

PE10-005

GM

4/14/2010

ATTACHMENT

Q 03

Subject Legal

ATT



GM Vehicle Inquiry System Summary

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VIN :	1G1AL14F157
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VEHICLE INFORMATION

Merchandising Model :	1AL37 -2005 COBALT 2-DOOR LS COUPE				Warranty Start Date :		05/21/2005	
BARS Order Type :	70 - RETAIL - STOCK							
Delivering Dealer :	HARRY GREEN CHEVROLET, INC. PO BOX 1527 CLARKSBURG , WV 26302-1527 (304) 624-6304				Selling Source :		13 - CHEVROLET	
					Site Code :		13172	
					Business Associate Code :		113544	
Service Contract :	No	Branded Title :	No	Warranty Block :	No	PDI Status :	Paid	

REQUIRED FIELD ACTIONS

Vehicle Has No Current Record Of Outstanding Campaigns
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SERVICE INFORMATIONAL ITEMS

Vehicle Has No Current Record Of Outstanding Service Information
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ON STAR AND XM SATELLITE RADIO INFORMATION

OnStar Equipped	No	OnStar Status	N/A	Refer to Help page for details or go to OnStar Online Enrollment (located on the "OnStar" tab in GM InfoNET) or (888)ONSTAR1 (888) 667-8271.		
XM Equipped	Yes	XM Radio ID	260R90ME	XM Status	Active	Refer to Help page for details or: www.xmradio.gm.ca or Dealer Hotline 1.877.GET.XMST (1-877-438-9677).

APPLICABLE WARRANTIES

Description	Effective Date	Effective Odometer	End Date	End Odometer
36/36000 BUMPER TO BUMPER LIMITED WARRANTY	05/21/2005	10 miles	05/21/2008	36010 miles
72/100000 SHEET METAL COVERAGE RUST THROUGH LIMITED WARRANTY	05/21/2005	10 miles	05/21/2011	100010 miles
96/80000 FEDERAL EMISSION CATALYTIC CONV. AND PCM	05/21/2005	10 miles	05/21/2013	80010 miles
36/36000 FEDERAL EMISSION	05/21/2005	10 miles	05/21/2008	36010 miles

60/60000 POWERTRAIN - U.S. LIMITED WARRANTY	05/21/2005	10 miles	05/21/2010	60010 miles
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CLAIM HISTORY

R.O Date	R.O Number	Type	Labor Operation	Odometer Reading
07/31/2007	075315	B	C2990 - KNOB, CONTROL AND/OR SELECT - ONE AND/OR ALL - REPLACE	36723 miles
05/01/2007	074119	#	C2990 - KNOB, CONTROL AND/OR SELECT - ONE AND/OR ALL - REPLACE	32755 miles
05/01/2007	074119	#	H9991 - CUSTOMER CONCERN NOT DUPLICATED	32755 miles
02/27/2007	073168	#	B5608 - SPOILER - ONE PIECE - R&R OR REPLACE	29125 miles
02/27/2007	073168	#	L2020 - HANGER AND/OR CLAMP, EXHAUST SYSTEM - REPLACE	29125 miles
02/27/2007	073168	#	E4300 - BEARING AND HUB ASSEMBLY, REAR WHEEL - RIGHT - REPLACE	29125 miles
10/23/2006	073442	#	C2990 - KNOB, CONTROL AND/OR SELECT - ONE AND/OR ALL - REPLACE	23002 miles
10/23/2006	073442	#	C3331 - PANEL, FRONT DOOR TRIM FINISH UPPER FRONT - LEFT - R&R OR	23002 miles
10/23/2006	073442	#	B4281 - FRONT SIDE DOOR INSIDE HANDLE REPLACEMENT - LEFT SIDE	23002 miles
03/30/2006	068751	#	C2990 - KNOB, CONTROL AND/OR SELECT - ONE AND/OR ALL - REPLACE	13680 miles
03/30/2006	068751	#	C3301 - PLATE, FRONT DOOR ARMREST SWITCH MOUNTING - LEFT - R&R OR	13680 miles
03/30/2006	068751	#	E2320 - BEARING AND HUB ASSEMBLY, FRONT WHEEL - RIGHT - REPLACE	13680 miles
03/30/2006	068751	#	L2004 - EXHAUST SYSTEM - ALIGN	13680 miles
03/30/2006	068751	#	Z5001 - VIP FREIGHT/POSTAGE REIMBURSEMENT	13680 miles
01/10/2006	067080	#	J9993 - CUSTOMER CONCERN NOT DUPLICATED	9172 miles
04/28/2005	A29404	I	Z7000 - PRE-DELIVERY INSPECTION - BASE TIME	0 miles

CHECK HISTORY INFORMATION

Vehicle Has No Associated Check History Information.
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CLAIM HISTORY

Repair Order Date :		07/31/2007		Repair Order Number :		075315		Odometer Reading :		36723 miles	
Serviced By :		PERFORMANCE MOTOR SALES, INC. PO BOX 424 PARSONS, WV 26287-0424 (304) 478-2831				Selling Source :		13 - CHEVROLET			
						Site Code :		13230			
						Business Associate Code :		113550			
Cycle Date	Cycle Nbr	Case	Type	Labor Operation		Part	Auth Code	Person Code	Line Total	Comments	
08/10/2007	820	01	B	C2990 - KNOB, CONTROL AND/OR SELECT - ONE AND/OR ALL - REPLACE		22724498 - HANDLE	G	N/A	\$ 101.53	N	

Repair Order Date :		05/01/2007		Repair Order Number :		074119		Odometer Reading :		32755 miles	
Serviced By :		PERFORMANCE MOTOR SALES, INC. PO BOX 424 PARSONS, WV 26287-0424 (304) 478-2831				Selling Source :			13 - CHEVROLET		
						Site Code :			13230		
						Business Associate Code :			113550		
Cycle Date	Cycle Nbr	Case	Type	Labor Operation		Part	Auth Code	Person Code	Line Total	Comments	
05/11/2007	794	01	#	C2990 - KNOB, CONTROL AND/OR SELECT - ONE AND/OR ALL - REPLACE		22724498 - HANDLE	N/A	N/A	\$ 101.53	N	
05/11/2007	794	02	#	H9991 - CUSTOMER CONCERN NOT DUPLICATED		N/A	N/A	N/A	\$ 14.91	N	

Repair Order Date :		02/27/2007	Repair Order Number :		073168	Odometer Reading :		29125 miles	
Serviced By :	PERFORMANCE MOTOR SALES, INC. PO BOX 424				Selling Source :		13 - CHEVROLET		

PARSONS, WV 26287-0424 (304) 478-2831				Site Code :		13230			
				Business Associate Code :		113550			
Cycle Date	Cycle Nbr	Case	Type	Labor Operation	Part	Auth Code	Person Code	Line Total	Comments
04/03/2007	783	01	#	B5608 - SPOILER - ONE PIECE - R&R OR REPLACE	N/A	EE	N/A	\$ 69.59	Y
03/09/2007	776	01	#	L2020 - HANGER AND/OR CLAMP, EXHAUST SYSTEM - REPLACE	N/A	N/A	N/A	\$ 9.94	N
03/09/2007	776	02	#	E4300 - BEARING AND HUB ASSEMBLY, REAR WHEEL - RIGHT - REPLACE	15839050 - BEARING	N/A	N/A	\$ 172.08	N

Repair Order Date :		10/23/2006		Repair Order Number :		073442		Odometer Reading :		23002 miles	
Serviced By :		ELLIOTT CHEVROLET CADILLAC PO BOX 2129 STAUNTON, VA 24402-2129 (540) 885-1584				Selling Source :		13 - CHEVROLET			
						Site Code :		14255			
						Business Associate Code :		113764			
Cycle Date	Cycle Nbr	Case	Type	Labor Operation		Part		Auth Code	Person Code	Line Total	Comments
11/03/2006	740	01	#	C2990 - KNOB, CONTROL AND/OR SELECT - ONE AND/OR ALL - REPLACE		22724498 - HANDLE		N/A	N/A	\$ 104.45	N
11/03/2006	740	02	#	C3331 - PANEL, FRONT DOOR TRIM FINISH UPPER FRONT - LEFT - R&R OR		22733536 - PLATE		B	N/A	\$ 23.22	N
11/03/2006	740	03	#	B4281 - FRONT SIDE DOOR INSIDE HANDLE REPLACEMENT - LEFT SIDE		22722755 - BEZEL		N/A	N/A	\$ 27.88	N

Repair Order Date :		03/30/2006		Repair Order Number :		068751		Odometer Reading :		13680 miles	
Serviced By :		ELLIOTT CHEVROLET CADILLAC PO BOX 2129 STAUNTON, VA 24402-2129 (540) 885-1584				Selling Source :		13 - CHEVROLET			
						Site Code :		14255			
						Business Associate Code :		113764			
Cycle	Cycle	Case	Type	Labor Operation		Part		Auth	Person	Line	Comments

Date	Nbr					Code	Code	Total	
04/18/2006	683	01	#	C2990 - KNOB, CONTROL AND/OR SELECT - ONE AND/OR ALL - REPLACE	22724498 - HANDLE	N/A	N/A	\$ 100.21	N
04/18/2006	683	02	#	C3301 - PLATE, FRONT DOOR ARMREST SWITCH MOUNTING - LEFT - R&R OR	22733545 - PLATE	N/A	N/A	\$ 22.87	N
04/18/2006	683	03	#	E2320 - BEARING AND HUB ASSEMBLY, FRONT WHEEL - RIGHT - REPLACE	22701516 - BEARING	N/A	N/A	\$ 183.47	N
04/18/2006	683	04	#	L2004 - EXHAUST SYSTEM - ALIGN	N/A	N/A	N/A	\$ 19.30	N
04/18/2006	683	05	#	Z5001 - VIP FREIGHT/POSTAGE REIMBURSEMENT	22701516 - BEARING	N/A	N/A	\$ 23.47	N

Repair Order Date :		01/10/2006		Repair Order Number :		067080		Odometer Reading :		9172 miles	
Serviced By :	ELLIOTT CHEVROLET CADILLAC PO BOX 2129 STAUNTON, VA 24402-2129 (540) 885-1584					Selling Source :		13 - CHEVROLET			
						Site Code :		14255			
						Business Associate Code :		113764			
Cycle Date	Cycle Nbr	Case	Type	Labor Operation		Part		Auth Code	Person Code	Line Total	Comments
01/17/2006	657	01	#	J9993 - CUSTOMER CONCERN NOT DUPLICATED		N/A		N/A	N/A	\$ 19.30	N

Repair Order Date :		04/28/2005		Repair Order Number :		A29404		Odometer Reading :		0 miles	
Serviced By :		HARRY GREEN CHEVROLET, INC. PO BOX 1527 CLARKSBURG, WV 26302-1527 (304) 624-6304				Selling Source :		13 - CHEVROLET			
						Site Code :		13172			
						Business Associate Code :		113544			
Cycle Date	Cycle Nbr	Case	Type	Labor Operation		Part		Auth Code	Person Code	Line Total	Comments
05/03/2005	583	01	I	Z7000 - PRE-DELIVERY INSPECTION - BASE TIME		N/A		N/A	N/A	\$ 64.90	N

CHECK HISTORY

Vehicle Has No Associated Check History.

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GM Vehicle Inquiry System Vehicle Build

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VIN	1G1AL14F157
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VEHICLE BUILD

Merchandising Model :	1AL37-2005 COBALT 2-DOOR LS COUPE		
Gross Vehicle Weight Rating :	1684 kg (3713 lb)	Order Number :	JCKV9X
Build Date :	04/28/2005	Build Plant :	157A

GMVIS is not the definitive source of GM Vehicle RPO information and is intended for service reference only. Should there be any questions about the vehicle's original build or RPO information please refer to the original vehicle invoice or window sticker.

OPTION CODES

AK5 - DRIVER & RIGHT FRONT PASSENGER AIR BAGS	AR9 - DELUXE FRONT BUCKET SEAT
ASF - AIRBAGS, SIDE HEAD-CURTAIN	C67 - ELECT. FRONT AIR CONDITIONER
DG7 - ELEC TWIN REMOTE SPORT MIRRORS	FE1 - SUSPENSION SYSTEM-SOFT RIDE
FE9 - 50-STATE EMISSIONS	FR6 - 3.84 FINAL DRIVE TRANSAXLE RATIO
IPC - INTERIOR TRIM DESIGN	JM4 - 4-WHEEL ANTI-LOCK BRAKE SYSTEM
K64 - 115 AMP GENERATOR	LOD - ASSEMBLY PLANT - LORDSTOWN, OHIO
L61 - 2.2L DOHC 4 CYL ENGINE	MMS - 5-SPEED MANUAL TRANSMISSION
M86 - MANUAL 5 SPEED TRANSMISSION	NP5 - LEATHER WRAPPED STEERING WHEEL
NT7 - FEDERAL EMISSION TIER 2	PFD - 16" ALUMINUM WHEEL
QQR - 205/55R16 TOURING BW TIRES	RE8 - UPGRADE ORNAMENTATION
SLM - STOCK ORDERS	TV5 - SPORT PACKAGE
T37 - DELUXE FOG LAMPS	T43 - REAR DECK-LID SPOILER
UK3 - LEATHER WRAPPED STEERING WHEEL	UQ3 - PIONEER 7 SPKR AMPLIFIED SYSTEM
US8 - RADIO, AM/FM STEREO W CD & MP3	U2K - XM SATELLITE RADIO-OVER 130 CHNLS OF DIGITAL ENTERTAINMENT. SERVICE FEE EXTRA 1ST.3MOS.INCL
VM3 - CONSUMER INFORMATION LABEL	VY7 - LEATHER SHIFT KNOB
V73 - STATEMENT OF VEHICLE CERT.-U.S./CANADA	1SB - 1SB SPORT PACKAGE INCLUDES: *WHITE FACED SPORT GAUGES *LEATHER WRAPPED SHIFT LEVER *LEATHER WRAPPED STEERING WHEEL *SPORT FASCIA W/FOG LAMPS *REAR

	SPOILER *16" ALUMINUM WHEELS *205/55R16 TIRES *CHROME EXHAUST TIP
1SZ - OPTION PACKAGE DISCOUNT	19C - EBONY SPORT CLOTH
19I - EBONY	6AP
7AP	8AB - REAR SPRING
9AB - REAR SPRING	9IU - ARRIVAL BLUE METALLIC

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ESIS/GM Central Claims Unit
P.O. Box 300
Mail Code 482 C20 D71
Detroit, MI 48265-3000

800.888.0164 *tel*
313.665.0911 *fax*

Tiffini Hails
Claims Administrator

May 6, 2008

[REDACTED]
Staunton, VA [REDACTED]

RE: Claimant: [REDACTED]
Our File No.: [REDACTED]
Our Client: General Motors Corporation
Date/Event: September 7, 2007
VIN: 1G1AL14F157 [REDACTED]

Dear [REDACTED]

I am writing to confirm our conversation of April 30, 2008 during which you agreed to allow us to inspect your 2005 Chevrolet Cobalt and retrieve data from the air bag system. I estimate the inspection will take about two (2) hours. I also understand from our conversation that you alleged that the steering gear failed in your vehicle causing you to get into an accident and sustain injuries. ESIS Field Investigator, Raymond Michael has been assigned to assist me in the investigation of this claim. He will contact you to schedule an appointment to interview you, inspect, photograph and download the SDM. I have also enclosed a medical authorization form to obtain your medical records concerning this accident. If there are any out of pocket expenses regarding this claim please provide.

As part of the inspection, we will likely take photographs and measurements. Also, your vehicle is equipped with an air bag Sensing and Diagnostic Module (SDM). As explained in the Owner's Manual, in addition to its other functions, the SDM records information about the air bag system and other crash related data in an air bag deployment event and some near-deployment crashes. The SDM in your vehicle also records the following pre-crash data: vehicle speed, throttle position, brake application and engine RPM for 5 seconds prior to the deployment or near deployment event. As part of our investigation, we will download the SDM data using the Vetronix Crash Data Retrieval software. We will provide you with a copy of that data at the time we retrieve it or as soon after as is practical. As we discussed, we will also provide a copy of the data to [REDACTED]

Please note the potential GM uses of this crash data once GM has a copy in its files. Once collected, the SDM crash data is available for GM's research needs. Also, in summary form, this information may be provided to non-GM organizations (i) which have a reasonable need for it, (ii) which have a demonstrated ability to utilize such data, and (iii) which are expected to use it for studies aimed at improving safety to the benefit of the public at large, the auto industry, or GM. However, information which ties SDM crash data to a particular vehicle, such as VIN, owner name, or date and location, will generally not be disclosed by GM other than (a) to the involved owner/lessee or his/her designated agent, (b) in response to an official request of police or similar government office, (c) for research where appropriate confidentiality is maintained and need is shown, (d) as part of GM's defense of litigation involving the subject vehicle or other GM products, or (e) as otherwise required by law.

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If you have any additional questions about our upcoming inspection, you can contact me at 1.800.888.0164 Monday through Friday from 8:00 AM to 4:00 PM.

Sincerely,

Tiffini Hails

CDR File Information

Vehicle Identification Number	1G1AL14F157 [REDACTED]
Investigator	RAY MICHAEL
Case Number	[REDACTED]
Investigation Date	Thursday, May 8 2008
Crash Date	Friday, September 7 2007
Filename	1G1AL14F157 [REDACTED] CDR
Saved on	Thursday, May 8 2008 at 03:59:39 PM
Collected with CDR version	Crash Data Retrieval Tool 3.00
Reported with CDR version	Crash Data Retrieval Tool 3.00
EDR Device Type	airbag control module
Event(s) recovered	None

Data Limitations

SDM Recorded Crash Events:

There are two types of SDM recorded crash events. The first is the Non-Deployment Event. A Non-Deployment Event is an event severe enough to "wake up" the sensing algorithm but not severe enough to deploy the air bag(s). It can contain Pre-Crash and Crash data. The SDM can store up to one Non-Deployment Event. This event can be overwritten by an event that has a greater SDM recorded vehicle forward velocity change. This event will be cleared by the SDM after the ignition has been cycled 250 times.

The second type of SDM recorded crash event is the Deployment Event. It also can contain Pre-Crash and Crash data. The SDM can store up to two different Deployment Events, if they occur within five seconds of one another. Deployment Events cannot be overwritten or cleared from the SDM. Once the SDM has deployed the air bag, the SDM must be replaced.

The data in the Non-Deployment Event file will be locked after a Deployment Event, if the Non-Deployment Event occurred within 5 seconds before the Deployment Event unless a Deployment Level Event occurs within 5 seconds after the Deployment Event, and then the Deployment Level Event will overwrite the Non-Deployment Event file.

SDM Data Limitations:

-SDM Recorded Vehicle Forward Velocity Change reflects the change in forward velocity that the sensing system experienced during the recorded portion of the event. SDM Recorded Vehicle Forward Velocity Change is the change in velocity during the recording time and is not the speed the vehicle was traveling before the event, and is also not the Barrier Equivalent Velocity. This data should be examined in conjunction with other available physical evidence from the vehicle and scene when assessing occupant or vehicle forward velocity change. For Deployment Events and Deployment Level Events, the SDM will record 220 milliseconds of data after deployment criteria is met and up to 70 milliseconds before deployment criteria is met. For Non-Deployment Events, the SDM will record up to the first 300 milliseconds of data after algorithm enable. The minimum SDM Recorded Vehicle Forward Velocity Change, that is needed to record a Non-Deployment Event, is 5 MPH.

-Maximum Recorded Vehicle Velocity Change is the maximum recorded velocity change in the vehicle's combined "X" and "Y" axis. It is calculated every ten ms by taking the square of the "X" axis value and adding it to the square of the "Y" axis value and then taking the square root of the sum. The greatest calculated value is the one that is stored.

-Event Recording Complete will indicate if data from the recorded event has been fully written to the SDM memory or if it has been interrupted and not fully written.

-SDM Recorded Vehicle Speed accuracy can be affected if the vehicle has had the tire size or the final drive axle ratio changed from the factory build specifications.

-Brake Switch Circuit Status indicates the status of the brake switch circuit.

-Pre-Crash Electronic Data Validity Check Status indicates "Data Invalid" if the SDM receive an invalid message from the module sending the pre-crash data.

-Driver's and Passenger's Belt Switch Circuit Status indicates the status of the seat belt switch circuit. The Passenger Belt Switch Circuit Status for 2005 vehicles is only available on the Cadillac STS. Also, the Passenger Belt Switch Circuit Status for 2006 Chevrolet Cobalt Sport Coupe (AP) model vehicles, with the option package that includes Recaro brand seats (RPO ALV), will always report a default value of "Buckled".

-The Time Between Non-Deployment and Deployment Events is displayed in seconds. If the time between the two events is greater than 5 seconds, "N/A" is displayed in place of the time. If the value is negative, then the Deployment Event occurred first. If the value is positive, then the Non-Deployment Event occurred first.

-If power to the SDM is lost during a crash event, all or part of the crash record may not be recorded.

-The ignition cycle counter relies upon the transitions through OFF->RUN->CRANK power-modding messages, on the GMLAN communication bus, to increment the counter. Applying and removing of battery power to the module will not increment the ignition counter.

-Steering Wheel Angle data is displayed as a positive value, when the steering wheel is turned to the right, and a negative value, when the steering wheel is turned to the left. For Cadillac STS models with StabiliTrac 3 systems, the Steering Wheel Angle data will be displayed just the opposite. When the steering wheel is turned to the right, a negative value will be displayed and when the steering wheel is turned to the left, a positive value will be displayed.

SDM Data Source:

All SDM recorded data is measured, calculated, and stored internally, except for the following:

-Vehicle Status Data (Pre-Crash) is transmitted to the SDM, by various vehicle control modules, via the vehicle's

communication network.

-The Belt Switch Circuit is wired directly to the SDM.

