IN THE COURT OF COMMON PLEAS
SUMMIT COUNTY, OHIO

MEMBER WILLIAMS, et al., Plaintiffs, vs. KISLING, NESTICO & REDICK, LLC, *et al.*, Defendants.	Case No. CV-2016-09-3928 Judge James A. Brogan **Notice of Filing Volume IV of Exhibits to the Deposition of Defendant Sam Ghoubrial**

Plaintiffs hereby give notice of filing Volume IV of exhibits to the deposition of Defendant Sam Ghoubrial, taken on April 9, 2019.

Respectfully submitted,

/s/ Rachel Hazelet

Peter Pattakos (0082884)
Rachel Hazelet (0097855)
THE PATTAKOS LAW FIRM LLC
101 Ghent Road
Fairlawn, Ohio 44333
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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

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

MEDICAL LIEN

Re: Patient TaJuan Canter

First date of service: 10-14-15

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 10-14-15.

Said amount being fair and reasonable price of medical services provided by Hanchrist Medical Professionals 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: 10/14/15

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: 10/28/15

Slater and Zurz, LLP
Attorneys at Law

Slater and Zurz LLP
One Cascade Plaza, Suite 2210
Akron, Ohio 44308-1135
(330) 762-0700
(330) 762-3923 (fax)

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Phone: (330) 331-7207
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PENGAD 800-631-6989 PLAINTIFF'S EXHIBIT 19

Ghoubrial - 000647

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

October 14, 2015
Taijuan Carter

The patient is a 40-year-old gentleman who states he is a renter of a house and fell through the basement steps. Apparently one of the steps gave out and he fell through it and injured his right knee, right ankle, neck and back. He went to the emergency room at Summa Western Reserve where he was treated and released. Unfortunately, he continues to have pain in his neck and lower back. On a scale of 1 to 10, his pain is 10. He has difficulty twisting, turning and bending. He has been walking with the aid of a crutch since the day of the accident, October 6, 2015.

Past Medical History: Unremarkable.

Past Surgical History: Unremarkable.

Social History: No history of illicit drug use. Unremarkable. He is engaged to be married.

MEDICATIONS: None.

ALLERGIES: Statins.

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: No scars are present. He has loss of lordosis of the lumbar spine with severe pain and guarding. He has guarding and tenderness of the periscapular region bilaterally.

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. He has swelling to the medial and lateral malleoli of the right ankle. He is wearing an ankle splint. He has severe decreased range of motion on flexion to his right knee. He has marked effusion.

MUSCULOSKELETAL: The patient's gait is antalgic. He is walking with a crutch.

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. Periscapular strain, thoracic region.
2. Lumbar strain.
3. Right knee injury.
4. Right ankle injury.

PROCEDURE: I identified eight trigger points, two at T2, two at T4, two at T5, and two at T6. I injected each with 1/2 cc of methylprednisolone and Marcaine mixture under sterile technique.

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, two times daily.

PLAN: I prescribed Norco 5/325 mg, #30, one PO b.i.d.; Zanaflex 4 mg, #30, one at night; and Naprosyn 500 mg, #60, one PO b.i.d. I will see the patient back in one week for follow-up.

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. Ghoubrial M.D./rtd

Progress Notes

Name: Taijuan Carter

3 Taijuan Carter

10/14/15 Initial visit (NS)

10/21/15 5 Taijuan Carter

FOllOW up. (NS)

Taijuan Carter October 21, 2015

The patient is here for a follow-up visit. He received Norco, Zanaflex, Naprosyn and trigger point injections along with a TENS unit. He states his condition is minimally better.

EXAM: He is still having pain in his neck and back. He is still ambulating with a crutch.

PLAN: I will see him back in one week. If he still has issues, we will make some changes.

SNG/rtd

4 TAIJUAN CARTER

10/28/15 FOllOW UP (NS)

Taijuan Carter October 28, 2015

The patient is here for a follow-up visit. He is still ambulating with a crutch. Unfortunately, he still has difficulty getting around.

EXAM: The patient still has difficulty twisting, turning and bending. He is ambulating with a crutch. He has discomfort in the left trapezius complex.

PROCEDURE: I identified four trigger points, one at C7, T1, T2, T3, left side. I injected each with 1/2 cc of methylprednisolone and Marcaine mixture under sterile technique. He tolerated the injections well.

PLAN: I prescribed Percocet 5/325 mg, #42, one PO t.i.d.

SNG/rtd

Progress Notes

Name: Taijuan Carter

11 TAIJUAN CARTER

11-11-15 FOLLOW UP (NS)

Taijuan Carter November 11, 2015

The patient is here for follow-up.

EXAM: He has discomfort in his trapezius complex on the right side.

PLAN: I will give him another prescription for Percocet 5/325 mg, #60, one PO t.i.d.; I will write for Zanaflex 4 mg, #60, one b.i.d.; and Naprosyn 500 mg, #60, one PO b.i.d. Hopefully this will help. I will see him back in four weeks.

SNG/rtd Sng

12-9-15 NO SHOW #1 (NS)

Clearwater Billing Services, LLC

Patient Name: Taijuan Carter DOA: 4/16/11

Attorney: KWR

Diagnosis:

1. 847.0
2. 846.0
3.
4.

*Initial Visit: 99204 DOS: 4/22/11

DX: 1 2 : :
SNG RHG FDL

Procedure

20552 20553 97032 97010

Medication

J1020 J1030 J1040

DME L0631 E0730

*Follow- Up Visit: 99213 DOS: 5/13/11

DX: 1 2 : :
SNG RHG FDL

Procedure

20552 20553 97032 97010

Medication

J1020 J1030 J1040

DME L0631 E0730

*Follow- Up Visit: 99213 DOS: 6/3/11

DX: 1 2 : :
SNG RHG FDL

Procedure

20552 20553 97032 97010

Medication

J1020 J1030 J1040

DME L0631 E0730

*Follow- Up Visit: 99213 DOS: 6/24/11

DX: 1 2 : :
SNG RHG FDL

Procedure

20552 20553 97032 97010

Medication

J1020 J1030 J1040

DME L0631 E0730

*Follow- Up Visit: 99213 DOS: 7/15/11

DX: 1 2 : :
SNG RHG FDL

Procedure

20552 20553 97032 97010

Medication

J1020 J1030 J1040

DME L0631 E0730

*Follow- Up Visit: 99213 DOS:

DX: : :
SNG RHG FDL

Procedure

20552 20553 97032 97010

Medication J1020 J1030 J1040

DME L0631 E0730

Ghoubrial - 000606

Invoice for Medical Services

Re: Tai Juan Carter
Date of Accident: 10/6/15
Date of Birth: [redacted]

Medical services for the above- named client.		**Amount**
10/14/15-10/28/15	See detailed HCFA 1500	$1980.00
10/28/15-11/11/15	See detailed HCFA 1500	$1030.00
12/1/15	Document preparation fee	$50.00
	Total amount due:	**$3060.00**

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

SLATER & ZURZ LLP
ONE CASCADE PLAZA #2210
AKRON, OH 44308

HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

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

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

CITY: [redacted] STATE: [redacted]

8. RESERVED FOR NUCC USE

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 (La[redacted]

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH [redacted] SEX M F

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: SLATER & ZURZ LLP

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO # yes, complete items 9, 9a, and 9d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 12 01 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: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 10 06 15 QUAL 431

15. OTHER DATE QUAL 439 10 06 15

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES X NO $ CHARGES: 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. S46.119A	B. S23.3XXA	C. S33.8XXA	D. M25.461
E. S46.119D	F. S23.3XXD	G. S33.8XXD	H. S13.4XXD
I.	J.	K.	L.

22. RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (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 10 14 15	10 14 15	11		99203		A,B,C,	300.00	1		NPI	1003892217
2 10 14 15	10 14 15	11		20553		A,B,C,	800.00	1		NPI	1003892217
3 10 14 15	10 14 15	11		J1040		A,B,C,	80.00	1		NPI	1003892217
4 10 14 15	10 14 15	11		E0730		A,B,C,	500.00	1		NPI	1003892217
5 10 21 15	10 21 15	11		99213		E,F,G,	150.00	1		NPI	1003892217
6 10 28 15	10 28 15	11		99213		H,F,G,	150.00	1		NPI	1003892217

25. FEDERAL TAX I.D. NUMBER: 270796590 SSN EIN X

26. PATIENT'S ACCOUNT NO.: [redacted]

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

28. TOTAL CHARGE: $ 1980.00

29. AMOUNT PAID: $ 0.00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SAM N. GHOUBRIAL, MD DATE: 12 01 15

32. SERVICE FACILITY LOCATION INFORMATION
AKRON CHIROPRACTOR
S ARLINGTON ST
AKRON, OH 44306
a. 1669702841

33. BILLING PROVIDER INFO & PH #: (330) 331 7207
CLEARWATER BILLING SERVICES LLC
P.O BOX 1243
BATH, OH 44210
a. 1487982112

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Ghoubrial_000645

PATIENT AND INSURED INFORMATION — CARRIER — PHYSICIAN OR SUPPLIER INFORMATION

FOR ATTORNEY EYES ONLY - CONFIDENTIAL SUBJECT TO PROTECTIVE ORDER

SLATER & ZURZ LLP
ONE CAGE PLAZA #2210
AKRON, OH 44308

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#) X (ID#)	[redacted]
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE / SEX
CARTER, TAI JUAN	[redacted] M X F
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED
[redacted]	Self X Spouse Child Other
CITY / STATE	8. RESERVED FOR NUCC USE
[redacted]	
ZIP CODE / TELEPHONE (Include Area Code)	
[redacted]	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
9a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO
9b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES X NO PLACE (State) OH
9c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES X NO
9d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)

7. INSURED'S NAME (Last Name, First Name, Middle Initial)
CARTER, TAI JUAN
7. INSURED'S ADDRESS (No., Street)
[redacted]
CITY / STATE
[redacted]
ZIP CODE / TELEPHONE (Include Area Code)
[redacted]
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. INSURED'S DATE OF BIRTH / SEX
[redacted] M X F
b. OTHER CLAIM ID (Designated by NUCC)
c. INSURANCE PLAN NAME OR PROGRAM NAME
SLATER & ZURZ LLP
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 12 01 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 SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. 439 MM DD YY 10 06 15
10 06 15 QUAL. 431	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY
FROM TO
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY
FROM TO
20. OUTSIDE LAB? YES X NO $ CHARGES 0.00
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. S13.4XXD B. S23.3XXD C. S33.8XXD D. M25.461
E. F. G. H.
I. J. K. L.

