 622.50

Total due Others

\$ 14,087.50**Total Deductions****\$ 14,399.17****Total Amount Due To Client****\$ 6,600.83****Less Previously Paid To Client****\$ 500.00****Net Amount Due Client****\$ 6,100.83**

I hereby approve the above settlement and distribution of proceeds. I have reviewed the above information and I acknowledge that it accurately reflects all outstanding expenses associated with my injury claim. I further understand that the itemized bills listed above will be deducted and paid from the gross amount of my settlement except as otherwise indicated. Finally, I understand that any bills not listed above, including but not limited to Health Insurance or Medical Payments Subrogation and/or those initiated by me to indicate that they are not being paid from the settlement are my responsibility and not the responsibility of Kisling, Nestico & Redick, LLC.

Date: _____ Name: _____

247295 / Chetoiri Beasley

Settlement MemorandumRecovery:

REC Pekin Insurance Company
 PSF Preferred Capital Funding-Ohio, LLC

\$ 20,500.00

\$ 500.00

\$ 21,000.00

DEDUCT AND RETAIN TO PAY:

Kisling, Nestico & Redick, LLC

Floros, Dr. Minas; narr fee

MRS Investigations, Inc.

Summa Health System

Summa Health System

Clearwater Billing Services, LLC

Total Due

\$ 150.00

\$ 50.00

\$ 22.47

\$ 39.20

\$ 50.00

\$ 311.67

DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron Square Chiropractic

Clearwater Billing Services, LLC

Kisling, Nestico & Redick, LLC

National Diagnostic Imaging Consultants

Ohio Tort Recovery Unit

Preferred Capital Funding-Ohio, LLC

Total Due Others

\$ 3,880.00

\$ 3,000.00

(\$6,833.33) \$ 6,075.00

\$ 110.00

\$ 400.00

\$ 622.50

\$ 14,087.50

Total Deductions

\$ 14,399.17

Total Amount Due to Client

\$ 6,600.83

Less Previously Paid to Client

\$ 500.00

Net Amount Due to Client\$ 6,100.83

I hereby approve the above settlement and distribution of proceeds. I have reviewed the above information and I acknowledge that it accurately reflects all outstanding expenses associated with my injury claim. I further understand that the itemized bills listed above will be deducted and paid from the gross amount of my settlement except as otherwise indicated. Finally, I understand that any bills not listed above, including but not limited to Health Insurance or Medical Payments Subrogation and/or those initialed by me to indicate that they are not being paid from the settlement are my responsibility and not the responsibility of Kisling, Nestico & Redick, LLC.

Date: _____

Name: _____

Chetoiri Beasley

Firm: _____

Kisling, Nestico & Redick, LLC

APR-25-2011 11:21AM FROM:Sam Ghoubril MD

3309259030

T-828 P.004/012 F-642

Sam N. Ghoubril M.D.
Richard H. Gunning M.D.
MEDICAL ASSIGNMENT

Re: Patient Tai Juan CarterFirst date of service: 4/22/11

I hereby direct you to pay to Clearwater Billing Services, LLC from the net proceeds of any settlement, claim, judgment, verdict or award, for any and all services rendered as a result of an injury that I received on 4/16/11.

Said amount being fair and reasonable price of medical services provided by Hancrist, LLC for me at the direction of my doctor or doctors. I authorize you to withhold said sums from the net proceeds of any settlement, claim, judgment, verdict, or awards as may be necessary to pay Clearwater Billing Services, LLC

I fully understand that I am directly and fully responsible to Clearwater Billing Services, LLC for the aforementioned account submitted to me by Clearwater Billing Services, LLC for services rendered me, and that this agreement is made solely for its additional protection and in consideration of its awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, verdict or award by which I may eventually recover said fee.

Dated: 4/22/11

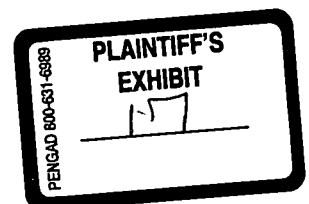
The undersigned being attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such claims from the net proceeds of any settlement, claim, judgment, verdict, or award as may be necessary to adequately protect Clearwater Billing Services, LLC provided that said lien is subordinate to attorney's lien herein.