Hexadecimal Data

All of the data that the vehicle manufacturer has requested to be retrieved is shown in the hexadecimal data section of the CDR report. It may contain data that is not converted by the CDR program.

```

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$03 02 00 00 00 00 00 00
$04 02 00 00 00 00 00 00
$05 00 00 00 00 00 00 00
$06 00 4A 00 00 19 94 31
$07 00 29 00 00 00 00 00
$08 00 FF 00 00 00 00 00
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$0B 00 00 05 0F 00 00 00
$0C 00 00 00 00 00 00 00
$0D 00 00 40 00 00 00 00
$0E 00 00 00 00 00 00 00
$0F 92 00 00 00 00 00 00
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$24 00 00 00 00 00 00 00
$25 00 00 00 00 00 00 00
$26 00 00 00 00 00 00 00
$27 FF 00 FF 00 00 00 00
$2A 00 00 00 00 00 00 00
$2B 00 00 00 00 00 00 00
$2D 00 00 00 00 00 00 00
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\$44 C6 00 00 FC C0 C0
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\$47 0A 64 02 04 04 05 0A 06 04 0A 00 00 FA 00 00 FF 04 64
\$48 18 08 08
\$B0 58
\$B1 FD FE 00
\$B2 FF FF FF FF FF
\$B4 41 53 39 34 33 31 32 33 30 38 46 34 20 20 20 20
\$B7 50 AA 01 0F 01
\$B8 54 41 68 04 02
\$C1 30 46 30 31
\$CA 30 46 30 31
\$CB 00 E8 B0 17
\$CC 00 E8 B0 17
\$D1 00 00
\$DB 00 00
\$DC 00 00

Comments

Lamp status-flashed and went out
Downloaded through DLC
Powered by vehicle battery
Mileage-49666
Location-1020 Rockway St, Saunton, VA
Present-Tanya Lambert and Ray Michael

State Farm Insurance Companies



February 6, 2007

Frederick Operations Center
Attn: Auto Claim Central
One State Farm Drive PO Box 953
Frederick, Md 21705-0953
Phone (888)-613-3966
Fax (888)-613-3969

[REDACTED]
Hambleton, WV [REDACTED]

RE: Claim Number: [REDACTED]
Date of Loss: February 4, 2007
Our Insured: [REDACTED]

Dear [REDACTED]:

We are in receipt of the above claim for damage to your car. After reviewing your repair options, you have chosen to utilize the Service First program and have selected Performance Auto Body, Llc to repair your vehicle. This repair facility will provide you with a copy of your estimate and will begin repairs upon your authorization.

We will pay Performance Auto Body, Llc directly upon receipt of the final repair estimate and your authorization to pay. Please contact this repair facility directly to begin the repair process.

Based on the loss facts we received from your agent, your claim will be processed under your Comprehensive Coverage with a \$0.00 deductible. We also want to advise you about your Rental coverage.

We will pay you 80% of the daily rental charge, subject to the limitations set forth in your policy, when you rent a car from a car rental agency or garage. "Rental charge" means the daily rental rate plus charges for mileage and related taxes.

The most we will pay for your Car Rental Expense incurred in any one occurrence is \$1000.00.

Under all Physical Damage Coverages, including Rental, the right of recovery of any party we pay passes to us. You cannot collect from both the other party, or their insurance company, and us.

If you have any questions, please contact us at 1-888-613-3966 and speak to anyone on Team 2.

Sincerely,

Page 2

February 6, 2007

Margaret A. Huffer

Margaret A. Huffer

Claim Processor

State Farm Mutual Automobile Insurance Company

02/10/2007 at 11:38 AM
42884

Job Number:

PERFORMANCE AUTO BODY
License #:78207 Federal ID #:203258216
222 DAVIS ST
PARSONS, WV 26287
(304)478-2839 Fax: (304)478-2983

PRELIMINARY ESTIMATE

Written By: JEFF YUCHEK
Adjuster:

Insured:
Owner:
Address:
Evening:

HAMBLETON, WV

Claim #
Policy #
Deductible:
Date of Loss:
Type of Loss:
Point of Impact: 1. Right Front

Inspect
Location:

Insurance
Company:

Days to Repair

2005 CHEV COBALT LS 4-2.2L-FI 2D CPE BLUE Int:GRAY
VIN: 1G1AL14F157 Lic: WV Prod Date: Odometer: 28295
Air Conditioning Rear Defogger Tilt Wheel
Cruise Control Intermittent Wipers Keyless Entry
Body Side Moldings Dual Mirrors Clear Coat Paint
Power Steering Power Brakes Power Windows
Power Locks Power Mirrors AM Radio
FM Radio Stereo CD Player
Anti-Lock Brakes (4) Driver Air Bag Passenger Air Bag
Cloth Seats Bucket Seats 5 Speed Transmission
Aluminum/Alloy Wheels

NO.	OP.	DESCRIPTION	QTY	EXT. PRICE	LABOR	PAINT
1		FRONT BUMPER				
2		O/H front bumper			2.6	
3	Repl	Bumper cover	1	280.51	Incl.	2.6
4		Add for Clear Coat				1.0
5		Add for fog lamps			0.4	
6*	Repl	RT Outer grille WITH FOG	1	20.56	Incl.	
		LIGHTS				
7#	Rpr	BUFF HOOD			1.0	
8		FRONT LAMPS				
9	Repl	RT Fog lamp assy	1	119.23	Incl.	
10		Aim fog lamps			0.3	
11#	Rpr	BUFF REAR BUMPER			1.0	
12		WINDSHIELD				
13	Repl	Windshield NAGS coupe	1	288.25	2.2	
14#	Rpr	BUFF RT FENDER			1.0	

02/10/2007 at 11:38 AM
42884

Job Number:

PRELIMINARY ESTIMATE

2005 CHEV COBALT LS 4-2.2L-FI 2D CPE BLUE Int:GRAY

NO.	OP.	DESCRIPTION	QTY	EXT.	PRICE	LABOR	PAINT
15		QUARTER PANEL					
16	Repl	RT Liner retainer	2		0.28		
17#		CAR COVER	1		3.00	T 0.2	
N 18#	Repl	TIRE MOUNT & BALANCE	1		10.00		M
Subtotals ==>					721.83	8.7	3.6

Line 18 : RT FRT TIRE DUE TO ROCKS IN RIM

Parts		718.83
Body Labor	8.7 hrs @ \$ 38.00/hr	330.60
Paint Labor	3.6 hrs @ \$ 38.00/hr	136.80
Paint Supplies	3.6 hrs @ \$ 22.00/hr	79.20
Sublet/Misc.		3.00
SUBTOTAL		\$ 1268.43
Sales Tax	\$ 1268.43 @ 6.0000	76.11
GRAND TOTAL		\$ 1344.54
ADJUSTMENTS:		
Deductible		0.00
CUSTOMER PAY		\$ 0.00
INSURANCE PAY		\$ 1344.54

PERFORMANCE AUTO BODY COLLISION REPAIR WORK IS COVERED BY A ONE YEAR
WORKMANSHIP WARRANTY

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

02/10/2007 at 11:38 AM
42884

Job Number:

PRELIMINARY ESTIMATE

2005 CHEV COBALT LS 4-2.2L-FI 2D CPE BLUE Int:GRAY

Estimate based on MOTOR CRASH ESTIMATING GUIDE. Unless otherwise noted all items are derived from the Guide DRICL05 Database Date 12/2006, CCC Data Date 12/2006, and the parts selected are OEM-parts manufactured by the vehicles Original Equipment Manufacturer. OEM parts are available at OE/Vehicle dealerships. OPT OEM (Optional OEM) or ALT OEM (Alternative OEM) parts are OEM parts that may be provided by or through alternate sources other than the OEM vehicle dealerships. OPT OEM or ALT OEM parts may reflect some specific, special, or unique pricing or discount. OPT OEM or ALT OEM parts may include "Blemished" parts provided by OEM's through OEM vehicle dealerships. Asterisk (*) or Double Asterisk (**) indicates that the parts and/or labor information provided by MOTOR may have been modified or may have come from an alternate data source. Tilde sign (-) items indicate MOTOR Not-Included Labor operations. Non-Original Equipment Manufacturer aftermarket parts are described as AM, Qual Repl Parts or Comp Repl Parts which stands for Competitive Replacement Parts. Used parts are described as LKQ, Qual Recy Parts, RCY, or USED. Reconditioned parts are described as Recon. Recored parts are described as Recore. NAGS Part Numbers and Benchmark Prices are provided by National Auto Glass Specifications. Labor operation times listed on the line with the NAGS information are MOTOR suggested labor operation times. NAGS labor operation times are not included. Pound sign (#) items indicate manual entries. Some 2006 vehicles contain minor changes from the previous year. For those vehicles, prior to receiving updated data from the vehicle manufacturer, labor and parts data from the previous year may be used. The Pathways estimator has a complete list of applicable vehicles. Parts numbers and prices should be confirmed with the local dealership.

CCC Pathways - A product of CCC Information Services Inc.

03/01/2007 at 03:13 PM
42884

Job Number: 1741

PERFORMANCE AUTO BODY
License #:78207 Federal ID #:203258216
222 DAVIS ST
PARSONS, WV 26287
(304)478-2839 Fax: (304)478-2983

SUPPLEMENT OF RECORD 3 WITH SUMMARY

Written By: JEFF YUCHEK 03/01/2007 03:08 PM
Adjuster: Processor Team 2

Insured:

Owner:

Address:

HAMBLETON, WV

Evening:

Claim #

Policy #

Deductible:

Date of Loss: 02/04/2007 at 03:00 PM

Type of Loss: Comprehensive

Point of Impact: 5. Right Rear

Inspect

Location:

Insurance STATE FARM INSURANCE COMPANIES
Company: 21 TYGART VALLEY MALL
FAIRMONT, WV 26554

Days to Repair

2005 CHEV COBALT LS 4-2.2L-FI 2D CPE BLUE Int:GRAY

VIN: 1G1AL14F157

Lic:

WV

Prod Date:

Odometer: 28295

Air Conditioning

Rear Defogger

Tilt Wheel

Cruise Control

Intermittent Wipers

Keyless Entry

Body Side Moldings

Dual Mirrors

Clear Coat Paint

Power Steering

Power Brakes

Power Windows

Power Locks

Power Mirrors

AM Radio

FM Radio

Stereo

CD Player

Anti-Lock Brakes (4)

Driver Air Bag

Passenger Air Bag

Cloth Seats

Bucket Seats

5 Speed Transmission

Aluminum/Alloy Wheels

NO.	OP.	DESCRIPTION	QTY	EXT. PRICE	LABOR	PAINT
1		FRONT BUMPER				
2		O/H front bumper			2.6	
3	Repl	Bumper cover	1	280.51	Incl.	2.6
4		Add for Clear Coat				1.0
5		Add for fog lamps			0.4	
6* S01	Repl	RT Outer grille WITH FOG LIGHTS	1	21.12	Incl.	
7#	Rpr	BUFF HOOD			1.0	
8		FRONT LAMPS				
9	Repl	RT Fog lamp assy	1	119.23	Incl.	
10		Aim fog lamps			0.3	
11#	Rpr	BUFF REAR BUMPER			1.0	
12		WINDSHIELD				
13* S02	Repl	Windshield NAGS coupe	1	335.00	2.2	

03/01/2007 at 03:13 PM
42884

Job Number: 1741

SUPPLEMENT OF RECORD 3 WITH SUMMARY
2005 CHEV COBALT LS 4-2.2L-FI 2D CPE BLUE Int:GRAY

NO.	OP.	DESCRIPTION	QTY	EXT.	PRICE	LABOR	PAINT
14#	Rpr	BUFF RT FENDER				1.0	
15		QUARTER PANEL					
16	Repl	RT Liner retainer	2		0.28		
17#		CAR COVER	1		3.00 T	0.2	
18# S01	Rpr	BUFF RT QUARTER				1.0	
N 19# S01	Rpr	WET Sand				1.0	
20# S02	Repl	URETHANE	1		18.75		
N 21# S03	Subl	PAINT&MAT PRICE DIFFERENCE	1		91.05 X		
Subtotals ==>					868.94	10.7	3.6

Line 19 : TIME FOR DEEP SCRATCHES

Line 21 : INVOICE IN FOLDER PICTURE UPLOADED.

Parts		774.89
Body Labor	10.7 hrs @ \$ 38.00/hr	406.60
Paint Labor	3.6 hrs @ \$ 38.00/hr	136.80
Paint Supplies	3.6 hrs @ \$ 22.00/hr	79.20
Sublet/Misc.		94.05
SUBTOTAL		\$ 1491.54
Sales Tax	\$ 1400.49 @ 6.0000%	84.03
GRAND TOTAL		\$ 1575.57
ADJUSTMENTS:		
Deductible		0.00
CUSTOMER PAY		\$ 0.00
INSURANCE PAY		\$ 1575.57

PERFORMANCE AUTO BODY COLLISION REPAIR WORK IS COVERED BY A ONE YEAR
WORKMANSHIP WARRANTY

PERFORMANCE AUTO BODY COLLISION REPAIR WORK OFFERS A LIMITED LIFETIME WARRANTY
FOR WORKMANSHIP INCLUDING REFINISHING AS LONG AS CUSTOMER OWNS THE VEHICLE .

Any person who knowingly presents a false or fraudulent claim for payment of a
loss or benefit or knowingly presents false information in an application for
insurance is guilty of a crime and may be subject to fines and confinement in
prison.

SUPPLEMENT OF RECORD 3 WITH SUMMARY
2005 CHEV COBALT LS 4-2.2L-FI 2D CPE BLUE Int:GRAY

Estimate based on MOTOR CRASH ESTIMATING GUIDE. Unless otherwise noted all items are derived from the Guide DR1CLO5 Database Date 01/2007, CCC Data Date 01/2007, and the parts selected are OEM-parts manufactured by the vehicles Original Equipment Manufacturer. OEM parts are available at OE/Vehicle dealerships. OPT OEM (Optional OEM) or ALT OEM (Alternative OEM) parts are OEM parts that may be provided by or through alternate sources other than the OEM vehicle dealerships. OPT OEM or ALT OEM parts may reflect some specific, special, or unique pricing or discount. OPT OEM or ALT OEM parts may include "Blemished" parts provided by OEM's through OEM vehicle dealerships. Asterisk (*) or Double Asterisk (**) indicates that the parts and/or labor information provided by MOTOR may have been modified or may have come from an alternate data source. Tilde sign (~) items indicate MOTOR Not-Included Labor operations. Non-Original Equipment Manufacturer aftermarket parts are described as AM, Qual Repl Parts or Comp Repl Parts which stands for Competitive Replacement Parts. Used parts are described as LKQ, Qual Recy Parts, RCY, or USED. Reconditioned parts are described as Recond. Recored parts are described as Recore. NAGS Part Numbers and Benchmark Prices are provided by National Auto Glass Specifications. Labor operation times listed on the line with the NAGS information are MOTOR suggested labor operation times. NAGS labor operation times are not included. Pound sign (#) items indicate manual entries. Some 2006 vehicles contain minor changes from the previous year. For those vehicles, prior to receiving updated data from the vehicle manufacturer, labor and parts data from the previous year may be used. The Pathways estimator has a complete list of applicable vehicles. Parts numbers and prices should be confirmed with the local dealership.

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03/01/2007 at 03:13 PM
42884

Job Number: 1741

SUPPLEMENT OF RECORD 3 WITH SUMMARY
2005 CHEV COBALT LS 4-2.2L-FI 2D CPE BLUE Int:GRAY

NO.	OP.	DESCRIPTION	QTY	EXT. PRICE	LABOR	PAINT
----- ADDED ITEMS -----						
N 21#	S03	Subl PAINT&MAT PRICE DIFFERENCE	1	91.05	X	
Subtotals ==>				91.05	0.0	0.0

Line 21 : INVOICE IN FOLDER PICTURE UPLOADED.

Parts	0.00
Sublet/Misc.	91.05

SUBTOTAL	\$ 91.05

TOTAL SUPPLEMENT AMOUNT	\$ 91.05

NET COST OF SUPPLEMENT	\$ 91.05

Estimate	1293.39	JEFF YUCHEK
Supplement S01	81.15	JEFF YUCHEK
Supplement S02	109.98	JEFF YUCHEK
Supplement S03	91.05	JEFF YUCHEK

Job Total \$ 1575.57

INSURANCE PAY \$ 1575.57

PERFORMANCE AUTO BODY COLLISION REPAIR WORK IS COVERED BY A ONE YEAR
WORKMANSHIP WARRANTY

PERFORMANCE AUTO BODY COLLISION REPAIR WORK OFFERS A LIMITED LIFETIME WARRANTY
FOR WORKMANSHIP INCLUDING REFINISHING AS LONG AS CUSTOMER OWNS THE VEHICLE .

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loss or benefit or knowingly presents false information in an application for
insurance is guilty of a crime and may be subject to fines and confinement in
prison.

SUPPLEMENT OF RECORD 3 WITH SUMMARY
2005 CHEV COBALT LS 4-2.2L-FI 2D CPE BLUE Int:GRAY

Estimate based on MOTOR CRASH ESTIMATING GUIDE. Unless otherwise noted all items are derived from the Guide DR1CL05 Database Date 01/2007, CCC Data Date 01/2007, and the parts selected are OEM-parts manufactured by the vehicles Original Equipment Manufacturer. OEM parts are available at OE/Vehicle dealerships. OPT OEM (Optional OEM) or ALT OEM (Alternative OEM) parts are OEM parts that may be provided by or through alternate sources other than the OEM vehicle dealerships. OPT OEM or ALT OEM parts may reflect some specific, special, or unique pricing or discount. OPT OEM or ALT OEM parts may include "Blemished" parts provided by OEM's through OEM vehicle dealerships. Asterisk (*) or Double Asterisk (**) indicates that the parts and/or labor information provided by MOTOR may have been modified or may have come from an alternate data source. Tilde sign (~) items indicate MOTOR Not-Included Labor operations. Non-Original Equipment Manufacturer aftermarket parts are described as AM, Qual Repl Parts or Comp Repl Parts which stands for Competitive Replacement Parts. Used parts are described as LRQ, Qual Recy Parts, RCY, or USED. Reconditioned parts are described as Recond. Recored parts are described as Recore. NAGS Part Numbers and Benchmark Prices are provided by National Auto Glass Specifications. Labor operation times listed on the line with the NAGS information are MOTOR suggested labor operation times. NAGS labor operation times are not included. Pound sign (\$) items indicate manual entries. Some 2006 vehicles contain minor changes from the previous year. For those vehicles, prior to receiving updated data from the vehicle manufacturer, labor and parts data from the previous year may be used. The Pathways estimator has a complete list of applicable vehicles. Parts numbers and prices should be confirmed with the local dealership.

CCC Pathways - A product of CCC Information Services Inc.

ELLIOTT COLLISION CENTER
PO BOX 2129
STAUNTON, VA 24402
PHONE (540) 213-2267
FAX (540) 213-2269

DATE 5/6/08

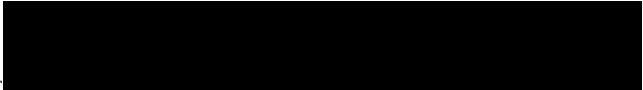
NUMBER OF PAGES (INCLUDING COVER) 2

TO SHANNON

FAX NUMBER 888-613-3569

FROM B. H. Shuffett

REMARKS ☐ URGENT ☐ REPLY ☐ PLEASE COMMENT ☐ FOR YOUR REVIEW ☐

CLAIM # 

ELLIOTT CHEVROLET-CADILLAC

1100 GREENVILLE AVE / P.O. BOX 2129

STAUNTON, VA. 24402-2129

540-885-1584 540-943-3225

85361LAM

HAMBLETON		WV		VEHICLE IDENTIFICATION		MILEAGE OUT	DATE OUT	INVOICE NO.
				1G1AL14F157		49558	05/02/08	85361
				YEAR	MAKE	MODEL	COLOR	TAG NO.
				05	CHEVROLET	COBALT	BLUE	00000
CUST. NO.	LICENSE	HOME PHONE	WORK PHONE	STOCK NO.	PROD. DATE	SERV. ADV.	TERMS	
			540- -		00/00/00	60 1474ND	CASH	
CUST. LABOR RATE	DELIV. DATE	DELIV. MILES	MILEAGE IN	DATE IN	IN-SERV DATE			
71.95	05/21/05		49558	04/30/08	05/21/05			

YOU MAY RECEIVE A SURVEY FROM YOUR VEHICLE MANUFACTURE IN A FEW DAYS REGARDING THE QUALITY OF OUR SERVICE. IF FOR ANY REASON YOU CAN NOT ANSWER "COMPLETELY SATISFIED" TO ALL THE QUESTIONS, PLEASE CONTACT OUR SERVICE MANAGEMENT TEAM BEFORE RESPONDING TO THIS SURVEY. THANK YOU

LINE	OP. CODE	FAIL-CD	TECH.	HOURS/QT	TYPE	AMOUNT
A	CUSTOMER STATES PLEASE CHECK OVER MOTOR MOUNT, DRIVELINE, AND UNDERCARRIAGE,					
	EVERYTHING IS IN CORRECT WORKING ORDER ALL IS TIGHT AND STEADY					
	A18	2766		1.00	C	71.95
	Line Total.....					71.95

B	CUSTOMER STATES PLEASE CHECK IF BUMPER IS ALIGNED CORRECTLY					
	BODY SHOP					
	A18	2766				
	Line Total.....					

Labor	71.95
SHOP SUPPLIES	7.20
TOTAL-AMOUNT	79.15

CUSTOMER COPY - PAGE 01

STATEMENT OF DISCLAIMER

The factory warranty constitutes all of the warranties with respect to the sale of this item/items. The seller hereby expressly disclaims all warranties either express or implied, including any implied warranty of merchantability or fitness for a particular purpose. Seller neither assumes nor authorizes any other person to assume for it any liability in connection with the sale of this item/items.

CUSTOMER SIGNATURE

On behalf of servicing dealer, I hereby certify that the information contained hereon is accurate unless otherwise shown. Warranty services described were performed at no charge to owner. There was no indication from the appearance of the vehicle or otherwise, that any part repaired or replaced under this claim had been connected in any way with any accident, negligence or misuse. Records supporting this claim are available for (1) year from the date of payment notification at the servicing dealer for inspection by manufacturer's representative.

(SIGNED) DEALER, GENERAL MANAGER OR AUTHORIZED PERSON (DATE)



HARRY GREEN CHEVROLET Inc.

Route 50 East P.O. Box 1527
CLARKSBURG, W. VA. 26302-1527
Telephone 624-6304 or 1-800-35 CHEVY



CUSTOMER NO 60405	ADVISOR ROBERT P SMITH	TAG NO 109	404	INVOICE DATE 05/28/05	INVOICE NO CVCS216720
[REDACTED] HAMBLETON, WV	LABOR RATE	LICENSE NO	1,111	COLOR ARRIVAL BLU	STOCK NO DW404
	YEAR / MAKE / MODEL 05/CHEVROLET/COBALT/COBALT LS			DELIVERY DATE 05/21/05	INVENTORY MILES 10
	VEHICLE ID NO 1 G 1 A L 1 4 F 1 5 7			DELIVERY DATE 05/28/05	INVENTORY DATE
F T E NO			P O NO	MO: 1112	
COMMENTS E# 2.2L 4CYL					

LABOR & PARTS
J# 1 05CVZ08 DOOR LOCK/LATCH UNITS: 3.50 TECH(S):351 174.83
CUSTOMER STATES INSTALL DOOR HANDLES SUPPLIED BY CUSTOMER
ON PASSENGER SEAT.
REPLACED DOOR HANDLES AS PER CUSTOMER REQUEST.
OK AT THIS TIME.

JOB # 1 TOTAL LABOR & PARTS 174.83

ESTIMATE
CUSTOMER HEREBY ACKNOWLEDGES RECEIVING
ORIGINAL ESTIMATE OF \$185.00 (+TAX)

TOTALS
PARTS DESIGNATED WITH ASTERIK (*) INDICATES LIFETIME
GUARANTEE APPLIES FOR CUSTOMER PAY REPAIRS

TOTAL LABOR.... 174.83
TOTAL PARTS.... 0.00
TOTAL SUBLET... 0.00
TOTAL G.O.G.... 0.00
TOTAL MISC CHG. 0.00
TOTAL MISC DISC 0.00
TOTAL TAX..... 10.49

TOTAL INVOICE \$ 185.32

CUSTOMER SIGNATURE

WE HONOR:



VISIT US ON THE INTERNET

AT

<http://www.harrygreen.com>

ALL PARTS NEW UNLESS SPECIFIED OTHERWISE

FOR YOUR CONVENIENCE SERVICE DEPT. HOURS

MON. - FRI. 7:00 am - 7:00 pm
SAT 9:00 am - 5:00 pm

PARTS DEPT. HOURS

MON - FRI 7:30 am - 7:00 pm
SAT 9:00 am - 5:00 pm

BODY SHOP HOURS

MON - FRI 7:30 am - 5:30 pm

7 ACRES OF CARS AND TRUCKS.
THE CAR OR TRUCK YOU WANT.
WHEN YOU WANT IT, NOW.

IMPORTANT

YOU MAY RECEIVE A
QUESTIONNAIRE FROM THE
MANUFACTURER IN THE NEXT FEW
DAYS IF FOR ANY REASON YOU
CANNOT GRADE US "COMPLETELY
SATISFIED." IN DESCRIBING YOUR
SERVICE EXPERIENCE WITH US.
PLEASE CONTACT YOUR
SERVICE ADVISOR SHOWN BELOW.
THANK YOU.
HARRY GREEN CHEV. INC.
304-624-6304



HARRY GREEN CHEVROLET Inc.

Route 50 East P.O. Box 1527
CLARKSBURG, W. VA. 26302-1527
Telephone 624-6304 or 1-800-35 CHEVY



CUSTOMER NO 60405	ADVISOR ROBERT P SMITH	TAG NO 109 404	INVOICE DATE 09/09/05	INVOICE CVC
HAMBLETON, WV	LABOR RATE	LICENSE NO	ARRIVAL BLU	STOCK DW4
	YEAR MAKE / MODEL 05/CHEVROLET/COBALT/COBALT LS		DELIVERY DATE 05/21/05	OFFLINE
	VEHICLE ID NO 1 G 1 A L 1 4 F 1 5 7			MAJOR
	DISCRIPTION E# 2.2L 4CYL			

LABOR & PARTS
 JOB # 1 17CVZ-3K 3,000 MILE SERVICE UNITS: TECH(S):471 11.20
 CUSTOMER REQUEST 3000 MILE SERVICE
 PERFORM 3000 MILE SERVICE AS PER MENU

PARTS	QTY	FP-NUMBER	DESCRIPTION	LIST PRICE	UNIT PRICE	PRICE
JOB # 1	1	12579143	FILTER 1.836	5.25	5.25	5.25
JOB # 1	1	6550	TTL DEPOS	19.95	19.95	19.95
BROOKSIDE SALES (BG) AFTERMARKET						

JOB # 1 TOTAL PARTS 25.20

JOB # 1 TOTAL LABOR & PARTS 36.40

G.O.G. & SUPPLIES
 JOB # 1 1.0 CASTROL 5W30 - 5 QTS @ 8.500 /UNIT 8.50
 TOTAL - GOG 8.50

MISC CODE DESCRIPTION CONTROL NO
 JOB # A SHOPSUPPLY SS.ENVIRONMENTAL & HAZ.WASTE CHG. 0.84
 TOTAL - MISC 0.84

ESTIMATE
 CUSTOMER HEREBY ACKNOWLEDGES RECEIVING
 ORIGINAL ESTIMATE OF \$50.00 (+TAX)
 COMMENTS: 109

TOTALS
 PARTS DESIGNATED WITH ASTERIK (*) INDICATES LIFETIME
 GUARANTEE APPLIES FOR CUSTOMER PAY REPAIRS

TOTAL LABOR	11.20
TOTAL PARTS	25.20
TOTAL SUBLET	0.00
TOTAL G.O.G.	8.50
TOTAL MISC CHG.	0.84
TOTAL MISC DISC	0.00
TOTAL TAX	2.74

TOTAL INVOICE \$ 48.48

CUSTOMER SIGNATURE

WE HONOR:



VISIT US ON THE IF
AT

<http://www.harrygre>

ALL PARTS NEW UNLESS
OTHERWISE

FOR YOUR CONVEI
SERVICE DEPT. H

MON - FRI 7:00 a.m. - 7
SAT 9:00 a.m. - 5:00

PARTS DEPT. HC

MON - FRI 7:30 a.m. - 7
SAT 9:00 a.m. - 5:00

BODY SHOP HO

MON - FRI 7:30 a.m. - 5

7 ACRES OF CARS AND
THE CAR OR TRUCK YC
WHEN YOU WANT IT

IMPORTANT

YOU MAY RECEIVE
 QUESTIONNAIRE FROM
 MANUFACTURER IN THE 10
 DAYS IF FOR ANY REAS
 CANNOT GRADE US "COM
 SATISFIED." IN DESCRIB
 SERVICE EXPERIENCE W
 PLEASE CONTACT YC
 SERVICE ADVISOR SHOWN
 THANK YOU.
 HARRY GREEN CHEV.
 304-624-6304



OWNER OF VEHICLE: **ENTERPRISE RENT-A-CAR COMPANY**
 BRANCH ADDRESS: **1000 N. 10TH ST. SUITE 1000, NORFOLK, VA 23510**

RENTAL AGREEMENT NO. **D 01**

RENTAL TYPE		SOURCE	LD
RENTER		DATE	
START CHARGES IF DIFFERENT			
ORIGINAL VEHICLE			
COLOR	LICENSE NO.		
MODEL	YEAR		
MILEAGE	IN	OUT	
DRIVEN			
CONDITION AND FUEL X LIFE AGREES TO RENTER			
BILL TO COMPANY			
ATTN: PROLESIS			
REFERENCE NUMBER			
ADDITIONAL AUTHORIZED DRIVER(S) - EXCEPT AS REQUIRED BY LAW, NONE PERMITTED WITHOUT OWNER'S WRITTEN APPROVAL. REQUEST OWNER'S PERMISSION TO ALLOW NO OTHER DRIVER PERMITTED			
WHO IS UNDER MY CONTROL AND DIRECTION TO DRIVE VEHICLE FOR ME AND ON MY BEHALF I AM RESPONSIBLE FOR THEIR ACTS WHILE THEY ARE DRIVING. AND FOR FULFILLING TERMS AND CONDITIONS OF THIS RENTAL AGREEMENT. USE OF VEHICLE BY AN UNAUTHORIZED DRIVER WILL AFFECT MY LIABILITY AND RIGHTS UNDER THIS AGREEMENT.			
RENTER: X			
PERMISSION GRANTED TO OPERATE VEHICLE ONLY IN THE STATE OF RENTAL AND THE FOLLOWING STATE(S):			
OPERATION IN ANY OTHER STATE OR COUNTRY WILL AFFECT YOUR LIABILITY AND RIGHTS UNDER THIS AGREEMENT.			
RENTER DECLINES OPTIONAL COLLISION DAMAGE WAIVER (CDW) AND ASSUMES DAMAGE RESPONSIBILITY. SEE PAGE 2, PARAGRAPH 8.		RENTER ACCEPTS OPTIONAL COLLISION DAMAGE WAIVER (CDW) AT FEE SHOWN IN COLUMN TO RIGHT. SEE NOTICE TO LEFT AND PAGE 3, PARAGRAPH 16. CDW IS NOT INSURANCE.	
RENTER: X Declines CDW		RENTER: X	
RENTER DECLINES OPTIONAL PERSONAL ACCIDENT INSURANCE (PAI). SEE PAGE 2, PARAGRAPH 12.		RENTER ACCEPTS OPTIONAL PERSONAL ACCIDENT INSURANCE (PAI) AT FEE SHOWN IN COLUMN TO RIGHT. SEE PAGE 3, PARAGRAPH 16.	
RENTER: X Declines PAI		RENTER: X	
RENTER DECLINES OPTIONAL SUPPLEMENTAL LIABILITY PROTECTION (SLP). SEE PAGE 2, PARAGRAPH 7.		RENTER ACCEPTS OPTIONAL SUPPLEMENTAL LIABILITY PROTECTION (SLP) AT FEE SHOWN IN COLUMN TO RIGHT. SEE PAGE 3, PARAGRAPH 17.	
RENTER: X Declines SLP		RENTER: X	
ACKNOWLEDGMENT OF THE ENTIRE AGREEMENT, WHICH CONSISTS OF PAGES 1 THROUGH 4.			
I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS ON PAGES 1 THROUGH 4 OF THIS AGREEMENT AND BY MY SIGNATURE BELOW I AM THE RENTER UNDER THIS AGREEMENT. BY SIGNING BELOW, I AM AUTHORIZING OWNER TO PROCEED WITH CHARGES ON MY CREDIT CARD(S) AND/OR DEBIT CARD(S) FOR ADVANCE DEPOSITS, INCREMENTAL AUTHORIZATIONS, DEPOSITS, AND CHARGES INCURRED, AS WELL AS PAYMENT. THIS REFUSED BY A THIRD PARTY TO WHOM BILLING WAS DIRECTED. I CERTIFY THAT THE DRIVER'S LICENSE(S) PRESENTED IS CURRENTLY VALID AND IS NOT SUSPENDED, EXPIRED, REVOKED, CANCELLED OR SURRENDERED.			
RENTER: X		DATE: 10/14/04	
REPLACEMENT VEHICLE		OWNER REP: X	
COLOR	LICENSE NO.		
MODEL	YEAR		
MILEAGE	IN	OUT	
DRIVEN			
CONDITION AND FUEL X LIFE AGREES TO RENTER			
NO DAMAGE			
PRICE			
OUT	IN		
I WILL RETURN CAR BY:			
DATE	TIME	AMOUNT	PAID BY
ADDITIONAL INFORMATION			
TOTAL CHARGES			
DEPOSITS			
REFUNDS			
AMOUNT DUE			
CLOSED BY			
PAID BY	CASH	CHECK	
RECEIPT OF CASH/REFUND	DATE	AMOUNT	

*VLF is the Vehicle License Fee recovery, see Page 2, 3.c.7

OWNER IS AN AFFILIATE OF ENTERPRISE RENT-A-CAR COMPANY, WHICH OWNS ALL RIGHTS TO ENTERPRISE NAMES AND MARKS

© ENTERPRISE LEASING COMPANY OF NORFOLK, VA

S07405

North American Corporation of Illinois 1-800-220-9020

ELLIOTT CHEVROLET-CADILLAC
 1100 GREENVILLE AVE / P.O. BOX 2129
 STAUNTON, VA. 24402-2129
 540-885-1584 540-943-3225

68751LAM

NICKY-SERVICE

HAMBLETON WV [REDACTED]				VEHICLE IDENTIFICATION		MILEAGE OUT	DATE OUT	INVOICE NO.
				1G1AL14F157 [REDACTED]		13680	04/05/06	68751 PART-CLOS
				YEAR	MAKE	MODEL	COLOR	TAG NO.
				05	CHEVROLET	COBALT	BLUE	00000
CUST. NO.	LICENSE	HOME PHONE	WORK PHONE	STOCK NO.	PROD. DATE	SERV. ADV.	TERMS	
	[REDACTED]	[REDACTED]	540- -		00/00/00	46 1436RB	CASH	
CUST. LABOR RATE	DELIV. DATE	DELIV. MILES	MILEAGE IN	DATE IN	IN-SERV DATE			
65.95	05/21/05		13680	03/30/06	05/21/05			

YOU MAY RECEIVE A SURVEY FROM YOUR VEHICLE MANUFACTURER IN A FEW DAYS REGARDING THE QUALITY OF OUR SERVICE. IF FOR ANY REASON YOU CAN NOT ANSWER "COMPLETELY SATISFIED" TO ALL THE QUESTIONS, PLEASE CONTACT OUR SERVICE MANAGEMENT TEAM BEFORE RESPONDING TO THIS SURVEY. THANK YOU

LINE	OP. CODE	FAIL-CD	TECH.	HOURS/QT	TYPE	AMOUNT
A	CUSTOMER STATES CHROME IS PEELING OFF OF GEAR SHIFT KNOB					
	KNOB, CONTROL AND/OR SHIFT - ONE AND/OR ALL - REPLACE					
	C2990	5C	A18 2766	.20	W	
Auth:	Claim Type:		Complaint Cd: VV	LaborHrs: 0.2	OtherHrs: 0.0	
	X [REDACTED]	HANDLE		1	W	
	Line Total.....					

B	CUSTOMER STATES LEFT DOOR SWITCH BEZEL GRAY PAINT IS PEELING					
	PLATE, FRONT DOOR ARMREST SWITCH MOUNTING - LEFT - R&A;R					
	OR REPLACE					
	C3301	5L	A18 2766	.20	W	
Auth:	Claim Type:		Complaint Cd: VV	LaborHrs: 0.2	OtherHrs: 0.0	
	X [REDACTED]	PLATE		1	W	
	Line Total.....					

C	CUSTOMER STATES WHEN BRAKING AT 45 MPH AND ABOVE BRAKE VIBRATION					
	DEVELOPS					
	BEARING AND HUB ASSEMBLY, FRONT WHEEL - RIGHT - REPLACE					
	E2320	4X	A18 2766	1.00	W	
Auth:	Claim Type:		Complaint Cd: O4	LaborHrs: 1.0	OtherHrs: 0.0	
	X [REDACTED]	BEARING		1	W	
		-FREIGHT-	-FREIGHT-	1	W	
	Line Total.....					

CUSTOMER COPY - PAGE 01

STATEMENT OF DISCLAIMER
 The factory warranty constitutes all of the warranties with respect to the sale of this item/items. The Seller hereby expressly disclaims all warranties either express or implied, including any implied warranty of merchantability or fitness for a particular purpose. Seller neither assumes nor authorizes any other person to assume for it any liability in connection with the sale of this item/items.

CUSTOMER SIGNATURE

On behalf of servicing dealer, I hereby certify that the information contained herein is accurate unless otherwise shown. Warranty services described were performed at no charge to owner. There was no indication from the appearance of the vehicle or otherwise, that any part repaired or replaced under this claim had been connected in any way with any accident, negligence or misuse. Records supporting this claim are available for (1) year from the date of payment in connection with the claim. Inspection by manufacturer's representative at the servicing dealer for inspection by manufacturer's representative.

(SIGNED) DEALER, GENERAL MANAGER OR AUTHORIZED PERSON (DATE)

ELLIOTT CHEVROLET-CADILLAC
 1100 GREENVILLE AVE / P.O. BOX 2129
 STAUNTON, VA. 24402-2129
 540-885-1584 540-943-3225

68751LAM

<div style="background-color: black; width: 150px; height: 40px; margin: 0 auto;"></div> HAMBLETON		WV <div style="background-color: black; width: 80px; height: 20px; display: inline-block;"></div>		VEHICLE IDENTIFICATION 1G1AL14F157		MILEAGE OUT 13680		DATE OUT 04/05/06		INVOICE NO. 68751 PART-CLOSE																																																						
		YEAR 05		MAKE CHEVROLET		MODEL COBALT		COLOR BLUE		TAG NO. 00000																																																						
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CUSTOMER COPY - PAGE 02																																																																
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ELLIOTT CHEVROLET-CADILLAC

1100 GREENVILLE AVE / P.O. BOX 2129

STAUNTON, VA. 24402-2129

540-885-1584 540-943-3225

67080LAM

[REDACTED] HAMBLETON WV [REDACTED]		VEHICLE IDENTIFICATION		MILEAGE OUT	DATE OUT	INVOICE NO.	
		1G1AL14F157 [REDACTED]		9172	01/10/06	67080 PART-CLOSE	
		YEAR	MAKE	MODEL	COLOR	TAG NO.	
		05	CHEVROLET	COBALT	BLUE	00000	
CUST.NO.	LICENSE	HOME PHONE	WORK PHONE	STOCK NO.	PROD.DATE	SERV.ADV.	TERMS
	[REDACTED]	[REDACTED]	540- -		00/00/00	48 8083PK	CASH
CUST.LABOR RATE	DELIV.DATE	DELIV.MILES	MILEAGE IN	DATE IN	IN-SERV DATE		
65.95	05/21/05		9172	01/10/06	05/21/05		

YOU MAY RECEIVE A SURVEY FROM YOUR VEHICLE MANUFACTURE IN A FEW DAYS REGARDING THE QUALITY OF OUR SERVICE. IF FOR ANY REASON YOU CAN NOT ANSWER "COMPLETELY SATISFIED" TO

ALL THE QUESTIONS, PLEASE CONTACT OUR SERVICE MANAGEMENT TEAM BEFORE RESPONDING TO THIS SURVEY. THANK YOU

LINE	OP.CODE	FAIL-CD	TECH.	HOURS/QTY	TYPE	AMOUNT
TOTAL-AMOUNT						NoCharge

CUSTOMER COPY - PAGE 02

STATEMENT OF DISCLAIMER
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(SIGNED) DEALER, GENERAL MANAGER OR AUTHORIZED PERSON (DATE)

ELLIOTT CHEVROLET-CADILLAC
 1100 GREENVILLE AVE / P.O. BOX 2129
 STAUNTON, VA. 24402-2129
 540-885-1584 540-943-3225

67080LAM

[REDACTED] HAMBLETON WV [REDACTED]		VEHICLE IDENTIFICATION		MILEAGE OUT	DATE OUT	INVOICE NO.
		1G1AL14F157 [REDACTED]		9172	01/10/06	67080 PART-CLOSE
		YEAR	MAKE	MODEL	COLOR	TAG NO.
		05	CHEVROLET	COBALT	BLUE	00000
CUST.NO.	LICENSE	HOME PHONE	WORK PHONE	STOCK NO.	PROD.DATE	SERV.ADV.
	[REDACTED]	[REDACTED]	540- -		00/00/00	48 8083PK
CUST.LABOR RATE	DELIV.DATE	DELIV.MILES	MILEAGE IN	DATE IN	IN-SERV DATE	
65.95	05/21/05		9172	01/10/06	05/21/05	

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LINE	OP.CODE	FAIL-CD	TECH.	HOURS/QT	TYPE	AMOUNT
A	CUSTOMER STATES THAT SOMETIMES THE STARTER STAYS ENGAGED AFTER YOU LET OFF THE KEY.					
	COULD NOT DUPLICATE COMPLAINT, NO PROBLEM FOUND AT THIS TIME.					
	J9993	9Z	A16 4779	.30	W	
Auth:	Claim Type:	Complaint Cd:	OF	LaborHrs:	0.3	OtherHrs: 0.0
				Line Total:	

B	CUSTOMER STATES THAT HER BRAKE PEDAL WILL GO TO THE FLOOR AFTER STEPPING ON THE PEDAL ABOUT 3 TIMES. CUSTOMER STATES THAT IT FEELS LIKE YOU ARE BLEEDING THE BRAKES.					
	NO PROBLEM FOUND					
			A16 4779			
				Line Total:	

C	CUSTOMER STATES THAT HER CAR TRIES TO ACCELERATE WHEN LETTING OFF THE BRAKE PEDAL BUT WITHOUT STEPPING ON THE GAS PEDAL.					
	NO PROBLEM FOUND					
			A16 4779			
				Line Total:	

CUSTOMER COPY - PAGE 01

STATEMENT OF DISCLAIMER

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CUSTOMER SIGNATURE

(SIGNED) DEALER, GENERAL MANAGER OR AUTHORIZED PERSON (DATE)

05/22/2006 at 11:54 AM
42384

Job Number:

PERFORMANCE AUTO BODY
License #:78207 Federal ID #:203258216
222 DAVIS ST
PARSONS, WV 26287
(304)478-2839 Fax: (304)478-2983

PRELIMINARY ESTIMATE

Written By: WARREN JUDY
Adjuster:

Insured:
Owner:
Address:
Evening:

[REDACTED]
[REDACTED]
HAMBLETON, WV [REDACTED]
[REDACTED]

Claim #
Policy #
Deductible:
Date of Loss:
Type of Loss:
Point of Impact:

Inspect PERFORMANCE AUTO BODY
Location: 222 DAVIS ST
PARSONS, WV 26287

Business: (304)478-2839

Insurance
Company:

Days to Repair

2005 CHEV COBALT LS 4-2.2L-FI 2D CPE BLUE Int:

VIN: 1G1AL14F157

Lic: [REDACTED]

Prod Date:

Odometer:

Air Conditioning

Rear Defogger

Tilt Wheel

Cruise Control

Intermittent Wipers

Keyless Entry

Body Side Moldings

Dual Mirrors

Clear Coat Paint

Power Steering

Power Brakes

Power Windows

Power Locks

Power Mirrors

AM Radio

FM Radio

Stereo

CD Player

Anti-Lock Brakes (4)

Driver Air Bag

Passenger Air Bag

Cloth Seats

Bucket Seats

5 Speed Transmission

Aluminum/Alloy Wheels

NO.	OP.	DESCRIPTION	QTY	EXT.	PRICE	LABOR	PAINT
1#	Repl	STRIP KIT	1		307.96	1.0	
Subtotals ==>					307.96	1.0	0.0

Parts		307.96
Body Labor	1.0 hrs @ \$ 38.00/hr	38.00
SUBTOTAL		\$ 345.96
Sales Tax	\$ 345.96 @ 6.0000%	20.76
GRAND TOTAL		\$ 366.72

ADJUSTMENTS:
Deductible

0.00

AutoTrin
Express
89304

5/22/2006 at 11:54 AM
2884

Job Number:

PRELIMINARY ESTIMATE

2005 CHEV COBALT LS 4-2.2L-FI 2D CPE BLUE Int:

CUSTOMER PAY	\$ 0.00
INSURANCE PAY	\$ 366.72

PERFORMANCE MOTORS COLLISION REPAIR WORK IS COVERED BY A ONE YEAR WORKMANSHIP WARRANTY

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Estimate based on MOTOR CRASH ESTIMATING GUIDE. Unless otherwise noted all items are derived from the Guide DR1CLO5 Database Date 05/2006, CCC Data Date 05/2006, and the parts selected are OEM-parts manufactured by the vehicles Original Equipment Manufacturer. OEM parts are available at OE/Vehicle dealerships. OPT OEM (Optional OEM) parts are OEM parts that may be provided by or through alternate sources other than the OE/Vehicle dealerships. OPT OEM parts may reflect some specific, special, or unique pricing or discount. Asterisk (*) or Double Asterisk (**) indicates that the parts and/or labor information provided by MOTOR may have been modified or may have come from an alternate data source. Tilde sign (~) items indicate MOTOR Not-Included Labor operations. Non-Original Equipment Manufacturer aftermarket parts are described as AM, Qual Repl Parts or Comp Repl Parts which stands for Competitive Replacement Parts. Used parts are described as LKQ, Qual Repl Parts, RCY, or USED. Reconditioned parts are described as Recon. Recored parts are described as Recore. NAGS Part Numbers and Benchmark Prices are provided by National Auto Glass Specifications. Labor operation times listed on the line with the NAGS information are MOTOR suggested labor operation times. NAGS labor operation times are not included. Pound sign (#) items indicate manual entries. Some 2006 vehicles contain minor changes from the previous year. For those vehicles, prior to receiving updated data from the vehicle manufacturer, labor and parts data from the previous year may be used. The Pathways estimator has a complete list of applicable vehicles. Parts numbers and prices should be confirmed with the local dealership.

CCC Pathways - A product of CCC Information Services Inc.

05/22/2006 at 11:41 AM
42884

Job Number:

PERFORMANCE AUTO BODY
License #:78207 Federal ID #:203258216
222 DAVIS ST
PARSONS, WV 26287
(304)478-2839 Fax: (304)478-2983

PRELIMINARY ESTIMATE

Written By: WARREN JUDY
Adjuster: Processor Team 1

Insured:

Claim #

Owner:

Policy #

Address:

Deductible:

HAMBLETON, WV

Date of Loss: 05/22/2006 at 07:34 AM

Evening:

Type of Loss: Comprehensive

Point of Impact: 12. Front

Inspect

Day: ()-

Location: IN USE

Insurance STATE FARM INSURANCE COMPANIES
Company: 21 TYGART VALLEY MALL
FAIRMONT, WV 26554

Days to Repair

2005 CHEV COBALT LS 4-2.2L-FI 2D CPE BLUE Int:GRAY

VIN: 1G1AL14F157 Lic: WV Prod Date: 01/2005 Odometer: 16759

Air Conditioning	Rear Defogger	Tilt Wheel
Cruise Control	Intermittent Wipers	Keyless Entry
Body Side Moldings	Dual Mirrors	Clear Coat Paint
Power Steering	Power Brakes	Power Windows
Power Locks	Power Mirrors	AM Radio
FM Radio	Stereo	CD Player
Anti-Lock Brakes (4)	Driver Air Bag	Passenger Air Bag
Cloth Seats	Bucket Seats	Automatic Transmission
Aluminum/Alloy Wheels		

NO.	OP.	DESCRIPTION	QTY	EXT. PRICE	LABOR	PAINT
1		FRONT BUMPER				
2		O/H front bumper			2.6	
3	Repl	Bumper cover BASE, LS	1	280.51	Incl.	2.6
4		Add for Clear Coat				1.0
5		Add for fog lamps			0.4	
6	Repl	Lower grille	1	24.71	Incl.	
7	Repl	RT Outer grille w/fog lamps	1	20.40	Incl.	
8		GRILLE				
9	Repl	Grille	1	128.39	Incl.	
10		HOOD				
11	Repl	Hood	1	239.70	1.1	2.8
12		Add for Clear Coat				1.1
13		Add for Underside(Complete)				1.4
14		Add for Clear Coat				0.3

PRELIMINARY ESTIMATE

2005 CHEV COBALT LS 4-2.2L-FI 2D CPE BLUE Int:GRAY

NO.	OP.	DESCRIPTION	QTY	EXT.	PRICE	LABOR	PAINT
15		FENDER					
16	Blnd RT	Fender					0.9
17	Blnd LT	Fender					0.9
18		COOLING					
19**	Repl Qual	Repl Parts Radiator +25%	1	231.25	m	1.6	
20		Add for auto trans			m	0.2	
21#	Repl	COVER CAR	1	3.00		0.2	
22#	Subl	HAZARDOUS WASTE	1	5.00	X		
Subtotals ==>				932.96		6.1	11.0

Parts		927.96
Body Labor	6.1 hrs @ \$ 38.00/hr	231.80
Paint Labor	11.0 hrs @ \$ 38.00/hr	418.00
Paint Supplies	11.0 hrs @ \$ 22.00/hr	242.00
Sublet/Misc.		5.00

SUBTOTAL		\$ 1824.76
Sales Tax	\$ 1819.76 @ 6.0000	109.19

GRAND TOTAL \$ 1933.95

ADJUSTMENTS:

Deductible 0.00

CUSTOMER PAY \$ 0.00
INSURANCE PAY \$ 1933.95

PERFORMANCE MOTORS COLLISION REPAIR WORK IS COVERED BY A ONE YEAR WORKMANSHIP WARRANTY

PERFORMANCE MOTORS COLLISION REPAIR WORK IS COVERED BY A ONE YEAR WORKMANSHIP WARRANTY INCLUDING REFINISHING.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

THIS ESTIMATE HAS BEEN PREPARED BASED ON THE USE OF AFTERMARKET CRASH PARTS THAT ARE NOT MANUFACTURED BY THE ORIGINAL MANUFACTURER OF THE VEHICLE OR BY A MANUFACTURER AUTHORIZED BY THE ORIGINAL MANUFACTURER TO USE ITS NAME OR TRADEMARK. THE USE OF AN AFTERMARKET CRASH PART MAY INVALIDATE ANY REMAINING WARRANTIES OF THE ORIGINAL MANUFACTURER ON THAT CRASH PART.

05/22/2006 at 11:41 AM
42884

Job Number:

PRELIMINARY ESTIMATE

2005 CHEV COBALT LS 4-2.2L-FI 2D CPE BLUE Int:GRAY

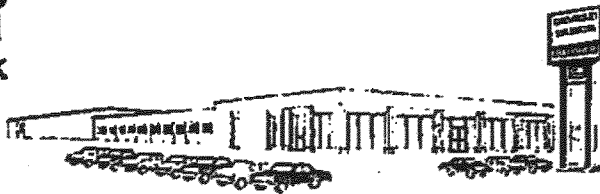
Estimate based on MOTOR CRASH ESTIMATING GUIDE. Unless otherwise noted all items are derived from the Guide DRICL05 Database Date 05/2006, CCC Data Date 05/2006, and the parts selected are OEM-parts manufactured by the vehicles Original Equipment Manufacturer. OEM parts are available at OE/Vehicle dealerships. OPT OEM (Optional OEM) parts are OEM parts that may be provided by or through alternate sources other than the OE/Vehicle dealerships. OPT OEM parts may reflect some specific, special, or unique pricing or discount. Asterisk (*) or Double Asterisk (**) indicates that the parts and/or labor information provided by MOTOR may have been modified or may have come from an alternate data source. Tilde sign (~) items indicate MOTOR Not-Included Labor operations. Non-Original Equipment Manufacturer aftermarket parts are described as AM, Qual Repl Parts or Comp Repl Parts which stands for Competitive Replacement Parts. Used parts are described as LKQ, Qual Recy Parts, RCY, or USED. Reconditioned parts are described as Recon. Recored parts are described as Recore. NAGS Part Numbers and Benchmark Prices are provided by National Auto Glass Specifications. Labor operation times listed on the line with the NAGS information are MOTOR suggested labor operation times. NAGS labor operation times are not included. Pound sign (#) items indicate manual entries. Some 2006 vehicles contain minor changes from the previous year. For those vehicles, prior to receiving updated data from the vehicle manufacturer, labor and parts data from the previous year may be used. The Pathways estimator has a complete list of applicable vehicles. Parts numbers and prices should be confirmed with the local dealership.

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Waynesboro, Virginia 22980

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Fax: (540) 941-2220
Body Shop: (540) 941-2260
Toll Free: (800) 489-7199

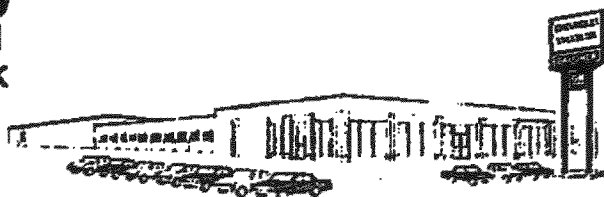
Email: generalinfo@baugherautos.com
Visit us @ www.baugherautos.com

CUSTOMER NO 68407		ADVISOR GENERAL ADVISOR 241		TAG NO		INVOICE DATE 02/28/08		INVOICE NO CVCS340744	
[REDACTED]		LABOR RATE 80.00		LICENSE NO [REDACTED]		MILEAGE 49,520		COLOR BLUE/	
HAMBLETON, WV		YEAR, MAKE / MODEL 05/CHEVROLET/COBALT/2 DOOR COUPE		VEHICLE ID NO 1G1AL14F157		DELIVERY DATE		DELIVERY MILEAGE	
[REDACTED]		DATE NO		P.O. NO		02/28/08		MO: 49520	
LABOR & PARTS									
# 1 50CVZE2024 FOUR WHEEL ALIGNMENT UNITS: TECH(S):742 69.95									
THRUST ALLIGNMENT CHECKED FRONT AND REAR ALIGNMENT. INSPECTED ALL SUSPENSION. ADJUSTED CASTER, CAMBER & TOE TO PROPER SPECIFICATIONS.									