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 10 28 15 10 28 15	11		20553		A,B,C,	800.00	1			1003892217 NPI
2 10 28 15 10 28 15	11		J1040		A,B,C,	80.00	1			1003892217 NPI
3 11 11 15 11 11 15	11		99213		A,B,C,	150.00	1			1003892217 NPI
4										NPI
5										NPI
6										NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
270796590 X	[redacted]	X YES NO	$ 1030.00	$ 0.00	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (330) 331 7207
SAM N. GHOUBRIAL, MD 12 01 15	AKRON CHIROPRACTOR S ARLINGTON ST AKRON, OH 44306	CLEARWATER BILLING SERVICES LLC P.O BOX 1243 BATH, OH 44210
SIGNED DATE	a. 1669702841	b. 1487982112

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

236538 / Taijuan Carter

Settlement Memorandum

Recovery:

REC	American Family Insurance*	$ 6,000.00
MP	Electric Insurance Company	$ 1,000.00
REC	Preferred Capital Funding	$ 500.00
		$ 7,500.00

DEDUCT AND RETAIN TO PAY:

Kisling, Nestico & Redick, LLC

Clearwater Billing Services, LLC;	$ 50.00
Floros, Dr. Minas; MZ	$ 200.00
P & G Reporting, LLC; inv # 4150	$ 27.50
Summit County filing fee	$ 360.50
AMC Investigations;	$ 50.00
Total Due	$ 688.00

DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron Square Chiropractic	$ 1,350.00
Clearwater Billing Services, LLC	$ 1,300.00
Kisling, Nestico & Redick, LLC	$ 1,350.00
National Diagnostic Imaging Consultants	$ 110.00
Preferred Capital Funding	$ 622.50
Total Due Others	$ 4,732.50

Total Deductions	$ 5,420.50
Total Amount Due to Client	$ 2,079.50
Less Previously Paid to Client	$500.00
Net Amount Due to Client	$ 1,579.50

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, 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: 4/20/15

Name: Taijuan Carter

Firm: Kisling, Nestico & Redick, LLC

1/8/2015 08:39 AM

236538 / Carter, Mr. Taijuan

Settlement Memorandum

Recovery:

MP	Electric Insurance Company	$ 1,000.00
REC	Preferred Capital Funding	$ 500.00
REC	American Family Insurance*	$ 6,000.00
		$ 7,500.00

DEDUCT AND RETAIN TO PAY:

Kisling Legal Group

AMC Investigations;	$ 50.00	
Clearwater Billing Services, LLC; prep fee-MZ	$ 50.00	
Floros, Dr. Minas; MZ	$ 200.00	
P & G Reporting, LLC; inv # 4150/bjd	$ 27.50	**split cost with campanion. ck**
Summit County filing fee/bjd	$ 360.50	**Pd w/ Credit Card**
Total due Kisling Legal Group		$ 688.00

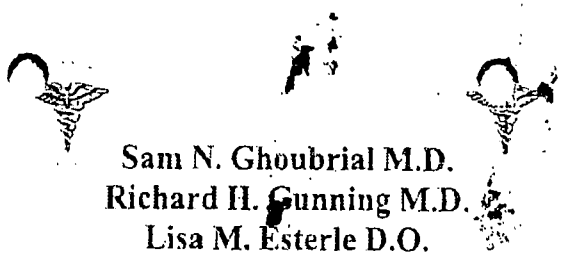
DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron Square Chiropractic	$ 4,840.00	(1,350)
Clearwater Billing Services, LLC	$ 2,480.00	(1,300)
Kisling, Nestico & Redick, LLC	$ 2,333.33	(1,350)
National Diagnostic Imaging Consultants	$ 110.00	
Preferred Capital Funding	$ 622.50	
Total due Others		$ 10,385.83

Total Deductions	2,207	$ 11,073.83
Total Amount Due To Client		$ -3,573.83
Less Previously Paid To Client	- 622.50	$ 0.00
Net Amount Due Client	1,579.50	**$ -3,573.83**

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:** _____



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

MEDICAL LIEN

Re: Patient Kimberly Fields

First date of service: 10-11-17

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 9-20-17.

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: 10-11-17 _____

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.

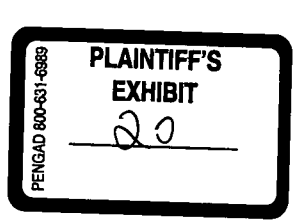
Dated: 10-13-17 _____

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

October 11, 2017
Kimberly Fields

Kimberly is a 47-year-old very pleasant woman involved in a motor vehicle accident on September 20, 2017. She was the restrained front seat passenger of a vehicle when the driver apparently T-boned a parked car. Unfortunately, Kimberly injured her neck and back during the collision. 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 has been in pain since the accident. She has been receiving chiropractic care.

Past Medical History: 1. Atonic bladder with catheterization.

Past Surgical History: 1. Bladder surgery.

Social History: No history of illicit drug use. Positive for tobacco use.

MEDICATIONS: Prophozol for bladder.

ALLERGIES: Motrin.

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: No scars are present. She has guarding and tenderness of the cervical trapezius complex.

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.

Patient Name: Kimberly Fields
Page Two

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 strain.
2. Trapezius muscle strain.

PLAN: I prescribed Zanaflex 4 mg, #30, one at night; and Mobic 15 mg, #30, one a day.

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, two times daily.

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. Ghoubrial M.D./rtd

Progress Notes

Name: Kimberly Fields

10-11-17 1 Kim Fields
Initial visit. (NS)

10/18/17 16 Kim Fields
FOLLOW UP. (NS)

Kimberly Fields October 18, 2017
She is here for a follow-up visit.
EXAM: The patient still has some residual tenderness in her back. She has guarding and tenderness of the right trapezius complex which is fairly significant.
PROCEDURE: I identified four trigger points, one at C6, C7, T1, T2, right side. I injected a total of 1 cc methylprednisolone and 3 cc of Marcaine.
ADDENDUM: After the trigger point injections, she became a little lightheaded. She hadn't eaten all day. We did get some food for her. Her symptoms are completely resolved at this time.
SPECIAL NOTE: I gave the patient more soft touch pads for her TENS unit.
SNG/rtd

Sue Tedds

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, Kimberly Fields, was issued an Ultima 3t Unit on 10/11/17 and instructed how to use this device and given a manual on a **3t Ultima Lot No.** 170228. 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.

Patients Signature 10/11/17
Date

Kimberly Fields
Please print name

Authorized Representative for Clearwater Billing Services, LLC

CLIENT: Kimberly Fields

INSURANCE CO: Allstate

DEFENDANT: Dierre Spaulding

ADJUSTER: Cathy Muczynski

DATE OF LOSS: 09/20/2017

CLAIM NO: 0475724340 6CL

PHYSICIANS:	MEDICAL SPECIALS	AMOUNT
Akron Square Chiropractic	(09/27/2017 - 10/18/2017)	$ 1,135.00
Clearwater Billing Services, LLC	(10/11/2017 - 10/18/2017)	$ 2,160.00
TOTAL MEDICAL SPECIALS:		**$ 3,295.00**

Invoice for Medical Services

Re: Kimberly Fields
Date of Accident: 9/20/17
Date of Birth: [redacted]

Medical services for the above- named client.		**Amount**
10/11/17	See detailed HCFA 1500	$2160.00
10/26/17	Document preparation fee	$50.00
	Total amount due:	**$2210.00**

Please make checks payable to:

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

Tax ID: 27-0796590

KIMBERLY FIELDS [redacted]

HEALTH INSURANCE CLAIM FORM

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

PICA PICA

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

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

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

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

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

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

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

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

CITY [redacted] STATE [redacted]

8. RESERVED FOR NUCC USE

CITY [redacted] STATE [redacted]

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

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: KIMBERLY FIELDS

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 10 26 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.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 9 20 17 QUAL. 431

15. OTHER DATE QUAL. 439 09 20 17

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES 0.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. S16.1XXA B. S23.3XXA C. S16.1XXD D. S23.3XXD
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (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 10 11 17	10 11 17	11		99203		A,B	300.00	1		NPI	1003892217
2 10 11 17	10 11 17	11		E0730		A,B	500.00	1		NPI	1003892217
3 10 18 17	10 18 17	11		99213		C,D	150.00	1		NPI	1003892217
4 10 18 17	10 18 17	11		20553		C,D	1000.00	1		NPI	1003892217
5 10 18 17	10 18 17	11		J1030		C,D	50.00	1		NPI	1003892217
6 10 18 17	10 18 17	11		A4556		C,D	160.00	1		NPI	1003892217

25. FEDERAL TAX I.D. NUMBER 270796590 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 2160.00

29. AMOUNT PAID $ 0.00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SAM N. GHOUBRIAL, MD SIGNED 10 26 17 DATE

32. SERVICE FACILITY LOCATION INFORMATION
AKRON CHIROPRACTOR
S ARLINGTON ST
AKRON, OH 44306
a. 1669702841 b.

33. BILLING PROVIDER INFO & PH # (330) 331-7207
CLEARWATER BILLING SERVICES LLC
P.O BOX 1243
BATH, OH 44210
a. 1487982112 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION | PHYSICIAN OR SUPPLIER INFORMATION | CARRIER

Akron Square Chiropractic
1419 South Arlington Rd.
Akron, OH 44306
330-773-3882
ID#: 31-1528200
Minas Floros DC NPI#: 1306928650
Wednesday November 1, 2017

Patient : KIMBERLY FIELDS [redacted]
Itemized Statement: - 11/01/2017
DOB : [redacted]
Onset date : 09/20/2017

Mail to:
KIMBERLY FIELDS
[redacted]

Insured **Insurance Carrier (primary)**

DOB:
Policy#:

Attorney **Employer**
KNR
3412 WEST MARKET ST
AKRON OH 44333

Current Diagnosis
S13.4XXA Sprain of ligaments of cervical spine, initial encounte
S23.3XXA Sprain of ligaments of thoracic spine, initial encounte
G44.209 Headache (facial pain NOS)
M62.830 Muscle spasm of back