Dated: 4-25-11

Kisling, Nestico & Redick, LLC
Attorneys at Law

Kisling, Nestico & Redick, LLC
3200 W. Market St., Suite 300
Akron, Ohio 44333
(330) 869-9007
(330) 869-9008 (fax)

1134 Brown Street Suite 1A Akron, Ohio 44301 (330) 925-1500



1500

KISLING, NESTICO & REDICK
3412 WEST MARKET STREET
AKRON, OH 44333

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #)		MEDICAID <input type="checkbox"/> (Medicaid #)		TRICARE <input type="checkbox"/> (Sponsor's SSN)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)		FECA BLK LUNG <input checked="" type="checkbox"/> (SSN)		OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CARTER, TAIJUAN								3. PATIENT'S BIRTH DATE MM DD YY [REDACTED]		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) CARTER, TAIJUAN			
5. PATIENT'S ADDRESS (No., Street) [REDACTED]								6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street) [REDACTED]			
CITY [REDACTED]				STATE [REDACTED]				8. PATIENT STATUS [REDACTED]				CITY [REDACTED]			
ZIP CODE [REDACTED]				TELEPHONE (Include Area Code) [REDACTED]				[REDACTED]				CITY [REDACTED]			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER				12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.			
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				a. INSURED'S DATE OF BIRTH MM DD YY [REDACTED]				SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY [REDACTED]				b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				b. EMPLOYER'S NAME OR SCHOOL NAME				c. INSURANCE PLAN NAME OR PROGRAM NAME KISLING, NESTICO & REDICK			
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE [REDACTED]								13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE [REDACTED]							
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 04/18/2011								15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY [REDACTED]							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE								18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY [REDACTED]							
19. RESERVED FOR LOCAL USE								20. OUTSIDE LAB? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 847.0 2. 846.0 3. [REDACTED] 4. [REDACTED]								22. MEDICAID RESUBMISSION CODE [REDACTED]							
23. PRIOR AUTHORIZATION NUMBER								24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #							
1 04/22/11 04/22/11 11 99204 1,2 \$350.00 1 NPI 1508856915															
2 05/13/11 05/13/11 11 99213 1,2 \$150.00 1 NPI 1508856915															
3 05/13/11 05/13/11 11 L0631 1,2 \$1,500.00 1 NPI 1508856915															
4 06/03/11 06/03/11 11 99213 1,2 \$150.00 1 NPI 1508856915															
5 06/24/11 06/24/11 11 99213 1,2 \$150.00 1 NPI 1508856915															
6 07/15/11 07/15/11 11 99213 1,2 \$150.00 1 NPI 1508856915															
25. FEDERAL TAX ID NUMBER 270845852 SSN EIN [REDACTED]								26. PATIENT ACCOUNT NO. [REDACTED]							
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO								28. TOTAL CHARGE \$2,450.00 29. AMOUNT PAID \$0.00 30. BALANCE DUE \$2,450.00							
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.) RICHARD H. GUNNING 08/10/11								32. SERVICE FACILITY LOCATION INFORMATION HANCHRIST LLC 1134 BROWN ST AKRON, OH 44301							
33. BILLING INFORMATION CLEARWATER BILLING SERVICES P.O. BOX 1243 BATH, OH 44210								a. 1487982112 b. [REDACTED]							