JOB # 1 TOTAL LABOR & PARTS 69.95									
# 2 05CVZ STEERING/SUSPENSION UNITS: 1.90 TECH(S):742 152.00									
CUSTOMER STATES THAT WE ARE TO REPLACE THE GEAR ASSY PER ESTIMATE REPLACED STEERING RACK ASSY									
JOB # 2 TOTAL LABOR & PARTS 152.00									
ESTIMATE									
CUSTOMER HEREBY ACKNOWLEDGES RECEIVING ORIGINAL ESTIMATE OF \$577.96 (+TAX)									
TOTALS									
COMPLETELY SATISFIED									
IS HOW WE WANT YOU TO FEEL AFTER YOUR EXPERIENCE IN OUR SERVICE, PARTS AND BODY SHOP. HERE AT BAUGHER'S WHEN YOU ARE SURVEYED BY GENERAL MOTORS. IF YOU ARE NOT PLEASE CONTACT *****BILL BURKE*****									
TOTAL LABOR.... 221.95									
TOTAL PARTS.... 0.00									
TOTAL SUBLET.... 0.00									
TOTAL G.O.G.... 0.00									
TOTAL MISC CHG.... 0.00									
TOTAL MISC DISC.... 0.00									
TOTAL TAX..... 0.00									
TOTAL INVOICE \$ 221.95									
SERVICE ADVISOR JIM ALLEY 540-941-2240									
SERVICE DIRECTOR 540-941-2243									
COLLISION CENTER MANAGER JON BAUGHER 540-941-2260									
PARTS MANAGER MIKE SHIELDS 540-941-2252									
*****VISIT OUR STATE OF THE ART BODY SHOP*****									
*****HOURS OF OPERATION 8:00 AM TO 5:30 PM MON-FRI.									
SERVICE AND PARTS DEPT. HOURS OF OPERATION									
**MON-FRI 7:00 AM - 6:00 PM									
CUSTOMER SIGNATURE									
***** DUPLICATE INVOICE *****									
A BUSINESS FORMS 1100 1M 02/07 1/10/04									
PAGE 1 OF 1									
CUSTOMER COPY									
[END OF INVOICE] 01:38pm									
CASH <input type="checkbox"/> CHECK <input type="checkbox"/> CREDIT CARD <input type="checkbox"/>									
CHARGE <input type="checkbox"/>									
Thank You!									
WE APPRECIATE YOUR CONFIDENCE IN OUR DEALERSHIP.									
CUSTOMER SIGNATURE									

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Email: generalinfo@baugherautos.com
Visit us @ www.baugherautos.com

CUSTOMER NO 88407		ADVISOR JOHN E BAUGHER		TAG NO 795	INVOICE DATE 02/29/08	INVOICE NO CVCB340602
[REDACTED]		LABOR RATE 40.00	LICENSE NO [REDACTED]	SALES TAX 49,520	BLUE/	STOCK NO
HAMBLE CO. VA [REDACTED]		YEAR MAKE MODEL (5) CHEVROLET/COBALT/2 DOOR COUPE			DATE VERIFIED	DATE VERIFIED
[REDACTED]		VEHICLE ID NO 1C1A114F157			DATE OF PURCHASE	DATE OF PURCHASE
[REDACTED]		CURRENTLY			02/21/08	
						MO: 49520
LABOR & PARTS JOB # 300V7 BODY REPAIR UNITS: 3.70 TECH(S):970 155.40 REPAIR VEHICLE FOR STATE INSURANCE ESTIMATE				EXCLUSION OF WARRANTIES (APPLYS TO GM PARTS & ACCESSORIES ONLY) Any warranties on the parts and accessories sold hereby are made by the manufacturer. The undersigned purchaser understands and agrees that dealer makes no warranties of any kind, express or implied, and disclaims all warranties, including warranties of merchantability or fitness for a particular purpose, with regard to the parts and/or accessories purchased; and that in no event shall dealer be liable for incidental or consequential damages or commercial losses arising out of such purchase. The undersigned purchaser further agrees that the warranties excluded by dealer, include, but are not limited to any warranties that such parts and/or accessories are of merchantable quality or that they will enable any vehicle or any of its systems to perform with reasonable safety, efficiency, or comfort.		
PARTS QTY DESCRIPTION LIST PRICE UNIT PRICE JOE # 1 1 PAINT 339.06 339.06 JOE # 2 1 PAINT 8.56 8.56 JOE # 3 1 PAINT 8.56 8.56 JOB # 1 TOTAL PARTS 347.62						
JOB # 1 TOTAL LABOR & PARTS				503.02		
JOB # 200VZ PAINT/REPAIR UNITS: 10.80 TECH(S):970 453.60 REPAIR VEHICLE FOR STATE INSURANCE ESTIMATE						
PARTS QTY DESCRIPTION LIST PRICE UNIT PRICE JOE # 1 1 PAINT 0.00 0.00 JOE # 2 1 PAINT 0.00 0.00 JOE # 3 1 PAINT 0.00 0.00 JOB # 2 TOTAL PARTS 0.00						
JOB # 2 TOTAL LABOR & PARTS				453.60		
G.O.G. & SUBLET JOE # 1 1 G.O.G. & SUBLET 324.00 324.00 TOTAL - G.O.G. 324.00						
ESTIMATE CUSTOMER HAS ACKNOWLEDGED RECEIVING ORIGINAL ESTIMATE OF 1,280.62 (TAX) TOTAL						
EMPLOYER'S SIGNATURE (PLEASE PRINT) IS - I AM THE MAN (OR THE PERSON) WITH AUTHORITY TO SIGN FOR THIS VEHICLE AND I HAVE READ AND UNDERSTAND THE TERMS OF THIS AGREEMENT AND I HAVE SIGNED IT FOR THE REASON STATED				TOTAL LABOR.... 609.00 TOTAL PARTS.... 347.62 TOTAL SUBLET.... 0.00 TOTAL G.O.G.... 324.00 TOTAL HISC CHG. 0.00 TOTAL HISC DISC 0.00 TOTAL TAX..... 33.59 TOTAL INVOICE \$ 1314.21		
SERVICE ADVISOR: JIMMY LEE 941-2240 SERVICE ADVISOR: JIMMY LEE 941-2240 SERVICE ADVISOR: JIMMY LEE 941-2240 COLLECTION: JIMMY LEE 941-2240 PARTS MANAGER: JIMMY LEE 941-2240 *****PLEASE PRINT NAME OF THE PARTS MANAGER***** *****PLEASE PRINT NAME OF THE PARTS MANAGER***** *****PLEASE PRINT NAME OF THE PARTS MANAGER***** *****PLEASE PRINT NAME OF THE PARTS MANAGER*****						
CUSTOMER SIGNATURE				Thank You! WE APPRECIATE YOUR CONFIDENCE IN OUR DEALERSHIP. Cash <input type="checkbox"/> Check <input type="checkbox"/> Credit Card <input type="checkbox"/> Charge <input type="checkbox"/>		

BODKINS ENTERPRISES INC.

ELKINS RV/PERFORMANCE TIRE
U-SAV RENTAL/BODKINS MOTOR
1654 HARRISON AVE.
ELKINS, WV 26241

Phone # 304-636-3027

Sold To

HAMBLETON, WV

Sales Receipt

Date 2/28/2007
Sales No 12148

Check No. Payment Method Project

CREDIT CARD

Item	Description	Qty	Rate	Amount
205 55R16 #41008	MICH HYDROEDGE 89T #41008 DOT# APT2N4XX3506 X 3 3406 MILEAGE: 28724	4	140.50	\$562.00

Subtotal 1362.00

Sales Tax (6.0%) 81.72

Total \$1443.72

THE TIRE INDUSTRY REGISTRATION CARD HAS BEEN GIVEN TO YOU TO
SEND IN. NOT RESPONSIBLE FOR LOSS OF LUGNUTS ON
ALUMINUM RIMS/HAVE RETORQUED AFTER FIRST 50 MILES.

09/16/2006 at 08:32 AM
42884

Job Number:

PERFORMANCE AUTO BODY
License #:78207 Federal ID #:203258216
222 DAVIS ST
PARSONS, WV 26287
(304)478-2839 Fax: (304)478-2983

PRELIMINARY ESTIMATE

Written By: JEFF YUCHEK
Adjuster: Processor Team 1

Insured:
Owner:
Address:
Evening:

HAMBLETON, WV

Claim #
Policy #

Deductible:

Date of Loss: 09/10/2006 at 08:30 PM

Type of Loss: Comprehensive

Point of Impact: 12. Front

Day: ()-

Inspect
Location: IN USE

Insurance STATE FARM INSURANCE COMPANIES
Company: 21 TYGART VALLEY MALL
FAIRMONT, WV 26554

Days to Repair

2005 CHEV COBALT LS 4-2.2L-FI 2D CPE BLUE Int:GRAY
VIN: 1G1AL14F157 Lic: WV Prod Date: 01/2005 Odometer: 21400
Air Conditioning Rear Defogger Tilt Wheel
Cruise Control Intermittent Wipers Keyless Entry
Body Side Moldings Dual Mirrors Clear Coat Paint
Power Steering Power Brakes Power Windows
Power Locks Power Mirrors AM Radio
FM Radio Stereo CD Player
Anti-Lock Brakes (4) Driver Air Bag Passenger Air Bag
Cloth Seats Bucket Seats 5 Speed Transmission
Aluminum/Alloy Wheels

NO.	OP.	DESCRIPTION	QTY	EXT.	PRICE	LABOR	PAINT
1		FRONT BUMPER					
2*	Rpr	Bumper cover BASE, LS				2.0	2.6
3		Add for Clear Coat					1.0
4#	Refn	Blend color clear complete					
5		GRILLE					
6		O/H bumper assy				2.6	
7	Repl	Grille	1	128.39		Incl.	
8	Repl	Grille retainer	1	1.22			
9		RADIATOR SUPPORT					
10*	Rpr	Upper tie bar				s 1.0	1.5
11#	Refn	Blend color clear complete					
12		HOOD					
13	Repl	Hood	1	239.70		1.1	2.8
14		Add for Clear Coat					1.1

09/16/2006 at 08:32 AM
42884

Job Number:

PRELIMINARY ESTIMATE

2005 CHEV COBALT LS 4-2.2L-FI 2D CPE BLUE Int:GRAY

NO.	OP.	DESCRIPTION	QTY	EXT.	PRICE	LABOR	PAINT
15		Add for Underside(Complete)					1.4
16		Add for Clear Coat					0.3
17		AIR CONDITIONER & HEATER					
18**	Repl	Qual Repl Parts Condenser	1	187.00	m	1.1 M	
19		Evacuate & recharge			m	1.4 M	
20		Refrigerant recovery			m	0.4 M	
21#	Repl	FROEN 134	2	17.00	T		M
22#	Subl	HAZARDOUS WASTE	1	5.00	X		
23#	Repl	RESTORE CORROSION PROTECTION	1	5.00		0.3	
Subtotals ==>				583.31		9.9	10.7

Parts		561.31
Body Labor	7.0 hrs @ \$ 38.00/hr	266.00
Paint Labor	10.7 hrs @ \$ 38.00/hr	406.60
Mechanical Labor	2.9 hrs @ \$ 50.00/hr	145.00
Paint Supplies	10.7 hrs @ \$ 22.00/hr	235.40
Sublet/Misc.		22.00

SUBTOTAL		\$ 1636.31
Sales Tax	\$ 1631.31 @ 6.0000	97.88
GRAND TOTAL		\$ 1734.19

ADJUSTMENTS:		
Deductible		0.00

CUSTOMER PAY	\$	0.00
INSURANCE PAY		\$ 1734.19

PERFORMANCE AUTO BODY COLLISION REPAIR WORK IS COVERED BY A ONE YEAR WORKMANSHIP WARRANTY

PERFORMANCE MOTORS COLLISION REPAIR WORK IS COVERED BY A ONE YEAR WORKMANSHIP WARRANTY INCLUDING REFINISHING.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

THIS ESTIMATE HAS BEEN PREPARED BASED ON THE USE OF AFTERMARKET CRASH PARTS THAT ARE NOT MANUFACTURED BY THE ORIGINAL MANUFACTURER OF THE VEHICLE OR BY A MANUFACTURER AUTHORIZED BY THE ORIGINAL MANUFACTURER TO USE ITS NAME OR TRADEMARK. THE USE OF AN AFTERMARKET CRASH PART MAY INVALIDATE ANY REMAINING WARRANTIES OF THE ORIGINAL MANUFACTURER ON THAT CRASH PART.

09/16/2006 at 08:32 AM
42884

Job Number:

PRELIMINARY ESTIMATE

2005 CHEV COBALT LS 4-2.2L-FI 2D CPE BLUE Int:GRAY

Estimate based on MOTOR CRASH ESTIMATING GUIDE. Unless otherwise noted all items are derived from the Guide DR1CL05 Database Date 08/2006, CCC Data Date 08/2006, and the parts selected are OEM-parts manufactured by the vehicles Original Equipment Manufacturer. OEM parts are available at OE/Vehicle dealerships. OPT OEM (Optional OEM) parts are OEM parts that may be provided by or through alternate sources other than the OE/Vehicle dealerships. OPT OEM parts may reflect some specific, special, or unique pricing or discount. Asterisk (*) or Double Asterisk (**) indicates that the parts and/or labor information provided by MOTOR may have been modified or may have come from an alternate data source. Tilde sign (~) items indicate MOTOR Not-Included Labor operations. Non-Original Equipment Manufacturer aftermarket parts are described as AM, Qual Repl Parts or Comp Repl Parts which stands for Competitive Replacement Parts. Used parts are described as LKQ, Qual Recy Parts, RCY, or USED. Reconditioned parts are described as Recon. Recored parts are described as Recore. NAGS Part Numbers and Benchmark Prices are provided by National Auto Glass Specifications. Labor operation times listed on the line with the NAGS information are MOTOR suggested labor operation times. NAGS labor operation times are not included. Pound sign (#) items indicate manual entries. Some 2006 vehicles contain minor changes from the previous year. For those vehicles, prior to receiving updated data from the vehicle manufacturer, labor and parts data from the previous year may be used. The Pathways estimator has a complete list of applicable vehicles. Parts numbers and prices should be confirmed with the local dealership.

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09/16/2006 at 08:32 AM
42884

Job Number:

PRELIMINARY ESTIMATE

2005 CHEV COBALT LS 4-2.2L-FI 2D CPE BLUE Int:GRAY

ALTERNATE PARTS SUPPLIERS

18 Qual Repl Parts Condenser	Part No. CNDDPI4718	Price \$187.00
------------------------------	---------------------	----------------

Keystone - NWPP
4170 PERIMETER DRIVE
COLUMBUS, OH 43228

(800)820-3962
(614)272-8600

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Toll Free: (800) 489-7199

Email: generalinfo@baugherautos.com

Visit us @ www.baugherautos.com

CUSTOMER NO	68407	ADVISOR	JON E BAUGHER	795	TAG NO		INVOICE DATE	03/31/08	INVOICE NO	CVCB340991
		LABOR RATE	40.00		SALES TAX	49,520	COLOR	BLUE/		
		YEAR MAKE MODEL	05/CHEVROLET/COBALT/2 DOOR COUPE							
		VEHICLE ID NO	1 G 1 A L 1 4 F 1 5 7							
		FILE NO								
		COMMENTS	03/11/08							
MO: 49520										
LABOR & PARTS										
J#	1	90CVZ	BODY REPAIR	UNITS:	TECH(S):970		147.61	EXCLUSION OF WARRANTIES (APPLYS TO GM PARTS & ACCESSORIES ONLY)		
REPLACE DECAL PER ESTIMATE								Any warranties on the parts and accessories sold hereby are made by the manufacturer. The undersigned purchaser understands and agrees that dealer makes no warranties of any kind, express or implied, and disclaims all warranties, including warranties of merchantability or fitness for a particular purpose, with regard to the parts and/or accessories purchased; and that in no event shall dealer be liable for incidental or consequential damages or commercial losses arising out of such purchase. The undersigned purchaser further agrees that the warranties excluded by dealer, include, but are not limited to any warranties that such parts and/or accessories are of merchantable quality or that they will enable any vehicle or any of its systems to perform with reasonable safety, efficiency, or comfort.		
CLAIM#48										
COMPLETE										
PARTS	QTY	FP	NUMBER	DESCRIPTION	LIST PRICE	UNIT PRICE				
JOB # 1	1		30101-146	30101-14 DECAL-KIT	233.56	233.56	233.56			
JOB # 1 TOTAL PARTS							233.56			
JOB # 1 TOTAL LABOR & PARTS							381.17			
J#	2	90CVZ1	BODY REPAIR	UNITS:	4.40	TECH(S):970		184.80		
REPAIR REAR BUMPER PER STATE FARM ESTIMATE										
CLAIM#										
COMPLETE										
PARTS	QTY	FP	NUMBER	DESCRIPTION	LIST PRICE	UNIT PRICE				
JOB # 2 TOTAL PARTS							0.00			
JOB # 2 TOTAL LABOR & PARTS							184.80			
J#	3	99CVZ	PAINT/REFINISH	UNITS:	4.20	TECH(S):970		176.40		
REFINISH REAR BUMPER PER ESTIMATE										
CLAIM# 48										
COMPLETE										
PARTS	QTY	FP	NUMBER	DESCRIPTION	LIST PRICE	UNIT PRICE				
JOB # 3 TOTAL PARTS							0.00			
JOB # 3 TOTAL LABOR & PARTS							176.40			
J#	4	90CVZ2	BODY REPAIR	UNITS:	TECH(S):970		436.80			
REPAIR PRIOR DAMAGE ESTIMATE PER REQUEST										
DOORS,LT A-PILLAR,MIRROR COVERS,VENTSHADES										
COMPLETE										
PARTS	QTY	FP	NUMBER	DESCRIPTION	LIST PRICE	UNIT PRICE				
JOB # 4	1		12499549	COVER 10.186 48090	39.00	39.00	39.00			
JOB # 4	1		17800128	DEFLECTOR 10.707	59.00	59.00	59.00			
JOB # 4 TOTAL PARTS							98.00			
JOB # 4 TOTAL LABOR & PARTS							534.80			
J#	5	99CVZ1230	REFINISH RT FRT DOOR	UNITS:	6.80	TECH(S):970		285.60		
REFINISH PRIOR DAMAGE ESTIMATE PER REQUEST										
LT DOOR LT A-PILLAR RT DOOR										
REFINISHED PER PRIOR DAMAGE ESTIMATE										
PARTS	QTY	FP	NUMBER	DESCRIPTION	LIST PRICE	UNIT PRICE				
JOB # 5 TOTAL PARTS							0.00			
JOB # 5 TOTAL LABOR & PARTS							285.60			
Goodwrench Service Plus										
SERVICE HOURS										
MONDAY - FRIDAY										
7:00 A.M. - 6:00 P.M.										
PARTS HOURS										
MONDAY - FRIDAY										
7:30 A.M. - 5:30 P.M.										
BODY SHOP HOURS										
MONDAY - FRIDAY										
8:00 A.M. - 6:00 P.M.										
Thank You!										
WE APPRECIATE YOUR CONFIDENCE IN OUR DEALERSHIP.										
Cash <input type="checkbox"/> Check <input type="checkbox"/> Credit Card <input type="checkbox"/>										
Charge <input type="checkbox"/>										
PAGE 1 OF 2										
CUSTOMER COPY										
(CONTINUED ON NEXT PAGE) 05:06pm										
CUSTOMER SIGNATURE										

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Visit us @ www.baugherautos.com

CUSTOMER NO 68407	ADVISOR DON E BAUGHER	TAG NO 795	INVOICE DATE 03/31/08	INVOICE NO CVCB340991
HAMBLETON, WV	LABOR RATE 40.00	SALES TAX 49,520	COLOR BLUE/	STOCK NO
	YEAR MAKE MODEL 05/CHEVROLET/COBALT/2 DOOR COUPE		DELIVERY DATE	WARRANTY PERIOD
	VEHICLE ID NO 1G1AL14F157		FINANCIAL INSTITUTION	FINANCIAL INSTITUTION
	FINANCE NO		FINANCE NO	
TERMS		DATE 03/11/08		MO: 49520

G.O.G. & SUPPLIES				
JOB # 3	1.0	PAINT AND MATERIALS	@	126.000 /UNIT
JOB # 3	1.0	FLEX ADDITIVE	@	3.000 /UNIT
JOB # 4	1.0	BODY SUPPLIES	@	15.300 /UNIT
JOB # 5	1.0	PAINT AND MATERIALS	@	204.000 /UNIT
JOB # 5	1.0	CAR COVER	@	5.000 /UNIT
JOB # 5	1.0	HAZARDOUS WASTE DISPOSAL	@	3.500 /UNIT
TOTAL - GOG				356.80

ESTIMATE-----
CUSTOMER HEREBY ACKNOWLEDGES RECEIVING
ORIGINAL ESTIMATE OF \$1919.57 (+TAX)
TOTALS-----

COMPLETED SATISFIED		TOTAL LABOR....	1231.21
IS HOW WE WANT YOU TO FEEL AFTER YOUR EXPERIENCE IN OUR		TOTAL PARTS....	331.56
SERVICE, PARTS AND BODY SHOP. HERE AT BAUGHER'S WHEN YOU ARE		TOTAL SUBLET....	0.00
SURVEYED BY GENERAL MOTORS. IF YOU ARE NOT PLEASE CONTACT		TOTAL G.O.G....	356.80
		TOTAL MISC CHG....	0.00
		TOTAL MISC DISC....	0.00
		TOTAL TAX.....	34.00
		TOTAL INVOICE \$	1953.57

SERVICE ADVISOR JIM ALLEY 540-941-2240
SERVICE ADVISOR JENNIFER HARTMAN 540-941-2240
SERVICE MANAGER LOIS IRVINE 540-941-2240
COLLISION CENTER MANAGER JON BAUGHER 540-941-2260
PARTS MANAGER MIKE SHIELDS 540-941-2252
*****VISIT OUR STATE OF THE ART BODY SHOP*****
*****HOURS OF OPERATION 8:00 AM TO 5:30 PM MON-FRI.
SERVICE AND PARTS DEPT. HOURS OF OPERATION
**MON-FRI 7:00 AM - 6:00 PM

EXCLUSION OF WARRANTIES
(APPLYS TO GM PARTS & ACCESSORIES ONLY)
Any warranties on the parts and accessories sold hereby are made by the manufacturer. The undersigned purchaser understands and agrees that dealer makes no warranties of any kind, express or implied, and disclaims all warranties, including warranties of merchantability or fitness for a particular purpose, with regard to the parts and/or accessories purchased; and that in no event shall dealer be liable for incidental or consequential damages or commercial losses arising out of such purchase. The undersigned purchaser further agrees that the warranties excluded by dealer, include, but are not limited to any warranties that such parts and/or accessories are of merchantable quality or that they will enable any vehicle or any of its systems to perform with reasonable safety, efficiency, or comfort.

Goodwrench Service Plus
SERVICE HOURS
MONDAY - FRIDAY
7:00 A.M. - 6:00 P.M.
PARTS HOURS
MONDAY - FRIDAY
7:30 A.M. - 5:30 P.M.
BODY SHOP HOURS
MONDAY - FRIDAY
8:00 A.M. - 6:00 P.M.

Thank You!
WE APPRECIATE
YOUR CONFIDENCE IN
OUR DEALERSHIP.
Cash ☐ Check ☐ Credit Card ☐
Charge ☐

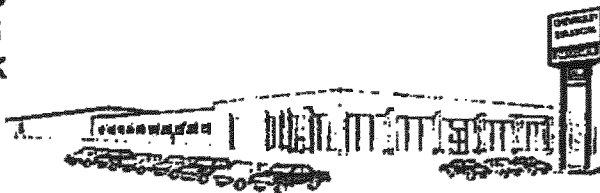
*pd \$1167.51
ck # 7670
4/25/08*

CUSTOMER SIGNATURE

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Visit us @ www.baugherautos.com

CUSTOMER NO 68407		ADVISOR JAMES A ALLEY		TAG NO 659		INVOICE DATE 04/22/08		INVOICE NO CVCS341450	
HAMBLETON, WV		LABOR RATE 80.00		RELEASE 49,521		COLOR BLUE/		STOCK NO	
		YEAR MAKE MODEL 05/CHEVROLET/COBALT/2 DOOR COUPE		DELIVERY DATE		DELIVERY MILES			
		VEHICLE ID NO 1G1AL14F157		RELINQUISH DATE		FINANCE TERM DATE			
		TYPE NO		FIN NO		FINANCE TERM DATE			
		WARRANTY				04/02/08			
MO: 49523									
LABOR & PARTS									
# 1 05CVZ STEERING/SUSPENSION UNITS: TECH(S):703 0.00 CUSTOMER STATES CLUNKING NOISE IN STEERING WHEN TURNING REPLACED RACK-SEE IF REPAIRED JOB # 1 TOTAL LABOR & PARTS 0.00									
# 2 07CVZ BRAKE REPAIR UNITS: TECH(S):703 0.00 CUSTOMER STATES PULSATION WHEN BRAKING ROTORS WARPED.NEED TO REFINISH..T A JOB # 2 TOTAL LABOR & PARTS 0.00									
# 3 11CVZJ5000 DIAGNOSIS.ENG FUEL UNITS: TECH(S):703 0.00 CUSTOMER STATES ENGINE ACCELERATING BY ITSELF WHEN ON A BUMPY ROAD,PICKS UP SPEED DIAGNOSE,ROAD TEST,VEHICLE OPERATES TO SPEC JOB # 3 TOTAL LABOR & PARTS 0.00									
# 4 15CVK6100 DIAGNOSIS,TRANS UNITS: TECH(S):703 0.00 CUSTOMER STATES CLICKING NOISE FROM TRANS WHEN CHANGING GEAR VEHICLE OPERATES TO SPEC JOB # 4 TOTAL LABOR & PARTS 0.00									
# 5 05CVZ1 STEERING/SUSPENSION UNITS: 1.00 TECH(S):703 80.00 CUSTOMER STATES ROARING/BUMPING SOUND FROM FRONT END WHEN DRIVING JOB # 5 TOTAL LABOR & PARTS 80.00									
# 6 10CVZ ENGINE ELECTRICAL UNITS: TECH(S):703 0.00 CUSTOMER STATES STARTER STAYS ENGAGED AT TIMES WHEN STARTED VEHICLE OPERATES TO SPEC JOB # 6 TOTAL LABOR & PARTS 0.00									
SUBLET PO# VEND INV# INV DATE DESCRIPTION JOB # 4 48286 336354 04/03/08 GAS 23.44 TOTAL - SUBLET 23.44									
ESTIMATE CUSTOMER HEREBY ACKNOWLEDGES RECEIVING ORIGINAL ESTIMATE OF \$200.00 (+TAX)									

Goodwrench Service Plus

SERVICE HOURS
MONDAY - FRIDAY
7:00 A.M. - 6:00 P.M.

PARTS HOURS
MONDAY - FRIDAY
7:30 A.M. - 5:30 P.M.

BODY SHOP HOURS
MONDAY - FRIDAY
8:00 A.M. - 6:00 P.M.

Thank You!
WE APPRECIATE
YOUR CONFIDENCE IN
OUR DEALERSHIP.

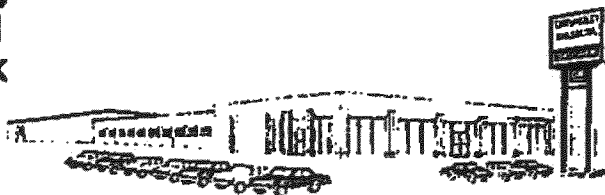
Cash ☐ Check ☐ Credit Card ☐
Charge ☐

CUSTOMER SIGNATURE

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Is
Better



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Body Shop: (540) 941-2260
Toll Free: (800) 469-7199

Email: generalinfo@baugherautos.com
Visit us @ www.baugherautos.com

CUSTOMER NO 68407	ADVISOR JAMES A ALLEY	TAG NO 659	INVOICE DATE 04/22/08	INVOICE NO CVCS341450
	LABOR RATE 80.00	COLOM 49.521	DELIVERY DATE BLUE/	STOCK NO
HAMBLETON, WV	YEAR, MAKE / MODEL 05/CHEVROLET/COBALT/2 DOOR COUPE		DELIVERY DATE	DELIVERY DATE
	VEHICLE ID NO 1G1AL14F157		SELLING TRAILER NO	YEAR, GETTING DATE
	TYPE NO		TRAILER	
	CARVIN		04/02/08	

MO: 49523

TOTALS

COMPLETED	SATISFIED
IS HOW WE WANT YOU TO FEEL AFTER YOUR EXPERIENCE IN OUR	
SERVICE, PARTS AND BODY SHOP. HERE AT BAUGHER'S WHEN YOU ARE	
SURVEYED BY GENERAL MOTORS. IF YOU ARE NOT PLEASE CONTACT	
*****BILL BURKE*****	

TOTAL LABOR....	80.00
TOTAL PARTS....	0.00
TOTAL SUBLET...	23.44
TOTAL G.O.G....	0.00
TOTAL MISC CHG.	0.00
TOTAL MISC DISC	0.00
TOTAL TAX.....	0.00
TOTAL INVOICE \$	103.44

SERVICE ADVISOR JIM ALLEY 540-941-2240
SERVICE DIRECTOR 540-941-2243
COLLISION CENTER MANAGER JON BAUGHER 540-941-2260
PARTS MANAGER MIKE SHIELDS 540-941-2252
*****VISIT OUR STATE OF THE ART BODY SHOP*****
*****HOURS OF OPERATION 8:00 AM TO 5:30 PM MON-FRI.
SERVICE AND PARTS DEPT. HOURS OF OPERATION
**MON-FRI 7:00 AM - 6:00 PM

EXCLUSION OF WARRANTIES
(APPLYS TO GM PARTS & ACCESSORIES ONLY)

Any warranties on the parts and accessories sold hereby are made by the manufacturer. The undersigned purchaser understands and agrees that dealer makes no warranties of any kind, express or implied, and disclaims all warranties, including warranties of merchantability or fitness for a particular purpose, with regard to the parts and/or accessories purchased; and that in no event shall dealer be liable for incidental or consequential damages or commercial losses arising out of such purchase. The undersigned purchaser further agrees that the warranties excluded by dealer, include, but are not limited to any warranties that such parts and/or accessories are of merchantable quality or that they will enable any vehicle or any of its systems to perform with reasonable safety, efficiency, or comfort.

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7:00 A.M. - 6:00 P.M.

PARTS HOURS
MONDAY - FRIDAY
7:30 A.M. - 5:30 P.M.

BODY SHOP HOURS
MONDAY - FRIDAY
8:00 A.M. - 6:00 P.M.

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Charge ☐

CUSTOMER SIGNATURE

**P.O. BOX 305
BEVERLY, WEST VIRGINIA 26253
PHONE: (304) 636-2714 • FAX: (304) 636-2714**

NAME		DATE	
[REDACTED]		10-12-07	
ADDRESS		CITY	STATE ZIP
[REDACTED]		Hamblyton	WV
BUSINESS PHONE		HOME PHONE	
[REDACTED]		[REDACTED]	
YEAR	MAKE	MODEL	LICENSE
2005	Chevy	Cobalt	
		ODOMETER	MOTOR NO
		40109	

[illegible]

OPERATOR	TIME UNITS	DESCRIPTION
		As Per Estimate
		250. ⁰⁰ Deductible
		Paid
537	Bob	

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At Champion Auto we offer more than just a quality paint job. We pride ourselves on our service. So, if for any reason, you are not happy with the service you've received, please let us know and we guarantee that it will be corrected. By Champion Auto.

**SIGN
HERE**

Your signature is required on this invoice as a satisfied customer for service received for the total amount of this invoice. Please sign above.

[illegible]

PERFORMANCE MOTOR SALES, INC.
224 PENNSYLVANIA AVENUE
PARSONS, WV 26287
304-478-2831

HAMBLETON

WV

* REPRINT ***

PAGE 1

DATE	YEAR	MAKE	MODEL	VIN	STK/CUS	MILES IN	MILES OUT	TAG
02/27/07	05	CHEV	COBALT	1G1AL14F157	61424	29125	0	0000
SERVICE DATE	NOTIFIED	SVC ADV	PROMISED DATE/TIME	LICENSE	RATE	PAYMENT	INV. DATE	
00/00/00	02/28/07	09	00/00/00 00:00	7JY778	.00	01	02/28/07	
R.O. NUMBER	TAX ID	HOME PHONE	BUSINESS PHONE					
73174						BLUE		1

***** REPAIR LINE 01 *****

ROTOR VIBRATION - FRONT ROTORS WARPED. CUSTOMER REQUEST ROTORS BE REPLACED WITH OEM ROTORS AND NOT RESURFACED.

BILL CODE -

C

REPLACE

ROTORS

91

M A

62.00

GM

22702612

-ROTOR

TOTAL LABOR

62.00

2

249.06

TOTAL PARTS

249.06

PAYMENT TYPE - 1

334.98

38284

29125

9159

PD
Thank
You!

ON BEHALF OF SERVICING DEALER, I HEREBY CERTIFY THAT THE INFORMATION CONTAINED HEREON IS ACCURATE UNLESS OTHERWISE SHOWN. SERVICES DESCRIBED WERE PERFORMED AT NO CHARGE TO OWNER. THERE WAS NO INDICATION FROM THE APPEARANCE OF THE VEHICLE OR OTHERWISE, THAT ANY PART REPAIRED OR REPLACED UNDER THIS CLAIM HAD BEEN CONNECTED IN ANY WAY WITH ANY ACCIDENT, NEGLIGENCE OR ABUSE. RECORDS SUPPORTING THIS CLAIM ARE AVAILABLE FOR (1) YEAR FROM THE DATE OF PAYMENT NOTIFICATION AT THE SERVICING DEALER FOR INSPECTION BY MANUFACTURER'S REPRESENTATIVE.	STATEMENT OF DISCLAIMER		LABOR AMOUNT	62.00
	THE FACTORY WARRANTY CONSTITUTES ALL OF THE WARRANTIES WITH RESPECT TO THE SALE OF THIS ITEM/ITEMS. THE SELLER HEREBY EXPRESSLY DISCLAIMS ALL WARRANTIES, EITHER EXPRESS OR IMPLIED, INCLUDING ANY IMPLIED WARRANTY OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE. SELLER NEITHER ASSUMES NOR AUTHORIZES ANY OTHER PERSON TO ASSUME FOR IT ANY LIABILITY IN CONNECTION WITH THE SALE OF THIS/ITEMS/ITEMS.		PARTS AMOUNT	249.06
(SIGNED) DEALER, GENERAL MANAGER OR AUTHORIZED PERSON (DATE)	>	CUSTOMER SIGNATURE	MISC. SALES	.00
			MATERIALS	4.96
			TOTAL CHARGE	316.02
			DEDUCTIBLE	.00
			SALES TAX	18.96
			OTHER PAY	.00
			CUSTOMER PAY	334.98

HAMBLETON

WV

PERFORMANCE CHEVROLET
224 PENNSYLVANIA AVENUE
PARSONS, WV 26287
304-478-2831

PAGE 1

DATE	YEAR	MAKE	MODEL	VIN	STK/CUS	MILES IN	MILES OUT	TAG
08/15/07	05	CHEV	COBALT	1G1AL14F157	61424	38284	0	0000
SERVICE DATE	NOTIFIED	SVC ADV	PROMISED DATE/TIME	LICENSE	RATE	PAYMENT	INV. DATE	
00/00/00	08/15/07	09	00/00/00 00:00		.00	01	08/15/07	
R.O. NUMBER	TAX ID	HOME PHONE	BUSINESS PHONE					
75553						BLUE		1

===== REPAIR LINE 01 =====

RADIO INOP

BILL CODE -

C

REPLACE

RADIO

35

M A

62.00

TOTAL LABOR

62.00

GM

15272192

-RADIO

1

471.20

TOTAL PARTS

471.20

===== REPAIR LINE 02 =====

VEHICLE HAS A METAL TO METAL NOISE IN FRONT END. BOTH LOWER CONTROL ARM BUSHINGS FELL OUT.

BILL CODE -

C

REPLACE

CONTROL ARM BUSHIN

35

M A

105.40

46

ALIGN FRT END

35

M A

44.95

TOTAL LABOR

150.35

GM

15240087

-BUSHING

2

35.08

TOTAL PARTS

35.08

===== REPAIR LINE 03 =====

INTERMEDIATE STEERING SHAFT CLUNKING. REPLACED SHAFT AND STILL HAS NOISE IN COLUMN. NEEDS STEERING COLUMN TO GET RID OF NOISE.

BILL CODE -

C

REPLACE

SHAFT

35

M A

31.00

TOTAL LABOR

31.00

GM

10394225

-SHAFT K

1

131.52

TOTAL PARTS

131.52

===== REPAIR LINE 04 =====

CHECK BATTERY DRAW - HAVE TO JUMP START

STARTER PROBLEMS? TURN KEY AND CRANKS BUT KEY WILL NOT KICK BACK.

ACTS LIKE "DOUBLE STARTING". CHECKED BATTERY AND GOOD, CHECKED

CHARGING SYSTEM AND OK. COULD NOT DUPLICATE CONCERN AT THIS TIME.

BILL CODE -

C

CHECKED

ELECTRICAL SYS

35

M A

31.00

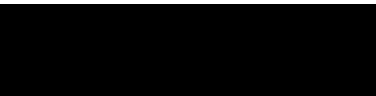
TOTAL LABOR

31.00

PAYMENT TYPE - 1

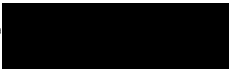
977.48

ON BEHALF OF SERVICING DEALER, I HEREBY CERTIFY THAT THE INFORMATION CONTAINED HEREON IS ACCURATE UNLESS OTHERWISE SHOWN. SERVICES DESCRIBED WERE PERFORMED AT NO CHARGE TO OWNER. THERE WAS NO INDICATION FROM THE APPEARANCE OF THE VEHICLE OR OTHERWISE, THAT ANY PART REPAIRED OR REPLACED UNDER THIS CLAIM HAD BEEN CONNECTED IN ANY WAY WITH ANY ACCIDENT, NEGLIGENCE OR MISUSE. RECORDS SUPPORTING THIS CLAIM ARE AVAILABLE FOR (1) YEAR FROM THE DATE OF PAYMENT NOTIFICATION AT THE SERVICING DEALER FOR INSPECTION BY MANUFACTURER'S REPRESENTATIVE.	STATEMENT OF DISCLAIMER	LABOR AMOUNT	274.35	
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			MISC. SALES	.00
			MATERIALS	10.00
			TOTAL CHARGE	922.15
			DEDUCTABLE	.00
			SALES TAX	55.33
			OTHER PAY	.00
(SIGNED) DEALER, GENERAL MANAGER OR AUTHORIZED PERSON (DATE)	>	CUSTOMER PAY	977.48	



HAMBLETON

WV



PERFORMANCE CHEVROLET
224 PENNSYLVANIA AVENUE
PARSONS, WV 26287
WORK ORDER

PAGE 1

DATE	YEAR	MAKE	MODEL	VIN	STK/CUS	MILES IN	MILES OUT	TAG
07/31/07	05	CHEV	COBALT	1G1AL14F157	61424	36723	0	0000
SERVICE DATE	NOTIFIED	SVC ADV	PROMISED DATE/TIME	LICENSE	RATE	PAYMENT	INV. DATE	
00/00/00	00/00/00	06	00/00/00 00:00		.00	00	07/31/07	
R.O. NUMBER	TAX ID	HOME PHONE	BUSINESS PHONE					
75315						BLUE		2

===== REPAIR LINE 01 =====

CHROME ON SHIFT KNOB IS PEELING - CHROME PLATING PEELING FROM SHIFTER KNOB AGAIN. REPLACED KNOB.

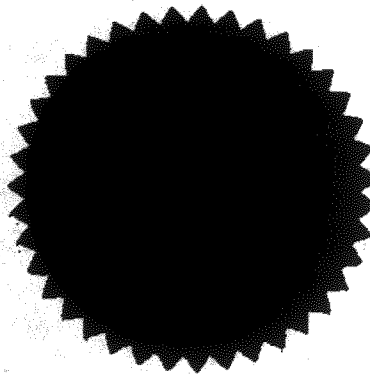
BILL CODE -

W

GM

22724498 -HANDLE

1



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			MISC. SALES	
			MATERIALS	
			TOTAL CHARGE	
			DEDUCTABLE	
			SALES TAX	
			OTHER PAY	
(SIGNED) DEALER, GENERAL MANAGER OR AUTHORIZED PERSON (DATE)	CUSTOMER SIGNATURE	CUSTOMER PAY		

PERFORMANCE CHEVROLET
224 PENNSYLVANIA AVENUE
PARSONS, WV 26287
WORK ORDER

HAMBLETON

WV

PAGE 1

DATE	YEAR	MAKE	MODEL	VIN	STK/CUS	MILES IN	MILES OUT	TAG
07/31/07	05	CHEV	COBALT	1G1AL14F157	61424	36723	0	0000
SERVICE DATE	NOTIFIED	SYCADV	PROMISED DATE/TIME	LICENSE	RATE	PAYMENT	INV. DATE	
00/00/00	00/00/00	06	00/00/00 00:00		.00	00	07/31/07	
R.O. NUMBER	TAX ID	HOME PHONE	BUSINESS PHONE					
75316						BLUE	2	

===== REPAIR LINE 01 =====

RADIO INOP. ORDERED RADIO 15272192.

BILL CODE - C NO CHARGE - Y
BUDDY

===== REPAIR LINE 02 =====

VEHICLE HAS A METAL TO METAL NOISE IN FRONT END. BOTH LOWER CONTROL ARM BUSHINGS FELL OUT. INTERMEDIATE STEERING SHAFT MAKING NOISE. ORDERED PARTS.

BILL CODE - C NO CHARGE - Y
BUDDY

===== REPAIR LINE 03 =====

REAR SPOILER IS HOLDING WATER IN MOUNTS. CHECKED OVER, SPOILER HAS SOME FLEX ALLOWING WATER UNDERNEATH. SPOILER DOES NOT HAVE GASKETS - CHECKED COMPUTER SYSTEM AND SPOILER DOES NOT CONTAIN GASKETS FROM FACTORY. RECOMMEND TRYING A SEALANT TO CORRECT CONCERN.

BILL CODE - C NO CHARGE - Y

ON BEHALF OF SERVING DEALER, I HEREBY CERTIFY THAT THE INFORMATION CONTAINED HEREON IS ACCURATE UNLESS OTHERWISE SHOWN. SERVICES DESCRIBED WERE PERFORMED AT NO CHARGE TO OWNER. THERE WAS NO INDICATION FROM THE APPEARANCE OF THE VEHICLE OR OTHERWISE, THAT ANY PART REPAIRED OR REPLACED UNDER THIS CLAIM HAD BEEN CONNECTED IN ANY WAY WITH ANY ACCIDENT, NEGLIGENCE OR MISUSE. RECORDS SUPPORTING THIS CLAIM ARE AVAILABLE FOR (1) YEAR FROM THE DATE OF PAYMENT NOTIFICATION AT THE SERVING DEALER FOR INSPECTION BY MANUFACTURER'S REPRESENTATIVE.	STATEMENT OF DISCLAIMER	LABOR AMOUNT		
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			MISC. SALES	
			MATERIALS	
			TOTAL CHARGE	
			DEDUCTABLE	
			SALES TAX	
			OTHER PAY	
(SIGNED) DEALER, GENERAL MANAGER OR AUTHORIZED PERSON (DATE)	>	CUSTOMER PAY		

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF CONFIDENTIAL MEDICAL INFORMATION

I, the undersigned, hereby authorize the following Authorized Health Care Providers to make the authorized use and/or disclosure of confidential information contained in my medical records to ESIS at the address below:

① <u>Marie Baldwin College Health Center</u> <u>540-831-7195</u> <u>Staunton VA 24401</u>
Name, address, telephone number of medical providers
② <u>Augusta Medical Center</u> <u>540-333-4000</u> <u>P.O. Box 100 Fishersville, VA 22939</u>
Name, address, telephone number of medical providers
③ <u>ENT-Michael Plautz</u> <u>540-333-5994</u> <u>AMC Suite 307 Fishersville, VA 22939</u>
Name, address, telephone number of medical providers
④ <u>Dr. Glick-Augusta Pain Management Center</u> <u>540-932-5147</u> <u>70 Medical Center Circle</u> <u>Suite 305 Fishersville VA, 22939</u>
Name, address, telephone number of medical providers
Name, address, telephone number of medical providers
Name, address, telephone number of medical providers

I understand that the purpose(s) for which this information is to be used and/or disclosed is for a product liability claim against General Motors Corporation for an incident which occurred on or about September 7, 2008.

The confidential information from my medical records and/or x-rays to be disclosed has no limitations as to the dates of visits or injuries to be disclosed. I understand that full disclosure is authorized. This includes interviews of doctors, EMTs, and other attendants regarding all matters relating to my examination, diagnosis, care, and treatment.

I understand that:

- I have a right to inspect or copy my confidential information that is to be used or disclosed.
- if my confidential health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed by the recipient and would no longer be protected.
- I may revoke this authorization at any time with respect to any Authorized Health Care Provider by notifying such Authorized Health Care Provider in writing of my revocation of this authorization and delivering to such Authorized Health Care Provider my revocation by mail or personal delivery. ESIS requests a copy of such revocation.
- the above-listed medical providers may not condition (withhold or refuse) treating me on whether I sign this Authorization.

A photocopy of this authorization can be accepted with the same authority as the original.

<u>[Redacted]</u>	Date of Birth <u>7/15/74</u>
<u>[Redacted]</u>	Social Security Number <u>[Redacted]</u>
Signature of Patient or Personal Representative*	Date Signed <u>5/14/08</u>
Relationship to Individual*	Authority to act for individual*

RECEIVED
MAY 21 2008
ESIS-GM CLAIMS UNIT

*If you are a personal representative signing this Authorization, please provide a description of your relationship to the individual and a description of your authority to act for the individual below.

EXPIRATION OF AUTHORIZATION: THIS AUTHORIZATION FOR USE AND/OR DISCLOSURE OF CONFIDENTIAL MEDICAL INFORMATION WILL REMAIN IN EFFECT FOR AS LONG AS MY CLAIM AGAINST GENERAL MOTORS CORPORATION IS PENDING UNLESS IT IS EXPRESSLY REVOKED IN WRITING BY ME AS NOTED ABOVE.

ESIS - General Motors Claims
PO Box 300
M/C 482-C20-D71
Detroit, MI 48265-3000

Claim Number: 652566
Claims Administrator: Tiffini Hails

ESIS is the third-party administrator for General Motors Corporation.

AUGUSTA PAIN MANAGEMENT CENTER

Medical Office Building, Suite 305
70 Medical Center Circle
Fishersville, Virginia 22939
Telephone (540) 932-5747
(540) 332-5747

Victor C. Lee, M.D.
Darlinda Grice, M.D.
D. Preston Grice, M.D.
Mary Luebben, FNP
Holly Robedeau, Psy. D

PATIENT NAME: [REDACTED]
DOB: 07/15/1974
AMC #: [REDACTED]

Status of report is Signed

***Report is final only after physician signature**

DATE OF SERVICE 05/19/2008

REFERRING PHYSICIAN: Michael Plautz, MD

CHIEF COMPLAINT: Neck, shoulder and headache pain. The patient is also complaining of diffuse back and spine pain.

HISTORY OF PRESENT ILLNESS/INTERIM HISTORY The patient was last seen in clinic by me on February 5, 2008. Since that time the patient has had MRI of the lumbosacral spine. This essentially revealed no abnormalities whatsoever. She was also seen by a local rheumatologist. She returns to the clinic today stating that "I got knots in my head." She says she is having diffuse raised lesions on her head that are painful. She also says that she is having pain in her neck and spots on her neck that "fill up with fluid." She says she can actually feel the fluid in her neck. She also notes that when she pushes on her spinous process at approximately the C7-T1 level, this makes pain radiate all the way down her spine and into her tailbone. She complains of numbness and tingling in the arms and hands. She says that when she lies on her back her arms go numb and when she lies on her belly her legs go numb. She denies any bowel or bladder incontinence. She continues on her Zanaflex. She says this helps her to sleep, but only gives her about 1 hour per night.

ALLERGIES/ADVERSE DRUG REACTIONS: Local anesthetics, penicillin, sulfa, valproic acid, Zonegran, fentanyl TTS, tramadol.

MEDICATIONS: Zanaflex

REVIEW OF SYSTEMS. The patient is complaining of diffuse neck, shoulder and head pain as per HPI. She is also complaining of some shortness of breath, which is associated with the heat, as well as diarrhea and swelling into her hands and fingers. She denies any chest pain, nausea or vomiting, constipation or bowel or bladder incontinence.

PHYSICAL EXAMINATION

VITAL SIGNS Pulse 76, blood pressure 126/82.

GENERAL: Well-developed, well-nourished, extremely thin white female who is awake, alert and oriented and in no acute distress. She has a flat affect; however, at times appears to have pressured speech with notable lack of intonation. She at times appear to be slightly tangential.

HEENT: Normocephalic, atraumatic. There is some slight tenderness to palpation into the right occipital region. There are no overt palpable masses on the cranium or scalp. The area that the patient says there is a mass is an area of tenderness just above the frontal bone about 1/4 of the way up the skull. She questions whether or not I could feel the mass. I feel no other masses on the skull. There are multiple piercings throughout the face to include the ears, nose and lip.

NECK: Supple without lymphadenopathy. Cervical range of motion is within functional limits. I do not

Re: [REDACTED]

detect any "fluid" on the patient's neck. There is no swelling or lymphadenopathy. There is some slight tightness and tenderness into the cervical paraspinal musculature and trapezia bilaterally.

BACK/SPINE: There is diffuse tenderness throughout the lumbosacral spine, which goes all the way up the thoracic spine.

EXTREMITIES: Upper and lower limbs without swelling or edema.

NEUROLOGIC/MENTAL STATUS: Awake, alert and oriented, fluent speech, follows commands. Strength - 5/5 throughout upper and lower limbs bilaterally. Reflexes - Unable to obtain throughout upper limbs bilaterally. Sensory - Grossly intact to light touch throughout upper limbs bilaterally.

IMPRESSION

1. Chronic diffuse cervical pain. Once again, I am uncertain of the exact nature of the patient's pain. The patient's magnetic resonance imaging is completely normal.
2. Notable myofascial pain overlay.
3. Consider the possibility of cervical facet mediated pain. The patient however, does not always have a consistent exam with this.
4. Strongly consider the possibility of somatization disorder. While I always like to make this a diagnosis of exclusion, I am once again coming to a realization that this might be exactly what is happening with the patient.
5. Lumbosacral pain. Once again, I do not know the nature of the patient's pain.
6. Suboptimal response to conservative therapy
7. Question of fibromyalgia. This was brought up by a rheumatologist that she had recently seen.

RECOMMENDATIONS

1. Trial of Lyrica. I am somewhat at a loss as to what else to begin to try for the patient. If she does have fibromyalgia this would be an optimal treatment given that this is the only FDA approved medication for fibromyalgia.
2. Referral to pain psychology. I would really like our pain psychologist to take a look at this patient overall. While again I believe the patient is thoroughly perceiving some type of pain, I am uncertain of the nature of this. Also, I would like to more aggressively rule out the possibility of a somatization disorder.
3. Consider intermittent trigger point injections. Again, I really do not want to aggressively pursue these.
4. The patient is to continue other medications as previously prescribed.
5. The patient is to follow up with her PCP as previously scheduled.
6. The patient is to return to the clinic in approximately 16 weeks for a followup visit.

Approximately 25 minutes were spent with the patient total.

D. Preston Grice, MS, MD

GRIDP/ProScript

D: 5/19/2008 9:39:00 PM EST

T: 5/20/2008 8:53:24 PM EST

J: 89-891943492

Electronically Signed/Signature on File: D Preston Grice MD 05/30/08 1918

AUGUSTA RHEUMATOLOGY AND OSTEOPOROSIS

57 N. Medical Park Drive
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Matthew S. Hogenmiller, M.D.
Daniel G. El-Bogdadi, M.D.

PATIENT NAME [REDACTED]

DOB: 07/15/1974

AMC #: [REDACTED]

Status of this report is Signed

****Report is final only after physician signature****

Date of Service: 02/25/2008

CHIEF COMPLAINT AND REASON FOR REFERRAL: Neck pain and back pain and history of vasculitis.

HISTORY OF PRESENT ILLNESS: The patient is a 33-year-old female referred by Dr. Preston Grice because the patient reports a past history of vasculitis. The patient states that she has been in eight car accidents, the last one was in October 2007. She has had persistent pain in her neck and lower back, trouble sleeping, and in certain positions she has trouble feeling certain parts of her body when she lays on them. She was told that she had vasculitis in the 8th grade. She was diagnosed because she was bruising easily and was tired and they thought she had leukemia at the time because she had a cousin with leukemia, and she went to several doctors without a diagnosis and finally she went to a doctor who told her she had vasculitis and gave her two steroid injections and this put her "into remission." She reports that she has occasional swelling of her joints. She feels a deep aching in her bones. She was told that she had gout in the past. She denies any rashes. She does have a history of frequent bronchitis and she is also wondering if her back pain and neck pain are related to vasculitis as well.