Date	Description	Amount
09/27/17	72050 X-RAY, SPINE, CERVICAL; 4+ VIEWS	$ 200.00
09/27/17	97014 ELECTRIC STIMULATION THERAPY	$ 45.00
09/27/17	97010 APPLICATION, AREAS; HOT/COLD PACKS	$ 30.00
10/02/17	98940 (CMT); SPINAL, 1-2 REGIONS	$ 85.00
10/02/17	97014 ELECTRIC STIMULATION THERAPY	$ 45.00
10/02/17	97010 APPLICATION, AREAS; HOT/COLD PACKS	$ 30.00
10/02/17	97140 59, 52 MANUAL THERAPY, EACH 15 MIN	$ 55.00
10/10/17	98940 (CMT); SPINAL, 1-2 REGIONS	$ 85.00
10/10/17	97014 ELECTRIC STIMULATION THERAPY	$ 45.00
10/10/17	97010 APPLICATION, AREAS; HOT/COLD PACKS	$ 30.00
10/10/17	97140 59, 52 MANUAL THERAPY, EACH 15 MIN	$ 55.00
10/11/17	98940 (CMT); SPINAL, 1-2 REGIONS	$ 85.00
10/11/17	97014 ELECTRIC STIMULATION THERAPY	$ 45.00
10/11/17	97010 APPLICATION, AREAS; HOT/COLD PACKS	$ 30.00
10/11/17	97140 59, 52 MANUAL THERAPY, EACH 15 MIN	$ 55.00
10/18/17	98940 (CMT); SPINAL, 1-2 REGIONS	$ 85.00
10/18/17	97014 ELECTRIC STIMULATION THERAPY	$ 45.00
10/18/17	97010 APPLICATION, AREAS; HOT/COLD PACKS	$ 30.00
10/18/17	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
Payer Payments : $ 0.00

Total Charges : $ 1135.00
Total Received : $ 0.00
Total Adjustment : $ 0.00
Balance (based on search) : $ 1135.00

Summary of Check Requests

Party Name Memo Payee Address	Case Number Debit Account Requestor	Value Code	Amount From To Report?
Fields, Ms. Kimberly Attorney Fees / KMZ Kisling, Nestico & Redick 3412 West Market Street, Akron, OH 44333	274303 Cost Account STOETZER	ATT	$ 464.00 Us Provider No
Fields, Ms. Kimberly Cost Reimbursement / KMZ Kisling, Nestico & Redick 3412 West Market Street, Akron, OH 44333	274303 Cost Account STOETZER	CAR	$ 250.00 Us Provider No
Fields, Ms. Kimberly 22442 Clearwater Billing Services, LLC P.O. Box 1243, Bath, OH 44210-1243	274303 Cost Account STOETZER	DR.	$ 500.00 Us Provider No
Fields, Ms. Kimberly 3970 Akron Square Chiropractic 1419 S. Arlington St., Akron, OH 44306	274303 Cost Account STOETZER	DR.	$ 500.00 Us Provider No
Fields, Ms. Kimberly PI Final Proceeds Fields, Ms. Kimberly [redacted]	274303 Cost Account STOETZER	PIP	$ 500.00 Us Provider No
Fields, Ms. Kimberly 5003 National Diagnostic Imaging Consultants 3414 West Tuscarawas Street, Canton, OH 44708	274303 Cost Account STOETZER	RAD	$ 100.00 Us Provider No

274303 / Kimberly Fields

Settlement Memorandum

Recovery:

REC	Allstate Insurance	$ 2,314.00

DEDUCT AND RETAIN TO PAY:

Kisling, Nestico & Redick

Clearwater Billing Services, LLC	$ 50.00
Floros, Dr. Minas; narrative report	$ 150.00
AMC Investigations	$ 50.00
Total Due	$ 250.00

DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron Square Chiropractic	($1,135.00)	$ 500.00
Clearwater Billing Services, LLC	($2,160.00)	$ 500.00
Kisling, Nestico & Redick	($771.33)	$ 464.00
National Diagnostic Imaging Consultants	($110.00)	$ 100.00
Total Due Others		$ 1,564.00

Total Deductions	$ 1,814.00
Total Amount Due to Client	$ 500.00
Less Previously Paid to Client	~~$ 0.00~~
Net Amount Due to Client	**$ 500.00**

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 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.

Date: 3-20-18

Name: (X) _____
Kimberly Fields

Firm: _____
Kisling, Nestico & Redick

274303 / Fields, Ms. Kimberly

Settlement Memorandum

Recovery:

REC	Allstate Insurance	$ 2,314.00
		$ 2,314.00

DEDUCT AND RETAIN TO PAY:

Kisling Legal Group

AMC Investigations;	$ 50.00	
Clearwater Billing Services, LLC; 22442/lml	$ 50.00	
Floros, Dr. Minas; narrative report	$ 150.00	
Total due Kisling Legal Group		$ 250.00

DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron Square Chiropractic	$ 1,135.00	500
Clearwater Billing Services, LLC	$ 2,160.00	500
Kisling, Nestico & Redick	$ 771.33	464
National Diagnostic Imaging Consultants	$ 110.00	100
Total due Others		$ 4,176.33

Total Deductions	$ 4,426.33
Total Amount Due To Client	$ -2,112.33
Less Previously Paid To Client	$ 0.00
Net Amount Due Client	**$ -2,112.33**

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. If any amount was witheld 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 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.

Date: _____ **Name:** _____

- Ref by former client Devin
- PD was $ 520 repair, NO MP

3/15/2018 07:54 AM

274303 / Fields, Ms. Kimberly

Settlement Memorandum

Recovery:

REC	Allstate Insurance	$ 2,314.00
		$ 2,314.00

DEDUCT AND RETAIN TO PAY:

Kisling Legal Group

AMC Investigations;	$ 50.00	
Clearwater Billing Services, LLC; 22442/lml	$ 50.00	
Floros, Dr. Minas; narrative report	$ 150.00	
Total due Kisling Legal Group		$ 250.00

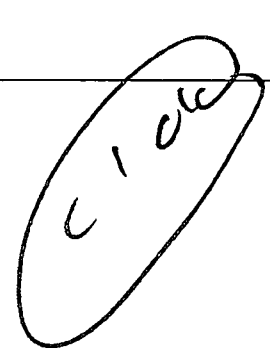
DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron Square Chiropractic	$ 500.00	
Clearwater Billing Services, LLC	$ 500.00	
Kisling, Nestico & Redick	$ 464.00	
National Diagnostic Imaging Consultants	$ 100.00	
Total due Others		$ 1,564.00

Total Deductions	$ 1,814.00
Total Amount Due To Client	$ 500.00
Less Previously Paid To Client	$ 0.00
Net Amount Due Client	**$ 500.00**

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. If any amount was witheld 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 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.

Date: _____ **Name:** _____



Sam N. Ghoubrial M.D.
Richard H. Gunning M.D.
Joshua M. Jones M.D.
MEDICAL ASSIGNMENT

Re: Patient Monique Norris

First date of service: 8/2/13

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 7/29/13.

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.

X Dated: 8/2/13 X Monique Norris

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: _____

Kisling, Nestico & Redick, LLC
Attorneys at Law

@ 8-2-13 TS

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

1134 Brown Street Suite 1A Akron, Ohio 44301
Phone: (330) 331-7207
Fax: (330) 331-7567

PENGAD 800-631-6989

PLAINTIFF'S EXHIBIT 21

Richard H. Gunning, M.D.
1134 Brown Street, Suite A1
Akron, Ohio 44301
PHONE 330-331-7207
FAX 330-331-7567

August 2, 2013
Monique Norris

Monique is a 26-year-old African-American female who was involved in a motor vehicle accident on July 29, 2013. She was the seat-belted driver who broadsided a vehicle running through a red light. EMS came on the scene and took her to Akron General where x-rays were done of her left shoulder and left hip and no findings were noted. She was discharged on no medications. She saw the chiropractor who did x-rays and told her she had loss of the normal lordotic curve in her neck. She had sciatica and decreased disc spaces in her lower spine as well as uneven hips.

Past Medical History: 1. Endometriosis for which she will have a hysterectomy on August 12. If she starts any antiinflammatories she will have to stop them on August 5 and start them back up after she is cleared following surgery.

Social History: Unremarkable.

MEDICATIONS: None.

ALLERGIES: Percocet allergy. She cannot tolerate Vicodin.

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: Thyroid gland could not be palpated. No evidence of any cervical lymphadenopathy. No JVD is noted. She has reproducible pain in the right side of her neck when she turns her head away from it.

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.

EXHIBIT A

Patient Name: Monique Norris
Page Two

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

BACK: No scars are present. She has pain in the lower back.

UPPER EXTREMITIES: Shoulders, wrists and elbows: demonstrate no scars or gross deformities. +2 radial pulses throughout. She has tenderness about her left shoulder joint, lateral, posterior and anterior. There is reproducible pain with movement of her shoulder in all directions. This is less so in the right shoulder.

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

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. Lumbosacral strain.
2. Cervical strain.
3. Left shoulder sprain.

PLAN: She declined shots. I prescribed Flexeril 10 mg, #30, one PO b.i.d. with no refills; and ibuprofen 800 mg, one PO b.i.d. #30. She is to stop the ibuprofen on August 5 and not take any until after her gynecologist has cleared her following the hysterectomy on August 12. I will see the patient back in two weeks.

SPECIAL NOTE: I provided the patient with a TENS unit. I gave instructions on its use.

Richard H. Gunning, M.D./rtd

NAME: Monique Norris

DATE	PROGRESS NOTES
8-2-13	MVA Initial Visit (EM)
14 Monique Norris	Flores
8/16/13	no show

Invoice for Medical Services

Re: Monique Norris
Date of Accident: 7/29/13
Date of Birth: [redacted]

Medical services for the above- named client.		**Amount**
8/2/13	See detailed HCFA 1500	$850.00
9/23/13	Document preparation fee	$50.00
	Total amount due:	**$900.00**

Please make checks payable to:

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

Tax ID: 27-0796590

CLIENT: Monique Norris

INSURANCE CO: Nationwide Insurance Company

DEFENDANT: Branson Price

ADJUSTER: Michael Starr

DATE OF LOSS: 7/29/2013

CLAIM NO: 99913011473

PHYSICIANS	MEDICAL SPECIALS	AMOUNT
Sam N. Ghoubrial, M.D.	(8/2/2013)	$ 850.00
CNS Center for Neuro and Spine	(10/30/2013)	$ 260.00
HOSPITALS:		
Akron General Medical Center	(7/29/2013)	$ 2,084.13
General Emergency Medical Specialists	(7/29/2013)	$ 230.00
Radiology & Imaging Services	(7/29/2013)	$ 58.00
American Medical Response OH	(7/29/2013)	$ 927.68
PHYSICAL THERAPY:		
Akron Square Chiropractic	(7/31/2013 - 9/4/2013)	$ 724.00
National Diagnostic Imaging	(8/16/2013)	$ 110.00
TOTAL MEDICAL SPECIALS:		**$ 5,243.81**

KNR004246

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

CARRIER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

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

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

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

3. PATIENT'S BIRTH DATE [redacted] SEX F X

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

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

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

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

CITY [redacted] STATE [redacted]

8. PATIENT STATUS [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) YES | NO X

a. INSURED'S DATE OF BIRTH [redacted] SEX M | F X

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: KISLING, NESTICO & REDICK

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE 09/23/13

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY 7 29 2013

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO X $ CHARGES

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

1. 846.0
2. 847.1
3. 840.9
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 08/02/13	08/02/13	11		99204		1,2,3	$350.00	1		NPI	150885691
2 08/02/13	08/02/13	11		E0730		1,2,3	$500.00	1		NPI	150885691
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER 270796590 SSN EIN