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Printed on Recycled Paper

1500

KISLING, NESTICO & REDICK
3412 WEST MARKET STREET
AKRON, OH 44333

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #)		MEDICAID <input type="checkbox"/> (Medicaid #)		TRICARE CHAMPUS (Sponsor's SSN)		CHAMPVA (Member ID#)		GROUP HEALTH PLAN (SSN or ID)		FECA BLK LUNG (SSN)		OTHER (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 297707566					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CARTER, TAIJUAN								3. PATIENT'S BIRTH DATE [REDACTED]		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) CARTER, TAIJUAN							
5. PATIENT'S ADDRESS (No. Street) [REDACTED]								6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No. Street) [REDACTED]									
CITY [REDACTED]				STATE [REDACTED]				CITY [REDACTED]				STATE [REDACTED]							
ZIP CODE [REDACTED]				TELEPHONE (Include Area Code) [REDACTED]				ZIP CODE [REDACTED]				TELEPHONE (Include Area Code) [REDACTED]							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)								10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER							
a. OTHER INSURED'S POLICY OR GROUP NUMBER								a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				a. INSURED'S DATE OF BIRTH [REDACTED] M <input checked="" type="checkbox"/> F <input type="checkbox"/>							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>								b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				b. EMPLOYER'S NAME OR SCHOOL NAME							
c. EMPLOYER'S NAME OR SCHOOL NAME								c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				c. INSURANCE PLAN NAME OR PROGRAM NAME KISLING, NESTICO & REDICK							
d. INSURANCE PLAN NAME OR PROGRAM NAME								10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete Item 9 a-d.							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE 08/10/11 NED DATE																			
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE SIGNED																			
14. DATE OF CURRENT: 04/16/2011				ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE RICHARD GUNNING,								17a. NPI 1508856915				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
19. RESERVED FOR LOCAL USE								20. OUTSIDE LAB? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES				22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 847.0 2. 846.0 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 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1000.								23. PRIOR AUTHORIZATION NUMBER											
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY				B. PLACE OF SERVICE EMG		C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTNER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #	
1 05/13/11 05/13/11 11						E0730		1,2		\$500.00		1						1508856915	
2																		NPI	
3																		NPI	
4																		NPI	
5																		NPI	
6																		NPI	
25. FEDERAL TAX ID NUMBER 270845852				SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$500.00		29. AMOUNT PAID \$0.00		30. BALANCE DUE \$500.00					
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.) RICHARD H. GUNNING 08/10/11				32. SERVICE FACILITY LOCATION INFORMATION HANCHRIST LLC 1134 BROWN ST AKRON, OH 44301		33. BILLING INFORMATION CLEARWATER BILLING SERVICES P.O BOX 1243 BATH, OH 44210													
SIGNED				DATE		a. 1669702841		b.		a. 1487982112									

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Printed on Recycled Paper

CLIENT: Taijuan Carter

INSURANCE CO: Merchants Insurance Group

INSURED: Taijuan Carter

ADJUSTER: Barbara Milne

DATE OF LOSS: 4/16/2011

CLAIM NO: PA06302901

PHYSICIANSMEDICAL SPECIALSAMOUNT

Akron Square Chiropractic
Clearwater Billing Services, LLC
Comprehensive Pain Management *

(4/21/2011 - 8/29/2011)
(4/22/2011 - 7/15/2011)
(8/16/2011 - 8/16/2011)

\$ 2,272.00
\$ 2,950.00
\$ 925.00

HOSPITALS:

St. Thomas Medical Center*
Summa Emergency Associates, Inc.*
Akron Radiology*

(4/16/2011 - 4/16/2011)
(4/16/2011 - 4/16/2011)
(4/16/2011 - 4/16/2011)

\$ 1,176.75
\$ 225.00
\$ 30.00

OTHERS:

National Diagnostic Imaging
Consultants
Millennium Laboratories
IMPI, Inc.*
Prescriptions

(4/28/2011 - 4/28/2011)
(8/16/2011 - 8/16/2011)
(8/18/2011 - 8/18/2011)

\$ 100.00
\$ 573.68
\$ 957.62
\$ 37.04

TOTAL SPECIALS**\$ 9,247.09**

FOR ATTORNEY EYES ONLY - CONFIDENTIAL SUBJECT TO PROTECTIVE ORDER

Richard H. Gunning, M.D.
1134 Brown Street, Suite A1
Akron, Ohio 44301
330-925-1500
330-925-9030

April 22, 2011
Tai Juan Carter

This is a 35-year-old male who was the seat-belted driver of vehicle involved in a motor vehicle accident on April 16, 2011, when he was rear-ended by a hit-and-run driver at Dodge and Portage Path in Akron. He had nearly immediate pain. His sister was taken by EMS to the emergency room. He took himself to St. Thomas Hospital where x-rays were done and didn't seem to show anything. He was given muscle relaxers and pain medications. He saw the chiropractor later who did x-rays yesterday, the results of which are not yet known. However, the patient has pain and tightness in his shoulder, neck and low back. He occasionally feels some tingling in his hands.