PAST MEDICAL HISTORY

1. History of chronic pain.
2. History of diabetes.
3. History of bronchitis.
4. History of collapsed lung from an injection.

FAMILY HISTORY: Her father had black lung and arthritis. Her mother had high blood pressure and diabetes. She has aunts with a "different type of arthritis."

SOCIAL HISTORY: She does not smoke. She does not drink alcohol. She is single.

CURRENT MEDICATIONS: Zanaflex 4 mg every 6 hours and two every night.

MEDICATION ALLERGIES: Penicillin. Preservatives. Sulfas which makes her have a rash. Valproic acid which causes her to swell. Ultram causes her to swell. Different antibiotics will cause her to have a swelling and a rash.

REVIEW OF SYMPTOMS: **CONSTITUTIONAL:** She denies any fever, weight loss, or fatigue but she does have trouble sleeping. **EYES:** She does have some dry eyes. **NEUROLOGIC:** She does have headaches, muscle weakness, numbness, and tingling. **ENDOCRINE:** She does have excessive thirst. **GASTROINTESTINAL:** She does have bowel problems with diarrhea and heartburn. **SKIN:** She does have dry skin. **MUSCULOSKELETAL:** She complains of pain, swelling, and stiffness as noted in the HPI. She denies any history of Raynaud. **EARS, NOSE, MOUTH, AND THROAT:** No oral ulcers. She does complain of difficulty swallowing and sinus problems. **CARDIOVASCULAR:** She has occasional

chest pain. She denies palpitations. **GENITOURINARY:** She does complain of frequent urination, and urinary frequency. She denies blood in her urine. **RESPIRATORY:** She does have a history of wheezing, occasional shortness of breath, and denies any coughing. **HEMATOLOGICAL/LYMPHATIC:** She does have the leg swelling. She denies any swollen glands. **PSYCHOLOGIC:** She denies any depression or anxiety, but does complain of trouble with sleep.

PHYSICAL EXAMINATION: VITAL SIGNS: Her blood pressure is 102/76, pulse is 64, respiratory rate is 16, temperature is 97.8, weight is 116, and height is 66 inches. Pain scale is 4/5. **GENERALLY:** She is in no apparent distress. She is well-appearing. She has multiple piercings noted. Her gait is normal. **HEENT EXAM:** Head is without any scalp lesions. Ears are normal. Eyes, there are no areas of injection or icterus. Nasal mucosa was clear. Oropharynx was clear. **NECK:** Supple. There was no lymphadenopathy or thyromegaly. **SKIN:** No rashes. **CARDIAC EXAM:** Regular rate and rhythm. **LUNGS:** Clear to auscultation. **ABDOMEN:** Soft, nontender, and nondistended. No organomegaly. **EXTREMITIES:** There is no cyanosis, clubbing, or edema. **NEUROLOGICALLY:** Strength was 5/5 in all extremities. Her reflexes were symmetric and equal. **MUSCULOSKELETAL EXAM:** She had a flexion contracture of the 5th right digit. She had multiple soft tissue tender points.

ASSESSMENT: This is a 33-year-old female with chronic pain likely fibromyalgia. There is no evidence to suggest vasculitis or active vasculitis at this time. I also question whether she had vasculitis at the time she was diagnosed given that she received a non-traditional therapy for vasculitis.

PLAN

1. I would like to check some baseline laboratory work to absolutely rule out vasculitis such as checking ANA, ANCA, complements, and inflammatory markers as well as rheumatoid factor and SSA and SSB antibodies. We will check hepatitis B and C serologies as these can sometimes bring out the vasculitis. She does have a tattoo.
2. We will check a baseline chest x-ray given her history of bronchitis as occasionally we can see some vasculitides presenting in the setting of asthma and she is young to have bronchitis so chronically.
3. I will otherwise see her back in 1 month for reevaluation and discussion of her blood work.

Daniel G. El-Bogdadi, MD

ELBDG/ProScript
D: 2/25/2008 5:22:00 PM EST
T: 2/25/2008 7:18:39 PM EST
J: 89-891887729

CC: Preston Grice, MD

D Preston Grice MD

Electronically Signed/Signature on File: Daniel G El-Bogdadi MD
Date/Time Signed: 02/27/08 1759

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Victor C. Lee, M.D.
Douglas DeGood, PhD
Darinda M. Grice, M.D.
D. Preston Grice, M.D.
Mary M. Luebben, FNP

DATE: 02/05/08

PATIENT NAME: [REDACTED]

DOB: 07/15/1974

AMC #: [REDACTED]

Status of report is Signed

Report is final only after physician signature

DATE OF SERVICE: 02/05/2008

REFERRING PHYSICIAN: Michael Plautz, MD

CHIEF COMPLAINT: Neck, shoulder and head pain. She is also complaining of some other diffuse symptoms throughout the entire thorax, down into the lower limbs.

HISTORY OF PRESENT ILLNESS/INTERIM HISTORY The patient was last seen in clinic on January 7, 2008. That was for a nurse followup visit. She underwent some trigger points at that time by our nurse practitioner. She returns to the clinic today with several complaints. The bulk of her pain however, is going from her neck up into the occiput. She says she has had a headache for 3 days. We tried her on some steroids before her last visit. She says this helped her head and neck a little bit, as well as some of her low back pain. She said it made the stiffness in her hands somewhat better, however, did not really make any significant improvement there. Today, she rates her pain as 10/10 on the NRS. Again, she is complaining of neck, shoulder and hip pain, as well as low back pain. There are some general diffuse complaints about joint stiffness. She complains of no other really upper limb radicular symptoms or lower limb radicular symptoms. She notes that her trigger point injections that she had recently helped the right side of her neck, but did not help the left. She is uncertain if the occipital nerve blocks did anything. As mentioned above, she notes that the Medrol taper that we had her on seemed to help somewhat, but did not provide any sustained benefit. She is complaining of some swelling at the joints of her hands. She continues on her Zanaflex. It provides her with some benefit, but nothing significant. If she takes 2 it will make her sleepy and she will get up to 3 hours of sleep before waking up.

ALLERGIES/ADVERSE DRUG REACTIONS. Local anesthetics, penicillin, sulfa, valproic acid, Zonegran, fentanyl TTS, tramadol

REVIEW OF SYSTEMS: The patient is complaining of diffuse neck, shoulder and head pain as per HPI. She is also complaining of diffuse pain into her back, as well as some numbness and tingling that goes down into the legs. She denies any chest pain, shortness of breath, nausea, vomiting, diarrhea, constipation or bowel or bladder incontinence.

PHYSICAL EXAMINATION

VITAL SIGNS: Pulse 76, blood pressure 90/60.

GENERAL: Well-developed, well-nourished, very thin white female who is awake, alert and oriented, no acute distress.

HEENT: Normocephalic, atraumatic. There are multiple piercings throughout the face to include the ears, nose and lip. There is some slight tenderness to palpation in the occipital regions bilaterally.

NECK: Supple without lymphadenopathy. There is some slight tightness into the left cervical paraspinal musculature and trapezia; however, there is nothing grossly or overtly noted in terms of spasms or trigger

Re: [REDACTED] [REDACTED]

points.

BACK/SPINE: There is some slight tightness into the left rhomboid and levator scapula. But again, there are no overt trigger points noted.

EXTREMITIES: There is some notable dryness of the skin with scaling and flaking on the back of the hands. There is however, no overt joint swelling noted. There is some mild erythema of the skin, but again it appears to be more related to weathering and chaffing as opposed to frank erythema associated with the joints or swelling. Lower limbs without swelling or edema.

NEUROLOGIC/MENTAL STATUS: Awake, alert and oriented, fluent speech, follows commands. Strength - 5/5 throughout upper and lower limbs bilaterally. Sensory - Grossly intact to light touch throughout upper and lower limbs bilaterally. Reflexes - 1+ throughout upper and lower limbs bilaterally.

IMPRESSION

1. Chronic diffuse cervical pain. I am uncertain of the exact nature of the patient's pain. She has no overt abnormalities for findings on her magnetic resonance imaging. Her cervical range of motion is within functional limits. While the patient describes a variety of pain in the neck, I have no specific source of it at this time.
2. Myofascial pain. While there appears to be a myofascial pain overlay, there does not appear to be any frank trigger points or muscle spasms.
3. Consider the possibility of facet mediated pain. The patient however again has good range of motion in the neck. There is no overt facet arthropathy noted on magnetic resonance imaging.
4. Consider the possibility of somatization disorder. While I always like to make this a diagnosis of exclusion, I am coming to the point where I do not have any really good diagnosis on which to base the significant amount of pain that the patient is describing. The patient has previously had, by her reports, a traumatic brain injury. This very well could be a contributing factor to her underlying perception.
5. Lumbosacral pain. Once again, I have no known source of her pain.
6. Consider the possibility of connective tissue disorder. The patient has expressed that she has been previously diagnosed with some type of unspecified vasculitis. Unfortunately, I have no records that account for this. I will not rule out the possibility of such a condition. The patient is notably thin. One must wonder if she does have some type of underlying connective tissue problem, rheumatological condition such as scleroderma.
7. Suboptimal response to conservative therapy. Again, I do not know specifically where to turn with the patient on this given her lack of tolerance to the multiple medications.

RECOMMENDATIONS

1. MRI of the lumbosacral spine. I would like to see what is going on with the patient at this time. I can not account for what is producing her lumbosacral pain or her lower limb radicular symptoms.
2. Referral to rheumatology. The patient has not pursued it at this time.
3. Obtain records from West Virginia. These supposedly account for all the patient's underlying medical conditions that have previously been problematic for her and yet may explain some of her symptoms.
4. Continue Zanaflex.
5. Consider intermittent trigger points; however, I do not necessarily want to pursue these aggressively without further diagnosis.
6. The patient is to continue other medications as previously prescribed.
7. The patient is to follow up with her PCP as previously scheduled.
8. The patient is to return to the clinic in approximately 8 weeks for nurse followup visit and 16 weeks to see me.

Approximately 25 minutes were spent with the patient total.

D. Preston Grice, MS, MD

GRIDP/ProScript

Re:

D: 2/7/2008 7:41:00 AM EST
T: 2/9/2008 8:01:09 PM EST
J: 89-891875295

Electronically Signed/Signature on File: D Preston Grice MD 02/21/08 1229

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Douglas DeGood, PhD
Darlinda M. Grice, M.D.
D. Preston Grice, M.D.
Mary M. Luebben, FNP

DATE: 01/24/08

PATIENT NAME: [REDACTED]

DOB: [REDACTED]

AMC #: [REDACTED]

Status of report is Signed

****Report is final only after physician signature****

DATE OF SERVICE: 1/24/2008

OFFICE PROCEDURE NOTE

DIAGNOSES

1. Cervical occipital pain, 726.90.
2. Cervicobrachial pain, 723.9.
3. Myalgia, unspecified, 729.1.

PROCEDURE: Trigger point injections, three or more sites (20553).

BRIEF CLINICAL NOTE: The patient is a 33-year-old, white female with chronic neck, shoulder and back pain with a history of being in several motor vehicle accidents. Her most recent MVA was in September 2007 in which she sustained a minor facial injury with some nasal problems and swallowing issues. A CT and CT of the cervical spine from September 2007 did not show any abnormalities in either her head or her neck and no abnormalities were noted with ENT consultation. The patient had previously been followed in pain management by Dr. Adetayo Mabadeje but was recently referred back to pain management and was seen by Dr. Preston Grice on November 19, 2007. MRI of the cervical spine which was done on January 2, 2008 was a normal examination but the patient continues to have multiple complaints of neck pain with radiation into the base of the skull as well as down into the shoulders and upper back. She has ongoing muscle spasms as well as episodic numbness in her hands and legs. She also has ongoing weakness in her arms and legs. She was last seen in clinic on January 16, 2008 and was prescribed baclofen for her muscle spasms but today reports that it made her spasms worse instead of better. She finds she is having increasing tingling into her hands and numbness into her legs if she lies on her side. She has had some swelling in the left posterior lateral neck and also has intermittent swelling into the wrist joints and left knee. She has a significant family history of rheumatoid arthritis and also has been treated for some type of vasculitis at her home in West Virginia but unfortunately her primary care physician is deceased. She was scheduled for trigger point injections with Dr. Preston Grice but these had to be canceled so we are proceeding with trigger point injections today.

DESCRIPTION OF PROCEDURE: Patient was identified and written and verbal consent was obtained. A copy is on the patient's chart. Tender areas were identified in the bilateral semispinalis cervicis, splenius capitis, levator scapula and upper trapezius. The skin was cleaned with isopropyl alcohol and a 27-gauge 1-1/4-inch needle was used for injection. Each trigger point was injected with 0.5-1 mL of Carbocaine 0.5% after negative aspiration for blood, fluid or air. Extra care was taken because of the patient's prior history of pneumothorax but that was with a pectoral trigger point injection that was done by Dr. Adetayo Mabadeje. A total of nine sites were injected and a total of 9 mL of Carbocaine 0.5% was used. No adverse effects were noted and the patient tolerated the injections well. She was observed for a period of 10 minutes and then was discharged comfortable and ambulatory. The patient was given some samples of tizanidine 2 mg and 4 mg and can try 2 mg 1 p.o. up to T.i.d. for muscle spasm or 1 to 2 at bedtime. She is to call for a prescription if these are effective. She was also prescribed a medrol 4 mg

Re: [REDACTED]

taper with instructions. We will send her for a CMP, thyroid profile, CRP, rheumatoid factor, CBC with diff ESR, urinalysis and ANA, HLAB27 and vitamin D level. She was referred to Augusta Rheumatology and is waiting for an appointment.

D Preston Grice, MD
Dictated by Mary Luebben, FNP

LUEMM/ProScript
D: 1/25/2008 5:37:00 PM EST
T: 1/27/2008 6:25:01 PM EST
J: 89-891867494
cc: Mary Baldwin College

*Electronically Signed/Signature on File: Mary Luebben NP 01/30/08 1308
D Preston Grice MD 01/28/08 1923*

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D. Preston Grice, M.D.
Mary M. Luebben, FNP

DATE: 01/16/08

PATIENT NAME: [REDACTED]

DOB: [REDACTED]

AMC #: [REDACTED]

Status of report is Signed

Report is final only after physician signature

DATE OF SERVICE: 01/07/2008

FOLLOWUP VISIT

REFERRING PHYSICIAN: Michael Plautz, MD

CHIEF COMPLAINT: Neck and shoulder pain.

HISTORY OF PRESENT ILLNESS: The patient is a 33-year-old white female who had been previously seen in the Pain Management Center for neck and shoulder pain, but had not been seen since October 2005. She was recently referred back to pain management following another motor vehicle accident in September 2007, when she was attempting to pull into a gas station, but could not turn her vehicle and ended up crashing her car. She sustained a facial injury and when her pain worsened, she developed some nasal problems and swallowing issues. She was referred to a local ENT specialist. Head CT and CT of the cervical spine from September 11, 2007 did not show any abnormalities in either her head or neck. She was then referred back to the patient management and was seen by Dr. Preston Grice on November 19, 2007. She returns today rating her pain at 10/10 on the NRS. Since her last visit she was sent for an MRI of the cervical spine that was done on January 2, 2008, that was a normal MRI examination of the cervical spine.

Today, she is complaining of pain in the posterior neck that radiates up to the base of the skull and then down into the shoulders and upper back. She has muscle spasms up into the back of her head, which will produce headaches. There is also pain that radiates down into the arm, mostly to the elbows that is worse in the left arm than the right. Her hands and legs intermittently go numb, especially when she is sitting or lying down. She has ongoing weakness in her arms, especially with gripping, as well as in her legs, mostly with lying or sitting. She denies any bowel or bladder incontinence. She notes that when she chews, she feels something poking into her throat and she hears a grinding noise when she moves her neck from side to side. She also complains of ongoing lower back pain. She has intermittent swelling into the lower extremities, especially if she has been on her feet for very long. This is from an undefined vasculitis, which she was previously treated for until her primary care physician in West Virginia died. She is from West Virginia, but attends Mary Baldwin College in Staunton and has not been established with any local physician, except for the one on campus. She has been involved in at least 6-8 motor vehicle accidents, as well as one bad snowboarding accident and has had ongoing complaints of neck, back and joint pain since about 1997.

In terms of medication, the patient is not currently taking any pain medications. She had been prescribed hydrocodone APAP after one of her emergency room visits, but is now out of them. Under Dr. Adetayo Mabadeje's care, she had been on fentanyl patch, which was fairly effective until she developed a skin reaction to the adhesive. She had been on Flexeril that was somewhat helpful. Dr. Grice did not want to prescribe any narcotics until the etiology of her pain could be determined.

ALLERGIES/ADVERSE DRUG REACTIONS: Penicillin, sulfa, valproic acid, preservatives, local

Re: [REDACTED]

anesthetics, Zonegran, fentanyl TTS, tramadol. The patient reports that she is gluten intolerant, but denies any allergies to iodine, shellfish, seafood, strawberries or IV contrast.

REVIEW OF SYSTEMS: The patient is complaining of neck, shoulder and head pain as per HPI. She has intermittent headaches, significant sleep disturbance, deficit in left eye vision and left ear hearing, easy bruising, cold and heat intolerance, intermittent diarrhea and knee pain. Otherwise, review of systems are negative.

PHYSICAL EXAMINATION

VITAL SIGNS: Blood pressure 108/58, pulse 60.

GENERAL: The patient is a well-developed, very thin, somewhat pale white female, who is awake, alert and oriented, and in no acute distress. The patient is friendly nondistended interactive.

HEENT: Head is normocephalic, atraumatic. The patient has noted tenderness through the occipital regions bilaterally. She has an upper partial dental plate. Otherwise, oropharynx is clear.

NECK: Cervical range of motion is within functional limits. She has significant tightness in the cervical paraspinal musculature and into the upper trapezia and levator scapula.

LUNGS: Clear to auscultation bilaterally.

HEART: Regular rate and rhythm.

ABDOMEN: Soft and nontender.

EXTREMITIES: Lower limbs without outstanding edema, although she does have some slight brawny discoloration over the shins bilaterally and has very thin tapering fingers with skin dryness of the hands.

BACK/SPINE: There is tenderness to palpation in the levator scapula and rhomboids bilaterally. There is some tenderness along the spinous processes at approximately T8-9, as well as along the spinous processes at about the L5 level. Seated straight leg raise is negative bilaterally.

NEUROLOGIC/MENTAL STATUS: Awake, alert and oriented, fluent speech, follows commands. Strength is 5/5 throughout upper and lower limbs bilaterally. Reflexes are difficult to elicit in the upper extremities, 1+ throughout lower limbs bilaterally. Sensory is grossly intact to light touch total in both upper and lower limbs bilaterally.

IMPRESSION

1. Subacute cervical pain with recent exacerbation following another motor vehicle accident.
2. ? Upper limb radicular pain.
3. Notable myofascial pain with significant tightness today through the cervical paraspinal muscles and into the upper trapezia.
4. Unspecified vasculitis, currently not undergoing any treatment. The patient has not been seen by rheumatology.
5. Multiple medication intolerances.
6. Occipital neuralgia.
7. Unspecified endocrine problem.

RECOMMENDATIONS

1. After discussion with Dr. Preston Grice the patient was scheduled for some trigger point injections with Dr. Grice to include some occipital nerve blocks.
2. Trial of baclofen 5 mg, 1-2 p.o. up to t.i.d. p.r.n. for muscle spasms.
3. Referral to rheumatology since she appears to have some underlying autoimmune condition.

Mary Luebben, FNP D. Preston Grice, MS, MD

LUEMM/ProScript

D: 1/8/2008 7:56:00 PM EST

T: 1/9/2008 11:53:33 AM EST

J: 89-891856071

Re:



***Electronically Signed/Signature on File: Mary Luebben NP 01/17/08 1819
D Preston Grice MD 01/18/08 1352***

AUGUSTA OTOLARYNGOLOGY ASSOCIATES

70 Medical Center Circle, Suite 104
Fishersville, Virginia 22939
Telephone (540) 245-7010
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Michael R. Plautz, M.D.

DOS: 10/16/07

PATIENT NAME: [REDACTED]

DOB: [REDACTED]

AMC #: [REDACTED]

Status of Report is Signed

****Report is final only after physician signature****

Date Dictated: 10/16/2007 12:06:00 PM EST

Date

Transcribed: {DATETIME_DICT} EST

BRIEF HISTORY: The patient presents today for initial evaluation for the chief complaint of right neck pain. She is a 33-year-old young woman with a history of chronic pain who was formally treated in the pain clinic. She has been involved in at least 6 or 8 motor vehicle accidents as well as 1 bad snow boarding accident with multiple complaints of joint and neck pain. Following a motor vehicle accident in September 2007, she has developed some right sided neck pain that she feels radiates to the neck and right side of her throat, and at times, feels like something is stuck in the throat. She has had no frank odynophagia, dysphagia, hoarseness or otalgia. She has multiple musculoskeletal as well as neurological complaints as well such as feeling that the lower half of her body is numb upon awakening in the morning and at times when she remains sedentary for an extended period of time. She has had no level of consciousness, fevers, chills, weight loss, unilateral numbness or weakness, and specifically, denies any dysphagia, dysarthria, diplopia, or urinary incontinence.

PAST MEDICAL/SURGICAL HISTORY: Jaw surgery in the past for dental fractures and avulsion.

ALLERGIES: INTOLERANT TO PENICILLIN, SULFA, ULTRAM, VALPROIC ACID, PRESERVATIVES.

FAMILY HISTORY: Endocrine disease, unspecified malignancy, arthritis.

SOCIAL HISTORY: She is a 33-year-old student at Mary Baldwin College who denies any smoking, drinking, or illicit drug abuse.

PHYSICAL EXAMINATION: The patient is in good spirits. Height 5 foot 9 inches, weight 126, temperature 98.4, pulse 100, BP 118/78. She reports 5/5 pain in the right neck that radiates along the lateral aspect of the neck to the throat and down her scapula. There is no focal hypoesthesia or evidence of muscle atrophy or fasciculation. Range of motion is normal with respect to her arms and neck. External ears and nose normal. Auditory canals are clear with healthy mobile drums and normal tuning fork testing. Pupils equally round and reactive. Extraocular movements intact. Nasal cavities show no purulence or polyp. There is a small area of dryness on the right caudal septum with evidence of recent bleeding but no acute bleeding, ulcer or mass. She has nasal folliculitis and cracking of the right nasal vestibule and ala but no purulence or focal lesion. Oral cavity is clear with a partially edentulous upper and lower alveolus with a midline tongue and uvula. Tonsils 2+. Laryngoscopy shows marked postcricoid and arytenoid edema with symmetrically mobile vocal cords and no evidence of mass or infection. Neck is supple. There is no lymphadenopathy or mass.

ASSESSMENT/PLAN: The patient is a 33-year-old woman with a chief complaint of neck pain which by history is radicular and may represent sequela of a cervical spine injury. She had a CT of the spine done at the time of her most recent car accident on September 11, 2007 which showed no evidence of fracture or dislocation. I have recommended that she followup with a neurologist as well as in the pain clinic, and have given her prescription for Bactroban ointment and recommendation for over-the-counter Prilosec for nasal folliculitis and reflux respectively. I have left her followup open ended and asked her to report to the ER should she have any acute worsening of any of these symptoms or have questions in general.

Re: [REDACTED]

DOS: 10/16/07

Michael R. Plautz, MD

PLAMR/ProScript
J: 89-891805291

Electronically Signed/Signature on File: Michael R. Plautz MD 10/19/07 0849

Emergency Department Dictation

Patient: [REDACTED]	Acct #: [REDACTED] Status: DEPER	Loc: ED1
MR #: [REDACTED]	Age/Sex: 33/F DOB: [REDACTED]	Adm Phys: J Scott Just, MD Dict Phys: Just, J Scott MD
Report #: 1011-0137	Admit Date: 10/11/07	Discharge Date: 10/11/07

Status of this Report is Signed

Please note that Reports in Draft Status are not Final Reports

*** Report is final after physician e-signature ***

CHIEF COMPLAINT: "My neck."

HISTORY OF PRESENT ILLNESS: The patient is a 33-year-old female, who says that she was involved in a motor vehicle crash in the past during which she suffered jaw injury and head injury. She was involved in another motor vehicle crash about 1 month ago. She has been seen here at the emergency department twice with complaints of neck pain and had a negative C-spine CT. She says, this morning, when she was getting out of bed, she had pain in the right side of her neck. It hurts to move her neck and to shrug her shoulders. She denies recent falls or trauma. She denies arm or leg weakness. Denies abdominal pain or chest pain.

REVIEW OF SYSTEMS: Otherwise negative.

MEDICATIONS: None.

ALLERGIES: PENICILLIN, SULFA, ULTRAM, AND VALPROIC ACID.

PAST MEDICAL HISTORY: Multiple motor vehicle accidents. She has been seen by the pain clinic in the past. She is not currently being seen by the pain clinic.

SOCIAL HISTORY: She does not smoke. She is a student at Mary Baldwin College.

PE

VITAL SIGNS: BP 108/72, P 98, R 14, T 35.9, pulse ox 100 platelet count - good oxygenation.

GENERAL: This is a 33-year-old female, nontoxic.

HEENT: Normocephalic, atraumatic. PERRL/EOMI. TMs are clear. Oropharynx is clear. She does have a maxillary partial plate noted. She has multiple piercings of the ears and lips.

NECK: Supple and nontender in the midline. She does have tenderness diffusely, which seems to be myofascial tenderness, in right trapezius musculature.

CHEST: Breath sounds are clear and equal.

HEART: Regular rate and rhythm. No murmur.

ABDOMEN: Soft and nontender. Normal bowel sounds.

EXTREMITIES: Without edema.

SKIN: Warm and dry.

NEUROLOGICALLY: Awake, alert, oriented x3. Cranial nerves II through XII are intact. There is no pronator drift. Finger-to-nose is within normal limits. Gait is normal.

MDM

IMPRESSION: The patient is a 33-year-old with myofascial pain in the right neck. Her record was reviewed. She does have previous normal CT scan obtained last month of her C-spine and head.

PLAN: She will be discharged home with a prescription for Flexeril and Naprosyn and advised to use ice on her neck and referred to followup with the school doctor if she

Patient:		Acct #:	
Unit #:		Report #:	1011-0137

continues to have pain, and they can refer her to the pain management center.
FINAL DISCHARGE DIAGNOSIS: MYOFASCIAL RIGHT NECK PAIN.

JUSJS/ProScript

D: 10/11/2007 11:22:00 AM EST

T: 10/11/2007 11:25:20 AM EST

J: 88-880077834

Electronically Signed/Signature on File: J Scott Just MD
Date/Time Signed: 10/12/07 0915

**Emergency Department Management
Departure Information**

Patient

ED Physician

Chief Complaint

Just, J Scott MD

Neck Pain

Unit No

Departure

Departure Date/Time 10/11/07 @ 1131

Disposition HOME

Emergency Department Dictation

Patient: [REDACTED]	Acct #: [REDACTED] Status: DEPER	Loc: ED1
MR #: [REDACTED]	Age/Sex: 33/F DOB: [REDACTED]	Adm Phys: Asher Brand, MD Dict Phys: Brand, Asher MD
Report #: 0918-0309	Admit Date: 09/17/07	Discharge Date: 09/17/07

Status of this Report is Signed

Please note that Reports in Draft Status are not Final Reports

*** Report is final after physician e-signature ***

CHIEF COMPLAINT: Motor vehicle crash.

HISTORY: This is a 33-year-old woman who was involved in a motor vehicle crash on September 11, 2007. She was seen at that time and had a negative CT of the head, cervical spine, and negative plain T-spine film, per Dr. Tucker's note. She presents today complaining of nose pain, persistent mild headache and stiffness across her back. She has no other complaints or problems. She apparently followed up with the Mary Baldwin doctor who prescribed her tramadol and apparently she developed a rash as a result of that.

REVIEW OF SYSTEMS: CONSTITUTIONAL: No fevers, chills, or rigors. SKIN: No rashes.

EYES: No complaints. ENT: As noted above. RESPIRATORY: No shortness of breath.

CARDIOVASCULAR: No chest pain. GI: No abdominal pain. GU: No flank pain.

MUSCULOSKELETAL: She is complaining of diffuse pain across her back. NEUROLOGIC: No headache. HEMATOLOGIC: No history of easy bleeding.

ALLERGIES: PENICILLIN, PRESERVATIVES, SULFA, VALPROIC ACID, SHELL FISH AND TRAMADOL.

FAMILY HISTORY: Noncontributory.

SOCIAL HISTORY: She is a college student. Denies any chance of pregnancy. Does not smoke.

PHYSICAL EXAMINATION

GENERAL APPEARANCE: Well appearing and in no distress.

VITAL SIGNS: BP 111/74, P 96, R 22, T 36.1. Pulse ox is 94% on room air. Pulse ox interpretation: normal oxygenation on room air.

SKIN: Warm and dry.

HEENT: Eyes are clear.

LYMPHATICS: No anterior cervical adenopathy.

CARDIAC: Regular rate, no murmurs.

CHEST: Chest wall is nontender. Breath sounds are clear and symmetric at the apices.

ABDOMEN: Soft and nontender.

GU: No flank tenderness.

MUSCULOSKELETAL: She is diffusely tender across her neck and back. She has a preserved range of motion of her cervicothoracolumbar spine. Her nose is minimally tender.

MDM

EMERGENCY DEPARTMENT COURSE: An x-ray of her nasal bones was obtained and was negative for a fracture, per ED physician reading.

PLAN: Cloniril and Flexeril.

DIAGNOSES

1. BLUNT TRAUMA, CAR CRASH.

Patient:	[REDACTED]	Acct #:	[REDACTED]
Unit #:	[REDACTED]	Report #:	0918-0309

2. MUSCLE STRAIN.

3. CONTUSION TO NOSE.

I discussed the situation with the patient. I expect that she will have an excellent prognosis and the soreness and stiffness should resolve within a few days barring any occult injury.

BRAA/ProScript

D: 9/17/2007 7:12:00 PM EST

T: 9/18/2007 4:05:24 PM EST

J: 88-880073761

Electronically Signed/Signature on File: Asher Brand MD

Date/Time Signed: 09/18/07 1708

**Emergency Department Management
Departure Information**

Patient [REDACTED] (33/F)
ED Physician Brand, Asher MD
Chief Complaint Multiple Complaints

Unit No [REDACTED]

Departure

Departure Date/Time 09/17/07 @ 1925
Disposition HOME

Emergency Department Dictation

Patient: [REDACTED]	Acct #: [REDACTED]	Loc: ED1
MR #: [REDACTED]	Status: DEPER	
	Age/Sex: 33/F	Adm Phys: Sally I Tucker
	DOB: [REDACTED]	Dict Phys: Tucker, Sally I
Report #: 0913-0357	Admit Date: 09/11/07	Discharge Date: 09/11/07

Status of this Report is Signed

Please note that Reports in Draft Status are not Final Reports

*** Report is final after physician e-signature ***

CHIEF COMPLAINT: Evaluation of injuries from an MVA.

HISTORY OF PRESENT ILLNESS: This is a 33-year-old white female that was the seat-belted driver in an MVA which occurred on September 7, 2007. She said she was in her car and she has been having some problems with it. When she went to turn at a gas station, it did not turn and she went straight ahead, running into the big metal protecting object that protects the pump. She says the car is not crivable. She hit her head on the top of the car above the windshield. She had no loss of consciousness. She said she had neck pain right away and it hurts in her neck to swallow. She says that radiates all the way down to her back. She has been having muscle spasms in her brain and she says she cannot move from her waist down after sitting straight up in class. She says she massages her back and then she is able to get up and move. She said she has had this numbness off and on over the last 4 years. She says today when she walked to school her head was spinning and she felt a little nauseous. She had no vomiting.

PAST MEDICAL HISTORY: Old record reviewed and positive for chronic neck and back pain since 1997 secondary to an MVA. She says she has a history of asthma. She has IBS and it has been questioned whether she has anorexia nervosa. She says she has a history of low blood sugar and she has had a right pneumothorax secondary to trigger point injection, and she says she has short-term and long-term memory loss.

FAMILY HISTORY: Positive for diabetes, cancer, and her mother has lung problems and diabetes.

SOCIAL HISTORY: The patient is a nonsmoker, nondrinker.

PHYSICAL EXAM

VITAL SIGNS: Blood pressure 97/69, pulse 71, respirations 18, her temp is 35.6, pulse ox is 97% on room air which is normal per my interpretation.

GENERAL: She is a well-developed, thin white female in no acute distress.

PSYCH: Normal affect.

SKIN: No rashes. She has no abrasions.

HEENT: Normocephalic, atraumatic.

NECK: Tender. There is no step-off. She has no adenopathy.

HEART: Regular rate and rhythm without murmur.

LUNGS: Clear to auscultation bilaterally.

ABDOMEN: Positive bowel sounds, soft, and non-tender. No masses or organomegaly.

GU: Negative for CVA tenderness.

MUSCULOSKELETAL: The patient has tenderness from the neck all the way down to her lumbar region. She has no bony deformities.

NEURO: She is alert and oriented. Her strength is 4/5 in the left grip and left lower

Patient:		Acct#:	
Unit#:		Report#:	0913-0357

extremity, 5/5 in the right lower extremity and right upper extremity. The patient is somewhat inconsistent with her strength though on testing.

MDM

HOSPITAL COURSE: The patient had a head CT and a C-spine CT which were both negative. Trauma T-spine was negative per my interpretation. A trauma LS-spine was negative per my interpretation. They are both negative for fracture. Patient was given Motric p.o. and Vicodin to go. The patient has had these symptoms intermittently for 4 years now and I do not think they were caused by the accident that she had on September 7, 2007. She did hit her head but she shows no evidence of intracranial abnormality, and I would ask her to follow up with either Dr. Lenker as the Mary Baldwin College doctor or one of the Augusta affiliated doctors for followup. The patient lives in West Virginia but says she does not want to see any doctors in West Virginia. She travels to this area to attend Mary Baldwin College.

DISCHARGE DIAGNOSES

1. ACUTE EVALUATION STATUS POST MOTOR VEHICLE ACCIDENT.
2. MINOR HEAD INJURY.

DISPOSITION: Patient was discharged to home. She is given a prescription for Vicodin #10, instructed to use over-the-counter NSAIDs.

TUCS/ProScript

D: 9/11/2007 8:50:00 PM EST

T: 9/12/2007 3:20:03 PM EST

J: 88-880072727

cc: Leon Lenker, MD - faxed

Electronically Signed/Signature on File: Sally I Tucker
Date/Time Signed: 09/14/07 0806

Emergency Department Dictation

Patient: [REDACTED]	Acct #: [REDACTED] Status: DEPER	Loc: ED1
MR #: [REDACTED]	Age/Sex: 33/F DOB: [REDACTED]	Adm Phys: Sally I Tucker Dict Phys: Tucker, Sally I
Report #: 0912-0291	Admit Date: 09/11/07	Discharge Date: 09/11/07

Status of this Report is Signed
Please note that Reports in Draft Status are not Final Reports

*** Report is final after physician e-signature ***

CHIEF COMPLAINT: Evaluation of injuries from an MVA.

HISTORY OF PRESENT ILLNESS: This is a 33-year-old white female that was the seat-belted driver in an MVA which occurred on September 7, 2007. She said she was in her car and she has been having some problems with it. When she went to turn at a gas station, it did not turn and she went straight ahead, running into the big metal protecting object that protects the pump. She says the car is not crivable. She hit her head on the top of the car above the windshield. She had no loss of consciousness. She said she had neck pain right away and it hurts in her neck to swallow. She says that radiates all the way down to her back. She has been having muscle spasms in her brain and she says she cannot move from her waist down after sitting straight up in class. She says she massages her back and then she is able to get up and move. She said she has had this numbness off and on over the last 4 years. She says today when she walked to school her head was spinning and she felt a little nauseous. She had no vomiting.

PAST MEDICAL HISTORY: Old record reviewed and positive for chronic neck and back pain since 1997 secondary to an MVA. She says she has a history of asthma. She has IES and it has been questioned whether she has anorexia nervosa. She says she has a history of low blood sugar and she has had a right pneumothorax secondary to trigger point injection, and she says she has short-term and long-term memory loss.

FAMILY HISTORY: Positive for diabetes, cancer, and her mother has lung problems and diabetes.

SOCIAL HISTORY: The patient is a nonsmoker, nondrinker.

PHYSICAL EXAM

VITAL SIGNS: Blood pressure 97/69, pulse 71, respirations 18, her temp is 35.6, pulse ox is 97% on room air which is normal per my interpretation.

GENERAL: She is a well-developed, thin white female in no acute distress.

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HEENT: Normocephalic, atraumatic.

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ABDOMEN: Positive bowel sounds, soft, and nontender. No masses or organomegaly.

GU: Negative for CVA tenderness.

MUSCULOSKELETAL: The patient has tenderness from the neck all the way down to her lumbar region. She has no bony deformities.

NEURO: She is alert and oriented. Her strength is 4/5 in the left grip and left lower

Patient#	Acct#:
Unit#:	Report#: 0912-0291

extremity, 5/5 in the right lower extremity and right upper extremity. The patient is somewhat inconsistent with her strength though on testing.

NDM

HOSPITAL COURSE: The patient had a head CT and a C-spine CT which were both negative. Trauma T-spine was negative per my interpretation. A trauma LS-spine was negative per my interpretation. They are both negative for fracture. Patient was given Motrin p.o. and Vicodin to go. The patient has had these symptoms intermittently for 4 years now and I do not think they were caused by the accident that she had on September 7, 2007. She did hit her head but she shows no evidence of intracranial abnormality, and I would ask her to follow up with either Dr. Lenker as the Mary Baldwin College doctor or one of the Augusta affiliated doctors for followup. The patient lives in West Virginia but says she does not want to see any doctors in West Virginia. She travels to this area to attend Mary Baldwin College.

DISCHARGE DIAGNOSES

1. ACUTE EVALUATION STATUS POST MOTOR VEHICLE ACCIDENT.
2. MINOR HEAD INJURY.

DISPOSITION: Patient was discharged to home. She is given a prescription for Vicodin #10, instructed to use over-the-counter NSAIDs.

TUCS/ProScript

D: 9/11/2007 8:50:00 PM EST

T: 9/12/2007 3:20:03 PM EST

J: 88-88007272?

cc: Leon Lenker, MD - faxed

Electronically Signed/Signature on File: Sally I Tucker
Date/Time Signed: 09/13/07 0640

**Emergency Department Management
Departure Information**

Patient

ED Physician

Chief Complaint

Tucker, Sally I

Headache/Facial Pain

Unit No

Departure

Departure Date/Time 09/11/07 @ 2115

Disposition HOME

AMC

Augusta Medical Center
78 Medical Center Drive
Fishersville, VA 22939

Department of Radiology
(540) 332-4400
(540) 832-4400