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $850.00

29. AMOUNT PAID $0.00

30. BALANCE DUE $850.00

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
SIGNED 09/23/13 DATE

32. SERVICE FACILITY LOCATION INFORMATION
HANCHRIST LLC
1134 BROWN ST
AKRON, OH 44301
a. 166970284 b.

33. BILLING PROVIDER INFO & PH # (330) 331-7207
CLEARWATER BILLING SERVICES
P.O BOX 1243
BATH, OH 44210
a. 148798211 b.

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

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

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)
#14710 - Medical Arts Press
Use with Envelope #14145 (gummed) or #14146 (self-seal)

KMP0004250

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

Tax I.D.31-1528200

Statement Date	Page
11/6/2013	1

Monique Norris
% KISLING NESTICO & REDICK
3412 WEST MARKET ST
AKRON, OH 44333

Diagnosis
847.0
847.2
847.1
728.85

Chart Number
NORMO002

Date	Description	Procedure Code	Amount
Date of Loss: 7/29/2013	**Previous Balance**		**0.00**
Patient: Monique Norris	Chart #: NORMO002	Case Description: mva	
7/31/2013	TEN POINT EXAM	10 PT	0.00
7/31/2013	X-ray Cervical AP& LAT, 2 or 3 views	72040	120.00
7/31/2013	X-ray Lumbosacral, AP & Lat	72100	80.00
8/1/2013	Spinal Manipulation 3-4 regions	98941	77.00
8/1/2013	Electrical Muscle Stimulation	97014	45.00
8/1/2013	Hot/Cold Packs to one or more areas	97010	20.00
8/1/2013	TriggerPoint/Massage(Distinct/Reduced)	97124-5952	40.00
8/8/2013	Electrical Muscle Stimulation	97014	45.00
8/8/2013	Traction, Mechanical	97012	45.00
8/8/2013	TriggerPoint/Massage(Distinct/Reduced)	97124-5952	40.00
9/4/2013	Spinal Manipulation 3-4 regions	98941	77.00
9/4/2013	Electrical Muscle Stimulation	97014	45.00
9/4/2013	Unlisted Modality	97039	50.00
9/4/2013	TriggerPoint/Massage(Distinct/Reduced)	97124-5952	40.00

Total Charges	Total Payments	Total Adjustments	Balance Due
$724.00	$0.00	$0.00	**724.00**

KNR004301

5/13/2014 02:50 PM

232154 / Norris, Ms. Monique

Settlement Memorandum

Recovery:

MP	Motorists Insurance Group *	$ 1,000.00
REC	Nationwide Insurance*	$ 4,982.55
		$ 5,982.55

DEDUCT AND RETAIN TO PAY:

Kisling Legal Group

Akron General Medical Center; 412140	$ 40.89	
Akron General Medical Center; Billing Fee /jks	$ 6.00	
Clearwater Billing Services, LLC; # 5299 /jks	$ 50.00	
First Healthcare; #000412140-jks	$ 12.00	
Floros, Dr. Minas;	$ 200.00	
Mercy Health Partners*; /bc	$ 15.00	
MRS Investigations, Inc.;	$ 50.00	
Professional Receivables Control, Inc.*; 336474	$ 16.00	
Total due Kisling Legal Group		$ 389.89

DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron Square Chiropractic	$ 724.00	
CNS Center for Neuro and Spine	$ 260.00	
Ghoubrial, M.D., Dr. Sam N.	$ 850.00	
Kisling, Nestico & Redick, LLC	$ 1,660.85	
Liberty Capital Funding LLC	$ 968.77	
National Diagnostic Imaging Consultants	$ 110.00	
Ohio Tort Recovery Unit*	$ 506.75	
Radiology & Imaging Services*	$ 58.00	
Total due Others		$ 5,138.37

Total Deductions	$ 5,528.26
Total Amount Due To Client	$ 454.29
Less Previously Paid To Client	$ 500.00
Net Amount Due Client	$ -45.71

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:** _____

232154 / Monique Norris

Settlement Memorandum

Recovery:

REC	Motorists Mutual Insurance Company	$ 250.00
MP	Motorists Insurance Group	$ 1,000.00
REC	Nationwide Insurance*	$ 4,982.55
REC	Liberty Capital Funding LLC	$ 500.00
		$ 6,732.55

DEDUCT AND RETAIN TO PAY:

Kisling, Nestico & Redick, LLC		
Akron General Medical Center	$ 6.00	
Clearwater Billing Services, LLC	$ 50.00	
First Healthcare	$ 12.00	
Floros, Dr. Minas	$ 200.00	
Mercy Health Partners	$ 15.00	
MRS Investigations, Inc.	$ 50.00	
Professional Receivables Control, Inc.	$ 16.00	
Akron General Medical Center	$ 40.89	
Total Due	$ 389.89	

DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron Square Chiropractic	$ 500.00	
Clearwater Billing Services, LLC	$ 600.00	
CNS Center for Neuro and Spine	$ 260.00	
Kisling, Nestico & Redick, LLC	($2,077.51) $ 1,750.00	
Liberty Capital Funding LLC	$ 800.00	
National Diagnostic Imaging Consultants	$ 80.00	
Ohio Tort Recovery Unit*	$ 506.75	
Total Due Others	$ 4,496.75	

Total Deductions	$ 4,886.64
Total Amount Due to Client	$ 1,845.91
Less Previously Paid to Client	$ 1,500.00
Net Amount Due to Client	$ 345.91

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: 5/25/14

Name: Monique Norris

Firm: Kisling, Nestico & Redick, LLC

KNR004235

232154 / Monique Norris

Settlement Memorandum

Recovery:

REC	Motorists Mutual Insurance Company	$ 250.00
MP	Motorists Insurance Group	$ 1,000.00
REC	Nationwide Insurance*	$ 4,982.55
REC	Liberty Capital Funding LLC	$ 500.00
		$ 6,732.55

DEDUCT AND RETAIN TO PAY:

Kisling, Nestico & Redick, LLC		
Akron General Medical Center	$ 6.00	
Clearwater Billing Services, LLC	$ 50.00	
First Healthcare	$ 12.00	
Floros, Dr. Minas	$ 200.00	
Mercy Health Partners	$ 15.00	
MRS Investigations, Inc.	$ 50.00	
Professional Receivables Control, Inc.	$ 16.00	
Akron General Medical Center	$ 40.89	
Total Due	$ 389.89	

DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron Square Chiropractic	$ 500.00	
Clearwater Billing Services, LLC	$ 600.00	
CNS Center for Neuro and Spine	$ 260.00	
Kisling, Nestico & Redick, LLC	($2,077.51) $ 1,750.00	
Liberty Capital Funding LLC	$ 800.00	
National Diagnostic Imaging Consultants	$ 80.00	
Ohio Tort Recovery Unit*	$ 506.75	
Total Due Others	$ 4,496.75	

Total Deductions	$ 4,886.64
Total Amount Due to Client	$ 1,845.91
Less Previously Paid to Client	$ 500.00
Net Amount Due to Client	$ 1,345.91

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: _____
Monique Norris

Firm: _____
Kisling, Nestico & Redick, LLC

KNR004237

5/13/2014 03:45 PM

RPH

232154 / Norris, Ms. Monique

Settlement Memorandum

Recovery:

MP	Motorists Insurance Group *	$ 1,000.00
REC	Nationwide Insurance*	$ 4,982.55
REC	Liberty Capital Funding LLC	$ 500.00
		$ 6,482.55

DEDUCT AND RETAIN TO PAY:

Kisling Legal Group

Akron General Medical Center; 412140	$ 40.89
Akron General Medical Center; Billing Fee /jks	$ 6.00
Clearwater Billing Services, LLC; # 5299 /jks	$ 50.00
First Healthcare; #000412140-jks	$ 12.00
Floros, Dr. Minas;	$ 200.00
Mercy Health Partners*; /bc	$ 15.00
MRS Investigations, Inc.;	$ 50.00
Professional Receivables Control, Inc.*; 336474	$ 16.00
Total due Kisling Legal Group	$ 389.89

Approved

SM

DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron Square Chiropractic	~~$724.00~~ 500.00	4 jks
CNS Center for Neuro and Spine	$ 260.00	
Clearwater ~~Ghoubrial, M.D., Dr. Sam N.~~	~~$850.00~~ 600.00	
Kisling, Nestico & Redick, LLC	$ 1,660.85	
Liberty Capital Funding LLC	$ 800.00	
National Diagnostic Imaging Consultants	~~$110.00~~ 80.00	
Ohio Tort Recovery Unit*	$ 506.75	
Radiology & Imaging Services*	50 $ 58.00	
Total due Others	$4,465.00	~~$4,969.60~~ $4,855.49

Total Deductions		~~$ 5,359.49~~
Total Amount Due To Client	$1,627.00	~~$ 1,123.06~~
Less Previously Paid To Client	$1,127.00	$ 500.00
Net Amount Due Client	$1,185.06	~~$ 623.06~~

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:** _____

Hates Floros. Wants him investigated for fraud"

RPH

KJC

5/16/2014 02:05 PM

232154 / Norris, Ms. Monique

Settlement Memorandum

Recovery:

MP	Motorists Insurance Group *	$ 1,000.00
REC	Motorists Mutual Insurance Company	$ 250.00
REC	Nationwide Insurance*	$ 4,982.55
REC	Liberty Capital Funding LLC	$ 500.00
		$ 6,732.55

DEDUCT AND RETAIN TO PAY:

Kisling Legal Group

Akron General Medical Center; 412140	$ 40.89	
Akron General Medical Center; Billing Fee /jks	$ 6.00	
Clearwater Billing Services, LLC; # 5299 /jks	$ 50.00	
First Healthcare; #000412140-jks	$ 12.00	
Floros, Dr. Minas;	$ 200.00	
Mercy Health Partners*; /bc	$ 15.00	
MRS Investigations, Inc.;	$ 50.00	
Professional Receivables Control, Inc.*; 336474	$ 16.00	
Total due Kisling Legal Group		$ 389.89

DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron Square Chiropractic	$ 500.00	
Clearwater Billing Services, LLC	~~$ 850.00~~ 600.00	
CNS Center for Neuro and Spine	$ 260.00	
Kisling, Nestico & Redick, LLC	~~$ 2,077.51~~ 1750.00	
Liberty Capital Funding LLC	$ 800.00	
National Diagnostic Imaging Consultants	~~$ 110.00~~ 80.00	
Ohio Tort Recovery Unit*	$ 506.75	
Radiology & Imaging Services*	$ 58.00	
Total due Others	$1,554.75 ~~$4,124.51~~	~~$ 5,162.26~~ $4944.64
Total Deductions		~~$ 5,552.15~~
Total Amount Due To Client		~~$ 1,180.40~~ $1787.91
Less Previously Paid To Client	1287.91	$ 500.00
Net Amount Due Client	$1345.91 ~~$1,177.51~~	~~$ 680.40~~