Past Medical History: Unremarkable.

Social History: Unremarkable.

MEDICATIONS: None.

ALLERGIES: NKDA.

PHYSICAL EXAM:

INTEGUMENTARY: The skin is without any cyanosis. No evidence of nail fungus, rash or abnormality. Elasticity appears to be WNL.

HEENT: Normocephalic and atraumatic. PERRLA. Mucous membranes are moist. The nose is patent and non-deviated tympanic membranes WNL.

NECK: Soft and supple. Thyroid gland could not be palpated. No evidence of any cervical lymphadenopathy. No JVD is noted. Range of motion of his neck is diminished and delayed due to stiffness and tightness.

CARDIOVASCULAR: RRR normal S1 S2, no murmurs rubs or gallops. No carotid bruits could be appreciated.

LUNGS: Clear to auscultation. No wheezes, rales, or rhonchi could be appreciated on exam.

ABDOMEN: Soft and non-tender with positive bowel sounds. No evidence of any ascites or hepatosplenomegaly. No guarding or rebound tenderness. Negative for hernias.

GRASP/MANIPULATION: Pincer movements and fine coordination appear to be WNL.

Ghoubrial - 000619

FOR ATTORNEY EYES ONLY - CONFIDENTIAL SUBJECT TO PROTECTIVE ORDER

Patient Name: Tai Juan Carter
Page Two

BACK: No scars are present. He has tenderness in his trapezius muscles and his lower spine.

UPPER EXTREMITIES: Shoulders, wrists and elbows: demonstrate no scars or gross deformities. +2 radial pulses throughout. He has pain in his shoulders.

LOWER EXTREMITIES: No venous insufficiency or edema. +2 pulses throughout. Ankles and hips demonstrate no gross abnormalities on exam.

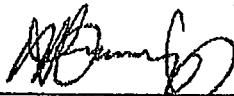
MUSCULOSKELETAL: The patient is able to get on and off the exam table without difficulty. The patient is able to do heel to toe walking. The patient doesn't walk with a cane or walker.

NEUROLOGICAL: The patient is alert and oriented x 3. Cranial nerves II-XII are grossly intact throughout. Reflexes are 2/4 throughout. Tactile sensation is WNL. There is a negative Romberg test. Cerebellar testing is within normal limits. There is a negative straight leg raise and negative bowstring sign.

ASSESSMENT:

1. Cervical and lumbosacral strain.

PLAN: He declined trigger point injections today. I gave him prescriptions for Percocet 5/325 mg, #90, one pill four times a day to last for three weeks; and Flexeril 10 mg, one every 8 hours as needed, #68; and Motrin 800 mg, every 8 hours with food PRN, #68. I will see the patient back in three weeks, sooner if needed.



Richard H. Gunning, M.D./rtd

FOR ATTORNEY EYES ONLY - CONFIDENTIAL SUBJECT TO PROTECTIVE ORDER

NAME: Tai Juan Carter

DATE	PROGRESS NOTES			
4/22/11	NP, MVA	10' later	10' later	10' later
5/13/11	MVA Follow Up			

Taijuan Carter May 13, 2011

He comes in today for a follow-up visit. He states he has to double up on the Percocet at times because of severe pain. He notes that he will be out of town until three weeks from now. He says he is going on vacation.

EXAM: He still has pain and tenderness in the same areas as before, especially in his low back.

PLAN: I refilled his Percocet 10/325 mg, #90 pills, one pill four times a day as needed. I fit him for a **Cybertech Premium Plus Brace**. I also gave him a **DermaStim TENS unit**. I refilled his Motrin #60, and Flexcril #45. I will see the patient back in three weeks. RHG/rtd

RHG/rtc

RHG/rtd

FOR ATTORNEY EYES ONLY - CONFIDENTIAL SUBJECT TO PROTECTIVE ORDER

NAME: Tai Juan Carter

DATE

PROGRESS NOTES

6/3/11 MVA Follow Up

Taijuan Carter June 3, 2011

He comes in today for a follow-up visit after a three week hiatus. He is still working with the chiropractor. He states his knee is beginning to bother him. He thinks he might have hurt them in the accident.