Patient: [REDACTED]	Acct #: [REDACTED] Status: REG CLI	MR #: [REDACTED]
Tech: RAD.NTW	Age/Sex: 33F	Loc: RAD
Report #: 0308-0044	Phys: Daniel G El-Bogdadi MD	Pat phone #: [REDACTED]
Transcriptionist: cr	Dict Date: 03/08/08 1105	Trans Date: 03/08/08 1149

Date of Service: 03/07/08

Exam(s): 0307-0111 DXR/DXR * Chest PA and Lateral

DOB: [REDACTED] Dictating Radiologist: James B. Huggins MD

Diagnosis: SHORTNESS OF BREATH

Reason for Exam: SHORTNESS OF BREATH

CHEST: 03/07/08

INDICATIONS: Shortness of breath.

COMPARISON: 10/08/04

PA and lateral erect views show increased AP diameter of the chest and peribronchial cuffing. No infiltrates or effusions are noted.

Contours of the heart and mediastinum are normal. There are no acute bony abnormalities.

IMPRESSION:

Pulmonary hyperinflation and peribronchial cuffing. History of asthma or chronic bronchitis? No acute process identified in the chest.

Dictated by James B. Huggins, M.D.

Reported by: James B. Huggins MD, M.D.

Signed by: HUGJ <<Signature on File>>

Date/Time signed: 03/08/08 1454

C: Daniel G El-Bogdadi, MD

RADIOLOGY REPORT

Signed

AMC

Augusta Medical Center
78 Medical Center Drive
Fishersville, VA 22839

Department of Radiology
(540) 332-4400
(540) 932-4400

Patient: [REDACTED]	Acct #: [REDACTED] Status: REG CLJ	MR #: [REDACTED]
Tech: SSH.TMC	Age/Sex: 33F	Loc: MRI
Report #: 0212-0309	Phys: D Preston Grice MD	Pat phone #: [REDACTED] CELL
Transcriptionist: deh	Dict Date: 02/12/08 1505	Trans Date: 02/12/08 1557

Date of Service: 02/12/08

Exam(s): 0212-0004 MRI/MRI * Spinal Canal Lumbar w/o

DOB: [REDACTED] Dictating Radiologist: Shashank C. Parekh

Diagnosis: INCREASING LUMBAR PAIN, LOWER LIMB PAIN/NUMBNESS

Reason for Exam: INCREASING LUMBAR PAIN, LOWER LIMB PAIN/NUMBNESS

*LUMBAR SPINE MRI 2/12/08

TECHNIQUE: T1 weighted and T2 weighted sagittal and axial images are obtained.

The alignment and curvature are normal. The vertebral bodies and intervertebral disc spaces have normal height and signal intensity. There is no evidence of focal disc herniation or canal stenosis. The neural foramina are patent. The visualized spinal cord has a normal appearance. No significant joint abnormality is seen.

IMPRESSION:

Negative examination.

Dictated by Shashank Parekh, MD

Reported by: Shashank C. Parekh, M.D.

Signed by: PARS <<Signature on File>>

Date/Time signed: 02/13/08 0840

C: D Preston Grice, MD; No Family Doc for this Patient

RADIOLOGY REPORT

Signed

AMC

Augusta Medical Center
78 Medical Center Drive
Fishersville, VA 22839

Department of Radiology
(540) 332-4400
(540) 932-4400

Patient: [REDACTED]	Acct #: [REDACTED] Status: REG CLI	MR #: [REDACTED]
Tech: SSHADJ	Age/Sex: 33F	Loc: MRI
Report #: 0103-0099	Phys: D Preston Grice MD	Pat phone #: [REDACTED] CELL
Transcriptionist: deh	Dict Date: 01/03/08 0826	Trans Date: 01/03/08 1015

Date of Service: 01/02/08

Exam(s): 0102-0017 MRI/MRI * Spine Canal Cervical w/o

DOB: [REDACTED] Dictating Radiologist: Matthew P. Shapiro MD

Diagnosis: CHRONIC CERVICAL PAIN W/UPPER LUMBAR PAIN

Reason for Exam: CHRONIC CERVICAL PAIN W/UPPER LUMBAR PAIN

MRI CERVICAL SPINE 1/2/08

CLINICAL INDICATION: Chronic neck pain.

TECHNIQUE: Sagittal and axial T1 weighted, and T2 weighted, and sagittal STIR images of the cervical spine were obtained.

Sagittal images visualized from the level of the foramen magnum to the lower body of T4, and axial images were obtained through the C1-2 thru C7-T1 disc levels.

Visualized vertebrae demonstrate normal height, alignment, and bone marrow signal intensity throughout, and the intervertebral discs are of normal height and signal intensity. There is no evidence of disc herniation identified. The cervical cord and surrounding subarachnoid space are normal in appearance.

IMPRESSION: Normal MRI examination of the cervical spine.

Dictated by Matthew Shapiro, MD

Reported by: Matthew P. Shapiro MD, M.D.

Signed by: SHAMP <<Signature on File>>

Date/Time signed: 01/03/08 1355

C: D Preston Grice, MD; No Family Doc for this Patient

RADIOLOGY REPORT

Signed

AMC

Augusta Medical Center
78 Medical Center Drive
Fishersville, VA 22939

Department of Radiology
(540) 332-4400
(540) 932-4400

Patient: [REDACTED]	Acct #: [REDACTED] Status: DEPER	MR #: [REDACTED]
Tech: RAD.PJE	Age/Sex: 33F	Loc: ED1
Report #: 0918-0249	Phys: Asher Brand MD	Pat phone #: [REDACTED]
Transcriptionist: jaw	Dict Date: 09/18/07 0915	Trans Date: 09/18/07 1629

Date of Service: 09/17/07

Exam(s): 0917-0053 XED/XED * Nasal Bones

DOB: [REDACTED] Dictating Radiologist: Shashank Parekh

Diagnosis: HEADACHE, NECK PAIN AND EPISTAXIS

Reason for Exam: INJURY

NASAL BONES: 09/17/07

Three images

No displaced fracture is seen. Orbital rims appear intact. There is no fluid in the sinuses. There is questionable soft tissue swelling over the left face.

IMPRESSION:

No evidence of fracture.

Dictated by Shashank Parekh, MD

Reported by: Shashank Parekh, M.D.
Signed by: PARS <<Signature on File>>
Date/Time signed: 09/19/07 0841

C: Asher Brand, MD; No Family Doc for this Patient

RADIOLOGY REPORT

Signed

AMC

Augusta Medical Center
78 Medical Center Drive
Fishersville, VA 22939

Department of Radiology
(540) 332-4400
(540) 932-4400

Patient: [REDACTED]	Acct #: [REDACTED]	MR #: [REDACTED]
	Status: DEPER	
Tech: SSH.JWN	Age/Sex: 33F	Loc: ED1
Report #: 0912-0156	Phys: Sally I Tucker	Pat phone #: [REDACTED]
Transcriptionist: deh	Dict Date: 09/11/07 1751	Trans Date: 09/12/07 1115

Date of Service: 09/11/07

Exam(s): 0911-0068 CT/CT * Head w/o Contrast; 0911-0069 CT/CT * Cervical w/o Contrast

DOB: [REDACTED] Dictating Radiologist: Shashank Parekh

Diagnosis: HEAD AND NECK PAIN FROM MVC

Reason for Exam: R/O BLEED

*HEAD CT 9/11/07

There are no intra-axial or extra-axial lesions demonstrated. There is no evidence of hemorrhage or hydrocephalus. No midline shift or mass effect is identified. The visualized paranasal sinuses are clear.

IMPRESSION:

Negative examination.

UNENHANCED AXIAL CT OF THE CERVICAL SPINE WITH MULTIPLANAR REFORMATION

Alignment is normal. There is no significant disc space narrowing or vertebral compression. No bony fracture is seen. Atlantoaxial distance is normal. No definite intraspinal abnormality is seen.

IMPRESSION: Negative examination.

Dictated by Shashank Parekh, MD

Reported by: Shashank Parekh, M.D

Signed by: PARS <<Signature on File>>

Date/Time signed: 09/12/07 1659

C: No Family Doc for this Patient; Sally I Tucker

RADIOLOGY REPORT

Signed

AMC

Augusta Medical Center
78 Medical Center Drive
Fishersville, VA 22939

Department of Radiology
(540) 332-4400
(540) 932-4400

Patient: [REDACTED]	Acct #: [REDACTED] Status: DEPER	MR #: [REDACTED]
Tech: RADATS	Age/Sex: 33F	Loc: ED1
Report #: 0912-0446	Phys: Sally I Tucker	Pat phone #: (304)478-3102
Transcriptionist: mep	Dict Date: 09/12/07 1048	Trans Date: 09/12/07 1826

Date of Service: 09/11/07

Exam(s): 0911-0055 XED/XED Thoracic Spine Trauma; 0911-0056 XED/XED
Lumbosacral Spine Trauma

DOB: 07/15/1974 Dictating Radiologist: Matthew P Shapiro MD

Diagnosis: HEAD AND NECK PAIN FROM MVC

Reason for Exam: MVC MAJ3

*LUMBOSACRAL SPINE: 09/12/07

INDICATION: Back pain. Trauma from motor vehicle collision.

Five views of the lumbar spine demonstrate lumbar vertebrae to be intact with normal alignment. Disc spaces appear preserved.

IMPRESSION: Negative.

*THORACIC SPINE: 09/12/07

INDICATION: Back pain. Injury from motor vehicle collision.

AP and lateral views of the thoracic spine demonstrate thoracic vertebrae to be intact with normal alignment.

IMPRESSION: Negative.

Dictated by Matthew Shapiro, MD

Reported by: Matthew P Shapiro MD, M.D.
Signed by: SHAMP <<Signature on File>>

Signed

RADIOLOGY REPORT

Patient:		Acct #:	
Unit #:		Report #:	0912-0446

Date/Time signed: 09/13/07 1002

C: No Family Doc for this Patient; Sally I Tucker

RUN DATE: 06/13/08
RUN TIME: 1402

Augusta Medical Center
78 Medical Center Drive
Fishersville, Virginia 22939
Summary Report by Patient

PAGE 1

PATIENT: [REDACTED] ACCT #: [REDACTED] LOC: SLAB U #: [REDACTED]
AGE/SX: 33/F ROOM: RES: 03/14/08
REG DR: El-Bogdadi, Daniel G MD STATUS: REG CLI BED: DIS:

***** HEMATOLOGY *****
[**ABNORM **H=HIGH **L=LOW **H=PANIC HIGH **L=PANIC LOW **=DELTA]

Date	Time	Reference	Units
=> WBC	6.3	(3.9-11.0)	THD/MM3
=> RBC	4.91	(3.7-5.0)	MIL/MM3
=> HGB	15.5	(11.0-16.0)	g/dL
=> HCT	H 45.1	(33-45)	%
=> MCV	91.9	(80-97)	fL
=> MCH	31.6	(27-34)	ug
=> MCHC	34.4	(33-36)	g/dL
=> RDW	13.7	(11.2-15.2)	%
=> PLT	H 470	(140-400)	THOUS
=> MPV	8.3	(7.3-10.1)	fL
=> SEG NEUTROP	58.7		%
=> SEG ABSOLUT	3.7	(2.0-8.0)	#/THCUS
=> LYMPHS	23.8		%
=> LYMPH ABSOL	1.5	(1.0-4.0)	#/THCUS
=> MONO	15.1		%
=> MONO ABSOLU	1.0	(0.3-1.2)	#/THCUS
=> EOS %	2.1		%
=> EOSN ABSOLU	0.1	(0.0-0.7)	#/THCUS
=> BASO %	0.3		%
=> BASO ABSOLU	0.0	(0.0-0.2)	#/THCUS

Patient: [REDACTED] Age/Sex: 33/F Acct: [REDACTED] Unit: [REDACTED]

RUN DATE: 06/13/08
RUN TIME: 1402

Angusta Medical Center
78 Medical Center Drive
Fishersville, Virginia 22939
Summary Report by Patient

PAGE 2

PATIENT:	[REDACTED]	ACCT #:	[REDACTED]	LOC:	SLAB	U #:	[REDACTED]
REG DR:	El-Bocdadi, Daniel G MD	AGE/SEX:	33/F	ROOM:		REG:	03/14/08
		STATUS:	REG CLI	BED:		DIE:	

***** SPECIAL HEMATOLOGY *****
[**=ABNORM, H=HIGH, L=LOW, **=PANIC HIGH, *L=PANIC LOW, *L=DRIFT]

Date MAR 14
Time 0955

Reference Units

-> ESR 8 (0-20) MM/HR

Patient: [REDACTED] Age/Sex: 33/F Acct: [REDACTED] Unit: [REDACTED]

RUN DATE: 06/13/08
RUN TIME: 1402

Augusta Medical Center
78 Medical Center Drive
Fishersville, Virginia 22939
Summary Report by Patient

PAGE 3

PATIENT: [REDACTED] ACCT #: [REDACTED] LOC: SIAB U #: [REDACTED]
REG DR: El-Bocdadi, Daniel G MD AGE/SX: 33/F ROOM: REG: 03/14/08
STATUS: REG CLI BED: DIS:

ELECTROLYTES
[**=ABNORM, H=HIGH, L=LOW, **H=PANIC HIGH, **L=PANIC LOW, Δ=DELTA]

Date	Time	Reference Units
=> SODIUM	MAR 14 139	(132-142) mmol/L
=> POTASSIUM	Δ 3.0	(3.6-5.0) mmol/L
=> CHLORIDE	101	(101-111) mmol/L
=> CARBON DIOX	28	(21-31) mmol/L
=> ANION GAP	13	(6-16)

Patient: [REDACTED] Age/Sex: 33/F Acct: [REDACTED] Unit: [REDACTED]

RUN DATE: 06/13/08
RUN TIME: 1402

Augusta Medical Center
78 Medical Center Drive
Fishersville, Virginia 22939
Summary Report by Patient

PAGE 4

PATIENT: LAMBERT, TONYA LEA

ACCT #: M00032322349 LOC: SLAB

U #: M0257215

AGE/SEX: 33/F

ROOM:

REG: 03/14/08

REG DR: El-Bocdadi, Daniel G MD

STATUS: REG CLI

BED:

DIS:

CHEMISTRY

(**=ABNORM, H=HIGH, L=LOW, *H=PANIC HIGH, *L=PANIC LOW, Δ=DELTA)

Date	MAR 14		
Time	0953		Reference Units
=> GLUCOSE	88		(60-100) mg/dl
=> BUN	8		(8-24) mg/dl
=> CREATININE	0.80(a)		(0.44-1.30) mg/dl
=> ESTIMATED G	>60(b)		
=> EGFR AFR-AM	>60(c)		
=> URIC ACID	5.0		(2.8-7.9) mg/dl
=> TOTAL BILIR	0.8		(0.0-1.2) mg/dl
=> ALK PHOS	H 127		(37-112) IU/L
=> CK	53		(22-269) IU/L
=> SGOT	29		(13-36) IU/L
=> SGPT	13		(10-60) IU/L
=> TOTAL PROTE	7.4		(6.1-8.0) g/dl
=> ALBUMIN	3.7		(3.2-5.5) g/dl
=> CALCIUM	9.2		(8.4-10.7) mg/dl
=> PHOSPHORUS	2.9		(2.5-4.7) mg/dl
=> MAGNESIUM	2.0		(1.8-2.5) mg/dl

- NOTES: (a) Creatinine method used in reporting EGFR is IDMS standardized as of 11-20-2007. Note: New Reference Interval as of 12-9-2007.
(b) Non-African American
(c) Use this value if patient is African American.

The EGFR is used to approximate the Glomerular Filtration Rate (GFR) which is the best overall measure of renal function. The EGFR is not a sensitive test for renal failure, cannot be used to detect mild renal impairment, is inappropriate to use with dialysis patients, and is only valid in persons 18 years of age or older. The units are ml/min/1.73m².

- *EGFR >99 = Normal GFR or mild decrease in GFR
*EGFR 30-99 = Moderate decrease in GFR (Stage 3 CKD)
*EGFR 15-29 = Severe decrease in GFR (Stage 4 CKD)
*EGFR <15 = End-stage kidney failure (Stage 5 CKD)

Patient:

Age/Sex: 33/F

Acct:

Unit:

RUN DATE: 06/13/08
RUN TIME: 1402

Augusta Medical Center
78 Medical Center Drive
Fishersville, Virginia 22939
Summary Report by Patient

PAGE 3

PATIENT: [REDACTED] ACCT #: [REDACTED] LOC: SIAB U #: [REDACTED]
AGE/SEX: 33/F ROOM: RES: 03/14/08
REG DR: El-Bogdadi, Daniel G MD STATUS: REG CLI BED: DIS:

SPECIAL CHEMISTRY

ABNORM: H-HIGH, L-LOW, H-PANIC HIGH, L-PANIC LOW, S-DELTA

Date MAR 14
Time 0953

Reference Units

=> TSH 0.616
=> C REACT. PR < 0.53

(0.318-5.903) uIU/mL
(0.0-0.99) mg/dL

Patient: [REDACTED] Age/Sex: 33/F Acct#: [REDACTED] Unit#: [REDACTED]

RUN DATE: 06/13/08
RUN TIME: 1402

Augusta Medical Center
78 Medical Center Drive
Fisheraville, Virginia 22939
Summary Report by Patient

PAGE 6

PATIENT: [REDACTED] ACCT #: [REDACTED] LOC: SLAB U #: [REDACTED]
AGE/SEX: 33/F ROOM: R36: 03/14/08
REG DR: El-Bogdadi, Daniel G MD STATUS: REG-CLI BED: DIS:

*****URINALYSIS*****
H=HIGH, L=LOW, B=PANIC HIGH, L=PANIC LOW, S=DIRTY

Date	MAR 14	Reference Units
Time	0953	
=> UR TYPE	(d)	
=> COLOR	DK YELLOW	
=> APPEARANCE	H HAZY	
=> SPEC GRAV	H 1.036	(1.003-1.030)
=> U. GLUC	H 100	(NEGATIVE) mg/dL
=> BILIRUBIN	NEGATIVE	(NEGATIVE) mg/dL
=> ICTOTEST	NEGATIVE	(NEGATIVE)
=> KETONES	NEGATIVE	(NEGATIVE) mg/dL
=> BLOOD	NEGATIVE	(NEGATIVE)
=> PH	6.0	(4.5-8.0) pH
=> PROTEIN	NEGATIVE	(NEGATIVE) mg/dL
=> UROBILINOGE	0.2	(0.2 - 1) EU/dL
=> NITRITES	NEGATIVE	(NEGATIVE) mg/dL
=> LEUKOCYTES	H TRACE	(NEGATIVE)
=> UR WBC	H 5-10	(NONE SEEN) /HPF
=> MUCOUS	H MANY/LARGE	(NONE SEEN) S
=> BACTERIA	H MANY/LARGE	(NONE SEEN)
=> EPITHELIAL	H MANY/LARGE	(FEW/SLIGHT) /LPF
=> URINE COME	SEE BELOW: (e)	

NOTES: (d) SPECIMEN TYPE
Clean voided urine
(e) URINALYSIS COMMENT: CLUE CELLS NOTED

Patient: [REDACTED] Age/Sex: 33/F Acct: [REDACTED] Unit: [REDACTED]

RUN DATE: 06/13/08
RUN TIME: 1402

Augusta Medical Center
78 Medical Center Drive
Fishersville, Virginia 22939
Summary Report by Patient

PAGE 7

PATIENT: [REDACTED] ACCT #: [REDACTED] LOC: SLAB U #: [REDACTED]
AGE/SX: 33/F ROOM: FEB: 03/14/08
REG DR: El-Bogdadi, Daniel G MD STATUS: REG CLI BED: DIS:

***** SEROLOGY *****

[**=ABNORM, H=HIGH, L=LOW, *H=PANIC HIGH, *L=PANIC LOW, Δ=DELTA]

Date MAR 14
Time 0955

Reference Units

=> C3	106.6(f)	(93.6-190.5) mg/dl
=> C4	32.8(g)	(10.9-38.4) mg/dl
=> RF QUANTITA	< 20(h)	IU/ml
=> ANA SCREEN	NEGATIVE	(NEGATIVE)

NOTES: (f) Or December 2, 2007 testing performed at AMC Laboratory.
Please note the change in reference ranges when evaluating patients.

(g) Or December 2, 2007 testing performed at AMC Laboratory.
Please note the change in reference ranges when evaluating patients.

(h) RHEUMATOID FACTOR REFERENCE VALES

< 20 IU/mL: NEGATIVE
20 - 50 IU/mL: WEAK POSITIVE
> 50 IU/mL: POSITIVE

Rheumatoid factor (RF) is not a finding isolated to rheumatoid arthritis and may be present in a number of connective tissue and inflammatory diseases including infectious mononucleosis, systemic lupus erythematosus, scleroderma and hepatitis.

Patient: [REDACTED] Age/Sex: 33/F Acct: [REDACTED] Unit: [REDACTED]

RUN DATE: 06/13/08
RUN TIME: 1402

Angusta Medical Center
78 Medical Center Drive
Fishersville, Virginia 22939
Summary Report by Patient

PAGE 8

PATIENT: [REDACTED] ACCT #: [REDACTED] LOC: SLAB U #: M0257219
REG DR: El-Bogdadi, Daniel G MD AGE/SEX: 33/F ROOM: REG: 03/14/08
STATUS: REG CLI BED: DIS:

*****REFERENCE LABORATORY REPORTS*****

Date Time	MAR 15 UNK	MAR 14 3955	Reference Units
=> HEP B SURF		Nonreactive	(Nonreactive)
=> HEPB SJRF N		(i)	(())
=> HEP B CORE		(k)	(Nonreactive)
=> ANTI-HBs QU		Nonreactive	(Nonreactive)
=> HEPATITIS C		Nonreactive	(Nonreactive)
=> SIGNAL/CUTO		0.12(j)	(<1.00) ratio
=> ANTI-SS-A	<1.0		(<1.0) AI
=> ANTI-SS-B	<1.0(j)		(<1.0) AI
=> MYELOPEROX		<6(l)	(<6) U/mL
=> PROTEINASE		<6(m)	(<6) U/mL
=> TOTAL PROTE		7.6	(6.2-8.3) g/dL
=> ALBUMIN		3.38	(3.50-4.70) g/dL
=> ALPHA 1 GLO		0.30	(0.10-0.30) g/dL
=> ALPHA 2 GLO		0.32	(0.50-1.00) g/dL
=> BETA GLOB		1.21	(0.80-1.40) g/dL
=> GAMMA GLOB		1.39	(0.60-1.60) g/dL
=> MONOCLONAL		REFORT(n)	(())
=> MONOCLONAL		DNR	(())

NOTES: (i) Not indicated.
See also (j)

(j) Test performed by Quest Diagnostics Nichols Institute
14225 Newbrook Drive
Chantilly, VA 20153-0841
Phone: 1-800-336-3713

Formerly known as American Medical Laboratories, Inc.

(k) Nonreactive

See also (j)

(l) Reference range:

Negative: <6 U/mL

Equivocal: 6 - 9 U/mL

Positive: >9 U/mL

See also (j)

(m) Reference range:

Negative: <6 U/mL

Equivocal: 6 - 9 U/mL

Positive: >9 U/mL

See also (j)

(n) No M Spike detected.

Patient: [REDACTED] Age/Sex: 33/F Acct: [REDACTED] Unit: [REDACTED]

RUN DATE: 06/13/08
RUN TIME: 1402

Angusta Medical Center
78 Medical Center Drive
Fishersville, Virginia 22939
Summary Report by Patient

PAGE 9

PATIENT: [REDACTED] ACCT # [REDACTED] LOC: SLAB U #: [REDACTED]
AGE/SEX: 33/F ROOM: REG: 03/14/08
REG DR: El-Bocdadi, Daniel G MD STATUS: REG CLI BED: DIE:

*****REFERENCE LABORATORY REPORTS*****

Date Time	MAR 15 UNK	MAR 14 0955	Reference Units
=> TPEL INTERP		REPORT(c)	(())
=> CCP IgG Ab		5(q)	(<20) U
=> HIV 1 & 2		NEGATIVE(r)	(NEG)
=> VITAMIN D 2		<2.5(r)	(()) ng/ml
=> VITAMIN D 2		3.1(r)	(()) ng/ml
=> VITAMIN D 2		p 3.1	(25-80) ng/ml

NOTES: (o) No monoclonal-type peaks are present.
See also (p)

(p) Test performed by Quest Diagnostics Nichols Institute
14225 Newbrook Drive
Chantilly, VA 20153-0841
Phone: 1-800-336-3713

Formerly known as American Medical Laboratories, Inc.

(q) Negative: Less than 20 U
Weak Positive: 20 - 39 U
Moderate Positive: 40 - 59 U
Strong Positive: 60 or Greater U
See also (p)

(r) Test performed by UNIVERSITY OF VIRGINIA HOSPITAL
Health Sciences Center Clinical Laboratories
Box 168
Charlottesville, VA 22908

Patient: [REDACTED] Age/Sex: 33/F Acct: [REDACTED] Unit: [REDACTED]

RUN DATE: 06/13/08
RUN TIME: 1402

Augusta Medical Center
78 Medical Center Drive
Fishersville, Virginia 22939
CLINICAL LABORATORY EXTERNAL INQUIRY

PAGE 1

PATIENT: [REDACTED] ACCT #: [REDACTED] LOC: SLAB U #: [REDACTED]
AGE/SX: 33/F ROOM: REG: 03/14/08
REG DR: El-Bogdadi, Daniel G MD DOB: 07/15/1974 BED: DIS:
STATUS: REG CLI TLLOC:

SPEC #: 0314:H00128R COLL: 03/14/08-0955 STATUS: COMP REQ #: 01960049
RECD: 03/14/08-1045 SUBM DR: El-Bogdadi, Daniel G MD
ENTERED: 03/14/08-0943 OTHER DR:
ORDERED: CBCD, ESR

Test	Result	Flag	Reference
CBCD			
CBC			
HH			
WBC	6.3		3.5-11.0 THO/MM3
RBC	4.91		3.7-5.0 MIL/MM3
HGB	15.5		11.0-16.0 g/dL
HCT	45.1	H	33-45 %
MCV	91.9		80-97 fL
MCH	31.6		27-34 ug
MCHC	34.4		33-36 g/dL
RDW	13.7		11.2-15.2 %
PLT	478	H	140-400 THOUS
MPV	9.3		7.3-10.1
DIFF			
SEG NEUTROPHIL	58.7		%
SEG ABSOLUTE #	3.7		2.0-8.0 #/THOUS
LYMPHS	23.8		%
LYMPH ABSOLUTE #	1.5		1.0-4.0 #/THOUS
MONO	15.1		%
MONO ABSOLUTE #	1.0		0.3-1.2 #/THOUS
EOS %	2.1		%
EOSN ABSOLUTE #	0.1		0.0-0.7 #/THOUS
BASO %	0.3		%
BASO ABSOLUTE #	0.0		0.0-0.7 #/THOUS
ESR	8		0-20 MM/HR

** END OF REPORT **

RUN DATE: 06/13/08
RUN TIME: 1403

Augusta Medical Center
78 Medical Center Drive
Fishersville, Virginia 22939
CLINICAL LABORATORY EXTERNAL INQUIRY

PAGE 1

PATIENT: [REDACTED] ACCT #: [REDACTED] LOG: SLAB U #: [REDACTED]
AGE/SX: 33/F ROOM: REG: 03/14/08
REG DR: El-Bogdadi, Daniel G MD DOB: 07/15/1974 BED: DIS:
STATUS: REG CLI TLOC:

SPEC #: 0314:U00027R COLL: 03/14/08-0955 STATUS: COMP REQ #: 01960049
RECD: 03/14/08-1043 SUBM DR: El-Bogdadi, Daniel G MD

ENTERED: 03/14/08-0943
ORDERED: Ucm, ICTOTEST

OTHER DR:

COMMENTS:

QUERIES: Is culture to be ordered if indicated? N
Collection technique? Clean voided urine

Test	Result	Flag	Reference
Ucm			
UR TYPE	SPECIMEN TYPE		
	Clean voided urine		
COLOR	DK YELLOW		
APPEARANCE	HAZY	H	
SPEC GRAV	1.036	H	1.003-1.030
U. GLUC	100	H	NEGATIVE mg/dl
BILIRUBIN	NEGATIVE		NEGATIVE mg/dl
ICTOTEST	NEGATIVE		NEGATIVE
KETONES	NEGATIVE		NEGATIVE mg/dl
BLOOD	NEGATIVE		NEGATIVE
PH	6.0		4.5-8.0 pH
PROTEIN	NEGATIVE		NEGATIVE mg/dl
UROBILINOGEN	0.2		0.2 - 1 EU/dl
NITRITES	NEGATIVE		NEGATIVE mg/dl
LEUKOCYTES	TRACE	H	NEGATIVE
UR WBC	5-10	H	NONE SEEN /HPF
MUCOUS	MANY/LARGE	H	NONE SEEN
BACTERIA	MANY/LARGE	H	NONE SEEN
EPITHELIAL	MANY/LARGE	H	FEW/SLIGHT /LPF
URYNR COMMENT	SEE BELOW:		
URINALYSIS COMMENT: CLUE CELLS NOTED			

** END OF REPORT **

RUN DATE: 06/13/08
RUN TIME: 1403

Augusta Medical Center
78 Medical Center Drive
Fishersville, Virginia 22939
CLINICAL LABORATORY EXTERNAL INQUIRY

PAGE 1

PATIENT: [REDACTED] ACCT #: [REDACTED] LOC: SLAB U #: [REDACTED]
AGE/SEX: 33/F ROOM: [REDACTED] REG: 03/14/08
REG DR: El-Bogdadi, Daniel G MD DOB: 07/15/1974 BED: [REDACTED] DIS: [REDACTED]
STATUS: REG CLI TLOC: [REDACTED]

SPEC #: 0314:C00191R COLL: 03/14/08-0955 STATUS: COMP REQ #: 01950049
RECD: 03/14/08-1045 SUBM DR: El-Bogdadi, Daniel G MD

ENTERED: 03/14/08-0943 OTHER DR:
ORDERED: CMP, URIC, CK, PHOS, NG, TSH, CRP, C3, C4, RF
QUERIES: Has THYROID PANEL (THYP) been requested? N

Test	Result	Flag	Reference
CMP			
BMP			
GLUCOSE	88		60-100 mg/dl
BUN	8		8-24 mg/dL
CRET			
CREATININE	3.80		0.44-1.30 mg/dl
Creatinine method used in reporting EGFR is IDMS standardized as of 11-20-2007. Note: New Reference Interval as of 12-5-2007.			
ESTIMATED GFR	>60		
EGFR AFR-AMERC	Non-African American >60		
Use this value if patient is African American.			
The EGFR is used to approximate the Glomerular Filtration Rate (GFR) which is the best overall measure of renal function. The EGFR is not a sensitive test for renal failure, cannot be used to detect mild renal impairment, is inappropriate to use with dialysis patients, and is only valid in persons 18 years of age or older. The units are ml/min/1.73m2.			
*EGFR ≥90 = Normal GFR or mild decrease in GFR *EGFR 30-89 = Moderate decrease in GFR (Stage 3 CKD) *EGFR 15-29 = Severe decrease in GFR (Stage 4 CKD) *EGFR <15 = End-stage kidney failure (Stage 5 CKD)			
URIC ACID	5.0		2.8-7.9 mg/dL
TOTAL BILIRUBIN	3.8		0.0-1.2 mg/dL
ALK PHOS	127	N	37-112 IU/L
CK	53		22-269 IU/L
SGOT	29		13-36 IU/L
SGPT	13		10-60 IU/L
TOTAL PROTEIN	7.4		6.1-8.6 g/dL
ALBUMIN	3.7		3.2-5.5 g/dL
CALCIUM	9.2		8.4-10.7 mg/dL
PHOSPHORUS	2.9		2.5-4.7 mg/dL
MAGNESIUM	2.0		1.8-2.5 mg/dL

** CONTINUED ON NEXT PAGE **

RUN DATE: 06/13/08
RUN TIME: 1403

Augusta Medical Center
78 Medical Center Drive
Fishersville, Virginia 22939
CLINICAL LABORATORY EXTERNAL INQUIRY

PAGE 1

PATIENT: [REDACTED] ACCT #: [REDACTED] LOC: SIAB U #: [REDACTED]
REG DR: El-Bogdadi, Daniel G MD AGE/SX: 33/F ROOM: REG: 03/14/08
DOB: 07/15/1974 BED: DIS:
STATUS: REG CLI TLLOC:

SPEC #: 0314:R00024R COLL: 03/14/08-0955 STATUS: COMP REQ #: 01960049
RECD: 03/14/08-1045 SUBM DR: El-Bogdadi, Daniel G MD

ENTERED: 03/14/08-0943 OTHER DR:
ORDERED: HEP PROF 68, ANCA PROF #1, TPEL, CCP IgG Ab, HIV1&2, VITD25 LVA
QUERIES: IS PATIENT FASTING? YES

Test	Result	Flag	Reference
HEPBSAG			
HEP B SURF AG	Nonreactive		Nonreactive
HEPB SURF NEUTR	Not indicated.		()
Test performed by Quest Diagnostics Nichols Institute 14225 Newbrook Drive Chantilly, VA 20153-0941 Phone: 1-800-336-3718 Formerly known as American Medical Laboratories, Inc.			
HEP B CORE AB	Nonreactive		Nonreactive
Test performed by Quest Diagnostics Nichols Institute 14225 Newbrook Drive Chantilly, VA 20153-0941 Phone: 1-800-336-3718 Formerly known as American Medical Laboratories, Inc.			
ANTI-HBs QUAL	Nonreactive		Nonreactive
HEPCAB			
HEPATITIS C AB	Nonreactive		Nonreactive
SIGNAL/CUTOFF	3.12		<1.00 ratio
Test performed by Quest Diagnostics Nichols Institute 14225 Newbrook Drive Chantilly, VA 20153-0941 Phone: 1-800-336-3718 Formerly known as American Medical Laboratories, Inc.			
ANCA PROF #1			
MYELOPEROX AB	<6		<6 U/mL
Reference range: Negative: <6 U/mL Equivocal: 6 - 9 U/mL Positive: >9 U/mL			
Test performed by Quest Diagnostics Nichols Institute 14225 Newbrook Drive Chantilly, VA 20153-0941			

** CONTINUED ON NEXT PAGE **

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AMC AUGUSTA MEDICAL CENTER
PO Box 1040
Fishersville, VA 22939

Patient: [REDACTED]
Acct# [REDACTED] MFW [REDACTED]
Date: 03/14/08 Time: 0935

CONSENT TO ADMISSION AND/OR TREATMENT

1. Consent: I voluntarily consent to treatment by AUGUSTA HEALTH CARE, INC. ("Hospital"), its agents, employees, and contractors as deemed necessary by my attending physician(s) or his/her consultants, associates or designees, including but not limited to x-rays, laboratory tests, anesthesia, medical or surgical procedures, nursing care and other hospital inpatient or outpatient services. I recognize that physicians and others rendering such services may not be employees of the hospital, but are independent contractors.
2. No Guaranty Or Warranty: The practice of medicine and surgery is not an exact science and diagnosis and treatment may involve risk, including injury or death. I acknowledge that no guarantees or warranties have been made regarding results of any examination or treatment.
3. Use Of Specimens, Etc.: Hospital may retain, photograph, preserve and/or use for scientific or teaching purposes, or dispose of in its discretion any specimens or tissues taken from me (Patient) during this hospitalization and/or treatment.
4. Release Of Health Information/Notice Of Privacy Practices: I understand that Hospital may release information from my medical and billing records in accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and statutory regulations of the Commonwealth of Virginia. My signature below acknowledges that I have received a copy of the federal Notice Of Privacy Practices at or prior to this service encounter.
5. Valuables: I have been afforded an opportunity to deposit my (Patient's) valuables and money with Hospital for safe keeping and unless deposited, I agree that the Hospital shall not be liable for loss or damage to any such personal property.
6. Advance Directive: Upon admission to the Hospital (adults only), I have received information regarding my right by state law and pursuant to Hospital policy to execute an Advance Directive to refuse life sustaining procedures under certain circumstances.
7. Notice Of Deemed Consent For HIV, Hepatitis B & C Blood Testing: The Virginia Code authorizes health care providers to test patients for HIV and Hepatitis B & C when provider or someone employed by/under direction or control of provider is exposed to bodily fluids of the patient in a manner which, according to current guidelines of the Center for Disease Control, may transmit HIV or Hepatitis B or C viruses. In the event of such an exposure, I am deemed to have consented to testing and release of results to person(s) exposed.
8. Assignment Of Benefits: In consideration of services rendered pursuant to this Consent whether during a single admission or on a continuing basis (including any infant(s) born to me during this admission), I agree to pay full charges for their services less any amounts paid by third party payors, and I hereby assign to the Hospital and any Independent Contractors/Providers to the extent necessary to satisfy any outstanding indebtedness, all sums payable to Patient pursuant to any health benefit plan, policy of insurance, (including health, liability, uninsured, under-insured, motorists or medical payments insurance) and/or pursuant to any settlement or judgement arising out of or related to any incident which caused this admission or medical treatment rendered pursuant to this Consent. I understand that I am financially responsible to the Hospital for all its charges not covered by a third party source, except as agreed between the Hospital and any third party source.
9. Medicare Patients: If I (Patient) am a Medicare patient, I request that payment be made in my behalf, and I assign the benefits payable for services furnished to me (Patient) by or in AUGUSTA HEALTH CARE, INC., including physicians services to the physician furnishing the services to the Hospital, or authorize such physician or the Hospital to submit a claim to Medicare for payment for me. I understand that I am responsible for any deductibles and the applicable percentages of the reasonable charges. I authorize any holder of medical or other information about me (Patient) to release to the Social Security Administration or its intermediaries or carriers any information needed for this/related Medicare/Medicaid claim. Medicare Inpatient: A copy of Important Message From Medicare has been provided to me.
10. Subsequent Release Of Detailed Billing Information: My signature below shall be deemed written authorization for Hospital to release to me itemized and detailed billing information regarding admission and/or services rendered pursuant to this Consent upon my later request. I further authorize and consent to the Hospital providing to the authorized representative named below, upon their written request, a copy of confidential itemized or detailed billing information or other itemized or detailed information for a period up to one year from the date of my signature.

I have read this consent, been given opportunity to ask questions and I accept its terms:

Signature of Patient/Responsible Party

Name Of Authorized Representative

Relationship

Witness

Date: (mm/dd/yyyy)

3/14/08
Date

SP

ADDITIONAL INFORMATION

[Redacted]

2/15/24

DATE OF BIRTH

1/2/1974

DATE OF EXAMINATION

2/15/24

DATE OF BIRTH

1/2/1974

EXAMINER

DR. P. J. L. AT

EXAMINER'S SIGNATURE

[Redacted]

1. I have examined the patient and find that the patient is suffering from the following condition(s):
2. I have examined the patient and find that the patient is suffering from the following condition(s):
3. I have examined the patient and find that the patient is suffering from the following condition(s):
4. I have examined the patient and find that the patient is suffering from the following condition(s):
5. I have examined the patient and find that the patient is suffering from the following condition(s):
6. I have examined the patient and find that the patient is suffering from the following condition(s):
7. I have examined the patient and find that the patient is suffering from the following condition(s):
8. I have examined the patient and find that the patient is suffering from the following condition(s):
9. I have examined the patient and find that the patient is suffering from the following condition(s):
10. I have examined the patient and find that the patient is suffering from the following condition(s):

NOTICE: TO COMPLETE THIS FORM WILL DELAY GRANTING OF THE EXAMINATION

DATE

2/15/24

[Signature]

AMC AUGUSTA MEDICAL CENTER
PO Box 1000
Fishersville, VA 22939

Patient: [REDACTED]
Acct# [REDACTED] MR# H0257215
Date: 03/07/08 Time: 1741

CONSENT TO ADMISSION AND/OR TREATMENT

1. Consent: I voluntarily consent to treatment by AUGUSTA HEALTH CARE, INC. ("Hospital"), its agents, employees, and contractors as deemed necessary by my attending physician(s) or his/her consultants, associates or designees, including but not limited to x-rays, laboratory tests, anesthesia, medical or surgical procedures, nursing care and other hospital inpatient or outpatient services. I recognize that physicians and others rendering such services may not be employees of the hospital, but are independent contractors.
2. No Guaranty Or Warranty: The practice of medicine and surgery is not an exact science and diagnosis and treatment may involve risk, including injury or death. I acknowledge that no guarantees or warranties have been made regarding results of any examination or treatment.
3. Use Of Specimens, Etc.: Hospital may retain, photograph, preserve and/or use for scientific or teaching purposes, or dispose of in its discretion any specimens or tissues taken from me (Patient) during this hospitalization and/or treatment.
4. Release Of Health Information/Notice Of Privacy Practices: I understand that Hospital may release information from my medical and billing records in accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and statutory regulations of the Commonwealth of Virginia. My signature below acknowledges that I have received a copy of the federal Notice Of Privacy Practices at or prior to this service encounter.
5. Valuables: I have been afforded an opportunity to deposit my (Patient's) valuables and money with Hospital for safe keeping and unless deposited, I agree that the Hospital shall not be liable for loss or damage to any such personal property.
6. Advance Directive: Upon admission to the hospital (adults only), I have received information regarding my right by state law and pursuant to Hospital policy to execute an Advance Directive to refuse life sustaining procedures under certain circumstances.
7. Notice Of Deemed Consent For HIV, Hepatitis B & C Blood Testing: The Virginia Code authorizes health care providers to test patients for HIV and Hepatitis B & C when provider or someone employed by/under direction or control of provider is exposed to bodily fluids of the patient in a manner which, according to current guidelines of the Center for Disease Control, may transmit HIV or Hepatitis B or C viruses. In the event of such an exposure, I am deemed to have consented to testing and release of results to person(s) exposed.
8. Assignment Of Benefits: In consideration of services rendered pursuant to this Consent whether during a single admission or on a continuing basis (including any infant(s) born to me during this admission), I agree to pay full charges for their services less any amounts paid by third party payors, and I hereby assign to the Hospital and any Independent Contractors/Providers to the extent necessary to satisfy any outstanding indebtedness, all sums payable to Patient pursuant to any health benefit plan, policy of insurance, (including health, liability, uninsured, under-insured, motorists or medical payments insurance) and/or pursuant to any settlement or judgement arising out of or related to any incident which caused this admission or medical treatment rendered pursuant to this Consent. I understand that I am financially responsible to the Hospital for all its charges not covered by a third party source, except as agreed between the Hospital and any third party source.
9. Medicare Patients: If I (Patient) am a Medicare patient, I request that payment be made in my behalf, and I assign the benefits payable for services furnished to me (Patient) by or in AUGUSTA HEALTH CARE, INC., including physicians services to the physician furnishing the services to the Hospital, or authorize such physician or the Hospital to submit a claim to Medicare for payment for me. I understand that I am responsible for any deductibles and the applicable percentages of the reasonable charges. I authorize any holder of medical or other information about me (Patient) to release to the Social Security Administration or its intermediaries or carriers any information needed for this/related Medicare/Medicaid claim. Medicare Inpatient: A copy of Important Message From Medicare has been provided to me.
10. Subsequent Release Of Detailed Billing Information: My signature below shall be deemed written authorization for Hospital to release to me itemized and detailed billing information regarding admission and/or services rendered pursuant to this Consent upon my later request. I further authorize and consent to the Hospital providing to the authorized representative named below, upon their written request, a copy of confidential itemized or detailed billing information or other itemized or detailed information for a period up to one year from the date of my signature.

Area Of Authorized Representative

Relationship

I have read this consent, been given opportunity to ask questions and I accept its terms.

Signature Of Patient/Responsible Party

Relationship

Witness

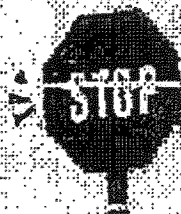
Date

SP



REQUEST FOR MRI EXAMINATION AUGUSTA MEDICAL CENTER

Time: _____



If patient answers YES to one of the following questions, they WILL NOT be able to have an MRI

Do you have a pacemaker or defibrillator?

☐ Yes ☒ No

Do you have any implanted devices (such as a lens unit or mechanical pump)?

☐ Yes ☒ No

Patient Name: _____

Address: _____

Telephone (H) _____ (W) _____

DOB: 7/15/74

Weight: _____

SS: _____

Pre-certification Required?

☐ Yes☒ No

Present # _____

CPT# 92178Type of Exam: MRI Lumbosacral spinePatient Symptoms: Increasing lumbosacral pain andReason for Exam: 1. Abused (Bladder limb pain & numbness)Suspected Pathology: L2/3 HNP (Lumbosacral)To Schedule a MRI, you must have an ICD-9 Code 724.4, 722.10Has patient had previous x-rays or MRI's of this area? ☐ Yes ☒ NoHas patient had recent labs for BUN and Creatinine? ☒ Yes ☒ NoPhysician signature: [Signature]

Additional Screening Questions:

☐ Yes
☐ Yes
☒ Yes
☐ Yes
☐ Yes
☐ Yes
☐ Yes
☐ Yes
☐ Yes
☒ Yes
☐ Yes

☒ No
☒ No
☐ No
☒ No
☒ No
☒ No
☒ No
☒ No
☒ No
☒ No
☐ No
☐ No

Do you have multiple myeloma?

Are you on dialysis?

Are you a diabetic?

Do you have any history of renal failure?

Are you claustrophobic? If yes, please bring driver

Have you had heart surgery? (Stents, filter, valves)

Have you ever done welding, grinding or been an auto mechanic?

Have you ever had anything metallic get into or removed from your eyes?

Have you ever had ear, eye or brain surgery? Description of Surgery _____

Do you have body piercing other than ears? If yes, it must be removed prior to exam. nose, lip, eyebrow, chin

If female, are you pregnant or using an IUD?

All Previous Surgeries: _____

Fax: 540.332 or 932.5341

Phone: 540.332 or 932.4395

SPINE QUESTIONNAIRE

Patient Name: [REDACTED] Duration of present back problems _____ years, _____ Months, _____ Days

Back problems are related.
(check all that apply)

- ☐ No known injury
☐ Work injury
☒ Car accident
☐ Lifting injury
☐ Bending injury
☐ Other Injury (please specify): _____

If back problems are related to an injury, please give date of injury: 8/03

Please describe your back problems: _____

Please describe any prior back problems:

LUMBAR/THORACIC

Back or buttock pain? Yes ☒ No ☐

Leg pain? Yes ☒ No ☐

Circle R L Both

Hip pain? Yes ☒ No ☐

Circle R L Both

Type of pain: (Check all that apply)

Constant ☒ No ☐

Intermittent ☒ No ☐

Dull ache ☒ No ☐

Sharp stabbing ☒ No ☐

Shooting ☒ No ☐

Burning ☒ No ☐

Throbbing ☒ No ☐

Tingling ☒ No ☐

Foot drop? ☐ No ☒

Any numbness in legs? ☐ No ☐

Circle: R L Both

Any weakness in legs? ☐ No ☐

Circle: R L Both

Any history of Cancer? ☐ No ☒

Where? _____

Previous back surgery? ☐ No ☒

Date(s): _____

CERVICAL

Neck pain? Yes ☐ No ☒

Shoulder pain? Yes ☐ No ☐

Circle: R L Both

Finger pain? Yes ☐ No ☐

Circle: R L Both

Which fingers? _____

Arm/hand numbness? Yes ☐ No ☐

Circle R L Both

Type of pain: (check all that apply)

Constant ☐ No ☐

Intermittent ☐ No ☐

Dull ache ☐ No ☐

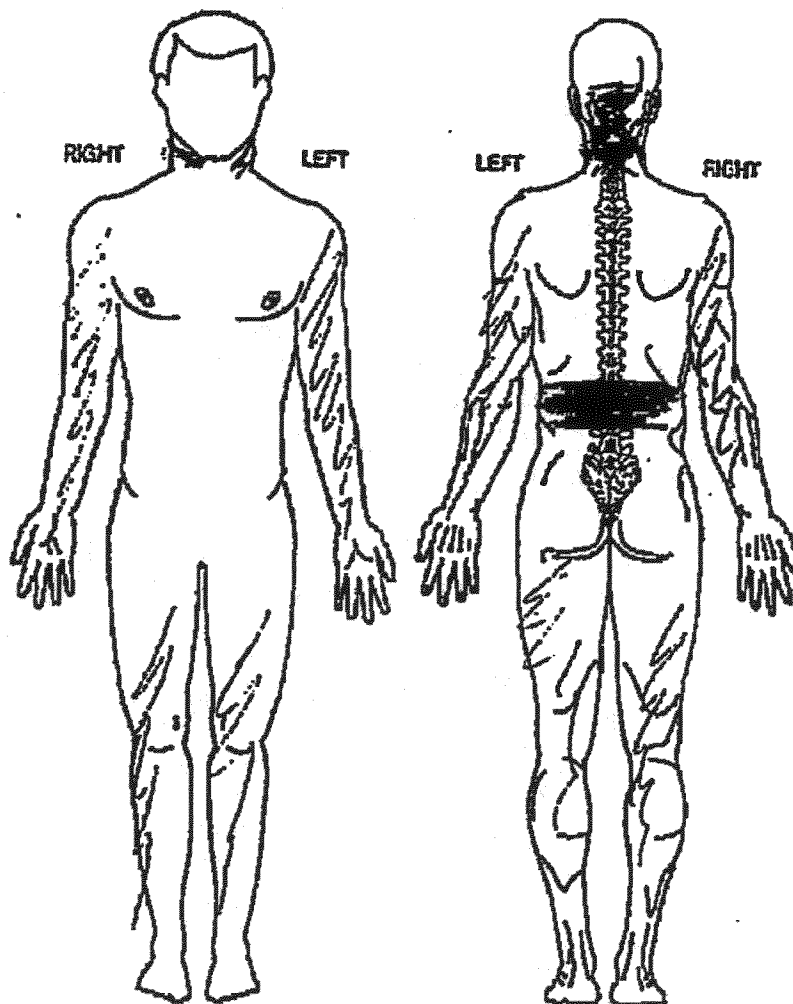
Sharp stabbing ☐ No ☐

Shooting ☐ No ☐

Tingling ☐ No ☐

Previous neck surgery? ☒ No ☐

Date(s): _____



On the drawings above, please shade in the area(s)
Of pain, numbness, or weakness

(Patient's/Signature

Technologist's Initials

Outpatient MRI Scheduling Form
SHENANDOAH SHARED HOSPITAL SERVICES, INC.

Patient: [REDACTED]		Physician: Grice, D Preston MD	
Address: [REDACTED] HAMBLETON, NV		Address: Augusta Pain Management 70 Medical Center Circle #3C5 Fishersville, Va 22939	
Home Ph: [REDACTED]	CELL [REDACTED]	Office Phone: (540)932-5747	
Work Ph: [REDACTED]	MSG [REDACTED]	Office FAX #: (540)932-5748	
SSN: [REDACTED]	Age: 33	DOB: 07/15/1974	Office Contact:
Height: [REDACTED]	Weight: 110		Scheduled By: Linda Bartley
Date Scheduled: 02/12/08	Time: 0745		Scan Requested: MRIN SPINAL CANAL LUMBAR
Rescheduled From:	Unit#: [REDACTED]	Reason: INCREASING LUMBAR PAIN, LOWER LIMB PAIN	
Ins1: SELF PAY	Pol#		Aut#
Ins2:	Pol#		Aut#

PREVIOUS X-RAYS, CT OR MRI SCANS OF AREA TO BE STUDIED	DATE	HOSPITAL

Yes	No	EVALUATION OF PATIENT	ACCOUNT# [REDACTED]
<input checked="" type="checkbox"/>	<input type="checkbox"/>	1. Do you have a pacemaker?	<i>PI refuses to remove all jewelry - E explained to her the potential for a burn/JL</i> <i>X Tonya Shank</i>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	2. Have you had heart surgery (stents, filter, valve)?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	3. If female, are you pregnant or using an IUD?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	4. Are you claustrophobic?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	5. Have you ever done welding, grinding or been an auto mechanic?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	6. Have you ever had anything metallic in or removed from your eyes?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	7. Have you ever had eye, ear, or brain surgery?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	8. Do you have a tattoo, tattoo eyeliner, or body piercing?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	9. List all previous surgeries <u>you</u> <u>implants</u>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	10. Drug Allergies <u>all pills, sulfur, penicillins</u>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	11. Do you have metal anywhere in your body?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	12. Do you have a hearing aid or mechanical voice box?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	13. Do you have a vena cava filter or umbrella for blood clots?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	14. Do you have any surgical clips or wire sutures?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	15. Do you have any implanted devices (insulin pump/neurostimulator/TENS/mech pump)?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	16. Have you ever had a war injury or gunshot wound?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	17. Do you have any transdermic patches on your body (ex. nicotine, contraceptive)?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	18. Do you have abnormal kidney function?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	19. Do you have Sickle Cell?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	20. Do you have an elevated temperature? If yes, give temp _____	