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:** _____

KNR004238

5/13/2014 02:43 PM

232154 / Norris, Ms. Monique

Settlement Memorandum

Recovery:

MP	Motorists Insurance Group *	$ 1,000.00
REC	Nationwide Insurance*	$ 4,982.55
		$ 5,982.55

DEDUCT AND RETAIN TO PAY:

Kisling Legal Group

Akron General Medical Center; 412140	$ 40.89	
Akron General Medical Center; Billing Fee /jks	$ 6.00	
Clearwater Billing Services, LLC; # 5299 /jks	$ 50.00	
First Healthcare; #000412140-jks	$ 12.00	
Floros, Dr. Minas;	$ 200.00	
Mercy Health Partners*; /bc	$ 15.00	
MRS Investigations, Inc.;	$ 50.00	
Professional Receivables Control, Inc.*; 336474	$ 16.00	
Total due Kisling Legal Group		$ 389.89

DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron Square Chiropractic 5 wks,	$ 724.00	
CNS Center for Neuro and Spine	$ 260.00	
Ghoubrial, M.D., Dr. Sam N.	$ 850.00	
Kisling, Nestico & Redick, LLC	$ 1,660.85	
Liberty Capital Funding LLC	$ 220.00	
National Diagnostic Imaging Consultants	$ 110.00	
Ohio Tort Recovery Unit*	$ 506.75	
Radiology & Imaging Services*	$ 58.00	
Total due Others		$ 4,389.60

Total Deductions	$ 4,779.49
Total Amount Due To Client	$ 1,203.06
Less Previously Paid To Client	$ 0.00
Net Amount Due Client	**$ 1,203.06**

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:** _____

KNR004239

5/4/2011 12:13 PM FROM: Fax TO: 8 330 925 9030 PAGE: 002 OF 004

MAY-02-2011 09:13AM FROM-Sam Ghoubrial MD 3309259030 T-009 P.002/009 F-165

[redacted]

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

Re: Patient Richie A Harbour

First date of service: 4/27/11

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 4/15/2011.

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: 4/27/11 [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: _____ [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)

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

PENGAD 800-631-6989

PLAINTIFF'S EXHIBIT 22

CLIENT: Richard A Harbour

INSURANCE CO: Erie Insurance Group

DEFENDANT: Ray A Kalamets

ADJUSTER: Jeanne Sprout

DATE OF LOSS: 4/15/2011

CLAIM NO: 010710306304

PHYSICIANS	**MEDICAL SPECIALS**	**AMOUNT**
Rolling Acres Chiropractic Inc	(4/18/2011 - 10/6/2011)	$ 5,386.00
Sam N. Ghoubrial, M.D.	(4/27/2011 - 6/22/2011)	$ 3,110.00
HOSPITALS:		
Akron General Medical Center	(4/16/2011 - 4/16/2011)	$ 342.00
General Emergency Medical Specialists, Inc.	(4/16/2011 - 4/16/2011)	$ 130.00
OTHERS:		
Akron General Medical Center	(6/28/2011 - 6/28/2011)	$ 2,470.00
TOTAL MEDICAL SPECIALS:		**$11,438.00**

KNR04592

Clearwater Billing Services, LLC

Patient Name: Richie Harbour DOA: 4-15-11

Attorney: KNR

Diagnosis:

1. 847.0
2. 847.2
3.
4.

*Initial Visit: 99204 DOS: 4-27-11

DX: 1 ; 2 ; ____ ; ____
SNG RHG FDL

Procedure

20552 20553 97032 97010

Medication

J1020 J1030 J1040

DME L0631 E0730

*Follow- Up Visit: 99213 DOS: 5-11-11

DX: 1 ; 2 ; ____ ; ____
SNG RHG FDL

Procedure

20552 20553 97032 97010

Medication

J1020 J1030 J1040

DME L0631 E0730

*Follow- Up Visit: 99213 DOS: 5-25-11

DX: 1 ; 2 ; ____ ; ____
SNG RHG FDL

Procedure

20552 C&L 20553 97032 97010

Medication

J1020 J1030 J1040

DME L0631 E0730

*Follow- Up Visit: 99213 DOS: 6-8-11

DX: 1 ; 2 ; ____ ; ____
SNG RHG FDL

Procedure

20552 20553 2 97032 97010

Medication

J1020 J1030 J1040

DME L0631 E0730

*Follow- Up Visit: 99213 DOS: 6-22-11

DX: 1 ; 2 ; ____ ; ____
SNG RHG FDL

Procedure

20552 20553 97032 97010

Medication

J1020 J1030 J1040

DME L0631 E0730

*Follow- Up Visit: 99213 DOS: _____

DX: ____ ; ____ ; ____ ; ____
SNG RHG FDL

Procedure

20552 20553 97032 97010

Medication J1020 J1030 J1040

DME L0631 E0730

Sam N. Ghoubrial M.D., Inc.
1134 Brown Street, Suite A1
Akron, Ohio 44301
330-925-1500
330-925-9030

April 27, 2011
Richie Harbour

Richie is a 30-year-old gentleman who was involved in a motor vehicle accident on April 15, 2011. He was the seat-belted driver of a vehicle that was struck by another vehicle adjacent to him. He states the vehicle next to him was in the right hand lane and abruptly turned left, striking the passenger side of his vehicle. As a result of the impact, he injured his back and neck. He went to the emergency room at Akron General where he was treated and released. On a scale of 1 to 10, his pain is a 6/10. He suffers from cerebral palsy and already has considerable problems with movement and spasm. This has made things considerably worse. He has difficulty with range of motion and walks with the aid of a walker. Since the accident, he is unable to perform his routine ADLs and work as a security officer. He has been experiencing headaches since the accident.

Past Medical History: 1. Cerebral palsy.

Social History: Unremarkable.

MEDICATIONS: Flexeril.

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. He has some guarding and spasm of the cervical spine with decreased range of motion on flexion and extension.

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.

Patient Name: Richie Harbour
Page Two

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

BACK: No scars are present. He has severe decreased range of motion of the lumbar spine. He has some guarding and spasm of the right paraspinal musculature. He also has some spasm on the left side with reproducible pain and tenderness.

UPPER EXTREMITIES: Shoulders, wrists and elbows: demonstrate no scars. +2 radial pulses throughout. He has some rigidity and decreased range of motion at the upper extremities bilaterally secondary to cerebral palsy. He has difficulty with fine manipulation of his hands.

LOWER EXTREMITIES: No venous insufficiency or edema. +2 pulses throughout. Ankles and hips demonstrate no gross abnormalities on exam. He has decreased range of motion of the lower extremities secondary to cerebral palsy. He has significant decreased range of motion at the hips and knees secondary to cerebral palsy with dystonia noted.

MUSCULOSKELETAL: The patient is unable to get on and off the exam table. The patient has an unsteady gait and walks with the aid of a walker. He has an antalgic gait with considerable bowing at the knees. He has some rigidity to his range of motion of the upper and lower extremities. He has some dystonia. He has some atrophy of the major muscle groups of the lower extremities.

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. Cerebral palsy.
2. History of dystonia.
3. Cervical strain.
4. Acute lumbar strain.
5. Exacerbation of dystonia.

PLAN: I put him on Flexeril #30, one b.i.d. to t.i.d.; ibuprofen 800 mg, one b.i.d. with food PRN, #30; and Vicodin #60, one pill 3 times daily PRN. I cautioned him that the medications can make him drowsy.

Sam N Ghoubrial MD

Sam N. Ghoubrial M.D./rtd

NAME: Richie Harbour

DATE	PROGRESS NOTES
1 Richie A Harbour 230 245	
4-27-11	MVA Initial Visit (SNG)
6 Richie A Harbour 230 245	
5-11-11	MVA follow-up (SN)

Richie Harbour May 11, 2011
He comes in for a follow-up visit. He continues to have tightness in his lower back and neck.
EXAM: He has persistent discomfort on flexion and extension. He has loss of lordosis to his lumbar spine with significant pain.
PLAN: He tells me that the Flexeril is working, the ibuprofen is working but the Vicodin isn't really killing his pain. I will give him a prescription for Percocet 5/325 mg, #60, one pill four times a day as needed. He will continue the Flexeril and ibuprofen as before. I cautioned him about sedation while taking Percocet. He knows about this. If he continues to have pain, I will probably give him some trigger point injections. SNG/rtd

12 Richie A Harbour 230 245	
5/25/11	MVA f/u (MC)

Richie Harbour May 25, 2011
He comes in today for a follow-up visit.
EXAM: He still has guarding and tenderness of the right cervical and right lower lumbar region with significant spasm.
PROCEDURE: I talked with him about the risks and benefits of trigger point injections. I identified two trigger points, one at C7 and one at L3, right side, and injected each with 1 cc of methylprednisolone and Marcaine under sterile technique.
PLAN: I refilled his Percocet 5/325 mg, #60, one pill four times a day; Flexeril 10 mg, #14, one at night; and Motrin 800 mg, #30, one b.i.d. No refills.
SNG/rtd

NAME: Richie Harbour

DATE	PROGRESS NOTES

20 Richie Harbour | 220 | 215.

6/8/11 MVA follow-up ON

Richie Harbour June 8, 2011

He comes in today for a follow-up visit. He got tremendous relief from the trigger point injections but unfortunately has had a recurrence over the past couple of day in his lower back. The trigger point injection in his neck was very beneficial. Unfortunately, he has a lot of guarding and tenderness to his lumbar spine.

PROCEDURE: I identified two trigger points at L2 and two trigger points at L5. I injected all four trigger points with 1/2 cc of methylprednisolone and Marcaine under sterile technique. He tolerated the injections well.

PLAN: I refilled his Percocet, Motrin and Flexeril as before. I will check on him again in two weeks.

John R. Auch MD SNG/rtd

Richie Harbour | L35 | WS 245

6/22/11 follow-up

Richie Harbour June 22, 2011

He comes in today for a follow-up visit. His neck is better but the lumbar spine is still giving him some trouble. I think an MRI is probably warranted. Dr. Auch is going to order this.

EXAM: He still has some guarding and tenderness of the lumbar spine although this is considerably better based on my exam. His range of motion is still somewhat limited.