EXAM: He has no crepitus, tenderness or swelling in his knees today. He does have tightness in his trapezius muscles. He could use refills of his medications. He declined shots.

PLAN: I refilled Percocet 10/325 mg, one pill four times a day, #90, no refills, since we won't be seeing him for the next three weeks; Flexeril 10 mg, #60, one pill three times a day as needed, no refills; and Motrin 800 mg, #30, one t.i.d. with food, no refills. I will see the patient back in three weeks.

RHG/rtf

2 Tai Juan Carter

6/24/11 follow-up no x-ray 1/6 swelling in neck - no more
L.S.V. - J.W. L.H.B.

Taijuan Carter June 24, 2011

He comes in for a follow-up appointment. He has had a three week hiatus. In fact, he will be gone for yet another three weeks. He still has tenderness in his neck and low back. It is a little bit better. He needs refills of his medications today.

PLAN: I refilled Percocet 10/325 mg, one pill four times a day, #90, no refills; Flexeril 10 mg, #60, one pill three times a day as needed; and Motrin 800 mg, #60, one pill three times a day with food. This will hold him over until I see him back in three weeks.

RHG/rtf

FOR ATTORNEY EYES ONLY - CONFIDENTIAL SUBJECT TO PROTECTIVE ORDER

NAME: Tg. Juan Carter

[illegible]

FOR ATTORNEY EYES ONLY - CONFIDENTIAL SUBJECT TO PROTECTIVE ORDER

INTERNAL MEDICINE CENTER OF RITTMAN

NAME:

TAJUAN CARTER

DATE	PROGRESS NOTES
8/2/11	pt. has a referral to see Dr. Lababidi
	Faxed pt. info - They call the pt on

Ghoubrial - 000615

Akron Square Chiropractic
1419 South Arlington Rd.
Akron, OH 44306
(330)773-3882

Tax I.D.31-1528200

Statement Date
9/20/2011

Page
1

Tai Juan Carter
% KISLING NESTICO & REDICK
3412 WEST MARKET ST
AKRON, OH 44333

Diagnosis
847.0
847.2
847.1
728.85

Chart Number
CARTA018

Date	Description	Procedure Code	Amount
Date of Loss: 4/16/2011	Previous Balance		0.00
Patient: Tai Juan Carter	Chart #: CARTA018	Case Description: mva	
4/21/2011	TEN POINT EXAM	10 PT	0.00
4/21/2011	X-ray Cervical AP& LAT, 2 or 3 views	72040	120.00
4/21/2011	X-ray Lumbosacral, complete, bending	72114	160.00
4/21/2011	Electrical Muscle Stimulation	97014	35.00
4/21/2011	Hot/Cold Packs to one or more areas	97010	20.00
4/22/2011	Electrical Muscle Stimulation	97014	35.00
4/22/2011	Unlisted Modality	97039	50.00
4/25/2011	Spinal Manipulation 3-4 regions	98941	77.00
4/25/2011	Unlisted Modality	97039	50.00
4/25/2011	Massage/TriggerPoint(Distinct/Reduced)	97124-5952	40.00
4/25/2011	Electrical Muscle Stimulation	97014	35.00
4/26/2011	Spinal Manipulation 3-4 regions	98941	77.00
4/26/2011	Electrical Muscle Stimulation	97014	35.00
4/26/2011	Unlisted Modality	97039	50.00
4/26/2011	Massage/TriggerPoint(Distinct/Reduced)	97124-5952	40.00
4/27/2011	Spinal Manipulation 3-4 regions	98941	77.00
4/27/2011	Electrical Muscle Stimulation	97014	35.00
4/27/2011	Unlisted Modality	97039	50.00
4/27/2011	Massage/TriggerPoint(Distinct/Reduced)	97124-5952	40.00
4/28/2011	Spinal Manipulation 3-4 regions	98941	77.00
4/28/2011	Electrical Muscle Stimulation	97014	35.00