(PT) TONYA MADE THE APPT HERSELF
 SELF PAY PER PT

The answers to these questions are felt to be correct and have been answered to the best of my ability.

Name Of Person Answering Questions Tonya Shank Relation To Pt self
 Secretary Review By [Signature] Date/Time 2/12/08 6:52
 Technologist Final Screening Reviewed By _____ Date/Time _____



MRI HISTORY SHEET

Patient Name: _____

Date of Exam: _____

Type of Exam: _____

Current Symptoms: Be specific about location of symptoms

Head, neck, shoulder, lower back pain

Any injury? ☒ Yes ☐ No If yes, Date: 8/15/17

Describe injury: MVA - rear ended

Any prior surgery to this area? ☐ Yes ☒ No Date of Surgery: _____

Surgeon: _____ What Hospital? _____

Type of surgery if known: _____

Recent x-rays of this area? ☒ Yes ☐ No If so where? AMC or OTHER

Have you had:

> A prior MRI of this area? ☒ Yes ☐ No If yes, date and Location _____

> A prior CT of this area? ☒ Yes ☐ No If yes, date and location _____

> A prior Nuclear Medicine study? ☐ Yes ☒ No If yes date and location _____

> A prior Bone Scan? ☐ Yes ☒ No If so, date and location _____

Medical History:

Do you have a history of cancer? ☐ Yes ☒ No If so, what type _____

Do you have Diabetes? ☒ Yes ☐ No

Do you have Arthritis? ☒ Yes ☐ No

Do you have kidney failure? ☐ Yes ☒ No

Do you take steroids? ☐ Yes ☒ No

AMC AUGUSTA MEDICAL CENTER
PO Box 1000
Fishersville, VA 22939

Patient: [REDACTED]
Acct# [REDACTED] MR# [REDACTED]
Date: 02/12/08 Time: 0728

CONSENT TO ADMISSION AND/OR TREATMENT

1. Consent: I voluntarily consent to treatment by AUGUSTA HEALTH CARE, INC. ("Hospital"), its agents, employees, and contractors as deemed necessary by my attending physician(s) or his/her consultants, associates or designees, including but not limited to x-rays, laboratory tests, anesthesia, medical or surgical procedures, nursing care and other hospital inpatient or outpatient services. I recognize that physicians and others rendering such services may not be employees of the hospital, but are independent contractors.
2. No Guaranty Or Warranty: The practice of medicine and surgery is not an exact science and diagnosis and treatment may involve risk, including injury or death. I acknowledge that no guarantees or warranties have been made regarding results of any examination or treatment.
3. Use Of Specimens, Etc.: Hospital may retain, photograph, preserve and/or use for scientific or teaching purposes, or dispose of in its discretion any specimens or tissues taken from me (Patient) during this hospitalization and/or treatment.
4. Release Of Health Information/Notice Of Privacy Practices: I understand that Hospital may release information from my medical and billing records in accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and statutory regulations of the Commonwealth of Virginia. My signature below acknowledges that I have received a copy of the federal Notice Of Privacy Practices at or prior to this service encounter.
5. Valuables: I have been afforded an opportunity to deposit my (Patient's) valuables and money with Hospital for safe keeping and unless deposited, I agree that the Hospital shall not be liable for loss or damage to any such personal property.
6. Advance Directive: Upon admission to the hospital (adults only), I have received information regarding my right by state law and pursuant to Hospital policy to execute an Advance Directive to refuse life sustaining procedures under certain circumstances.
7. Notice Of Deemed Consent For HIV, Hepatitis B & C Blood Testing: The Virginia Code authorizes health care providers to test patients for HIV and Hepatitis B & C when provider or someone employed by/under direction or control of provider is exposed to bodily fluids of the patient in a manner which, according to current guidelines of the Center for Disease Control, may transmit HIV or Hepatitis B or C viruses. In the event of such an exposure, I am deemed to have consented to testing and release of results to person(s) exposed.
8. Assignment Of Benefits: In consideration of services rendered pursuant to this Consent whether during a single admission or on a continuing basis (including any infant(s) born to me during this admission), I agree to pay full charges for their services less any amounts paid by third party payors, and I hereby assign to the Hospital and any Independent Contractors/Providers to the extent necessary to satisfy any outstanding indebtedness, all sums payable to Patient pursuant to any health benefit plan, policy of insurance, (including health, liability, uninsured, under-insured, motorists or medical payments insurance) and/or pursuant to any settlement or judgement arising out of or related to any incident which caused this admission or medical treatment rendered pursuant to this Consent. I understand that I am financially responsible to the Hospital for all its charges not covered by a third party source, except as agreed between the Hospital and any third party source.
9. Medicare Patients: If I (Patient) am a Medicare patient, I request that payment be made in my behalf, and I assign the benefits payable for services furnished to me (Patient) by or in AUGUSTA HEALTH CARE, INC., including physicians services to the physician furnishing the services to the Hospital, or authorize such physician or the Hospital to submit a claim to Medicare for payment for me. I understand that I am responsible for any deductibles and the applicable percentages of the reasonable charges. I authorize any holder of medical or other information about me (Patient) to release to the Social Security Administration or its intermediaries or carriers any information needed for this/related Medicare/Medicaid claim. Medicare Inpatient: A copy of Important Message From Medicare has been provided to me.
10. Subsequent Release Of Detailed Billing Information: My signature below shall be deemed written authorization for Hospital to release to me itemized and detailed billing information regarding admission and/or services rendered pursuant to this Consent upon my later request. I further authorize and consent to the Hospital providing to the authorized representative named below, upon their written request, a copy of confidential itemized or detailed billing information or other itemized or detailed information for a period up to one year from the date of my signature.

I have read this consent, been given opportunity to ask questions and I accept its terms:

[REDACTED]	<u>ack</u>	<u>WAD</u>	<u>2/12/08</u>
Signature Of Patient/Responsible Party	Relationship	Witness	Date

Outpatient MRI Scheduling Form

SHENANDOAH SHARED HOSPITAL SERVICES, INC.

Patient:			Physician: Grice, D Preston MD
Address:	HAMBLETON, WV		Address: Augusta Pain Management 70 Medical Center Circle #305 Fishersville, Va 22939
Home Ph:	CELL		Office Phone: (540) 932-5747
Work Ph:	MSG		Office FAX #: (540) 932-5748
SS#: [REDACTED]	Age: 33	DOB: 07/15/1974	Office Contact:
Height:	Weight: 110	7:15	Scheduled By: Linda Bartley
Date Scheduled: 02/12/08	Time: 0745		Scan Requested: MRIN SPINAL CANAL LUMBAR
Rescheduled From:	Unit#: [REDACTED]		Reason: INCREASING LUMBAR PAIN, LOWER LIMB PAIN
Ins1: SELF PAY			Pol#
Ins2:			Aut#
			Aut4

PREVIOUS X-RAYS, CT OR MRI SCANS OF AREA TO BE STUDIED	DATE	HOSPITAL

Yes	No	EVALUATION OF PATIENT	ACCOUNT#
		1. Do you have a pacemaker?	
		2. Have you had heart surgery (stents, filter, valve)?	
		3. If female, are you pregnant or using an IUD?	
		4. Are you claustrophobic?	
		5. Have you ever done welding, grinding or been an auto mechanic?	
		6. Have you ever had anything metallic in or removed from your eyes?	
		7. Have you ever had eye, ear, or brain surgery?	
		8. Do you have a tattoo, tattoo eyeliner, or body piercing?	
		9. List all previous surgeries	
		10. Drug Allergies	
		11. Do you have metal anywhere in your body?	
		12. Do you have a hearing aid or mechanical voice box?	
		13. Do you have a vena cava filter or umbrella for blood clots?	
		14. Do you have any surgical clips or wire sutures?	
		15. Do you have any implanted devices (insulin pump/neurostimulator/TENS/mech pump)?	
		16. Have you ever had a war injury or gunshot wound?	
		17. Do you have any transdermic patches on your body (ex. nicotine, contraceptive)?	
		18. Do you have abnormal kidney function?	
		19. Do you have Sickle Cell?	
		20. Do you have an elevated temperature? If yes, give temp	

(PT) [REDACTED] MADE THE APPT HERSELF

SELF PAY PER PT

Dr. Fayed 1/11/08

The answers to these questions are felt to be correct and have been answered to the best of my ability.

Name Of Person Answering Questions pt. Relation To Pt selfSecretary Review By LB Date/Time 2/11/08

Technologist Final Screening Reviewed By _____ Date/Time _____

SP

Handwritten initials



REQUEST FOR MRI EXAMINATION

AUGUSTA MEDICAL CENTER

Date of Exam: _____

Time: _____



If patient answers YES to one of the following questions, they WILL NOT be able to have an MRI

Do you have a pacemaker or defibrillator? ☐ Yes ☒ No

Do you have any implanted devices (such as a lens unit or mechanical pump)? ☐ Yes ☒ No

Insurance (payer): _____

Address: _____

Hambledon, WV

Telephone (H): _____

DOB: _____

Weight: 120#

SSN: _____

Pre-certification Required? ☐ Yes ☒ No

Facet # _____

CPT# _____

State Farm

Type of Exam: MRI cervical spine

Patient Symptoms: Chronic cervical pain

upper limb

Reason for Exam: pain

Suspected pathology: CLT / HNP / DDD

To Schedule a MRI, you must have an ICD-9 Code

723.4, 723.1, 723.9

Has patient had previous x-rays or MRI of this area? ☒ Yes ☐ No

Has patient had previous surgery for this area? ☒ Yes ☐ No

Physician Signature: _____

Patient Screening Questions

- ☒ Yes
- ☒ Yes
- ☒ Yes
- ☒ Yes
- ☒ Yes
- ☒ Yes
- ☒ Yes
- ☒ Yes
- ☒ Yes
- ☒ Yes

- ☒ No
- ☒ No
- ☒ No
- ☒ No
- ☒ No
- ☒ No
- ☒ No
- ☒ No
- ☒ No
- ☒ No

Do you have multiple myeloma?

Are you on dialysis?

Are you a diabetic?

Do you have any history of renal failure?

Are you claustrophobic? If yes, please bring sedative

Have you had heart surgery? (Stents, filter, valves)

Have you ever done welding, grinding or been an auto mechanic?

Have you ever had anything metallic get into or removed from your eyes?

Have you ever had ear, eye or sinus surgery? (Transposition of sinuses)

Do you have body piercing other than ears? If yes, it must be removed prior to exam

If female, are you pregnant or using an IUD?

All Previous Surgeries:

none of states she doesn't recall surgery in
hip, knee & back. She was told that they
might mess up

Phone: 540.332 or 932.4395

Images on MRI

SPINE QUESTIONNAIRE

Patient Name: [REDACTED]

Duration of present back problems _____ years, _____ Months

Back problems are related:
 (check all that apply)

☐ NO KNOWN INJURY
☒ Work injury
☐ Other injury (please specify): _____

☐ Car accident

☐ Bending injury

If back problems are related to an injury, please give date of injury: _____

Please describe your back problems: _____

Please describe any prior back problems:

LUMBAR/THORACIC

Back or buttock pain? _____

Leg pain? _____

Circle R L Both

Hip pain? _____

Circle R L Both

Type of pain: (Check all that apply)

Constant _____

Intermittent _____

Dull ache _____

Sharp stabbing _____

Shooting _____

Burning _____

Throbbing _____

Tingling _____

Foot drop? _____

Any numbness in legs? _____

Circle R L Both

Any weakness in legs? _____

Circle R L Both

Any history of Cancer? _____

Where? _____

Previous back surgery? _____

Date(s): _____

CERVICAL

Neck pain? _____

Shoulder pain? _____

Circle R L Both

Finger pain? _____

Circle R L Both

Which fingers? _____

Arm/hand numbness? _____

Circle R L Both

Type of pain: (check all that apply)

Constant _____

Intermittent _____

Dull ache _____

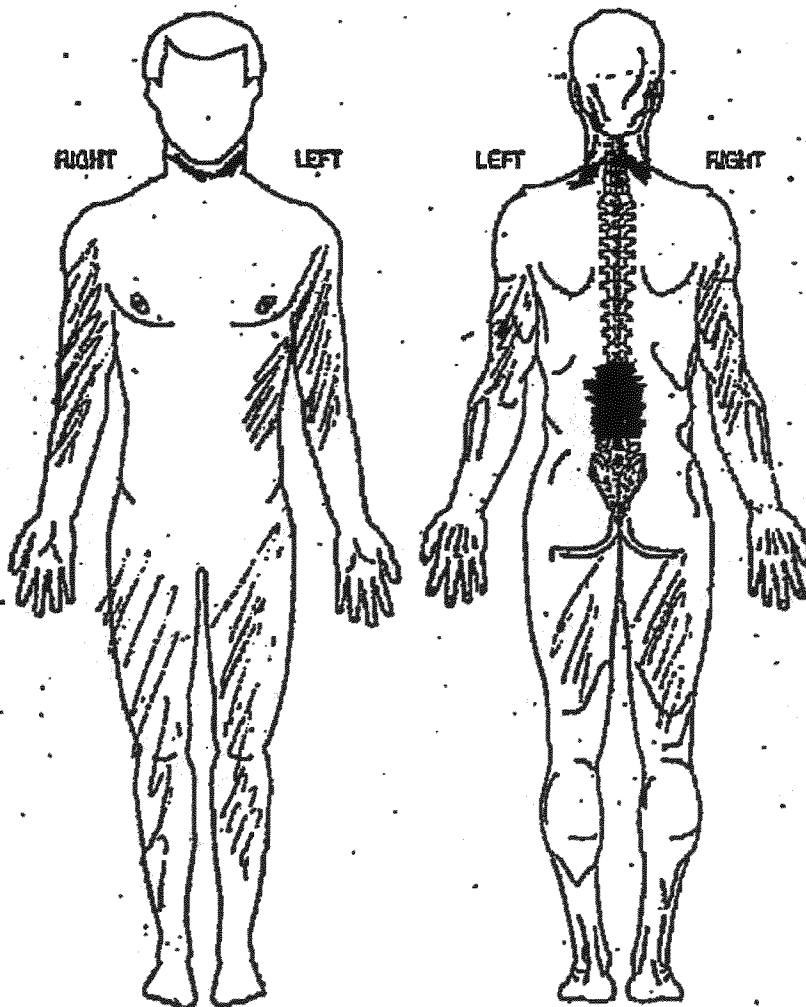
Sharp stabbing _____

Shooting _____

Tingling _____

Previous neck surgery? _____

Date(s): _____



On the drawings above, please shade in the area(s)
 Of pain, numbness, or weakness

Patient's Signature: [REDACTED]

Technologist's Initials: _____

Outpatient MRI Scheduling Form
SHENANDOAH SHARED HOSPITAL SERVICES, INC.

Patient: [REDACTED]		Physician: Grico, D Preston MD	
Address: [REDACTED]		Address: Augusta Pain Management	
HAMBLETON, WV [REDACTED]		70 Medical Center Circle #305	
		Fishersville, Va 22939	
Home Ph: [REDACTED]		Office Phone: (540)932-5747	
Work Ph: [REDACTED]		Office FAX #: (540)932-5748	
SS#: [REDACTED]	Age: 33	DOB: [REDACTED]	Office Contact:
Height: [REDACTED]	Weight: [REDACTED]	Scheduled By: Barbara DiCamillo	
Data Scheduled: 01/02/08		Time: 1045	
Rescheduled From: [REDACTED]		Unit#: M0257215	
Ins1: SELF PAY		Pol# [REDACTED] Aut# [REDACTED]	
Ins2: [REDACTED]		Pol# [REDACTED] Aut# [REDACTED]	

PREVIOUS X-RAYS, CT OR MRI SCANS OF AREA TO BE STUDIED	DATE	HOSPITAL

Yes	No	EVALUATION OF PATIENT	ACCOUNT# [REDACTED]
<input checked="" type="checkbox"/>	<input type="checkbox"/>	1. Do you have a pacemaker?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	2. Have you had heart surgery (stents, filter, valve)?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	3. If female, are you pregnant or using an IUD?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	4. Are you claustrophobic?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	5. Have you ever done welding, grinding or been an auto mechanic?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	6. Have you ever had anything metallic in or removed from your eyes?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	7. Have you ever had eye, ear, or brain surgery?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	8. Do you have a tattoo, tattoo eyeliner, or body piercing?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	9. List all previous surgeries <u>implants in jaw</u>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	10. Drug Allergies <u>all pills, antibiotics, ment</u>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	11. Do you have metal anywhere in your body? <u>mouth</u>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	12. Do you have a hearing aid or mechanical voice box?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	13. Do you have a vena cava filter or umbrella for blood clots?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	14. Do you have any surgical clips or wire sutures?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	15. Do you have any implanted devices (insulin pump/neurostimulator/trans cath pump)? <u>teeth plate</u>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	16. Have you ever had a war injury or gunshot wound?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	17. Do you have any transdermal patches on your body (ex. nicotine, contraceptive)?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	18. Do you have abnormal kidney function?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	19. Do you have Sickle Cell?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	20. Do you have an elevated temperature? If yes, give temp	

FAXED REQUEST 12/18/07

The answers to these questions are felt to be correct and have been answered to the best of my ability.

Name Of Person Answering Questions [REDACTED] Relation To Pt _____

Secretary Review By _____ Date/Time _____

Technologist Final Screening Reviewed By _____ Date/Time _____



MRI HISTORY SHEET

Patient Name: _____

Date of Exam: _____

Type of Exam: _____

Current Symptoms: Be specific about location of symptoms

HEAD, NECK, LOWER BACK

Any injury? ☒ Yes ☐ No If yes, Date: 2007

Describe injury: Auto accident

Any prior surgery to this area? ☐ Yes ☒ No Date of Surgery: _____

Surgeon: _____ What Hospital? _____

Type of surgery if known: _____

Recent x-rays of this area? ☒ Yes ☐ No If so where? AMC or OTHER

Have you had:

> A prior MRI of this area? ☒ Yes ☐ No If yes, date and Location: AMC

> A prior CT of this area? ☒ Yes ☐ No If yes, date and location _____

> A prior Nuclear Medicine study? ☐ Yes ☒ No If yes date and location _____

> A prior Bone Scan? ☐ Yes ☒ No If so, date and location _____

Medical History:

Do you have a history of cancer? ☐ Yes ☒ No If so, what type _____

Do you have Diabetes?

Do you have Arthritis?

Do you have kidney failure?

Do you take steroids?

☒ Yes

☒ Yes

☐ Yes

☐ Yes

☐ No

☐ No

☒ No

☒ No

AMC AUGUSTA MEDICAL CENTER
PO Box 1000
Fishersville, VA 22939

Patient: [REDACTED]
Acct# [REDACTED] MR# [REDACTED]
Date: 01/02/08 Time: 1005

CONSENT TO ADMISSION AND/OR TREATMENT

1. Consent: I voluntarily consent to treatment by AUGUSTA HEALTH CARE, INC. ("Hospital"), its agents, employees, and contractors as deemed necessary by my attending physician(s) or his/her consultants, associates or designees, including but not limited to x-rays, laboratory tests, anesthesia, medical or surgical procedures, nursing care and other hospital inpatient or outpatient services. I recognize that physicians and others rendering such services may not be employees of the hospital, but are independent contractors.
2. No Guaranty Or Warranty: The practice of medicine and surgery is not an exact science and diagnosis and treatment may involve risk, including injury or death. I acknowledge that no guarantees or warranties have been made regarding results of any examination or treatment.
3. Use Of Specimens, Etc.: Hospital may retain, photograph, preserve and/or use for scientific or teaching purposes, or dispose of in its discretion any specimens or tissues taken from me (Patient) during this hospitalization and/or treatment.
4. Release Of Health Information/Notice Of Privacy Practices: I understand that Hospital may release information from my medical and billing records in accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and statutory regulations of the Commonwealth of Virginia. My signature below acknowledges that I have received a copy of the federal Notice Of Privacy Practices at or prior to this service encounter.
5. Valuables: I have been afforded an opportunity to deposit my (Patient's) valuables and money with Hospital for safe keeping and unless deposited, I agree that the Hospital shall not be liable for loss or damage to any such personal property.
6. Advance Directive: Upon admission to the hospital (adults only), I have received information regarding my right by state law and pursuant to Hospital policy to execute an Advance Directive to refuse life sustaining procedures under certain circumstances.
7. Notice Of Deemed Consent For HIV, Hepatitis B & C Blood Testing: The Virginia Code authorizes health care providers to test patients for HIV and Hepatitis B & C when provider or someone employed by/under direction or control of provider is exposed to bodily fluids of the patient in a manner which, according to current guidelines of the Center for Disease Control, may transmit HIV or Hepatitis B or C viruses. In the event of such an exposure, I am deemed to have consented to testing and release of results to person(s) exposed.
8. Assignment Of Benefits: In consideration of services rendered pursuant to this Consent whether during a single admission or on a continuing basis (including any infant(s) born to me during this admission), I agree to pay full charges for their services less any amounts paid by third party payors, and I hereby assign to the Hospital and any Independent Contractors/Providers to the extent necessary to satisfy any outstanding indebtedness, all sums payable to Patient pursuant to any health benefit plan, policy of insurance, (including health, liability, uninsured, under-insured, motorists or medical payments insurance) and/or pursuant to any settlement or judgement arising out of or related to any incident which caused this admission or medical treatment rendered pursuant to this Consent. I understand that I am financially responsible to the Hospital for all its charges not covered by a third party source, except as agreed between the Hospital and any third party source.
9. Medicare Patients: If I (Patient) am a Medicare patient, I request that payment be made in my behalf, and I assign the benefits payable for services furnished to me (Patient) by or in AUGUSTA HEALTH CARE, INC., including physicians services to the physician furnishing the services to the Hospital, or authorize such physician or the Hospital to submit a claim to Medicare for payment for me. I understand that I am responsible for any deductibles and the applicable percentages of the reasonable charges. I authorize any holder of medical or other information about me (Patient) to release to the Social Security Administration or its intermediaries or carriers any information needed for this/related Medicare/Medicaid claim. Medicare Inpatient: A copy of Important Message From Medicare has been provided to me.
10. Subsequent Release Of Detailed Billing Information: My signature below shall be deemed written authorization for Hospital to release to me itemized and detailed billing information regarding admission and/or services rendered pursuant to this Consent upon my later request. I further authorize and consent to the Hospital providing to the authorized representative named below, upon their written request, a copy of confidential itemized or detailed billing information or other itemized or detailed information for a period up to one year from the date of my signature.

Name Of Authorized Representative

Relationship

I have read this consent, been given opportunity to ask questions and I accept its terms:

[REDACTED]
Signature Of Patient/Responsible Party

[REDACTED]
Relationship

[REDACTED]
Witness

1-2-08
Date

Outpatient MRI Scheduling Form

SHENANDOAH SHARED HOSPITAL SERVICES, INC.

Patient:		Physician: Grice, D Preston MD
Address:		Address: Augusta Pain Management
	HAMBLETON, VA	70 Medical Center Circle #305
		Fishersville, Va 22939
Home Ph:		Office Phone: (540) 932-5747
Work Ph:		Office FAX #: (540) 932-5748
SSN:	Age: 33 DOB:	Office Contact:
Height:	Weight:	Scheduled By: Barbara DiCamillo
Date Scheduled: 01/02/08	Time: 1045	Scan Requested: MRIN SPINAL CANAL CERVICAL
Rescheduled From:	Unit#:	Reason: CHRONIC CERVICAL PAIN W/UPPER LUMBAR PA
Ins1: SELF PAY		Pol# Aut#
Ins2:		Pol# Aut#

PREVIOUS X-RAYS, CT OR MRI SCANS OF AREA TO BE STUDIED

DATE

HOSPITAL

Yes NO EVALUATE

ACCOUNT# M00031578057

1. Do I

2. Have

3. If

4. Are you

5. Have you ever done welding, grinding or been an auto mechanic?

6. Have you ever had anything metallic in or removed from your eyes?

7. Have you ever had eye, ear, or brain surgery?

8. Do

9. List

10. Do

11. Do

12. Do

13. Do

14. Do

15. Do

16. Ha

17. Do

18. Do

19. Do

20. Do

(stents, filter, valve)?

or using an IUD?

/TENS/mech pump)?

, contraceptive)?

FAKED REQUEST

The answers to these questions are felt to be correct and have been answered to the best of my ability.

Name Of Person Answering Questions

Relation To Pt

Secretary Review By

Date/Time

Technologist Final Screening Reviewed By

Date/Time



HLEDNURNOT

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AGE 33
ADM/BER 10/11/07

SEX F



MR#

AF

Emergency Department Nursing Assessment Note [ED Major]

ADULT GLASGOW COMA SCALE		PEDIATRIC ≤2 YRS. GLASGOW COMA SCALE		PAIN SCALE	PEDIATRIC PAIN SCALE
Complaints: <u>Pain in neck & across shoulder</u>					
Name: <u>1052</u> Room #: <u>D</u>					
Finding		Finding		Admission	
EYE OPENING		EYE OPENING		CIRCLE APPROPRIATE	
Spontaneous 4		Spontaneous 4		Admission: 0. Pain Free 1. Comfortable 2. Mild Discomfort 3. Moderate Pain 4. Hard to Bear 5. Worst Possible Pain AS - Asleep When Charting	
To Voice 3		To Voice 3		0 1 2 3 4 5	
To Pain 2		To Pain 2			
None 1		None 1			
VERBAL RESPONSE		VERBAL RESPONSE		PAIN EVALUATION	
Oriented 5		Cries, babbles 5		CIRCULATORY	
Confused 4		Consolable 4		WARM	
Inappropriate Words 3		Cries To Pain 3		DRY	
Incomprehensible Sounds 2		Moans To Pain 2		PINK	
None 1		None 1		PALE	
MOTOR RESPONSE		MOTOR RESPONSE		HOT	
Obeys Commands 6		Normal Spontaneous 6		COOL	
Localizes (Pain) 5		Withdraws To Touch 5		CYANOTIC	
Withdraws (Pain) 4		Withdraws To Pain 4		DIAPHORETIC	
Flexion (Pain) 3		Abnormal Flexion 3		OTHER:	
Extension (Pain) 2		Abnormal Extension 2			
None 1		None 1			
TOTAL 15		TOTAL			
RESPIRATORY					
Normal Effect <input checked="" type="checkbox"/> Nasal Congestion <input type="checkbox"/> Clear <input checked="" type="checkbox"/> R <input checked="" type="checkbox"/> L					
Labored <input type="checkbox"/> Nasal Flaring <input type="checkbox"/> Rales <input type="checkbox"/>					
Productive Cough <input type="checkbox"/> Stridor <input type="checkbox"/> Rhonchi <input type="checkbox"/>					
Non Productive Cough <input type="checkbox"/> Retraction <input type="checkbox"/> Wheezing <input type="checkbox"/>					
Rate <input type="checkbox"/> Diminished <input type="checkbox"/>					
TIME: <input type="checkbox"/>					
Pulse OX <input type="checkbox"/> Room Air <input type="checkbox"/> O2 at <input type="checkbox"/>					
Placed on: <input type="checkbox"/> NRD Mask <input type="checkbox"/> liters <input type="checkbox"/> Placed on monitor <input type="checkbox"/> (Time)					
<input type="checkbox"/> Vent Mask <input type="checkbox"/> % <input type="checkbox"/> Rhythm /Rate: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular					
MENTAL STATUS					
Arousable <input checked="" type="checkbox"/> Denies complaints/abnormalities <input type="checkbox"/>					
Alert <input checked="" type="checkbox"/> Suicidal ideations/plan <input type="checkbox"/>					
Oriented <input checked="" type="checkbox"/> Homocidal ideations/plan <input type="checkbox"/>					
Disoriented <input type="checkbox"/> Hx of injurious behavior <input type="checkbox"/>					
Lethargic <input type="checkbox"/> Abusing drugs or ETOH <input type="checkbox"/>					
Unconscious <input type="checkbox"/> Safety precautions implemented <input type="checkbox"/>					
Playful <input type="checkbox"/> Flat Affects <input type="checkbox"/>					
If any of the below needs identified, consider appropriate referral.					
NUTRITION					
Change in appetite/unplanned weight loss <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Special diet <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
No need identified <input type="checkbox"/> Referral Made <input type="checkbox"/> Nutritional Education <input type="checkbox"/>					
FUNCTIONAL					
Speech: <input checked="" type="checkbox"/> Intact <input type="checkbox"/> Grips: <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal					
<input type="checkbox"/> Sturred <input type="checkbox"/> Swallow: <input checked="" type="checkbox"/> Able <input type="checkbox"/> Not Able					
<input type="checkbox"/> Unable <input type="checkbox"/> Unable to perform activities of daily living <input type="checkbox"/>					
Falls <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Weakness/paralysis <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
No need identified <input type="checkbox"/>					
ABUSE SCREEN					
Verbalizes abuse/neglect <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Unexplained bruise/scratches <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Unintentional poor hygiene <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
No need identified <input type="checkbox"/>					
D/C PLAN					
Lives Alone <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Family expresses concern regarding DC care needs <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Potential DC equipment/service needs: <input type="checkbox"/>					
No need identified <input type="checkbox"/>					
Page 1					

Discharge Instructions from J. Scott Just, M.D.
Augusta Medical Center Emergency Department



MRN [REDACTED]

AS [REDACTED]

MYOFASCIAL PAIN:

Your evaluation suggests that you are having pain originating in your muscles. This is caused by inflammation of the sheath or lining of the muscles and is usually the result of minor trauma or the stress of repeated muscle activity. The symptoms usually include pain that is increased with movement. Warmth and swelling can sometimes occur.

The treatment of myofascial pain includes rest of the inflamed area. Pain medicine and anti-inflammatory medicine are often used. Heat may be very helpful. Prevention of recurrence is important, and may require a change in the way a job is done.

NOTIFY YOUR DOCTOR or return here in case of the following:

- Pain is increasing or changes significantly.
- Pain is not gradually improving with treatment.
- Increased weakness or difficulty moving the muscle.
- Signs of infection - redness or red streaks, swelling, increasing pain, or pus drainage.
- The arm or leg becomes numb, tingly, cold, blue, pale, or weak.
- Increasing swelling.
- Development of chest pain or difficulty breathing.

MUSCLE SPASM:

It appears that your pain is due to spasm of a muscle. This may be due to a muscle strain or due to local injury or inflammation of the muscle. Spasms may occur by stretching of the muscle beyond its normal limits or may result from positional cramps. Cramps can be treated with passive stretching of the muscle. Rest of the injured area is the most important part of treatment of muscle strains. Elevation and ice for the first 2-3 days may often help. How long you need to stay at rest depends on the severity of the injury. For minor muscle spasms, you may be able to continue your normal duties. A good rule of thumb is to not do whatever causes much pain. Anti-inflammatory medications is often used for muscle strains. If this was advised or prescribed for you, take them regularly until you are well. They are not as effective if taken just when you feel you need them. Pain medications and muscle relaxants are often prescribed.

It is important to carefully and gradually resume activities as comfort allows. Initially attempt to increase activity with gentle stretching exercises. If you start having increased pain, it may be because of trying to get back to normal too soon. On the other hand, you probably shouldn't wait until the last twinge of discomfort is gone before starting to get active again. Use good judgement to find the right balance.

NOTIFY YOUR DOCTOR or return here in case of the following:

- The injured area becomes numb, tingly, cold, blue, pale, or weak.
- Increasing swelling.
- Pain is increasing or not gradually improving.
- Any difficulty in moving the extremities.

RX: FLEKXERIL 10 MG TABLETS Disp: # 30 / 0

Directions: 1 po tid for muscle relaxation. Causes drowsiness. No drinking/driving/working.

- Prescribed as a muscle relaxant. Should be taken regularly until you are better, and not just when you feel you need it.
- Common side effects - dizziness, drowsiness, blurred vision, dry mouth.



H.EDDCINST
ED DISCHARGE INSTRUCTIONS

- May also cause gastrointestinal upset - try taking it with antacids, if this occurs.

RX: NAPROSYN 500 MG Disp: # 20 / 0

Directions: 1 BID for inflammation, take with food

- Used for inflammation (especially arthritis) and relief of pain.
- Take regularly unless used for mild pain. It can take 1-2 weeks to be effective in arthritis.
- Try taking with food if it causes stomach upset.
- Can cause gastrointestinal bleeding.
- Other common side effects - dizziness, rash.

OTHER INSTRUCTIONS:

Use ice on your neck for 30 minutes every 3-4 hours for pain and inflammation

Call the school doctor for referral to the pain clinic

FOLLOW UP INSTRUCTIONS: School Doctor

Call School Doctor today or as soon as possible. Let the office know that you were seen in the Emergency Department at Augusta Medical Center and that you were told to call the office to arrange a follow-up visit.

If you have been referred to a physician other than your primary care provider (PCP), you should contact your PCP to approve this referral and to ensure that the referral is covered by your insurance company.

If your injury or illness is work related, you may have received a work release for temporary disability from your employer. The emergency department provides only emergent treatment and acute care recommendations. We are unable to provide ongoing reassessment nor can we accurately predict the duration of your work restrictions and/or disability. For this reason, completion of Disability Insurance forms, FMLA forms, or other similar forms is NOT the responsibility of the emergency department physician. You should see your personal physician or company doctor for recheck and completion of these forms in a timely fashion.

If you have more questions or problems with your medical condition or the treatment, see your doctor or call us at (540) 332-4444 or 932-4444.

My signature indicates that I understand, and have received a copy of, the above instructions.

[Redacted Signature]



H. FACESHT

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[REDACTED] AGE 33 SEX F
 ADM/SER 10/11/07



MR# [REDACTED]

J# [REDACTED]

Face Sheet

Patient: SS# [REDACTED]		Account No. [REDACTED]	Arrived by Location	Room Bed	Unit No. [REDACTED]
[REDACTED]			CAR		
HAMBLETON, WV [REDACTED]		Date of Birth [REDACTED]	Age Sex M/St Race	Source F/C	Religion
Employer: STUDENT			33 F S W	ER 3P	
Work Phone: [REDACTED]		Last InPt. Visit	Last Out Visit	Type	Reg. by
Guarantor: SS# [REDACTED]		09/28/04	09/17/07	ER	ER.ANP
[REDACTED]		Person to Notify/Address: Relation: M		Home Phone [REDACTED]	
HAMBLETON, WV [REDACTED]		[REDACTED]		Work Phone [REDACTED]	
Guer Phone: [REDACTED]		HAMBLETON, WV [REDACTED]			
Relationship: SELF-FEMALE		Next of Kin/Address: Relation: M		Home Phone [REDACTED]	
Employer: STUDENT		[REDACTED]		Work Phone [REDACTED]	
Work Phone: [REDACTED]		HAMBLETON, WV [REDACTED]			
Insurance Name		Policy Number	Coverage No.	Group No.	Subscriber Insured Name
SELF PAY					[REDACTED]
Hospice Patient?		Hospice Diagnosis:			
Visit Reason: NECK PAIN				Prior UC Patient?	
Comment:				Chart Review Needed?	
Adm/SerDate	Time	Attending Physician	ED Physician	Primary Care Physician	
10/11/07	1001		Physician, Emergency De	No Family Doc for this	
Dis Date	Time	Admitting Physician	Family Physician	Other Physician	
			No Family Doc for this		
Accid/OccDate	Time	Type	Accident Information	Privacy Notice?	Signed On
09/07/07	1800	11	MEDICAL EMERGENCY	Y	09/30/03
Allergies:					
ALL CILLINS, ALL PRESERVATIVES, SULFA, VALPORIC ACID					
PENICILLIN, SHELLFISH, SULFA, TRAMADOL					
Precautions:					
→ Physician: Please DO NOT document on this FORM.					



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AGE 33
AGE/SER 10/11/07

ADV/SER 10/11/07



1493

2

Emergency Department Patient Record

Initial Orders:		Nurse:	Initial Orders:		Nurse:	
Time:	Time/Initials	Time:	Time/Initials	Physician Time 1107	Chief Complaint: <i>My neck.</i>	
ET _____ INT x ____ CBC CBC-D FC ABO/RH HCG-L HCG-H BC x ____ BMP CMP LIVER AMYLASE LIPASE TROP B-NP D-DIMER TSH PT PTT PTNR		Urine Dip U-PREG UA cc UA cath UR cult Foley Pelvic Screen RBS ABG (RA) ABG (O2) O2 @ ___ lpm EKG ASA 160MG CXR POXR Trauma Panel Cardiac Panel OD Panel Monitor Pulse Ox Suture Tray D Tetanus		HPI: <i>mucous TB cough Swallowing food & liquid. Throat pain. In throat I feel warm coldish - or going away said X-ray / CT scan</i>	Ros: All systems reviewed and negative except	GI: GU: MS: Neu: Psy: Endo: Heme/Lymph: Allerg/Imm:
On Coumadin Yes No				PMH: [x] Old Records Reviewed	FMH:	
TIME	ADDITIONAL ORDERS <input type="checkbox"/> Trauma Alert		Nurse: Time/Initials			
1127	<i>Plexate 1g po Zinc 8mg Zn</i>		<i>EB MB EB AZO</i>	Social: Smokes: ☒ ETOH:		
<input checked="" type="checkbox"/> See Additional Order Sheet				<input type="checkbox"/> Meds & Allergies Reviewed		
Nurse/Tech Signatures <i>ESudo LPH</i>				Exam: Gen: Psych: Skin: Eye/ENT: Lymph/Endo: CV/Heme: Resp: GI: Rectal/QC_____ GU: MS: Neuro: HX/PE performed by ED attending. Agree with PA/NP except as noted. Course: Consult:		
<input type="checkbox"/> EMT Medical Command Given			Dx: <i>(1) Myofascial (?) Neck Pain.</i>	CPT:		
<input type="checkbox"/> Critical Care x hrs.						
<input type="checkbox"/> Ventilator Management						
<input type="checkbox"/> Orthopedic Splinting / Recheck						
<input type="checkbox"/> Cardiac Monitoring / EKG Interpretation			Procedures:	ICD:		
<input type="checkbox"/> Pulse Oximetry X-ray interpretation			Fax To:			

Condition: Improved Unchanged Stable Discharge Time: 13 Disposition: Admit Home AMA LWBS Transfer

Follow Up: Written Instructions
 See Continuation Sheet

Rev 03/07

Physician Signature

57

104

Date/Time

7834

Dictation #



A.CONTREA

AMC
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540-932-4000 or 540-332-4000
www.augustamed.com

DOB [REDACTED] AGE 33 SEX F
ADM/HER 10/11/07
[REDACTED] [REDACTED]
[REDACTED] [REDACTED]

Consent To Admission and / or Treatment

1. **Consent:** I voluntarily consent to treatment by Augusta Health Care, Inc. ("Hospital"), its agents, employees, and contractors as deemed necessary by my attending physician(s) or his/her consultants, associates or designees, including but not limited to x-rays, laboratory tests, anesthesia, medical or surgical procedures, nursing care and other hospital inpatient or outpatient services. I recognize that physicians and others rendering such services may not be employees of the hospital, but are independent contractors.

2. **No guaranty or warranty:** The practice of medicine and surgery is not an exact science. Diagnosis and treatment may involve risk, including injury or death. I acknowledge that no guarantees or warranties have been made regarding results of any examination or treatment.

3. **Use of Specimens, etc.:** Hospital may retain, photograph, preserve and/or use for scientific or teaching purposes, or dispose of in its discretion and specimens or tissues taken from me (Patient) during this hospitalization and/or treatment.

4. **Release of Health Information / Notice of Privacy Practices:** I understand that the Hospital may release information from my medical and billing records in accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and statutory regulations of the Commonwealth of Virginia. My signature below acknowledges that I have received a copy of the federal Notice of Privacy Practices at or prior to this service encounter.

5. **Valuables:** I have been afforded an opportunity to deposit my (Patient's) valuables and money with the Hospital for a safe keeping and unless deposited, I agree that the Hospital shall not be liable for loss or damage to any such personal property.

6. **Advance Directive:** Upon admission to the hospital (adults only), I have received information regarding my right by state law and pursuant to the hospital policy to execute an Advance Directive to refuse life sustaining procedures under certain circumstances.

7. **Notice of Deemed Consent for HIV, Hepatitis B & C Blood Testing:** The Virginia Code authorizes health care providers to test patients for HIV and Hepatitis B & C when provider or someone employed by/under direction or control of provider is exposed to bodily fluids of the patient in a manner which, according to current guidelines of the Center for Disease Control, may transmit HIV or Hepatitis B or C viruses. In the event of such an exposure, I am deemed to have consented to testing and release of results to person(s) exposed.