PLAN: I refilled his meds as before: Percocet #60, one pill four times a day; Motrin 800 mg, #30, one b.i.d.; and Flexeril 10 mg, #14, one at night. I also gave him a **DermaStim TENS unit.**

SNG/rtd

John R. Auch MD

4/25/2012

214858 / Richard A Harbour

Settlement Memorandum

Recovery:

REC	Erie Insurance	$ 20,000.00
		$ 20,000.00

DEDUCT AND RETAIN TO PAY:

Kisling, Nestico & Redick, LLC	
Akron General Medical Center **;	$ 31.23
Akron General Medical Center **; Records/KN	$ 34.38
AMC Investigations;	$ 50.00
Clearwater Billing Services, LLC;	$ 50.00
Akron General Health System;	$ 1.50
Total Due	$ 167.11

DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron General Medical Center **	RAH	$ 2,470.00
Akron General Medical Center **	RAH	$ 342.00
General Emergency Medical Specialists, Inc.*	RAH	$ 130.00
Ghoubrial, M.D., Dr. Sam N.		$ 2,000.00
Kisling, Nestico & Redick, LLC		$ 4,700.00
Rolling Acres Chiropractic Inc		$ 3,700.00
Total Due Others		$ 13,342.00

Total Deductions	$ 13,509.11
Total Amount Due to Client	$ 6,490.89

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: X 4/25/12

Name: X
Richard A Harbour

Firm:
Kisling, Nestico & Redick, LLC

KNR04589

3/20/2019

214858 / Richard A Harbour

Settlement Memorandum

Recovery:

REC	Erie Insurance	$ 20,000.00
		$ 20,000.00

DEDUCT AND RETAIN TO PAY:

Kisling, Nestico & Redick, LLC

Akron General Medical Center **;	$ 31.23
Akron General Medical Center **; Records/KN	$ 34.38
AMC Investigations;	$ 50.00
Clearwater Billing Services, LLC;	$ 50.00
Akron General Health System;	$ 1.50
Total Due	$ 167.11

DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron General Medical Center **	$ 2,470.00
Akron General Medical Center **	$ 342.00
General Emergency Medical Specialists, Inc.*	$ 130.00
Ghoubrial, M.D., Dr. Sam N.	$ 2,000.00
Kisling, Nestico & Redick, LLC	$ 4,700.00
Rolling Acres Chiropractic Inc	$ 3,700.00
Total Due Others	$ 13,342.00

Total Deductions	$ 13,509.11
Total Amount Due to Client	$ 6,490.89

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: _____

Richard A Harbour

Firm: _____

Kisling, Nestico & Redick, LLC

KNR04590

214858 / Richard A Harbour

Settlement Memorandum

Recovery:

REC	Erie Insurance	$ 20,000.00
		$ 20,000.00

DEDUCT AND RETAIN TO PAY:

Kisling, Nestico & Redick, LLC		
Akron General Medical Center	$ 31.23	
Akron General Medical Center	$ 34.38	
AMC Investigations;	$ 50.00	
Clearwater Billing Services, LLC	$ 50.00	
Akron General Health System	$ 1.50	
Total Due	$ 167.11	

DEDUCT AND RETAIN TO PAY TO OTHERS:

Akron General Medical Center	$ 2,470.00	
Akron General Medical Center	$ 342.00	
General Emergency Medical Specialists, Inc.	$ 130.00	
Dr. Sam N. Ghoubrial, M.D.	$ 2,300.00	
Kisling, Nestico & Redick, LLC	$ 6,666.66	
Rolling Acres Chiropractic Inc	$ 4,000.00	
Total Due Others	$ 15,908.66	

Total Deductions	$ 16,075.77
Total Amount Due to Client	$ 3,924.23
Less Previously Paid to Client	$ 0.00
Net Amount Due to Client	$ 3,924.23

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: _____

Richard A Harbour

Firm: _____

Kisling, Nestico & Redick, LLC

3/20/2019

214858 / Ray A Kalamets

Settlement Memorandum

Recovery:

DEDUCT AND RETAIN TO PAY:

Kisling, Nestico & Redick, LLC	
AMC Investigations;	$ 50.00
Total Due	$ 50.00

DEDUCT AND RETAIN TO PAY TO OTHERS:

Total Due Others	

Total Deductions	$ 50.00
Total Amount Due to Client	$ -50.00
Less Previously Paid to Client	$ 0.00
Net Amount Due to Client	$ -50.00

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 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: _____

Ray A Kalamets

Firm: _____

Kisling, Nestico & Redick, LLC

Sam N. Ghoubrial M.D.
Richard H. Gunning M.D.
Joshua M. Jones M.D.

MEDICAL LIEN

Re: Patient JALWAN CARTER

First date of service: 12/18/13

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 12/18/13.

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: 12/18/13

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: 1-20-14

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)

215 East Waterloo Road, Suite 12, Akron, Ohio 44319
Phone: (330) 331-7207
Fax: (330) 331-7567

PLAINTIFF'S EXHIBIT 18

PENGAD 800-631-6989

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

December 18, 2013
Taijuan Carter

Taijuan is a 38-year-old gentleman who was involved in a motor vehicle accident on December 15, 2013. He was the seat-belted driver of a vehicle struck by a car that pulled out of a parking space and struck the passenger side of his vehicle. As a result of the impact, he injured his neck and back. On a scale of 1 to 10, his pain is 9. He has difficulty twisting, turning and bending, and trouble sleeping. He has difficulty performing his activities of daily living. He has pain on a day to day basis. He has been getting chiropractic care but he continues to be in pain.

Past Medical History: Unremarkable.

Past Surgical History: Unremarkable.

Social History: No history of illicit drug use. He is single.

MEDICATIONS: None.

ALLERGIES: NKDA. Seasonal allergies.

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

SPINE/BACK: No scars are present. He has guarding and tenderness of the cervical and upper thoracic spine with pain on flexion and extension. He has reproducible pain and discomfort in the lumbar spine with loss of lordosis of the lumbar spine with guarding and tenderness.

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.

Patient Name: Taijuan Carter
Page Two

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. Cervicothoracic strain.
2. Lumbar strain.

PROCEDURE: I identified six trigger points, two at C4, two at C7, and two at T2. I injected each with 1/2 cc of methylprednisolone and Marcaine under sterile technique. He tolerated the injections well.

PLAN: I prescribed Norco 5/325 mg, #30, 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. Ghoubrial M.D./rtd

PROGRESS NOTE

NAME: Taijuan Carter

14 Taijuan Carter	
12/18/13	Initial Visit
17 Taijuan Carter	
1/3/14	follow Up TS

Taijuan Carter January 3, 2014

The patient is here for a follow-up visit. He still has exquisite pain in his neck and upper back. and lower back. On a scale of 1 to 10, his pain is rated as 9 out of 10. He said he hasn't had any improvement over the past few weeks and says the Norco doesn't touch his pain, it only makes him sick. He had some trigger point injections at his last visit.

EXAM: The patient has tenderness throughout the cervical and upper thoracic regions down through T4 with trigger points at T4 bilaterally. He has some mild tenderness at L3 bilaterally in the paraspinal musculature.

IMPRESSION: 1. Cervicothoracic and lumbar strain.

PLAN: He said Norco isn't touching his pain so we will give a prescription for Percocet 5/325 mg, #30, one PO b.i.d. PRN with no refills. I refilled his Motrin and Flexeril #30 of each, one PO b.i.d. PRN with no refills. I will see the patient back in two weeks. He will continue with the chiropractic therapy.

Joshua M. Jones, M.D./rtd

NAME: Taijuan Carter

DATE	PROGRESS NOTES				
18 Taijuan Carter	7:55				

1-17-14 Follow up

Taijuan Carter January 17, 2014

The patient is here for a follow-up visit. He said the shots he got initially actually seemed to make things worse rather than better. The Percocet works better than Norco. He still has significant pain, tenderness and tightness in his neck and trapezius muscles bilaterally. He says the roller table at the chiropractor's office just doesn't seem to reach that part as well, possibly for several reasons. I recommended inching down the table a bit and trying to lie flatter. He is still using Icy Hot. It may also help to have someone massage that area for him and reach what the roller table does not.

PLAN: I refilled his medications: Percocet 5/325 mg, Flexeril 10 mg, and ibuprofen 800 mg, #30 of each, a two week supply with no refills. I will see the patient back in two weeks. He will continue with the chiropractor.

RHG/rtd

5 Taijuan Carter						

1/31/14 MVA Follow up (EH)

Tens

Taijuan Carter January 31, 2014

The patient is here for a follow-up visit. He still has quite a bit of pain in the same areas. He declined shots because they really seemed to make things worse rather than better. The medications do help. He is still with the chiropractor. He would like a TENS unit.

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

PLAN: I refilled his medications: Percocet 5/325 mg, Flexeril 10 mg, and ibuprofen 800 mg, a two week supply of each. I will see him back in two weeks. Continue with the chiropractor.

RHG/rtd

PROGRESS NOTE

NAME: Taijuan Carter

9 Taijuan Carter

2-14-14 Follow-up

Taijuan Carter February 14, 2014

The patient is here for a follow-up visit. He says the TENS unit is helping. He is scooting down a little bit on the exam table so that it is getting the back of his neck better, and the chiropractor is still working with him. He says the medications help.

EXAM: He has full range of motion of his neck and he can shrug his shoulders without discomfort. He has minimal tenderness.

PLAN: I refilled his Flexeril and ibuprofen but I am changing his Percocet to Tramadol as he declines Norco. I will see the patient back in two weeks.

RHG/rtd

NAME: Taijuan Carter

DATE	PROGRESS NOTES
1 Taijuan Carter 2.28.14 follow up	

Taijuan Carter February 28, 2014

The patient is here for a follow-up visit. He is doing fairly well. He does need refills of medications today.

EXAM: He still has discomfort. Of concern, he has had some issues of urinary incontinence which occur when he is on the road approaching a situation where someone is about to barrel out of a parking lot next to him. It does not happen any other time. I don't suspect he has nerve damage as much as I suspect he may have a little PTSD. I recommended he go see a counselor.

PLAN: Pain wise, he is doing much better. I think the chiropractor may be releasing him soon. I will release him today as well. He can take over-the-counter antiinflammatories if he wishes.