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

Akron Square Chiropractic
1419 South Arlington Rd.
Akron, OH 44306
(330)773-3882

Tax I.D.31-1528200

Statement Date
9/20/2011

Page
2

Tai Juan Carter
% KISLING NESTICO & REDICK
3412 WEST MARKET ST
AKRON, OH 44333

Diagnosis
847.0
847.2
847.1
728.85

Chart Number
CARTA018

Date	Description	Procedure Code	Amount
4/28/2011	Unlisted Modality	97039	50.00
4/28/2011	Massage/TriggerPoint(Distinct/Reduced)	97124-5952	40.00
5/2/2011	Spinal Manipulation 3-4 regions	98941	77.00
5/2/2011	Electrical Muscle Stimulation	97014	35.00
5/2/2011	Unlisted Modality	97039	50.00
5/2/2011	Massage/TriggerPoint(Distinct/Reduced)	97124-5952	40.00
5/3/2011	Spinal Manipulation 3-4 regions	98941	77.00
5/3/2011	Electrical Muscle Stimulation	97014	35.00
5/3/2011	Unlisted Modality	97039	50.00
5/3/2011	Massage/TriggerPoint(Distinct/Reduced)	97124-5952	40.00
5/4/2011	Spinal Manipulation 3-4 regions	98941	77.00
5/4/2011	Electrical Muscle Stimulation	97014	35.00
5/4/2011	Unlisted Modality	97039	50.00
5/4/2011	Massage/TriggerPoint(Distinct/Reduced)	97124-5952	40.00
5/9/2011	Spinal Manipulation 3-4 regions	98941	77.00
5/9/2011	Electrical Muscle Stimulation	97014	35.00
5/9/2011	Unlisted Modality	97039	50.00
5/9/2011	Massage/TriggerPoint(Distinct/Reduced)	97124-5952	40.00
5/11/2011	Spinal Manipulation 3-4 regions	98941	77.00
5/11/2011	Massage/TriggerPoint(Distinct/Reduced)	97124-5952	40.00
5/12/2011	Spinal Manipulation 3-4 regions	98941	77.00
5/12/2011	Electrical Muscle Stimulation	97014	35.00
5/12/2011	Hot/Cold Packs to one or more areas	97010	20.00

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

Akron Square Chiropractic
1419 South Arlington Rd.
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Statement Date
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Page
3

Tai Juan Carter
% KISLING NESTICO & REDICK
3412 WEST MARKET ST
AKRON, OH 44333

Diagnosis
847.0
847.2
847.1
728.85

Chart Number
CARTA018

Date	Description	Procedure Code	Amount
5/12/2011	Traction, Mechanical	97012	25.00
5/12/2011	Massage/TriggerPoint(Distinct/Reduced)	97124-5952	40.00
5/16/2011	Spinal Manipulation 3-4 regions	98941	77.00
5/16/2011	Electrical Muscle Stimulation	97014	35.00
5/16/2011	Unlisted Modality	97039	50.00
5/16/2011	Massage/TriggerPoint(Distinct/Reduced)	97124-5952	40.00
5/17/2011	Spinal Manipulation 1-2 regions	98940	65.00
5/17/2011	Electrical Muscle Stimulation	97014	35.00
5/17/2011	Unlisted Modality	97039	50.00
5/18/2011	Spinal Manipulation 1-2 regions	98940	65.00
5/18/2011	Electrical Muscle Stimulation	97014	35.00
5/18/2011	Unlisted Modality	97039	50.00
5/18/2011	Massage/TriggerPoint(Distinct/Reduced)	97124-5952	40.00
5/31/2011	Spinal Manipulation 1-2 regions	98940	65.00
5/31/2011	Electrical Muscle Stimulation	97014	35.00
5/31/2011	Unlisted Modality	97039	50.00
5/31/2011	Massage/TriggerPoint(Distinct/Reduced)	97124-5952	40.00
6/3/2011	Electrical Muscle Stimulation	97014	35.00
6/3/2011	Hot/Cold Packs to one or more areas	97010	20.00
6/6/2011	Spinal Manipulation 1-2 regions	98940	65.00
6/6/2011	Electrical Muscle Stimulation	97014	35.00
6/6/2011	Unlisted Modality	97039	50.00
6/7/2011	Spinal Manipulation 1-2 regions	98940	65.00