8. **Assignment of Benefits:** In consideration of services rendered pursuant to this Consent whether during a single admission or on a continuing basis including and infant(s) born to me during this admission, I agree to pay full charges for their services less any amounts paid by third party payors, and I hereby assign to the Hospital and any Independent Contractors/Providers to the extent necessary to satisfy and outstanding indebtedness, all sums payable to Patient pursuant to any health benefit plan, policy of insurance, (including health, liability, uninsured, under insured, motorist or medical payments insurance) and/or pursuant to any settlement of judgement arising out of or related to any this party source.

9. **Medicare Patients:** If I (Patient) am a Medicare patient, I request that payment be made on my behalf, and I assign the benefits payable for services furnished to me by Augusta Health Care, Inc., including physicians services to the physician furnishing the services to the Hospital, or authorize such physician or the Hospital to submit a claim to Medicare for payment for me. I understand that I am responsible for any deductibles and the applicable percentages of the reasonable charges. I authorize any holder of medical or other information about me (Patient) to release to the Social Security Administration or its intermediaries or carriers any information needed for this/related Medicare/Medicaid Claim.

Medicare Inpatient: A copy of Important Message From Medicare has been provided to me.

10. **Subsequent Release of Detailed Billing Information:** My signature below shall be deemed written authorization for the Hospital to release to me itemized and detailed billing information regarding admission and/or services rendered pursuant to this Consent upon my later request. I further authorize and consent to the Hospital providing to the authorized representative named below, upon their written request, a copy of confidential itemized or detailed billing information or other itemized or detailed information for a period up one year from the date of signature.

Name of Authorized Representative _____ Relationship _____

I have read this consent and been given the opportunity to ask questions and I accept it's terms:

[REDACTED] / [REDACTED] / [REDACTED] / 10-11-07
Signature of Patient/Responsible Party Relationship Witness Date



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DOB [REDACTED] AGE 33 SEX F

ADM/SER 09/17/07



H.EDNURNOT

MR [REDACTED]

A [REDACTED]

Emergency Department Nursing Assessment Note [ED Major]

Name _____ Complaint: Ch. headache, tenderness @
Time: 1700 Room #: 500 tip of nose, neck pain

ADULT GLASGOW COMA SCALE		PEDIATRIC <2 YRS. GLASGOW COMA SCALE		PAIN SCALE	PEDIATRIC PAIN SCALE
Finding	Score	Finding	Score	CIRCLE APPROPRIATE	Admission
EYE OPENING		EYE OPENING		Admission: 0. Pain Free 1. Comfortable 2. Mild Discomfort 3. Moderate Pain 4. Intense Pain 5. Worst Possible Pain AS - Asleep When Chasing	0 1 2 3 4 5
Spontaneous	3	Spontaneous	4		
To Voice	3	To Voice	3		
To Pain	2	To Pain	2		
None	1	None	1		
VERBAL RESPONSE		VERBAL RESPONSE		PAIN EVALUATION	CIRCULATORY
Oriented	5	Coos, babbles	6	Denies	WARM
Confused	4	Consolable	5	Location: <u>head, neck, nose</u>	BEY
Inappropriate Words	3	Cries To Pain	3	Provoked by:	PINK
Incomprehensible Sounds	2	Moans To Pain	2	Radial to:	PALE
None	1	None	1	Sharp Dull Ache Pressure	HOT
MOTOR RESPONSE		MOTOR RESPONSE		Crampy Constant Intermittent	COOL
Obeys Commands	6	Normal Spontaneous	6	Tightness Burning	CYANOTIC
Localizes (Pain)	5	Withdraws To Touch	5	Onset: <u>2 days</u>	DIAPHORETIC
Withdraw (Pain)	4	Withdraws To Pain	4		OTHER:
Flexion (Pain)	3	Abnormal Flexion	3		
Extension (Pain)	2	Abnormal Extension	2		
None	1	None	1		
TOTAL	15	TOTAL		SKIN	

RESPIRATORY

Normal Effect	Nasal Congestion	Clear	R	L
Labored	Nasal Flaring	Rales		
Productive Cough	Sidor	Rhocht		
Non Productive Cough	Retraction	Wheezing		
	Rate	Diminished		

TIME: _____

Pulse OX _____ Room Air _____ O2 at _____

Placed on: _____ Placed on monitor _____ (Time)

NC _____ filters _____

NRB Mask _____ liters _____ Rhythm / Rate: _____ (Time)

Ventil Mask _____ % _____ Regular _____ Irregular _____

MENTAL STATUS

BEHAVIORAL:	Denies complaints/abnormalities
Awake	Suicidal ideation/plan
Alert	Homicidal ideation/plan
Oriented	Hx of inebriety behavior
Disoriented	Abusing drugs or ETOH
Lethargic	Safety precautions implemented
Unconscious	
Playful	

If any of the below needs identified, consider appropriate referral.

NUTRITION	FUNCTIONAL
Change in appetite/unplanned weight loss Yes No	Speech: Intact Graps: Equal Unequal
Special diet Yes No	Stured Swallow: Able Not Able
No need identified	Unable to perform activities of daily living Yes No
Referral Made	Falls Yes No
Nutritional Education	Weakness/paralysis Yes No
	No need identified

ABUSE SCREEN **REFERRAL MADE**

Verbal/sexual abuse/neglect Yes No	Obvious physical problems unattended Yes No
Unexplained bruises/injuries Yes No	Yes No
Unemployment/poor hygiene Yes No	No need identified

DC PLAN

Lives Alone Yes No

Family expresses concern regarding DC care needs Yes No

Potential DC equipment/service needs: _____

No need identified

GI **N/A** **GYN** **N/A**

Denies complaints/abnormalities

Pain/Tenderness

RLQ _____ Sc _____ Issues

RLQ _____ Right _____ Erosion x

LLQ _____ Non-tender _____ Discharge x

LLQ _____ Distended

Ergastic Tenderness

BOWEL SOUNDS: _____

Abdom _____ Present Last BM _____

GU **N/A**

Denies complaints/abnormalities

Urgency _____ Retention _____ Last ur _____

Dysuria _____ Incontinent _____ Odor _____

Frequency _____ Hematuria _____ Flank Pain L R _____ Color _____

VISUAL ACUITY **N/A**

OD: _____ OS: _____ Corrected: _____

PUPILS **N/A**

Equal _____ Size R _____ L _____

Unequal _____

Reactive _____

MDA 1 2 3 4 5 6 7 8 9

Catherine Elden RN

TIME / SIGNATURE OF PERSON GATHERING DATA

TIME / RN SIGNATURE

Mon Sep 17, 2007

Page 1

7:06 PM

Discharge Instructions from Asher Brand, M.D.
Augusta Medical Center Emergency Department

DOB [REDACTED] AGE 33 SEX F
ADM/SER 09/17/07



MR# [REDACTED]

A [REDACTED]

EVALUATION AFTER MOTOR VEHICLE COLLISION:

You have experienced potential injury from blunt trauma. Most injuries due to trauma are limited to the soft tissues (skin and muscles). Injuries from seat belts, shoulder harness or airbags can also occur and are usually limited to bruises, abrasions or superficial skin burns. Most often these injuries are minor compared to the potential injuries sustained by persons who are not restrained by these devices. Even if no severe injuries are diagnosed initially, the possibility of subtle but significant injury should be kept in mind for the next several days. You may expect increased muscle soreness over the next few days and may find areas of injury that are not apparent at this time.

Initial treatment of limited activity, icepacks and elevation of injured areas to decrease pain, bruising and swelling is recommended. Anti-inflammatory medication may also be helpful to decrease pain and inflammation.

NOTIFY YOUR DOCTOR or return here in case of the following:

- Increasing pain or pain that is not gradually improving.
- Weakness, fainting or severe dizziness.
- Shortness of breath.
- Vomiting.
- Abdominal or chest pain.
- Severe headache.



H.EDDCINBT

STRAINS:

A strain refers to injury of the muscle fibers. This may be a minor "pulled" muscle that most of us get after doing more than we are used to. Or the injury may be much more serious, involving extensive tearing of a muscle.

Rest of the injured area is the most important part of treatment of strains. Splinting may help in some cases. Elevation and ice for the first 2-3 days is often very helpful also. How long you need to stay at rest depends on the severity of the injury and what your work is. For minor strains, you may be able to continue your normal duties. A good rule of thumb is to not do whatever causes much pain.

Anti-inflammatory medications is often used for muscle strains. If this was advised or prescribed for you, take them regularly until you are well. They are not as effective if taken just when you feel you need them. Pain medications are often prescribed also for more major strains.

It is important to carefully and gradually resume activities as comfort allows. If you start having increased pain, it may be because of trying to get back to normal too soon. On the other hand, you probably shouldn't wait until the last twinge of discomfort is gone before starting to get active again. Use good judgement to find the right balance.

NOTIFY YOUR DOCTOR or return here in case of the following:

- The injured extremity becomes numb, tingly, cold, blue, pale, or weak.
- Increasing swelling.
- Pain is increasing or not gradually improving.
- Any difficulty in moving the fingers or toes.

RX: FLEXERIL 10 MG TABLETS Disp: # 35 / 0

Directions: 1 tid for muscle relaxation

- Prescribed as a muscle relaxant. Should be taken regularly until you are better, and not just when you feel you need it.
- Common side effects - dizziness, drowsiness, blurred vision, dry

---- Instructions are continued on next page. ----

[REDACTED] Mon Sep 17, 2007

Page 2

7:06 PM

mouth.

- May also cause gastrointestinal upset - try taking it with antacids, if this occurs.

RX: CLINORIL 200 MG Disp: # 10 / 0

Directions: One p.o. BID

FOLLOW UP INSTRUCTIONS: Skyline Internal Medicine

Call Skyline Internal Medicine (213-7899) today or as soon as possible. Let the office know that you were seen in the Emergency Department at Augusta Medical Center and that you were told to call the office to arrange a follow-up visit.

Skyline Internal Medicine 57 North Medical Park Circle, Suite 105, Fishersville

X [REDACTED]



H. FACESHT

AMC
Augusta Medical Center
 PO Box 1000, Fishersville, VA 22939
 540-932-4000 or 540-332-4000
 www.augustamed.com

DOB [REDACTED] AGE 33
 ADM/BER 09/17/07

SEX F



MR [REDACTED]

AF [REDACTED]

Face Sheet

Patient: [REDACTED] SS# [REDACTED]		Account No. [REDACTED]		Arrived by Location		Room Bed		Unit No. [REDACTED]	
[REDACTED]		[REDACTED]		CAR					
HAMBLETON, WV [REDACTED]		Date of Birth [REDACTED]		Age 33 Sex F M/SI S W Race		Source ER F/C SP		Religion	
[REDACTED] CELL		Last InPt Visit 09/28/04		Last Out Visit 09/11/07		Type ER		Reg. by ER, JLM	
Employer: STUDENT		Person to Notify/Address: [REDACTED]		Relation: M		Home Phone [REDACTED]		Print Date [REDACTED]	
Work Phone: [REDACTED]		[REDACTED]		[REDACTED]		Work Phone [REDACTED]			
Guarantor: [REDACTED] SS# [REDACTED]		Next of Kin/Address: [REDACTED]		Relation: M		Home Phone [REDACTED]			
[REDACTED]		[REDACTED]		[REDACTED]		Work Phone [REDACTED]			
HAMBLETON, WV [REDACTED]		HAMBLETON, WV [REDACTED]		HAMBLETON, WV [REDACTED]		HAMBLETON, WV [REDACTED]			
Guar Phone: [REDACTED]		HAMBLETON, WV [REDACTED]		HAMBLETON, WV [REDACTED]		HAMBLETON, WV [REDACTED]			
Relationship: SELF-FEMALE		HAMBLETON, WV [REDACTED]		HAMBLETON, WV [REDACTED]		HAMBLETON, WV [REDACTED]			
Employer: STUDENT		HAMBLETON, WV [REDACTED]		HAMBLETON, WV [REDACTED]		HAMBLETON, WV [REDACTED]			
Work Phone: [REDACTED]		HAMBLETON, WV [REDACTED]		HAMBLETON, WV [REDACTED]		HAMBLETON, WV [REDACTED]			
Insurance Name SELF PAY		Policy Number [REDACTED]		Coverage No. NO CARD		Group No. [REDACTED]		Subscriber Insured Name [REDACTED]	
Hospice Patient?		Hospice Diagnosis:							
Visit Reason: HEADACHE, NECK PAIN AND EXPISTAXIS						Prior UC Patient?			
Comment:						Chart Review Needed?			
Adm/SerDate 09/17/07		Time 1628		Attending Physician		ED Physician Physician, Emergency De		Primary Care Physician	
Dis Date		Time		Admitting Physician		Family Physician No Family Doc for this		Other Physician	
Accid/OccDate 09/08/07		Time 0800		Type 01		Accident Information AUTO ACCIDENT		Privacy Notice? Y	
								Signed On 09/30/03	
Allergies: ALL CILLINS, ALL PRESERVATIVES, SULFA, VALPORIC ACID									
PENICILLIN, SHELLFISH, SULFA, TRAMADOL									
Precautions:									
→ Physician: Please DO NOT document on this FORM.									

HLEDPATREC

AMC
Augusta Medical Center
PO Box 1000, Fishersville, VA 22939
540-932-4000 or 540-332-4000
www.augustamed.com

ADM/SER 09/17/97

AGE 33

SECRET



3578

42

Emergency Department Patient Record

Initial Orders:		Nurse:		Physician Time		Chief Complaint:	
Time:		Time/Initials		Time/Initials		HPI:	
ET INT x CBC CBC-D FC ABO/RH HCG-L HCG-N BC x BMP CMP LIVER AMYLASE LIPASE TROP B-NP D-DIMER TSH PT PTT PTINR		Urine Dip U-PREG UA cc UA cath UR cult FOLEY Pelvic Screen RBS ABG (RA) ABG (O2) O2 @ ___ lpm EKG ASA 160MG CXR PCXR Trauma Panel Cardiac Panel OD Panel Monitor Pulse Ox Suture Tray D Tetanus					
On Coumadin ___ Yes ___ No				ROS: <input checked="" type="checkbox"/> All systems reviewed and negative except Const: - Skin: - Eye: - ENT: - CV: - Resp: - PMH: <input type="checkbox"/> Old Records Reviewed		GI: - GU: - MS: - Neur: - Psy: - Endo: - Heme/Lymph: - Allerg/Imb: - FMH: -	
TIME		ADDITIONAL ORDERS		Nurse:			
		<input type="checkbox"/> Trauma Alert		Time/Initials			
1800 o perusal Bones				8076			
End o d/c PT						Social: - Smokes: - ETOH: -	
						<input type="checkbox"/> Meds & Allergies Reviewed Exam: Gen: Psych: - Skin: - Eye/ENT: - Lymph/Endo: - CV/Heme: - Resp: - GI: - Rectal: QC GU: - MS: - Neuro: -	
						HX/PE performed by ED attending. Agree with PAINP except as noted. Course: Consult:	
<input type="checkbox"/> See Additional Order Sheet Nurse/Tech Signatures 							
___ EMT Medical Command Given ___ Critical Care x ___ hrs. ___ Ventilator Management ___ Orthopedic Splinting / Recheck ___ Cardiac Monitoring / EKG Interpretation ___ Pulse Oximetry ___ X-ray Interpretation		DX:		CPT:			
				Blunt Trauma, Car Crash			
				Ankle Strain			
		Procedures:		Concussion to Head		ICD:	
		Fax To:					
Condition: Improved ___ Unchanged ___ Stable Discharge Time: 1905		Disposition: Admit ___ Home ___ AMA ___ LWBS ___ Transfer ___					
Follow Up: ___ Written Instructions ___ See Continuation Sheet		Physician Signature: [Signature]		772 1910 73761			
Physician Signature:		ID#		Date/Time		Dictation #	



A.CONTREA

AMC
Augusta Medical Center
PO Box 1000, Fishersville, VA 22939
540-932-4000 or 540-932-4000
www.augustamed.com

DOB [REDACTED] AGE 33 SEX F
ADM/EXR 09/17/07
MR# [REDACTED] AS [REDACTED]

Consent To Admission and / or Treatment

1. Consent: I voluntarily consent to treatment by Augusta Health Care, Inc. ("Hospital"), its agents, employees, and contractors as deemed necessary by my attending physician(s) or his/her consultants, associates or designees, including but not limited to x-rays, laboratory tests, anesthesia, medical or surgical procedures, nursing care and other hospital inpatient or outpatient services. I recognize that physicians and others rendering such services may not be employees of the hospital, but are independent contractors.

2. No guaranty or warranty: The practice of medicine and surgery is not an exact science. Diagnosis and treatment may involve risk, including injury or death. I acknowledge that no guarantees or warranties have been made regarding results of any examination or treatment.

3. Use of Specimens, etc.: Hospital may retain, photograph, preserve and/or use for scientific or teaching purposes, or dispose of in its discretion and specimens or tissues taken from me (Patient) during this hospitalization and/or treatment.

4. Release of Health Information / Notice of Privacy Practices: I understand that the Hospital may release information from my medical and billing records in accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and statutory regulations of the Commonwealth of Virginia. My signature below acknowledges that I have received a copy of the federal Notice of Privacy Practices at or prior to this service encounter.

5. Valuables: I have been afforded an opportunity to deposit my (Patient's) valuables and money with the Hospital for a safe keeping and unless deposited, I agree that the Hospital shall not be liable for loss or damage to any such personal property.

6. Advance Directive: Upon admission to the hospital (adults only), I have received information regarding my right by state law and pursuant to the hospital policy to execute an Advance Directive to refuse life sustaining procedures under certain circumstances.

7. Notice of Deemed Consent for HIV, Hepatitis B & C Blood Testing: The Virginia Code authorizes health care providers to test patients for HIV and Hepatitis B & C when provider or someone employed by/under direction or control of provider is exposed to bodily fluids of the patient in a manner which, according to current guidelines of the Center for Disease Control, may transmit HIV or Hepatitis B or C viruses. In the event of such and exposure, I am deemed to have consented to testing and release of results to person(s) exposed.

8. Assignment of Benefits: In consideration of services rendered pursuant to this Consent whether during a single admission or on a continuing basis including and infant(s) born to me during this admission), I agree to pay full charges for their services less any amounts paid by third party payors, and I hereby assign to the Hospital and any Independent Contractors/Providers to the extent necessary to satisfy and outstanding indebtedness, all sums payable to Patient pursuant to any health benefit plan, policy of insurance, (including health, liability, uninsured, under insured, motorist or medical payments insurance) and/or pursuant to any settlement of judgement arising out of or related to any this party source.

9. Medicare Patients: If I (Patient) am a Medicare patient, I request that payment be made on my behalf, and I assign the benefits payable for services furnished to me by Augusta Health Care, Inc., including physicians services to the physician furnishing the services to the Hospital, or authorize such physician or the Hospital to submit a claim to Medicare for payment for me. I understand that I am responsible for any deductibles and the applicable percentages of the reasonable charges. I authorize any holder of medical or other information about me (Patient) to release to the Social Security Administration or its intermediaries or carriers any information needed for this/related Medicare/Medicaid Claim.

Medicare Inpatient: A copy of Important Message From Medicare has been provided to me.


10. Subsequent Release of Detailed Billing Information: My signature below shall be deemed written authorization for the Hospital to release to me itemized and detailed billing information regarding admission and/or services rendered pursuant to this Consent upon my later request. I further authorize and consent to the Hospital providing to the authorized representative named below, upon their written request, a copy of confidential itemized or detailed billing information or other itemized or detailed information for a period up one year from the date of signature.

Name of Authorized Representative _____ Relationship _____

I have read this consent and been given the opportunity to ask questions and I accept it's terms:

Signature of Patient/Responsible Party _____ Relationship _____ Witness _____ Date 9/17/07

Discharge Instructions from Sally Tacker, M.D.
Augusta Medical Center Emergency Department

DOB	AGE 33	SEX F
ADM/GER 09/11/07		
		
MR	MR	

MINOR HEAD INJURY:

You appear to have a minor head injury or contusion of the head. Based on your description of symptoms, your examination, and any tests which may have been done, hospitalization is not necessary at this time. Treatment will usually consist of ice to any swollen areas, rest and pain medication as needed. You should not take sedatives, narcotic pain medications or alcohol. A light diet is recommended for 1-2 days. Avoid strenuous work and play for the next 24 hours.

The risk of a worse condition is low, but a responsible person should stay with you so that you can be observed for any complications of head injury. Awakening the injured patient every 4 hours during the first 24 hours after head injury is advised to ensure normal mental status. You should be rechecked promptly if you develop any of the following symptoms or other symptoms which cause you concern:

- Severe or worsening headache.
- Difficulty in awakening the head injured patient.
- Repeated vomiting.
- Fainting or severe dizziness.
- Prolonged or high fever.
- Change in mental status - too sleepy, confused, short of breath, more irritable or fussy, slurred speech, difficulty walking.
- The presence of a clear or bloody drainage from the nose or ear.

BACK PAIN:

The cause of your back pain is most likely due to a strain of the muscles or sprain of the ligaments that support your spine. The pain does not appear at this point to be caused by a ruptured disk or pressure on the sciatic nerve (sciatica). Many people have persistent or recurrent low back pain and need to take steps to prevent it. X-rays are often not indicated in evaluating back pain, unless there are complications, the pain is persistent, or there is a history of trauma. Plain x-rays will not show any abnormality in the muscles and ligaments.

If your back pain is mild, you may be able to perform routine tasks which do not involve any heavy lifting or bending. Gradually increasing activity to tolerance is important for a more rapid recovery. However, with moderate to severe back pain, you should limit activity for the next few days, gradually increasing activity to tolerance as the back discomfort improves. You should avoid any strenuous activity until the pain has resolved or you have been cleared by your doctor to resume your normal activities. Avoid any bending or lifting until your symptoms are completely better. When you have recovered, be sure to lift properly by bending your knees (not your back) and using your leg muscles to do the lifting. Anti-inflammatory and analgesic drugs are often prescribed. Skeletal muscle relaxants may be helpful also. Use ice or heat to your back several times daily for 30-40 minutes each time. Ice is probably better for acute injuries, but use whichever gives you greater comfort. An "ice slush" can be made by freezing a mixture of 1 cup water with 1/2 cup plain rubbing alcohol in a ziplock bag. Do not apply the bag directly to the skin, but first wrap it in a small towel moistened with water. After this episode of back pain is over, exercises to strengthen your back muscles and increase flexibility in your back and legs can be very helpful in preventing injuries in the future. Talk to your doctor about this or you can be referred to a physical therapist.

NOTIFY YOUR DOCTOR or return here in case of the following:

- Progressive symptoms of sciatica (pain, weakness or numbness in one or both legs).
- Back pain is worsening or is not improved within 4-5 days.
- Abdominal pain or change in the location of pain.
- Difficulty with urination or bowel movements.

---- Instructions are continued on next page. ----



H.XDDCINST

NECK INJURY:

There are many different causes for neck pain, which is a very common problem. A "whiplash" injury is a sprain of the cervical (neck) ligaments occurring from extreme flexion or hyperextension of the neck. We see this commonly after motor vehicle accidents, but it is also frequent in falls and sports injuries. The pain and stiffness may not develop until several hours or days after the injury occurs. Muscle strains of the neck may occur with or without injury. Sometimes, there is only the history of turning the head or waking up with pain. There may be muscle spasm, causing the head to be held in an abnormal position. Movement of the head or neck increases the pain. The evaluation of neck pain often includes x-rays to look for a neck fracture or other bony abnormality. Numbness or weakness may indicate nerve or spinal cord injury.

Resting the neck is very important in the treatment of acute neck pain. This means lying down or reclining so that the neck is not doing any work of holding the head up. A cervical collar is sometimes used to help support the head when the person is up - but this is not a good substitute for true neck rest. Pain medicine, muscle relaxants, and anti-inflammatory drugs are often used as well. Ice packs initially, followed by heat after 2-3 days are often very helpful. Other physical therapy may be indicated, especially if symptoms do not gradually improve after several days. Neck sprains may take weeks to heal completely. You will need follow-up with your doctor if you are not gradually getting well.

NOTIFY YOUR DOCTOR or return here in case of the following:

- Persistent or increasing pain.
- Numbness or weakness.
- Prolonged or high fever.
- Severe or worsening headache.
- Change in mental status - too sleepy, confused, short of breath, irritable, slurred speech, difficulty walking.

NSAID OTC INSTRUCTIONS:

You have been found to have pain related to an inflammatory condition. Many of the anti-inflammatory drugs which we prescribe can be obtained "over the counter" without a prescription and may be cheaper than most prescription drugs. All anti-inflammatory pain medications can cause stomach upset and should be taken with food. You should avoid these medications if you are taking steroids (e.g. prednisone), aspirin, or other nonsteroidal anti-inflammatory drugs (NSAIDs). Persons with history of ulcer disease should use these medications with caution.

The following anti-inflammatory pain medications can now be purchased without a prescription:

- Ibuprofen 200 mg (Motrin-IB, Advil, Nuprin, etc): Adults may take up to 600-800 mg (3-4 tablets) every 6 hours for pain.
- Ketoprofen 25 mg (Orudis KT, etc): Adults may take up to 50-75 mg (2-3 tablets) every 8 hours for pain.
- Naproxen 220 mg (Aleve, etc): Adults may take up to 440-550 mg (2-3 tablets) every 12 hours for pain.

OTHER INSTRUCTIONS:

follow up with dr. Lenker or other augusta affiliated dr.

REFERRAL: AMC Affiliated Groups - Augusta Family Practice
Augusta Family Practice Across street from AMC, Fishersville Office phone: 332 or 932-5666

REFERRAL: AMC Affiliated Groups - North Augusta Family Practice

---- Instructions are continued on next page. ----

North Augusta Family Practice 1 Green Hill's Drive, Verona Office phone: 248-8110

REFERRAL: AMC Affiliated Groups - Shenandoah Internal Medicine
Shenandoah Internal Medicine 907 Goosecreek Rd, Suite A03, Fishersville Office phone: 213-8800

REFERRAL: AMC Affiliated Groups - Skyline Internal Medicine
Skyline Internal Medicine 57 North Medical Park Circle, Suite 109, Fishersville Office phone:
213-7899

You are being referred to the doctor or office listed above. Call to arrange a follow-up visit and let them know that you were referred from the Emergency Department.

FOLLOW UP INSTRUCTIONS: Leon Lenker, M.D.

Call Leon Lenker, M.D. (885-3525) today or as soon as possible. Let the office know that you were seen in the Emergency Department at Augusta Medical Center and that you were told to call the office to arrange a follow-up visit.

Leon Lenker, M.D. Carilion Family Medicine Staunton Medical Center, Suite 522 40 Lambert Street,
Staunton

NSAID OTC INSTRUCTIONS:

You have been found to have pain related to an inflammatory condition. Many of the anti-inflammatory drugs which we prescribe can be obtained "over the counter" without a prescription and may be cheaper than most prescription drugs. All anti-inflammatory pain medications can cause stomach upset and should be taken with food. You should avoid these medications if you are taking steroids (e.g. prednisone), aspirin, or other nonsteroidal anti-inflammatory drugs (NSAIDs). Persons with history of ulcer disease should use these medications with caution.

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- Ketoprofen 25 mg (Orudis XT, etc): Adults may take up to 50-75 mg (2-3 tablets) every 8 hours for pain.
- Naproxen 220 mg (Aleve, etc): Adults may take up to 440-660 mg (2-3 tablets) every 12 hours for pain.

RX: VICODIN (5/500) Disp: # 10 / 0

Directions: Take 1 or 2 every 4-6 hr prn pain
maximum of 8 per day

- Narcotic - usually used for relief of pain or cough.
- Causes drowsiness.
- Narcotics are habit-forming. They should not be used on a regular basis, and you should not increase the dosage without your doctor's advice.
- Other common side effects - gastrointestinal upset, constipation, dizziness, allergic symptoms of rash, itching or breathing difficulty.

---- Instructions are continued on next page. ----

If you have been referred to a physician other than your primary care provider (PCP), you should contact your PCP to approve this referral and to ensure that the referral is covered by your insurance company.

If your injury or illness is work related, you may have received a work release for temporary disability from your employer. The emergency department provides only emergent treatment and acute care recommendations. We are unable to provide ongoing reassessment nor can we accurately predict the duration of your work restrictions and/or disability. For this reason, completion of Disability Insurance forms, FIMA forms, or other similar forms is NOT the responsibility of the emergency department physician. You should see your personal physician or company doctor for recheck and completion of these forms in a timely fashion.

If you have more questions or problems with your medical condition or the treatment, see your doctor or call us at (540) 332-4444 or 932-4444.

My signature indicates that I understand, and have received a copy of, the above instructions.



H.EDNURNOT

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PO Box 1000, Fishersville, VA 22939
540-932-4000 or 540-332-4000
www.augustamed.com

DOB [REDACTED] AGE 33 SEX F
ADT/SER 09/13/07

MR# [REDACTED]

A# [REDACTED]

Emergency Department Nursing Assessment Note [ED Major]

Name _____ Complaints: Muc. Ex. + w/vs. Knots on back of head, having
Time: 15:20 Room #: Hall 5 Headaches, burning, and back pain radiating to upper
back. ext.

ADULT GLASGOW COMA SCALE		PEDIATRIC ≤2 YRS. GLASGOW COMA SCALE		PAIN SCALE	PEDIATRIC PAIN SCALE
Finding		Finding		CIRCLE APPROPRIATE	Admission
EYE OPENING		EYE OPENING		Admission: 0. Fair Free 1. Comfortable 2. Mild Discomfort 3. Moderate Pain 4. Intense Pain 5. Worst Possible Pain AS - Asleep When Choking	
Spontaneous	4	Spontaneous	4		
To Voice	3	To Voice	3		
To Pain	2	To Pain	2		
None	1	None	1		
VERBAL RESPONSE		VERBAL RESPONSE		PAIN EVALUATION	
Oriented	5	Coos, babbles	5	CIRCULATORY	
Confused	4	Consolable	4	WARM	
Inappropriate Words	3	Cries To Pain	3	DRY	
Incomprehensible Sounds	2	Means To Pain	2	PINK	
None	1	None	1	PALE	
MOTOR RESPONSE		MOTOR RESPONSE		HOT	
Obeys Commands	6	Normal Spontaneous	6	COOL	
Localizes (Pain)	5	Withdraws To Touch	5	CYANOTIC	
Withdraw (Pain)	4	Withdraws To Pain	4	DIAPHRETIC	
Flexion (Pain)	3	Abnormal Flexion	3	OTHER:	
Extension (Pain)	2	Abnormal Extension	2		
None	1	None	1		
TOTAL		TOTAL			
15		15			

RESPIRATORY

<input checked="" type="checkbox"/> Normal Effect	<input type="checkbox"/> Nasal Congestion	<input checked="" type="checkbox"/> Clear	<input checked="" type="checkbox"/> R
<input type="checkbox"/> Labored	<input type="checkbox"/> Nasal Flaring	<input type="checkbox"/> Rales	<input type="checkbox"/>
<input type="checkbox"/> Productive Cough	<input type="checkbox"/> Stertor	<input type="checkbox"/> Rhonchi	<input type="checkbox"/>
<input type="checkbox"/> Non Productive Cough	<input type="checkbox"/> Retraction	<input type="checkbox"/> Wheezing	<input type="checkbox"/>
	<input type="checkbox"/> Rate	<input type="checkbox"/> Diminished	<input type="checkbox"/>

TIME: 15:20

☒ Pulse OX 97% Room Air ☒ O2 at 2L

Placed on: ☐ NC liters ☐ Placed on monitor (Time)

☐ NRB Mask liters ☐ Rhythm /Rate: Regular ☐ Irregular

☐ Vent Mask % ☐ Regular ☐ Irregular

MENTAL STATUS

<input checked="" type="checkbox"/> Awake	<input checked="" type="checkbox"/> Cooperative	<input type="checkbox"/> Denies complaints/abnormalities
<input checked="" type="checkbox"/> Oriented	<input type="checkbox"/> Uncooperative	<input type="checkbox"/> Suicidal Ideations/plan
<input type="checkbox"/> Disoriented	<input type="checkbox"/> Age Appropriate	<input type="checkbox"/> Homicidal Ideations/plan
<input type="checkbox"/> Lethargic	<input type="checkbox"/> Crying	<input type="checkbox"/> Hx of injurious behavior
<input type="checkbox"/> Unconscious	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Abusing drugs or ETOH
<input type="checkbox"/> Playful	<input type="checkbox"/> Fat Affects	<input type="checkbox"/> Safety precautions implemented

If any of the below needs identified, consider appropriate referral.

NUTRITION	FUNCTIONAL
Change in appetite/unplanned weight loss <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Speech: <input checked="" type="checkbox"/> Intact <input type="checkbox"/> Stuttered <input type="checkbox"/> Unable
Special diet <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Grips: <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal
<input type="checkbox"/> No need identified	Swallow: <input checked="" type="checkbox"/> Able <input type="checkbox"/> Not Able
<input type="checkbox"/> Referral Made	Unable to perform activities of daily living <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input type="checkbox"/> Nutritional Education	Falls <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Weakness/paralysis <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	<input type="checkbox"/> No need identified

ABUSE SCREEN ☐ REFERRAL MADE

Verbalizes abuse/neglect <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Obvious physical problems unattended <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Unexplained bruises/injuries <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Unsanitary/poor hygiene <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

D/C PLAN

Lives Alone ☐ Yes ☒ No

Family expresses concern regarding DC care needs ☐ Yes ☒ No

Potential DC equipment/service needs: ☐ Yes ☒ No

☐ No need identified

1520 Olmsted, Jr.

TIME SIGNATURE OF PERSON GATHERING DATA

[Signature]

TIME SIGNATURE

LABORATORY REPORTS

PLACE TOP OF REPORT #3 HERE

PLACE TOP OF REPORT #2 HERE

AGE 33 SEX F
 ADM/ISS 09/11/07
 [Barcode]
 [Barcode]

H. WETREAD

NAME: [REDACTED]
 ACCT# [REDACTED] INS: SP
 UNIT# [REDACTED] Exam Date: 09/11/07 1652
 ATTEND MD: Tucker, Sally I
 DIAGNOSIS: HEAD AND NECK PAIN FROM MVC
 Allergies:
 PENICILLIN, SHELLFISH, SULFA

DOB: [REDACTED] SEX: F
 LOC: ED1 PM/RED:
 ORDER MD: Tucker, Sally I
 OFFICE #: (540) 332-4473

ISOLATION

ALL CILLINS, ALL PRESERVATIVES, SULFA, VALPROIC ACID

CATEGORY: CAT Scan

EXAM: 0911-0068 CT * Head w/o Contrast

EXAM: 0911-0069 CT * Cervical w/o Contrast

EXAM:

Comment MAJ3

WET READING/CALL REPORT

WET READING: N
 TO WHOM?
 SER DATE: 09/11/07

Head 3 Neg
 C spine

Reading Radiologist:

WET READING

LABORATORY REPORTS

(REPRINT)

AUGUSTA MEDICAL CENTER
DEPARTMENT OF RADIOLOGY
78 MEDICAL CENTER DRIVE
FISHERSVILLE, VIRGINIA 22939

NAME: [REDACTED]
MR: [REDACTED]
DOB: [REDACTED]
DATE: 9/11/07

FEMALE PATIENT INQUIRY FOR RADIOLOGY PROCEDURES

Exam: TRAUMA THORACIC SPINE, TRAUMA L-5/S1
(Specify specific procedure, site, and left or right side)

I, [REDACTED], an _____ am not X pregnant.
(Patient Name)

I am _____ or am not X breast-feeding.

Date of last period: 3 weeks ago. Aug 25th, 2007

My signature below signifies that the information provided above is accurate to the best of my knowledge.

[REDACTED]
Patient or Guardian

9/11/07
Date

9-11-07
Date

PART 2 COMPLETE ON ALL PREGNANT OR POSSIBLY PREGNANT PATIENTS

If this section is completed, please make a copy of this entire form and provide immediately to the RIS Supervisor.

Weeks Pregnant _____ Exam(s) _____
exam room location _____ EXPOSURE FACTORS:
AP measurement _____ AP _____
lateral measurement _____ LAT _____
method of shielding _____ Other _____
Fluoro time _____
Monitoring Badge used? Yes _____ No _____



H. FACESHT

AMC
Augusta Medical Center
 PO Box 1000, Fishersville, VA 22939
 540-932-4000 or 540-332-4000
 www.augustamed.com

AGE 33 SEX F
 ADM/SER 09/11/07



MR.

AF

Face Sheet

Patient: SS# [REDACTED]		Account No.	Arrived by	Location	Room	Bed	Unit No.
[REDACTED]		[REDACTED]	CAR				[REDACTED]
HAMBLETON, WV		Date of Birth	Age	Sex	M/St	Race	Source F/C
[REDACTED]		[REDACTED]	33	F	S	W	ER SP
Employer: STUDENT		Last InPt. Visit	Last Out Visit	Type		Reg. by	Print Date
Work Phone:		09/28/04	06/16/05	CLI		ER.MLK	09/11/07
Guarantor: SS# [REDACTED]		Person to Notify/Address: Relation: M				Home Phone	
[REDACTED]		[REDACTED]				[REDACTED]	
HAMBLETON, WV		Work Phone					
Guar Phone: [REDACTED]		Next of Kin/Address: Relation: M				Home Phone	
Relationship: SELF-FEMALE		[REDACTED]				[REDACTED]	
Employer: STUDENT		Work Phone					
Work Phone:		HAMBLETON, WV					
Insurance Name		Policy Number	Coverage No.	Group No.	Subscriber Insured Name		
SELF PAY			NO CARD		[REDACTED]		
Hospice Patient?		Hospice Diagnosis:					
Visit Reason: HEAD AND NECK PAIN FROM MVC						Prior UC Patient?	
Comment:						Chart Review Needed?	
Adm/SerDate	Time	Attending Physician	ED Physician		Primary Care Physician		
09/11/07	1403		Physician, Emergency De		No Family Doc for this		
Dis Date	Time	Admitting Physician	Family Physician		Other Physician		
			No Family Doc for this				
Accid/OccDate	Time	Type	Accident Information		Privacy Notice?	Signed On	
09/07/07	1850	01	AUTO ACCIDENT		Y	09/30/03	
Allergies:							
ALL CILLINS, ALL PRESERVATIVES, SULFA, VALPORIC ACID							
PENICILLIN, SHELLFISH, SULFA							
Precautions:							
→ Physician: Please DO NOT document on this FORM.							



H.EDPATREC

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DOB [REDACTED] AGE 33
ADM/ERR 09/11/07

SEX F



MR [REDACTED]

24 [REDACTED]

Emergency Department Patient Record

Initial Orders:	Nurse:	Initial Orders:	Nurse:	Physician Time	Chief Complaint:
Time:	Time/Initials	Time:	Time/Initials		
ET		Urine Dip		1632	HPI: DA: CAS, HEAD HIT 1/2
INT x		U-PREG			LAST FU - KEEP / 2/24/07 DIZZY
CBC		UA cc			A LAMINAR. 9/7/07 MVA HIT METAL
CBC-D		UA cath			PROTECTIVE PLATE ALLO. IMP RIGID
FC		URI cult			NUM. WOUNDS IN NECK / 2/24/07
ABO/RH		FOLEY			RAD - LAMAR. MUSCLE SPASMS
HCG-L		Pelvic Screen			IN BACK. CANT MOVE F. GUT. SUTURING.
HCG-N		RBS			MASAGE LOW BACK.
BC x		ABG (RA)			HAS NO NUMBERS X4/07.
BMP		ABG (O2)			HEAD SPINNING. 1/24/07.
CMP		O2 @ ___ lpm			ROS: All systems reviewed and negative except
LIVER		EKG			GI:
AMYLASE		ASA 160MG			GU:
LIPASE		CXR			MS:
TROP		PCXR			Neu:
B-NP		Trauma Panel			Pay:
D-DIMER		Cardiac Panel			Endo:
TSH		OD Panel			Heme/Lymph:
PT		Monitor			Allerg/Imm:
PTT		Pulse Ox			PMH: Old Records Reviewed
PTNR		Suture Tray			FMH: Edm, CA
On Coumadin Yes No		D Tetanus			CHL. MIL & BK P. RINCE M - WIND PMS, 2/24/07
TIME	ADDITIONAL ORDERS	Nurse:	1997 2 nd MVA, Asthma		
	<input type="checkbox"/> Trauma Alert	Time/Initials	185 (3/24/07) 11/02		
	HEAD CT CONTRAST 1/2	1700Y	RPTX 2 nd MVA 1/2		Social:
	BLD		Short term memory loss		Strokes: A
	CERV CT	1720Y	Med & Allergies Reviewed		ETOH (-)
	T-SPINE-TRAUMA (-)	1700Y	Exam: Gen: T10N		
	TRAUMA L-SPINE (-)	1700Y	Psych:		
	MOTION 800, 20	2110Y	Skin:		
	UICOPIN 4 1/2	1700Y	Eye/ENT:		
			Lymph/Endo:		
			CV/Heme:		
			Resp:		
			GI:		
			Rectal: QC		
			GU:		
			MS:		
			Neuro:		4/5 STR (KAP & LEE)
			HX/PE performed by ED attending. Agree with PA/NP except as noted.		
			Course:		
			Consult:		
			DX: ACUTE EVALUATION SFO		CPT:
			MVA		
			MINOR HEAD INJURY		
			Procedures:		ICD:
			Fax To:		

Condition: Improved Unchanged Stable Discharge Time 1635 Disposition: Admit Home AMA LWBS Transfer

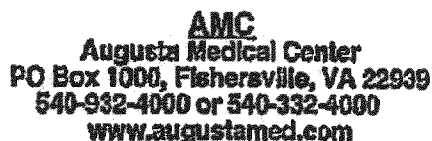
Follow Up: Written Instructions See Continuation Sheet

Physician Signature

ID#

Date/Time

Dictation #



Emergency Department Nursing Continuation Sheet

DOB [REDACTED] AGE 33 SEX F
ADM/SEC 09/11/07



DIR

TIME	BP	T	P	R	POX FEFR	GCS TS	PAIN SCALE	Reevaluation Assessment; Meds; Treatments; & Procedures
1515								dent and she hit a gas pump. ———, Chubb, red
1530								Placed on backboard & cervical collar ——— OK —
1600	115/74		88	18	95	15	5/5	pt moved into major 3. red NS ——— YL
1650								pt log rolled & Dr. Tucker in to assess posterior - pt return to board - collar remains on ——— J. Kroll on
1910								RETURNED TO XRAY FOR ADDITIONAL FILMS. ———
1950	105/75	(R)	85	18	97/94	15	5	RE VIS. PT OFF BACKBOARD. —
2035	104/71	(L)	80	18	97/94	15	5	AWAITING DISPOSITION. —

Rev 02/06



A.CONTREA

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DOB [REDACTED] AGE 33 SEX F
ADM/EXR 09/11/07



Consent To Admission and / or Treatment

1. Consent: I voluntarily consent to treatment by Augusta Health Care, Inc. ("Hospital"), its agents, employees, and contractors as deemed necessary by my attending physician(s) or his/her consultants, associates or designees, including but not limited to x-rays, laboratory tests, anesthesia, medical or surgical procedures, nursing care and other hospital inpatient or outpatient services. I recognize that physicians and others rendering such services may not be employees of the hospital, but are independent contractors.