RHG/rld

TAIJUAN CARTER [redacted]

1500

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

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

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

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

3. PATIENT'S BIRTH DATE [redacted] SEX M F

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 Spouse Child Other

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

CITY [redacted] STATE [redacted]

8. PATIENT STATUS Single Married Other

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

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH [redacted] SEX M F

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME
TAIJUAN CARTER

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 03/12/14

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

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY
12 15 2013

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1,2,3 or 4 to Item 24E by Line)
1. 847.0
2. 847.2
3. 847.1
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1 12/18/13	12/18/13	11		99204		1,2,3	$350.00	1		NPI	1003892217
2 12/18/13	12/18/13	11		20553		1,2	$800.00	1		NPI	1003892217
3 12/18/13	12/18/13	11		J1040		1,2	$80.00	1		NPI	1003892217
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER 270796590 SSN EIN

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $1,230.00

29. AMOUNT PAID $0.00

30. BALANCE DUE $1,230.00

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.)
SAN N. GHOUBRIAL, MD
03/12/14
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
HANCHRIST LLC
215 E WATERLOO #12
AKRON, OH 44319
a. 1669702841

33. BILLING PROVIDER INFO & PH #
CLEARWATER BILLING SERVICES
P.O BOX 1243
BATH, OH 44210
a. 1487982112

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

PHYSICIAN OR SUPPLIER INFORMATION — PATIENT AND INSURED INFORMATION — CARRIER

TAIJUAN CARTER
995 BELLOWS ST
AKRON, OH 44311

1500

HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

3. PATIENT'S BIRTH DATE [redacted] SEX M

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 | Spouse | Child | Other

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

CITY [redacted] STATE [redacted]

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

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

CITY [redacted] STATE [redacted]

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH [redacted] SEX M

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: TAIJUAN CARTER

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

6. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE 03/12/14

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 12 19 2013

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a

17b NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

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

1. F47.0
2. S47.
3. F47.2
4. 309.81

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1 01/17/14	01/17/14	11		99213		1,2,3	$150.00	1		NPI	1508856915
2 01/31/14	01/31/14	11		99213		1,2,3	$150.00	1		NPI	1508856915
3 01/31/14	01/31/14	12		E0730		1,2,3	$500.00	1		NPI	1508856915
4 02/14/14	02/14/14	11		99213		1,2,3	$150.00	1		NPI	1508856915
5 02/28/14	02/14/14	11		99213		1,2,3	$150.00	1		NPI	1508856915
6										NPI	

25. FEDERAL TAX I.D. NUMBER 270796590 SSN EIN

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $1,100.00

29. AMOUNT PAID $0.00

30. BALANCE DUE $1,100.00

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
03/12/14
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
HANCHRIST LLC
215 E WATERLOO #12
AKRON, OH 44319
a. 1669702841

33. BILLING PROVIDER INFO & PH #
CLEARWATER BILLING SERVICES
P.O BOX 1243
BATH, OH 44210
a. 1487952112

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

TAIJUAN CARTER [redacted]

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

PICA

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

1a. INSURED'S I.D. NUMBER [redacted]

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

3. PATIENT'S BIRTH DATE [redacted] SEX

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 [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS [redacted]

CITY [redacted] STATE [redacted]

8. PATIENT STATUS [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

9a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

9b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

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

b. EMPLOYER'S NAME OR SCHOOL NAME

9c. EMPLOYER'S NAME OR SCHOOL NAME

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

c. INSURANCE PLAN NAME OR PROGRAM NAME TAIJUAN CARTER

9d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

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

SIGNATURE ON FILE DATE 03/12/14

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 12 09 2013

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

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

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

1. R47.0

2. S47.1

3.

4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATES 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 01/03/14	01/03/14	11		99213		1,2,3	$150.00	1		NPI	1508095803
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER 270795590 SSN EIN

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $150.00

29. AMOUNT PAID $0.00

30. BALANCE DUE $150.00

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.)

JOSHUA M. JONES, MD 03/12/14

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

RANCHRIST LLC
315 E WATERLOO #12
AKRON, OH 44319

a. 1669702841

33. BILLING PROVIDER INFO & PH #

CLEARWATER BILLING SERVICES
P.O BOX 1243
BATH, OH 44210

a. 1487982112

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

FORM - Medical Arts Press
Use with Envelope #1414 (Segmented) or #1414-W (Window)

Invoice for Medical Services

Re: Taijuan Carter
Date of Accident: 12/15/13
Date of Birth: [redacted]

Medical services for the above- named client.		**Amount**
12/18/13	See detailed HCFA 1500	$1230.00
1/17/14	See detailed HCFA 1500	$1100.00
1/3/14	See detailed HCFA 1500	$150.00
3/12/14	Document preparation fee	$50.00
	Total amount due:	**$2530.00**

Please make checks payable to:

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

Tax ID: 27-0796590

TAIJUAN CARTER [redacted]

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	X
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	[redacted]
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	CARTER, TAIJUAN
3. PATIENT'S BIRTH DATE / SEX	[redacted] X / F
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 X / Spouse / Child / Other
7. INSURED'S ADDRESS (No., Street)	[redacted]
CITY	[redacted]
STATE	[redacted]
8. PATIENT STATUS	[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. [illegible]	
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	
a. EMPLOYMENT? (Current or Previous)	YES / NO X
a. INSURED'S DATE OF BIRTH / SEX	[redacted] / M X / F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX	M / F
b. AUTO ACCIDENT? / PLACE (State)	YES X / NO / OH
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	
c. OTHER ACCIDENT?	YES / NO X
c. INSURANCE PLAN NAME OR PROGRAM NAME	TAIJUAN CARTER
d. INSURANCE PLAN NAME OR PROGRAM NAME	
10d. RESERVED FOR LOCAL USE	
9. IS THERE ANOTHER HEALTH BENEFIT PLAN?	YES / NO X — If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE 03/12/14

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	MM DD YY 12 15 2013
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE	MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	MM DD YY FROM / MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a / 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	MM DD YY FROM / MM DD YY TO
19. RESERVED FOR LOCAL USE	
20. OUTSIDE LAB?	YES / NO X — $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	1. 847.0 2. 847.1 3. 847.2 4.
22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER	

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 12/18/13	12/18/13	11		99204		1,2,3	$350.00	1		NPI	1003892217
2 12/18/13	12/18/13	11		20553		1,2	$800.00	1		NPI	1003892217
3 12/18/13	12/18/13	11		J1040		1,2	$80.00	1		NPI	1003892217
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EN	270796590	26. PATIENT'S ACCOUNT NO.	[redacted]	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	X YES / NO
28. TOTAL CHARGE	$1,230.00	29. AMOUNT PAID	$0.00	30. BALANCE DUE	$1,230.00

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.)

SAM N. GHOUBRIAL, MD 03/12/14

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

HANCHRIST LLC
215 E WATERLOO #12
AKRON, OH 44319

a. 1669702841

33. BILLING PROVIDER INFO & PH # (330) 331-7207

CLEARWATER BILLING SERVICES
P.O BOX 1243
BATH, OH 44210

a. 1487982112

Ghoubrial_000627

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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Call toll-free: 1-800-328-2179

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

TAIJUAN CARTER [redacted]

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID) X	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	PICA

PATIENT AND INSURED INFORMATION

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CARTER, TAIJUAN	3. PATIENT'S BIRTH DATE [redacted] SEX X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) CARTER, TAIJUAN	
5. [redacted]	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. [redacted]	
CITY [redacted] STATE	8. PATIENT STATUS [redacted]	CITY [redacted] STATE	
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)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH [redacted] SEX M X F	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? X YES NO PLACE (State) OH	b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME TAIJUAN CARTER	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 03/12/14

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

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) 12 15 2013	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 847.0 2. 847.1 3. 847.2 4. 309.81		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01/17/14 01/17/14	11		99213	1,2,3	$150.00	1		NPI	1508856915
2 01/31/14 01/31/14	11		99213	1,2,3	$150.00	1		NPI	1508856915
3 01/31/14 01/31/14	11		E0730	1,2,3	$500.00	1		NPI	1508856915
4 02/14/14 02/14/14	11		99213	1,2,3	$150.00	1		NPI	1508856915
5 02/28/14 02/14/14	11		99213	1,2,3	$150.00	1		NPI	1508856915
6								NPI	

25. FEDERAL TAX I.D. NUMBER 270796590 SSN EIN	26. PATIENT'S ACCOUNT NO. [redacted]	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO	28. TOTAL CHARGE $1,100.00	29. AMOUNT PAID $0.00	30. BALANCE DUE $1,100.00

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 03/12/14
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
HANCHRIST LLC
215 E WATERLOO #12
AKRON, OH 44319
a. 1669702841 b.

33. BILLING PROVIDER INFO & PH # 330 331 7207
CLEARWATER BILLING SERVICES
P.O BOX 1243
BATH, OH 44210
a. 1487982112 b.

Ghoubrial_000628

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#14716 - Medical Arts Press
Use with Envelope #14145 (gummed) or #14146 (self-seal)

TAIJUAN CARTER [redacted]

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID) — X OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1) [redacted]
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CARTER, TAIJUAN	3. PATIENT'S BIRTH DATE [redacted] SEX X F
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 X Spouse Child Other
7. INSURED'S ADDRESS (No., Street) [redacted]	
CITY [redacted] STATE [redacted]	8. PATIENT STATUS [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) YES X NO
a. INSURED'S DATE OF BIRTH [redacted] SEX M X F	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? X YES NO PLACE (State) OH
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO
c. INSURANCE PLAN NAME OR PROGRAM NAME TAIJUAN CARTER	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 03/12/14

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SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY 12 15 2013 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 847.0 2. 847.1 3. 847.2 4.	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 01/03/14 01/03/14	11		99213	1,2,3	$150.00	1		NPI	1508095803
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN 270796590	26. PATIENT'S ACCOUNT NO [redacted]	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO	28. TOTAL CHARGE $150.00	29. AMOUNT PAID $0.00	30. BALANCE DUE $150.00

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.) JOSHUA M. JONES, MD 03/12/14 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION HANCHRIST LLC 215 E WATERLOO #12 AKRON, OH 44319 a. 1669702841	33. BILLING PROVIDER INFO & PH # (330) 331-7207 CLEARWATER BILLING SERVICES P.O BOX 1243 BATH, OH 44210 a. 1487982112

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PATIENT AND INSURED INFORMATION — CARRIER — PHYSICIAN OR SUPPLIER INFORMATION

CLIENT: Taijuan Carter

INSURANCE CO: American Family Insurance

DEFENDANT: Marry Foshee

ADJUSTER: Matthew Boldt

DATE OF LOSS: 12/15/2013

CLAIM NO: 943208658

PHYSICIANS	MEDICAL SPECIALS	AMOUNT
Akron Square Chiropractic	(12/16/2013 - 2/25/2014)	$ 4,840.00
Clearwater Billing Services, LLC	(12/18/2013 - 1/3/2014)	$ 2,480.00
National Diagnostic Imaging Consultants	(12/30/2013 - 12/30/2013)	$ 110.00
TOTAL SPECIALS		**$ 7,430.00**

We (KNR) referred Taijuan on his 1st MVA.

- Went to Akron Square day after his MVA.
- Spine adjustments
- Roller Bed.
- Electric Muscle Stimulation.