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

Akron Square Chiropractic
1419 South Arlington Rd.
Akron, OH 44306
(330)773-3882

Tax I.D.31-1528200

Statement Date
9/20/2011

Page
4

Tai Juan Carter
% KISLING NESTICO & REDICK
3412 WEST MARKET ST
AKRON, OH 44333

Diagnosis
847.0
847.2
847.1
728.85

Chart Number
CARTA018

Date	Description	Procedure Code	Amount
6/14/2011	Spinal Manipulation 1-2 regions	98940	65.00
6/15/2011	Spinal Manipulation 1-2 regions	98940	65.00
6/21/2011	Spinal Manipulation 1-2 regions	98940	65.00
6/23/2011	Spinal Manipulation 1-2 regions	98940	65.00
7/6/2011	Spinal Manipulation 1-2 regions	98940	65.00
7/7/2011	Spinal Manipulation 1-2 regions	98940	65.00
7/12/2011	Spinal Manipulation 1-2 regions	98940	65.00
7/12/2011	Traction, Mechanical	97012	25.00
7/18/2011	Spinal Manipulation 1-2 regions	98940	65.00
7/28/2011	Spinal Manipulation 1-2 regions	98940	65.00
7/28/2011	Unlisted Modality	97039	50.00
8/9/2011	Spinal Manipulation 1-2 regions	98940	65.00
8/16/2011	Spinal Manipulation 1-2 regions	98940	65.00
8/19/2011	INSURANCE PAYMENT	INSPAY	-64.00
8/19/2011	INSURANCE PAYMENT	INSPAY	-570.00
8/19/2011	INSURANCE PAYMENT	INSPAY	-190.00
8/19/2011	INSURANCE PAYMENT	INSPAY	-380.00
8/19/2011	INSURANCE PAYMENT	INSPAY	-796.00
8/22/2011	Spinal Manipulation 1-2 regions	98940	65.00
8/29/2011	Spinal Manipulation 1-2 regions	98940	65.00

Total Charges	Total Payments	Total Adjustments	Balance Due
\$4272.00	-\$2000.00	\$0.00	2,272.00

11/15/2011 02:42 PM

Page 1 of 1

214892 / Carter, Mr. Taijuan

Settlement MemorandumRecovery:

REC

Merchants Insurance Group

Includes 2 KMP
Paid All to ASC

\$16,000.00

\$16,000.00

DEDUCT AND RETAIN TO PAY:Kisling Legal Group

AMC Investigations; 214892	\$ 50.00
Clearwater Billing Services, LLC; docs fee	\$ 50.00
Comprehensive Pain Management *; recs fee EF	\$ 8.19
Floros, Dr. Minas; narrative fee	\$ 200.00
Summa Health System; 1105-95 05690599	\$ 34.80
Summa Health System; mrn 05690599	\$ 18.63

Total due Kisling Legal Group

\$ 361.62

DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron Radiology*	\$ 30.00
Akron Square Chiropractic	\$ 4,272.00 (2,272)
Clearwater Billing Services, LLC	\$ 2,950.00 2,150
Comprehensive Pain Management *	\$ 925.00 700
EMPI, Inc.*	\$ 957.62
Kisling, Nestico & Redick, LLC	\$ 5,333.33 3600
Millennium Laboratories	\$ 573.68
National Diagnostic Imaging Consultants	\$ 180.00
Preferred Capital Funding	\$ 249.00 428
Summa Emergency Associates, Inc.*	\$ 228.00

Total due Others

\$ 15,615.63

Total Deductions

\$ 15,977.25

Total Amount Due To Client

\$ 22.75

Less Previously Paid To Client

\$ 0.00

Net Amount Due Client

\$ 22.75

I hereby approve the above settlement and distribution of proceeds. I have reviewed the above information and I acknowledge that it accurately reflects all outstanding expenses associated with my injury claim. I further understand that the itemized bills listed above will be deducted and paid from the gross amount of my settlement except as otherwise indicated. Finally, I understand that any bills not listed above, including but not limited to Health Insurance or Medical Payments Subrogation and/or those initiated by me to indicate that they are not being paid from the settlement are my responsibility and not the responsibility of Kisling, Nestico & Redick, LLC.