Saw Chiro ever time.
Massage
Adjust.

Lower back & Neck area were still hurting while working b/c of sitting & standing for long
Being uncomfortable.

Chiro Treatment - helped.
Dr. Cho-Sui - 1 injection
it made it worse

NECK. → More neck & Shoulders meet on right side.

Low Back → occassional low back tightg.

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

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TaiJuan Carter
[redacted]

Diagnosis
847.0
847.2
847.1
728.85

Chart Number
CARTA020

Date	Description	Procedure Code	Amount
Date of Loss: 12/15/2013	**Previous Balance**		**0.00**
Patient: TaiJuan Carter	Chart #: CARTA020	Case Description: mva	
12/16/2013	TEN POINT EXAM	10 PT	0.00
12/16/2013	X-ray Cervical AP& LAT, 2 or 3 views	72040	120.00
12/16/2013	X-ray Lumbosacral, AP & Lat	72100	80.00
12/16/2013	Electrical Muscle Stimulation	97014	45.00
12/16/2013	Hot/Cold Packs to one or more areas	97010	30.00
./17/2013	Spinal Manipulation 3-4 regions	98941	87.00
12/17/2013	Electrical Muscle Stimulation	97014	45.00
12/17/2013	Unlisted Modality	97039	50.00
12/17/2013	TriggerPoint/Massage(Distinct/Reduced)	97124-5952	55.00
12/18/2013	Spinal Manipulation 3-4 regions	98941	87.00
12/18/2013	Electrical Muscle Stimulation	97014	45.00
12/18/2013	Hot/Cold Packs to one or more areas	97010	30.00
12/18/2013	TriggerPoint/Massage(Distinct/Reduced)	97124-5952	55.00
12/18/2013	Traction, Mechanical	97012	55.00
12/27/2013	Spinal Manipulation 1-2 regions	98940	85.00
12/27/2013	Electrical Muscle Stimulation	97014	45.00
12/27/2013	Traction, Mechanical	97012	55.00
12/27/2013	TriggerPoint/Massage(Distinct/Reduced)	97124-5952	55.00
12/30/2013	Spinal Manipulation 3-4 regions	98941	87.00
12/30/2013	Electrical Muscle Stimulation	97014	45.00
12/30/2013	Traction, Mechanical	97012	55.00

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

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Chart Number
CARTA020

TaiJuan Carter
[redacted]

Date	Description	Procedure Code	Amount
12/30/2013	TriggerPoint/Massage(Distinct/Reduced)	97124-5952	55.00
1/3/2014	Spinal Manipulation 1-2 regions	98940	85.00
1/3/2014	Electrical Muscle Stimulation	97014	45.00
1/3/2014	Unlisted Modality	97039	50.00
1/3/2014	TriggerPoint/Massage(Distinct/Reduced)	97124-5952	55.00
1/6/2014	Spinal Manipulation 1-2 regions	98940	85.00
1/6/2014	Electrical Muscle Stimulation	97014	45.00
3/2014	Traction, Mechanical	97012	55.00
1/6/2014	TriggerPoint/Massage(Distinct/Reduced)	97124-5952	55.00
1/7/2014	Spinal Manipulation 3-4 regions	98941	87.00
1/7/2014	Electrical Muscle Stimulation	97014	45.00
1/7/2014	Traction, Mechanical	97012	55.00
1/7/2014	TriggerPoint/Massage(Distinct/Reduced)	97124-5952	55.00
1/9/2014	Spinal Manipulation 1-2 regions	98940	85.00
1/9/2014	Electrical Muscle Stimulation	97014	45.00
1/9/2014	Unlisted Modality	97039	50.00
1/9/2014	TriggerPoint/Massage(Distinct/Reduced)	97124-5952	55.00
1/13/2014	Spinal Manipulation 3-4 regions	98941	87.00
1/13/2014	Electrical Muscle Stimulation	97014	45.00
1/13/2014	Traction, Mechanical	97012	55.00
1/13/2014	TriggerPoint/Massage(Distinct/Reduced)	97124-5952	55.00
1/14/2014	Electrical Muscle Stimulation	97014	45.00
1/14/2014	Traction, Mechanical	97012	55.00

Total Charges	Total Payments	Total Adjustments	Balance Due
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Chart Number
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TaiJuan Carter
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Date	Description	Procedure Code	Amount
1/14/2014	Spinal Manipulation 1-2 regions	98940	85.00
1/15/2014	Spinal Manipulation 1-2 regions	98940	85.00
1/15/2014	Electrical Muscle Stimulation	97014	45.00
1/15/2014	Traction, Mechanical	97012	55.00
1/17/2014	Spinal Manipulation 1-2 regions	98940	85.00
1/17/2014	Electrical Muscle Stimulation	97014	45.00
1/17/2014	Unlisted Modality	97039	50.00
20/2014	Spinal Manipulation 1-2 regions	98940	85.00
1/20/2014	Electrical Muscle Stimulation	97014	45.00
1/20/2014	Traction, Mechanical	97012	55.00
1/22/2014	Spinal Manipulation 1-2 regions	98940	85.00
1/22/2014	Traction, Mechanical	97012	55.00
1/23/2014	Spinal Manipulation 1-2 regions	98940	85.00
1/23/2014	Electrical Muscle Stimulation	97014	45.00
1/27/2014	Spinal Manipulation 1-2 regions	98940	85.00
1/27/2014	Traction, Mechanical	97012	55.00
1/28/2014	Spinal Manipulation 1-2 regions	98940	85.00
1/28/2014	Unlisted Modality	97039	50.00
1/31/2014	Spinal Manipulation 1-2 regions	98940	85.00
1/31/2014	Electrical Muscle Stimulation	97014	45.00
1/31/2014	Traction, Mechanical	97012	55.00
2/3/2014	Spinal Manipulation 1-2 regions	98940	85.00
2/3/2014	Electrical Muscle Stimulation	97014	45.00

Total Charges	Total Payments	Total Adjustments	Balance Due
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Date	Description	Procedure Code	Amount
2/3/2014	Traction, Mechanical	97012	55.00
2/5/2014	Spinal Manipulation 1-2 regions	98940	85.00
2/5/2014	Traction, Mechanical	97012	55.00
2/6/2014	Spinal Manipulation 1-2 regions	98940	85.00
2/6/2014	Traction, Mechanical	97012	55.00
2/10/2014	Spinal Manipulation 1-2 regions	98940	85.00
2/10/2014	Traction, Mechanical	97012	55.00
13/2014	Spinal Manipulation 1-2 regions	98940	85.00
2/13/2014	Traction, Mechanical	97012	55.00
2/19/2014	Spinal Manipulation 1-2 regions	98940	85.00
2/25/2014	Spinal Manipulation 1-2 regions	98940	85.00

Total Charges	Total Payments	Total Adjustments	Balance Due
$4840.00	$0.00	$0.00	**4,840.00**

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12/16/2013	X-ray Cervical AP& LAT, 2 or 3 views	72040	120.00
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12/16/2013	Electrical Muscle Stimulation	97014	45.00
12/16/2013	Hot/Cold Packs to one or more areas	97010	30.00
/17/2013	Spinal Manipulation 3-4 regions	98941	87.00
12/17/2013	Electrical Muscle Stimulation	97014	45.00
12/17/2013	Unlisted Modality	97039	50.00
12/17/2013	TriggerPoint/Massage(Distinct/Reduced)	97124-5952	55.00
12/18/2013	Spinal Manipulation 3-4 regions	98941	87.00
12/18/2013	Electrical Muscle Stimulation	97014	45.00
12/18/2013	Hot/Cold Packs to one or more areas	97010	30.00
12/18/2013	TriggerPoint/Massage(Distinct/Reduced)	97124-5952	55.00
12/18/2013	Traction, Mechanical	97012	55.00
12/27/2013	Spinal Manipulation 1-2 regions	98940	85.00
12/27/2013	Electrical Muscle Stimulation	97014	45.00
12/27/2013	Traction, Mechanical	97012	55.00
12/27/2013	TriggerPoint/Massage(Distinct/Reduced)	97124-5952	55.00
12/30/2013	Spinal Manipulation 3-4 regions	98941	87.00
12/30/2013	Electrical Muscle Stimulation	97014	45.00
12/30/2013	Traction, Mechanical	97012	55.00

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12/30/2013	TriggerPoint/Massage(Distinct/Reduced)	97124-5952	55.00
1/3/2014	Spinal Manipulation 1-2 regions	98940	85.00
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1/13/2014	Electrical Muscle Stimulation	97014	45.00
1/13/2014	Traction, Mechanical	97012	55.00
1/13/2014	TriggerPoint/Massage(Distinct/Reduced)	97124-5952	55.00
1/14/2014	Electrical Muscle Stimulation	97014	45.00
1/14/2014	Traction, Mechanical	97012	55.00

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1/14/2014	Spinal Manipulation 1-2 regions	98940	85.00
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1/22/2014	Traction, Mechanical	97012	55.00
1/23/2014	Spinal Manipulation 1-2 regions	98940	85.00
1/23/2014	Electrical Muscle Stimulation	97014	45.00
1/27/2014	Spinal Manipulation 1-2 regions	98940	85.00
1/27/2014	Traction, Mechanical	97012	55.00
1/28/2014	Spinal Manipulation 1-2 regions	98940	85.00
1/28/2014	Unlisted Modality	97039	50.00
1/31/2014	Spinal Manipulation 1-2 regions	98940	85.00
1/31/2014	Electrical Muscle Stimulation	97014	45.00
1/31/2014	Traction, Mechanical	97012	55.00
2/3/2014	Spinal Manipulation 1-2 regions	98940	85.00
2/3/2014	Electrical Muscle Stimulation	97014	45.00

Total Charges	Total Payments	Total Adjustments	Balance Due
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Chart Number
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Date	Description	Procedure Code	Amount
2/3/2014	Traction, Mechanical	97012	55.00
2/5/2014	Spinal Manipulation 1-2 regions	98940	85.00
2/5/2014	Traction, Mechanical	97012	55.00
2/6/2014	Spinal Manipulation 1-2 regions	98940	85.00
2/6/2014	Traction, Mechanical	97012	55.00
2/10/2014	Spinal Manipulation 1-2 regions	98940	85.00
2/10/2014	Traction, Mechanical	97012	55.00
13/2014	Spinal Manipulation 1-2 regions	98940	85.00
2/13/2014	Traction, Mechanical	97012	55.00
2/19/2014	Spinal Manipulation 1-2 regions	98940	85.00
2/25/2014	Spinal Manipulation 1-2 regions	98940	85.00

Total Charges	Total Payments	Total Adjustments	Balance Due
$4840.00	$0.00	$0.00	**4,840.00**