Date: _____

Name: _____

R-fob
ASC

214892 / Taijuan Carter

Settlement MemorandumRecovery:

REC Merchants Insurance Group
 REC Preferred Capital

\$ 16,000.00

\$ 350.00

\$ 16,350.00

DEDUCT AND RETAIN TO PAY:

Kisling, Nestico & Redick, LLC

Clearwater Billing Services, LLC; docs fee \$ 50.00

Comprehensive Pain Management *; recs fee EF \$ 8.19

Floros, Dr. Minas; narrative fee \$ 200.00

Summa Health System; 1105-95 05690599 \$ 34.80

Summa Health System; mrn 05690599 \$ 18.63

AMC Investigations; 214892 \$ 50.00

Total Due

\$ 361.62

DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron Radiology* \$ 30.00

Akron Square Chiropractic \$ 4,272.00

Clearwater Billing Services, LLC \$ 1,500.00

Comprehensive Pain Management * \$ 700.00

EMPI, Inc.* \$ 957.62

Kisling, Nestico & Redick, LLC (\$5,333.33) \$ 3,600.00

Millennium Laboratories \$ 573.68

Preferred Capital Funding \$ 481.50

Summa Emergency Associates, Inc.* \$ 225.00

Total Due Others

\$ 12,339.80

Total Deductions

\$ 12,701.42

Total Amount Due to Client

\$ 3,648.58

Total Amount to be Paid by Client

\$ 1,786.30

Net Amount Due to Client

\$ 5,434.88

Less Previously Paid to Client

\$ 350.00

Net Amount Due to Client**\$ 5,084.88**

I hereby approve the above settlement and distribution of proceeds. I have reviewed the above information and I acknowledge that it accurately reflects all outstanding expenses associated with my injury claim. I further understand that the itemized bills listed above will be deducted and paid from the gross amount of my settlement except as otherwise indicated. Finally, I understand that any bills not listed above, including but not limited to Health Insurance or Medical Payments Subrogation and/or those initiated by me to indicate that they are not being paid from the settlement are my responsibility and not the responsibility of Kisling, Nestico & Redick, LLC.

Date: 11/28/11

Name: Taijuan Carter

Firm: Kisling, Nestico & Redick, LLC

11/28/2011 09:11 AM

Page 1 of 1

214892 / Carter, Mr. Taijuan**Settlement Memorandum****Recovery:**

REC Merchants Insurance Group

\$ 16,000.00

\$ 16,000.00**DEDUCT AND RETAIN TO PAY:****Kisling Legal Group**

AMC Investigations; 214892	\$ 50.00
Clearwater Billing Services, LLC; docs fee	\$ 50.00
Comprehensive Pain Management *; recs fee EF	\$ 8.19
Floros, Dr. Minas; narrative fee	\$ 200.00
Summa Health System; 1105-95 05690599	\$ 34.80
Summa Health System; mrn 05690599	\$ 18.63

Total due Kisling Legal Group

\$ 361.62

DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron Radiology*	\$ 30.00 —
Akron Square Chiropractic	\$ 4,272.00 (2272)
Clearwater Billing Services, LLC	\$ 1,500.00
Comprehensive Pain Management *	\$ 700.00
EMPI, Inc.*	\$ 957.62 —
Kisling, Nestico & Redick, LLC	\$ 3,600.00
Millennium Laboratories	\$ 573.68 —
Preferred Capital Funding	\$ 498.00
Summa Emergency Associates, Inc.*	\$ 225.00 —

Total due Others\$ 12,356.30**Total Deductions**\$ 12,717.92**Total Amount Due To Client**

\$ 3,282.08

Less Previously Paid To Client\$ 0.00**Net Amount Due Client**\$ 3,282.08

I hereby approve the above settlement and distribution of proceeds. I have reviewed the above information and I acknowledge that it accurately reflects all outstanding expenses associated with my injury claim. I further understand that the itemized bills listed above will be deducted and paid from the gross amount of my settlement except as otherwise indicated. Finally, I understand that any bills not listed above, including but not limited to Health Insurance or Medical Payments Subrogation and/or those initialed by me to indicate that they are not being paid from the settlement are my responsibility and not the responsibility of Kisling, Nestico & Redick, LLC.

Date: _____

Name: _____