2. No guaranty or warranty: The practice of medicine and surgery is not an exact science. Diagnosis and treatment may involve risk, including injury or death. I acknowledge that no guarantees or warranties have been made regarding results of any examination or treatment.

3. Use of Specimens, etc.: Hospital may retain, photograph, preserve and/or use for scientific or teaching purposes, or dispose of in it's discretion and specimens or issues taken from me (Patient) during this hospitalization and/or treatment.

4. Release of Health Information / Notice of Privacy Practices: I understand that the Hospital may release information from my medical and billing records in accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and statutory regulations of the Commonwealth of Virginia. My signature below acknowledges that I have received a copy of the federal Notice of Privacy Practices at or prior to this service encounter.

5. Valuables: I have been afforded an opportunity to deposit my (Patient's) valuables and money with the Hospital for a safe keeping and unless deposited, I agree that the Hospital shall not be liable for loss or damage to any such personal property.

6. Advance Directive: Upon admission to the hospital (adults only), I have received information regarding my right by state law and pursuant to the hospital policy to execute an Advance Directive to refuse life sustaining procedures under certain circumstances.

7. Notice of Deemed Consent for HIV, Hepatitis B & C Blood Testing: The Virginia Code authorizes health care providers to test patients for HIV and Hepatitis B & C when provider or someone employed by/under direction or control of provider is exposed to bodily fluids of the patient in a manner which, according to current guidelines of the Center for Disease Control, may transmit HIV or Hepatitis B or C viruses. In the event of such and exposure, I am deemed to have consented to testing and release of results to person(s) exposed.

8. Assignment of Benefits: In consideration of services rendered pursuant to this Consent whether during a single admission or on a continuing basis including and infant(s) born to me during this admission), I agree to pay full charges for their services less any amounts paid by third party payors, and I hereby assign to the Hospital and any Independent Contractors/Providers to the extent necessary to satisfy and outstanding indebtedness, all sums payable to Patient pursuant to any health benefit plan, policy of insurance, (including health, liability, uninsured, under insured, motorist or medical payments insurance) and/or pursuant to any settlement of judgement arising out of or related to any this party source.

9. Medicare Patients: If I (Patient) am a Medicare patient, I request that payment be made on my behalf, and I assign the benefits payable for services furnished to me by Augusta Health Care, Inc., including physicians services to the physician furnishing the services to the Hospital, or authorize such physician or the Hospital to submit a claim to Medicare for payment for me. I understand that I am responsible for any deductibles and the applicable percentages of the reasonable charges. I authorize any holder of medical or other information about me (Patient) to release to the Social Security Administration or it's intermediaries or carriers any information needed for this/related Medicare/Medicaid Claim.

Medicare Inpatient: A copy of Important Message From Medicare has been provided to me.

10. Subsequent Release of Detailed Billing Information: My signature below shall be deemed written authorization for the Hospital to release to me itemized and detailed billing information regarding admission and/or services rendered pursuant to this Consent upon my later request. I further authorize and consent to the Hospital providing to the authorized representative named below, upon their written request, a copy of confidential itemized or detailed billing information or other itemized or detailed information for a period up one year from the date of signature.

Name of Authorized Representative _____ Relationship _____

I have read this consent and been given the opportunity to ask questions and I accept it's terms:

Signature of Patient/Responsible Party _____ Relationship _____ Witness *[Signature]* Date 9/11/07



COMMONWEALTH OF VIRGINIA

Virginia Central Registry for Brain Injury & Spinal Cord Injury

Section 51.5-11 of the Code of Virginia mandates that the Department (of Rehabilitative Services)... establish and maintain a central registry of persons who sustain spinal cord injury...and brain injury. Every hospital...shall report to the Department...any person sustaining brain injury and...spinal cord injury.

PLEASE PRINT CLEARLY AND LEGIBLY!

1. HOSPITAL MEDICAL RECORDS # [REDACTED] SS# [REDACTED]

Name [REDACTED] Date of Birth [REDACTED]

Address [REDACTED] Telephone [REDACTED]

City HAMBLETON State WV Zip Code [REDACTED]

2. DATE OF INJURY 09/07/2007 3. Male ☐ Female ☒

4. CAUSE OF INJURY (check one)

Motor vehicle ☒ Sports/recreation ☐ Diving ☐ Motorcycle ☐

Gunshot ☐ Bicycle ☐ Fall ☐ Pedestrian ☐

Assault ☐ Other/Unknown (specify) _____

5. INITIAL CONDITION OF PATIENT (check all that apply)

Was patient unconscious? Yes ☐ No ☒ Unknown ☐

If yes, how long? ☐ Less than 1 hour ☐ Over 1 hour, less than 24 ☐ More than 24 hours**

☐ Unknown **If unconscious for more than 24 hours, how many days? _____

Glasgow Coma Score: ☐ 3-8 (severe) ☐ 9-12 (moderate) ☒ 13-15 (mild) ☐ unknown

(use lowest known score)

6. PATIENT DIAGNOSES ICD-9 Codes (check all that apply)

BRAIN INJURY		SPINAL CORD INJURY	
348.1 <input type="checkbox"/> Anoxic Brain Damage	806.0 - 806.19 or 952.0 - 952.09 <input type="checkbox"/> Cervical		
800 - 801.9 <input type="checkbox"/> Fracture of Skull	806.20 - 806.39 or 952.10 - 952.19 <input type="checkbox"/> Thoracic		
803 - 804.9 <input type="checkbox"/> Other/Multiple Skull Fractures	806.4, 806.5 or 952.2 <input type="checkbox"/> Lumbar		
850 - 854.1 <input type="checkbox"/> Intracranial Injury	806.60 - 806.79 or 952.3 - 952.4 <input type="checkbox"/> Sacral/Coccyx		
959.01 <input checked="" type="checkbox"/> Head Injury, Unspecified	952.8 <input type="checkbox"/> Multiple Sites		
995.55 <input type="checkbox"/> Shaken Infant Syndrome	806.8, 806.9 or 952.9 <input type="checkbox"/> Unspecified Sites		
Unknown <input type="checkbox"/>			

7. DISPOSITION (check only ONE)

☒ Seen in our Emergency Department only Date of Treatment in ER: 09/11/2007

(treated and released OR treated and transferred) Date of Discharge from ER: 09/11/2007

☐ Admitted to our Hospital? Date of Admission to Hospital: / /

Date of Discharge from Hospital: / /

Discharged to: ☒ home

(complete for ALL patients) ☐ other facility _____ (specify)

☐ deceased _____ (date)

☐ unknown

8. FORM COMPLETED BY (fill out completely)

I certify that this form is filled out completely and accurately to the best of my knowledge.

Name LUKE VICARIO [Signature]

Today's date 10/23/2007 Hospital AUGUSTA MEDICAL CENTER

mo. day year

000002

ATTN: TIFFINI HAILS
ESIS GM CENTRAL CLAIMS
MAIL CODE 482 C19B561
PO BOX 300
DETROIT MI 48265-3000



011000002001



ATTENTION

Confidential information enclosed.
To be viewed by authorized persons only.

If you have questions regarding any information you have requested,
please call the phone number on the enclosed invoice

Health information is reproduced by HealthPort, a health information outsourcing service. Your healthcare facility contracts with HealthPort to process authorized copies of medical records.

Reproductions are made from the medical facility's original records. The confidentiality of these records is protected by federal and state laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

If you requested items that are not maintained in the medical record, your request for those items was forwarded to the appropriate department and will be sent under separate cover. Likewise, information that you asked to have delivered to another address is sent separately.

This package may or may not contain medical records, depending on what was requested and how it was processed.



esis

ESIS/GM Central Claims Unit
P.O. Box 300
Mail Code 482 C19 B61
Detroit, MI 48265-3000

800.888.0164 *tel*
313.665.0911 *fax*

Tiffini Hails
Claims Administrator

May 22, 2008

Dr. Guire
Augusta Pain Management Center
Attention: Medical Records Department
70 Medical Center Circle, Suite 305
Fishersville, VA 22939

JUN 02 2008

RECEIVED
JUN 27 2008
ESIS-GM CLAIMS UNIT

RE: Our File No.: [REDACTED]
Our Client: General Motors Corporation
Patient Name: [REDACTED]
Date/Event: September 7, 2007
Date of Birth: [REDACTED]

Dear Dr. Guire:

ESIS is the third party administrator handling claims on behalf of General Motors Corporation.

Please provide me with a complete copy of [REDACTED] medical records and medical bills for the above incident.

Enclosed please find the *Authorization for Use and/or Disclosure of Confidential Medical Information* form for your file. If there is a copying charge for these records, please forward the records along with your invoice and your Tax Identification Number.

Thank you for your cooperation.

Sincerely,

Tiffini Hails
Claims Administrator

Enclosure

Aurusta Pain Management Center - Patient Summary

DATE: 11/18/07

Patient's Name: [REDACTED] First [REDACTED] Middle [REDACTED] Last [REDACTED] Maiden [REDACTED]
 Date of Birth: [REDACTED] Age: 33 Social Security Number: [REDACTED]
 Address: [REDACTED] Telephone #: [REDACTED]
 City: Hamilton State: WV Zip Code: [REDACTED] Marital Status: Single
 Occupation: College Student Work Status: ☐ Retired ☐ Full Time ☐ Part Time ☐ Disability ☐ Other
 Employer: N/A Work Phone #: N/A
 Employer's Address: N/A
 Next of Kin Name: [REDACTED] Relationship: Mother Phone # [REDACTED]
 Next of Kin Address: [REDACTED]
 Emergency Contact Name: [REDACTED] Relationship: Girlfriend Phone # [REDACTED]
 Referring Physician: Michael B Plaurz Phone # [REDACTED]
 Primary Care Physician: N/A Phone # N/A

Insurance Information (Please bring your card(s) to your appoint - we need a photocopy on file)

Primary Carrier: State Farm Secondary Carrier: [REDACTED]
 Subscriber #: [REDACTED] Subscriber #: [REDACTED]

Was injury due to?: ☐ Work Related Accident ☒ Motor Vehicle Accident ☐ Other

Date of Injury: 09/07/2007 Time of Injury: 4:30 pm

Do you have an Advance Directive ☒ No ☐ Yes Refused packet. 3/18

Allergies: Medication/Food Reaction

C:

E:

Em:

Pain Assessment: Do You have Chronic Pain(other than reason you are here) ☐ No ☐ Yes If Yes, Please specify

Location, Character, Frequency and Treatment:

Social History: Do you use Street/Recreational Drugs ☒ No ☐ Yes Type and Frequency
 Do you smoke ☒ No ☐ Yes packs/day, for years Do you drink alcohol ☒ No ☐ Yes drinks/day
 Do you drink/eat caffeine ☐ No ☒ Yes amt per day Do you exercise regularly ☒ No ☐ Yes times/week

Patient's Medical and Biological Family History:

DISEASE	SELF	FAMILY MEMBER (WHO)	TYPE/SPECIFICS/COMMENTS
Diabetes, Thyroid, Glandular	<input checked="" type="checkbox"/>	UNCLE, GRANDMOTHER	LOW BLOOD SUGAR
Cancer		AUNTS, GRANDMOTHER	
Heart Problems, High Blood Pressure		MOTHER, GRANDMOTHER	
Asthma, Emphysema	<input checked="" type="checkbox"/>		
Infectious Disease			
Sleeping, Sleep Apnea	<input checked="" type="checkbox"/>	FATHER, MOTHER	
Arthritis	<input checked="" type="checkbox"/>	MOTHER, DAD, AUNTS	
Ulcer, GERD			
Kidney Disease			
Neurological, MS, Stroke			
Bleeding Disorder, Anemia			
Seizures, Convulsions			
Fibromyalgia, Lupus, Sjogren's			
Other	<input checked="" type="checkbox"/>		

List Surgeries and Hospitalizations:

DATE	PROCEDURE	DOCTOR	FACILITY

AUGUSTA PAIN MANAGEMENT CENTER

Pharmacy Flow Chart

Patient Name: [REDACTED]

Name of Pharmacy: [REDACTED]

Date	Prescription Name & Dosage	Refills	Initials	Date	Prescription Name & Dosage	Refills	Initials
1/2/04	Tylenol 3-11-11	0	CH				
8/10/04	Hydrocodone 7.5/3.1 PCN WTE 4/day	0	pw				
	# 120						
9/2/04	Hydrocodone 7.5/3.1 PCN WTE 4/day	0					
6/23/05	Remicade 50mg IV q 2 weeks	2	pw				
7/21/06	Hydrocodone 7.5/3.1 PCN WTE 4/day	0	CC				
1/2/07	Tylenol 3-11-11	2	CH				
3/24/08	Tizidine 4mg	3	pw				
8/12/08	Lyrica 50mg	4	pw				
	PCN CHS						

ERROR: timeout
OFFENDING COMMAND: timeout

STACK:

Emergency Department Dictation

Patient: [REDACTED]	Acct #: [REDACTED] Status: DEP ER	Loc: ED1
MR #: [REDACTED]	Age/Sex: 33/F DOB: [REDACTED]	Adm Phys: Sally I Tucker Dict Phys: Tucker, Sally I
Report #: 0913-0357	Admit Date: 09/11/07	Discharge Date: 09/11/07

Status of this Report is Signed
Please note that Reports in Draft Status are not Final Reports

*** Report is final after physician e-signature ***

CHIEF COMPLAINT: Evaluation of injuries from an MVA.

HISTORY OF PRESENT ILLNESS: This is a 33-year-old white female that was the seat-belted driver in an MVA which occurred on September 7, 2007. She said she was in her car and she has been having some problems with it. When she went to turn at a gas station, it did not turn and she went straight ahead, running into the big metal protecting object that protects the pump. She says the car is not drivable. She hit her head on the top of the car above the windshield. She had no loss of consciousness. She said she had neck pain right away and it hurts in her neck to swallow. She says that radiates all the way down to her back. She has been having muscle spasms in her brain and she says she cannot move from her waist down after sitting straight up in class. She says she massages her back and then she is able to get up and move. She said she has had this numbness off and on over the last 4 years. She says today when she walked to school her head was spinning and she felt a little nauseous. She had no vomiting.

PAST MEDICAL HISTORY: Old record reviewed and positive for chronic neck and back pain since 1997 secondary to an MVA. She says she has a history of asthma. She has IBS and it has been questioned whether she has anorexia nervosa. She says she has a history of low blood sugar and she has had a right pneumothorax secondary to trigger point injection, and she says she has short-term and long-term memory loss.

FAMILY HISTORY: Positive for diabetes, cancer, and her mother has lung problems and diabetes.

SOCIAL HISTORY: The patient is a nonsmoker, nondrinker.

PHYSICAL EXAM

VITAL SIGNS: Blood pressure 97/69, pulse 71, respirations 18, her temp is 35.6, pulse ox is 97% on room air which is normal per my interpretation.

GENERAL: She is a well-developed, thin white female in no acute distress.

PSYCH: Normal affect.

SKIN: No rashes. She has no abrasions.

HEENT: Normocephalic, atraumatic.

NECK: Tender. There is no step-off. She has no adenopathy.

HEART: Regular rate and rhythm without murmur.

LUNGS: Clear to auscultation bilaterally.

ABDOMEN: Positive bowel sounds, soft, and nontender. No masses or organomegaly.

GU: Negative for CVA tenderness.

MUSCULOSKELETAL: The patient has tenderness from the neck all the way down to her lumbar region. She has no bony deformities.

NEURO: She is alert and oriented. Her strength is 4/5 in the left grip and left lower

Patient:		Acct #:	
Unit #:		Report #:	0913-0357

extremity, 5/5 in the right lower extremity and right upper extremity. The patient is somewhat inconsistent with her strength though on testing.

MDM

HOSPITAL COURSE: The patient had a head CT and a C-spine CT which were both negative. Trauma T-spine was negative per my interpretation. A trauma LS-spine was negative per my interpretation. They are both negative for fracture. Patient was given Motrin p.o. and Vicodin to go. The patient has had these symptoms intermittently for 4 years now and I do not think they were caused by the accident that she had on September 7, 2007. She did hit her head but she shows no evidence of intracranial abnormality, and I would ask her to follow up with either Dr. Lenker as the Mary Baldwin College doctor or one of the Augusta affiliated doctors for followup. The patient lives in West Virginia but says she does not want to see any doctors in West Virginia. She travels to this area to attend Mary Baldwin College.

DISCHARGE DIAGNOSES

1. ACUTE EVALUATION STATUS POST MOTOR VEHICLE ACCIDENT.
2. MINOR HEAD INJURY.

DISPOSITION: Patient was discharged to home. She is given a prescription for Vicodin #10, instructed to use over-the-counter NSAIDs.

TUCS/ProScript

D: 9/11/2007 8:50:00 PM EST

T: 9/12/2007 3:20:03 PM EST

J: 88-880072727

cc: Leon Lenker, MD - faxed

*Electronically Signed/Signature on File: Sally I Tucker
Date/Time Signed: 09/14/07 0806*

Emergency Department Dictation

Patient: [REDACTED]	Acct #: [REDACTED] Status: DEP ER	Loc: ED1
MR #: [REDACTED]	Age/Sex: 33/F DOB: [REDACTED]	Adm Phys: Sally I Tucker Dict Phys: Tucker, Sally I
Report #: 0912-0291	Admit Date: 09/11/07	Discharge Date: 09/11/07

Status of this Report is Signed
Please note that Reports in Draft Status are not Final Reports

*** Report is final after physician e-signature ***

CHIEF COMPLAINT: Evaluation of injuries from an MVA.

HISTORY OF PRESENT ILLNESS: This is a 33-year-old white female that was the seat-belted driver in an MVA which occurred on September 7, 2007. She said she was in her car and she has been having some problems with it. When she went to turn at a gas station, it did not turn and she went straight ahead, running into the big metal protecting object that protects the pump. She says the car is not drivable. She hit her head on the top of the car above the windshield. She had no loss of consciousness. She said she had neck pain right away and it hurts in her neck to swallow. She says that radiates all the way down to her back. She has been having muscle spasms in her brain and she says she cannot move from her waist down after sitting straight up in class. She says she massages her back and then she is able to get up and move. She said she has had this numbness off and on over the last 4 years. She says today when she walked to school her head was spinning and she felt a little nauseous. She had no vomiting.

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FAMILY HISTORY: Positive for diabetes, cancer, and her mother has lung problems and diabetes.

SOCIAL HISTORY: The patient is a nonsmoker, nondrinker.

PHYSICAL EXAM

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Patient: [REDACTED]	Acct #: [REDACTED]
Unit #: [REDACTED]	Report #: 0912-0291

extremity, 5/5 in the right lower extremity and right upper extremity. The patient is somewhat inconsistent with her strength though on testing.

MDM

HOSPITAL COURSE: The patient had a head CT and a C-spine CT which were both negative. Trauma T-spine was negative per my interpretation. A trauma L5-spine was negative per my interpretation. They are both negative for fracture. Patient was given Motrin p.o. and Vicodin to go. The patient has had these symptoms intermittently for 4 years now and I do not think they were caused by the accident that she had on September 7, 2007. She did hit her head but she shows no evidence of intracranial abnormality, and I would ask her to follow up with either Dr. Lenker as the Mary Baldwin College doctor or one of the Augusta affiliated doctors for followup. The patient lives in West Virginia but says she does not want to see any doctors in West Virginia. She travels to this area to attend Mary Baldwin College.

DISCHARGE DIAGNOSES

1. ACUTE EVALUATION STATUS POST MOTOR VEHICLE ACCIDENT.
2. MINOR HEAD INJURY.

DISPOSITION: Patient was discharged to home. She is given a prescription for Vicodin #10, instructed to use over-the-counter NSAIDs.

TUCS/ProScript

D: 9/11/2007 8:50:00 PM EST

T: 9/12/2007 3:20:03 PM EST

J: 88-880072727

cc [REDACTED] Leon Lenker, MD - faxed

Electronically Signed/Signature on File: Sally I Tucker
Date/Time Signed: 09/13/07 0640

AMC

Augusta Medical Center
78 Medical Center Drive
Fishersville, VA 22939

Department of Radiology
(540) 332-4400
(540) 832-4400

Patient: [REDACTED]	Acct #: [REDACTED]	MR #: [REDACTED]
	Status: DEP ER	
Tech: SSH.JWN	Age/Sex: 33F	Loc: ED1
Report #: 0912-0156	Phys: Sally I Tucker	Pat phone #: [REDACTED]
Transcriptionist: deh	Dict Date: 09/11/07 1751	Trans Date: 09/12/07 1115

Date of Service: 09/11/07

Exam(s): 0911-0068 CT/CT * Head w/o Contrast; 0911-0069 CT/CT * Cervical w/o Contrast

DOB: [REDACTED] Dictating Radiologist: Shashank Parekh

Diagnosis: HEAD AND NECK PAIN FROM MVC

Reason for Exam: R/O BLEED

*HEAD CT 9/11/07

There are no intra-axial or extra-axial lesions demonstrated. There is no evidence of hemorrhage or hydrocephalus. No midline shift or mass effect is identified. The visualized paranasal sinuses are clear.

IMPRESSION:

Negative examination.

UNENHANCED AXIAL CT OF THE CERVICAL SPINE WITH MULTIPLANAR REFORMATION

Alignment is normal. There is no significant disc space narrowing or vertebral compression. No bony fracture is seen. Atlantoaxial distance is normal. No definite intraspinal abnormality is seen.

IMPRESSION: Negative examination.

Dictated by Shashank Parekh, MD

Reported by: Shashank Parekh, M.D.

Signed by: PARS <<Signature on File>>

Date/Time signed: 09/12/07 1659

C: No Family Doc for this Patient; Sally I Tucker

RADIOLOGY REPORT

Signed

AMC

Augusta Medical Center
78 Medical Center Drive
Fishersville, VA 22939

Department of Radiology
(540) 332-4400
(540) 932-4400

Patient: [REDACTED]	Acct #: [REDACTED] Status: DEP ER	MR #: [REDACTED]
Tech: RAD.ATS	Age/Sex: 33F	Loc: ED1
Report #: 0912-0446	Phys: Sally I Tucker	Pat phone #: [REDACTED]
Transcriptionist: mep	Dict Date: 09/12/07 1048	Trans Date: 09/12/07 1826

Date of Service: 09/11/07

Exam(s): 0911-0055 XED/XED Thoracic Spine Trauma; 0911-0056 XED/XED
Lumbosacral Spine Trauma

DOB: [REDACTED] Dictating Radiologist: Matthew P Shapiro MD

Diagnosis: HEAD AND NECK PAIN FROM MVC

Reason for Exam: MVC

MAJ3

*LUMBOSACRAL SPINE: 09/12/07

INDICATION: Back pain. Trauma from motor vehicle collision.

Five views of the lumbar spine demonstrate lumbar vertebrae to be intact with normal alignment. Disc spaces appear preserved.

IMPRESSION: Negative.

*THORACIC SPINE: 09/12/07

INDICATION: Back pain. Injury from motor vehicle collision.

AP and lateral views of the thoracic spine demonstrate thoracic vertebrae to be intact with normal alignment.

IMPRESSION: Negative.

Dictated by Matthew Shapiro, MD

Reported by: Matthew P Shapiro MD, M.D.
Signed by: SHAMP <<Signature on File>>

RADIOLOGY REPORT

Signed

Patient		Acct #:	
Unit #:		Report #:	0912-0446

Date/Time signed: 09/13/07 1002

C: No Family Doc for this Patient; Sally I Tucker

Signed

AMC

Augusta Medical Center
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Department of Radiology
(540) 332-4400
(540) 932-4400

Patient: [REDACTED]	Acct #: [REDACTED] Status: DEP ER	MR #: [REDACTED]
Tech: RAD.PJE	Age/Sex: 33F	Loc: ED1
Report #: 0918-0249	Phys: Asher Brand MD	Pat phone #: (304)478-3102
Transcriptionist: jaw	Dict Date: 09/18/07 0915	Trans Date: 09/18/07 1629

Date of Service: 09/17/07

Exam(s): 0917-0053 XED/XED * Nasal Bones

DOB: [REDACTED] Dictating Radiologist: Shashank Parekh

Diagnosis: HEADACHE, NECK PAIN AND EPISTAXIS

Reason for Exam: INJURY

NASAL BONES: 09/17/07

Three images.

No displaced fracture is seen. Orbital rims appear intact. There is no fluid in the sinuses. There is questionable soft tissue swelling over the left face.

IMPRESSION:

No evidence of fracture.

Dictated by Shashank Parekh, MD

Reported by: Shashank Parekh, M.D.

Signed by: PARS <<Signature on File>>

Date/Time signed: 09/19/07 0841

C: Asher Brand, MD; No Family Doc for this Patient

RADIOLOGY REPORT

Signed

AUGUSTA PAIN MANAGEMENT CENTER

Medical Office Building, Suite 305
70 Medical Center Circle
Fishersville, Virginia 22939
Telephone (540) 932-5747
(540) 332-5747

Victor C. Lee, M.D.
Darlinda Grice, M.D.
D. Preston Grice, M.D.
Mary Luebben, FNP
Holly Robedeau, Psy. D

PATIENT NAME: [REDACTED]

DOB: [REDACTED]

AMC #: [REDACTED]

Status of report is Signed

****Report is final only after physician signature****

DATE OF SERVICE: 05/19/2008

REFERRING PHYSICIAN: Michael Plautz, MD

CHIEF COMPLAINT: Neck, shoulder and headache pain. The patient is also complaining of diffuse back and spine pain.

HISTORY OF PRESENT ILLNESS/INTERIM HISTORY: The patient was last seen in clinic by me on February 5, 2008. Since that time the patient has had MRI of the lumbosacral spine. This essentially revealed no abnormalities whatsoever. She was also seen by a local rheumatologist. She returns to the clinic today stating that "I got knots in my head." She says she is having diffuse raised lesions on her head that are painful. She also says that she is having pain in her neck and spots on her neck that "fill up with fluid." She says she can actually feel the fluid in her neck. She also notes that when she pushes on her spinous process at approximately the C7-T1 level, this makes pain radiate all the way down her spine and into her tailbone. She complains of numbness and tingling in the arms and hands. She says that when she lies on her back her arms go numb and when she lies on her belly her legs go numb. She denies any bowel or bladder incontinence. She continues on her Zanaflex. She says this helps her to sleep, but only gives her about 1 hour per night.

ALLERGIES/ADVERSE DRUG REACTIONS: Local anesthetics, penicillin, sulfa, valproic acid, Zonegran, fentanyl TTS, tramadol.

MEDICATIONS: Zanaflex.

REVIEW OF SYSTEMS: The patient is complaining of diffuse neck, shoulder and head pain as per HPI. She is also complaining of some shortness of breath, which is associated with the heat, as well as diarrhea and swelling into her hands and fingers. She denies any chest pain, nausea or vomiting, constipation or bowel or bladder incontinence.

PHYSICAL EXAMINATION

VITAL SIGNS: Pulse 76, blood pressure 126/82.

GENERAL: Well-developed, well-nourished, extremely thin white female who is awake, alert and oriented and in no acute distress. She has a flat affect; however, at times appears to have pressured speech with notable lack of intonation. She at times appear to be slightly tangential.

HEENT: Normocephalic, atraumatic. There is some slight tenderness to palpation into the right occipital region. There are no overt palpable masses on the cranium or scalp. The area that the patient says there is a mass is an area of tenderness just above the frontal bone about 1/4 of the way up the skull. She questions whether or not I could feel the mass. I feel no other masses on the skull. There are multiple piercings throughout the face to include the ears, nose and lip.

NECK: Supple without lymphadenopathy. Cervical range of motion is within functional limits. I do not

Re: [REDACTED]

detect any "fluid" on the patient's neck. There is no swelling or lymphadenopathy. There is some slight tightness and tenderness into the cervical paraspinal musculature and trapezia bilaterally.

BACK/SPINE: There is diffuse tenderness throughout the lumbosacral spine, which goes all the way up the thoracic spine.

EXTREMITIES: Upper and lower limbs without swelling or edema.

NEUROLOGIC/MENTAL STATUS: Awake, alert and oriented, fluent speech, follows commands. Strength - 5/5 throughout upper and lower limbs bilaterally. Reflexes - Unable to obtain throughout upper limbs bilaterally. Sensory - Grossly intact to light touch throughout upper limbs bilaterally.

IMPRESSION

1. Chronic diffuse cervical pain. Once again, I am uncertain of the exact nature of the patient's pain. The patient's magnetic resonance imaging is completely normal.
2. Notable myofascial pain overlay.
3. Consider the possibility of cervical facet mediated pain. The patient however, does not always have a consistent exam with this.
4. Strongly consider the possibility of somatization disorder. While I always like to make this a diagnosis of exclusion, I am once again coming to a realization that this might be exactly what is happening with the patient.
5. Lumbosacral pain. Once again, I do not know the nature of the patient's pain.
6. Suboptimal response to conservative therapy.
7. Question of fibromyalgia. This was brought up by a rheumatologist that she had recently seen.

RECOMMENDATIONS

1. Trial of Lyrica. I am somewhat at a loss as to what else to begin to try for the patient. If she does have fibromyalgia this would be an optimal treatment given that this is the only FDA approved medication for fibromyalgia.
2. Referral to pain psychology. I would really like our pain psychologist to take a look at this patient overall. While again I believe the patient is thoroughly perceiving some type of pain, I am uncertain of the nature of this. Also, I would like to more aggressively rule out the possibility of a somatization disorder.
3. Consider intermittent trigger point injections. Again, I really do not want to aggressively pursue these.
4. The patient is to continue other medications as previously prescribed.
5. The patient is to follow up with her PCP as previously scheduled.
6. The patient is to return to the clinic in approximately 16 weeks for a followup visit.

Approximately 25 minutes were spent with the patient total.

D. Preston Grice, MS, MD

GRIDP/ProScript

D: 5/19/2008 9:39:00 PM EST

T: 5/20/2008 8:53:24 PM EST

J: 89-891943492

Electronically Signed/Signature on File: D Preston Grice MD 05/30/08 1918

70 Medical Center Circle, Suite 305
Fishersville, VA 22939

1943 Medical Center Circle, Su
Fishersville, VA 22939

Date: 5/14/08		Patient Name: [REDACTED]		Acct #: [REDACTED]	
BP: 161/87		Pulse: 116		Chief Complaint: neck, shoulder neck LB pain	
Pain Score Today:		No Pain		0 1 2 3 4 5 6 7 8 9 10 Worst Pain	
Activity Level Today:		No Limits Due to Pain		0 1 2 3 4 5 6 7 8 9 10 Severely Limited Due to Pain	
Pain Description:		<input checked="" type="checkbox"/> Sharp		<input checked="" type="checkbox"/> Dull	
("C" Constant "I" Intermittent)		<input checked="" type="checkbox"/> Stabbing		<input checked="" type="checkbox"/> Heavy	
		<input checked="" type="checkbox"/> Gnawing		<input checked="" type="checkbox"/> Aching	
		<input type="checkbox"/> Other		<input checked="" type="checkbox"/> Throbbing	
				<input checked="" type="checkbox"/> Hot Burning	
				<input checked="" type="checkbox"/> Shooting	
				<input type="checkbox"/> Tiring/Exhausting	
Do you have any weakness? <input type="checkbox"/> No <input type="checkbox"/> Yes Where?					
What makes your pain better?					
What makes your pain worse? sitting, standing, walking, bending, lying down					
Overall, how much pain relief have medications/treatments provided?					
No Relief 10% 20% 30% 40% 50% 60% 70% 80% 90% Complete Relief					
Do you have a driver available: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A			How many hours do you sleep a night? 3		
Where is your pain located? Circle area on body diagram			List of Current Pain Medication(s)		
			Tizanidine 4mg		
			Vib D		
			Changes in Medication List? <input type="checkbox"/> No <input type="checkbox"/> Yes		
			Changes in Drug Allergies? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
			Comments:		
			Nurse/CMA Signature: [Signature]		
New Problems: <input type="checkbox"/> No <input type="checkbox"/> Yes			Worse - more knots in head		
OBC: <input checked="" type="checkbox"/> None <input type="checkbox"/> Yes Number			(Reference OBC description in front of chart)		
Impression/Recommendation/Plan of Care:					
[Signature]					
Physician/Practitioner Signature: [Signature]					

neck \rightarrow occiput
3 day HA

Steroid helped head neck
a little LBP. stiffness a
little better

TPI's - helped R side but didn't
help L side, occipital NB? swelling
hand's
joints

Medes seemed to help

Zaraflox - drowsy sleep
3 hours then wide awake
8/15/21/24/

SCP SOB
N/V/D/I
TB/B
Fever, etc.

then
try in hand
- swelling



(L) trap
(L) cervical
(L) occip

NL

Ruby
memoir

AUGUSTA PAIN MANAGEMENT CENTER

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Victor C. Lee, M.D.
Douglas DeGood, PhD
Darlinda M. Grice, M.D.
D. Preston Grice, M.D.
Mary M. Luebben, FNP

DATE: 01/24/08

PATIENT NAME: [REDACTED]

DOB: [REDACTED]

AMC #: [REDACTED]

Status of report is Signed

****Report is final only after physician signature****

DATE OF SERVICE: 1/24/2008

OFFICE PROCEDURE NOTE

DIAGNOSES

1. Cervical occipital pain, 726.90.
2. Cervicobrachial pain, 723.9.
3. Myalgia, unspecified, 729.1.

PROCEDURE: Trigger point injections, three or more sites (20553).

BRIEF CLINICAL NOTE: The patient is a 33-year-old, white female with chronic neck, shoulder and back pain with a history of being in several motor vehicle accidents. Her most recent MVA was in September 2007 in which she sustained a minor facial injury with some nasal problems and swallowing issues. A CT and CT of the cervical spine from September 2007 did not show any abnormalities in either her head or her neck and no abnormalities were noted with ENT consultation. The patient had previously been followed in pain management by Dr. Adetayo Mabadeje but was recently referred back to pain management and was seen by Dr. Preston Grice on November 19, 2007. MRI of the cervical spine which was done on January 2, 2008 was a normal examination but the patient continues to have multiple complaints of neck pain with radiation into the base of the skull as well as down into the shoulders and upper back. She has ongoing muscle spasms as well episodic numbness in her hands and legs. She also has ongoing weakness in her arms and legs. She was last seen in clinic on January 16, 2008 and was prescribed baclofen for her muscle spasms but today reports that it made her spasms worse instead of better. She finds she is having increasing tingling into her hands and numbness into her legs if she lies on her side. She has had some swelling in the left posterior lateral neck and also has intermittent swelling into the wrist joints and left knee. She has a significant family history of rheumatoid arthritis and also has been treated for some type of vasculitis at her home in West Virginia but unfortunately her primary care physician is deceased. She was scheduled for trigger point injections with Dr. Preston Grice but these had to be canceled so we are proceeding with trigger point injections today.

DESCRIPTION OF PROCEDURE: Patient was identified and written and verbal consent was obtained. A copy is on the patient's chart. Tender areas were identified in the bilateral semispinalis cervicis, splenius capitis, levator scapula and upper trapezii. The skin was cleaned well isopropyl alcohol and a 27-gauge 1-1/4-inch needle was used for injection. Each trigger point was injected with 0.5-1 mL of Carbocaine 0.5% after negative aspiration for blood, fluid or air. Extra care was taken because of the patient's prior history of pneumothorax but that was with a pectoral trigger point injection that was done by Dr. Adetayo Mabadeje. A total of nine sites were injected and a total of 9 mL of Carbocaine 0.5% was used. No adverse effects were noted and the patient tolerated the injections well. She was observed for a period of 10 minutes and then was discharged comfortable and ambulatory. The patient was given some samples of tizanidine 2 mg and 4 mg and can try 2 mg p.o. up to t.i.d. for muscle spasm or 1 to 2 at bedtime. She is to call for a prescription if these are effective. She was also prescribed a medrol 4 mg

✓

Re: [REDACTED]

taper with instructions. We will send her for a CMP, thyroid profile, CRP, rheumatoid factor, CBC with diff, ESR, urinalysis and ANA, HLAB27 and vitamin D level. She was referred to Augusta Rheumatology and is waiting for an appointment.

D. Preston Grice, MD
Dictated by Mary Luebben, FNP

LUEMM/ProScript
D: 1/25/2008 5:37:00 PM EST
T: 1/27/2008 6:25:01 PM EST
J: 89-891867494
cc: Mary Baldwin College

*Electronically Signed/Signature on File: Mary Luebben NP 01/30/08 1308
D Preston Grice MD 01/28/08 1923*

Augusta Pain Management Center
70 Medical Center Circle, Suite 305
Fishersville, VA 22939

PATIENT ASSESSMENT

Date: 1/24/08 Patient Name: [REDACTED] Acct #: [REDACTED]

BP: 104/70 Pulse: 76 Chief Complaint: neck should back knee pain

Pain Score Today: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Activity Level Today: No Limits Due to Pain 0 1 2 3 4 5 6 7 8 9 10 Severely Limited Due to Pain

Pain Description: ☒ Sharp ☒ Dull ☐ Throbbing ☒ Hot Burning
("C" Constant "I" Intermittent) ☒ Stabbing ☐ Heavy ☒ Cramping ☒ Shooting
☒ Gnawing ☒ Aching ☐ Sickening ☐ Tiring/Exhausting
☐ Other

Do you have any weakness? ☒ No ☐ Yes Where?

What makes your pain better? nothing

What makes your pain worse? sitting standing sleeping

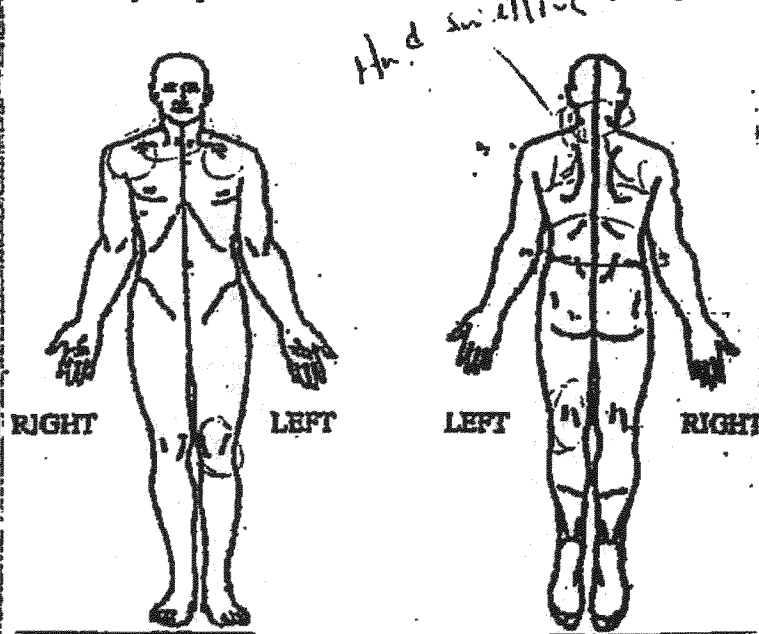
Overall, how much pain relief have medications/treatments provided?

No Relief 10% 20% 30% 40% 50% 60% 70% 80% 90% Complete Relief

Do you have a driver available: ☐ No ☒ Yes ☐ N/A

How many hours do you sleep a night? 2-4

Where is your pain located? Circle area on body diagram



List of Current Pain Medication(s)

needed

Brelofen made back tighter -
Sleeping less.

Changes in Medication List? ☐ No ☐ Yes

Changes in Drug Allergies? ☐ No ☐ Yes

Comments:

Hands tingling - legs feel
numb it lays on side

Nurse/CMA Signature:

[Signature] PCT

New Problems: ☐ No ☒ Yes None

OBC: ☐ None ☐ Yes Number (Reference OBC description in front of chart)

Impression/Recommendation/Plan of Care:

186 + 199
[Signature]

Physician/Practitioner Signature:

intercut
 a long time
 2 x 400 up

get Gnet, in my head
 [fills up a fluid]

push on neck 5 pinches
 process

radiates down to tail line

NT arm bands

If I lay on back arms go numb
 or belly legs go numb

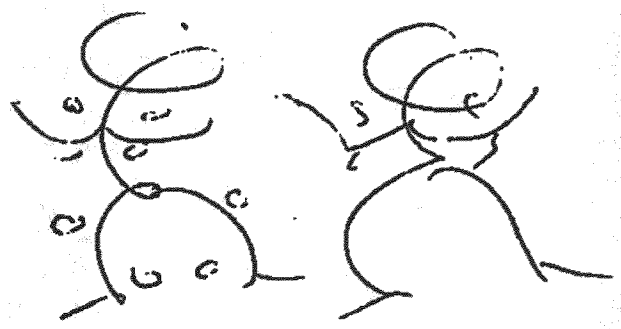
pairs down to my tail

SB/B SOB head-
 SWX

Zenofer give 1 hour sleep
 night

diameter
 SCPS
 N/N/D
 swelling
 lungs

5 swelling



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Victor C. Lee, M.D.
Douglas DeGood, PhD
Darlinda M. Grice, M.D.
D. Preston Grice, M.D.
Mary M. Luebben, FNP

DATE: 02/05/08

PATIENT NAME: [REDACTED]

DOB: [REDACTED]

AMC #: [REDACTED]

Status of report is Signed

Report is final only after physician signature

DATE OF SERVICE: 02/05/2008

REFERRING PHYSICIAN: Michael Plautz, MD

CHIEF COMPLAINT: Neck, shoulder and head pain. She is also complaining of some other diffuse symptoms throughout the entire thorax, down into the lower limbs.

HISTORY OF PRESENT ILLNESS/INTERIM HISTORY: The patient was last seen in clinic on January 7, 2008. That was for a nurse followup visit. She underwent some trigger points at that time by our nurse practitioner. She returns to the clinic today with several complaints. The bulk of her pain however, is going from her neck up into the occiput. She says she has had a headache for 3 days. We tried her on some steroids before her last visit. She says this helped her head and neck a little bit, as well as some of her low back pain. She said it made the stiffness in her hands somewhat better; however, did not really make any significant improvement there. Today, she rates her pain as 10/10 on the NRS. Again, she is complaining of neck, shoulder and hip pain, as well as low back pain. There are some general diffuse complaints about joint stiffness. She complains of no other really upper limb radicular symptoms or lower limb radicular symptoms. She notes that her trigger point injections that she had recently helped the right side of her neck, but did not help the left. She is uncertain if the occipital nerve blocks did anything. As mentioned above, she notes that the Medrol taper that we had her on seemed to help somewhat, but did not provide any sustained benefit. She is complaining of some swelling at the joints of her hands. She continues on her Zanaflex. It provides her with some benefit, but nothing significant. If she takes 2 it will make her sleepy and she will get up to 3 hours of sleep before waking up.

ALLERGIES/ADVERSE DRUG REACTIONS: Local anesthetics, penicillin, sulfa, valproic acid, Zonegran, fentanyl TTS, tramadol.

REVIEW OF SYSTEMS: The patient is complaining of diffuse neck, shoulder and head pain as per HPI. She is also complaining of diffuse pain into her back, as well as some numbness and tingling that goes down into the legs. She denies any chest pain, shortness of breath, nausea, vomiting, diarrhea, constipation or bowel or bladder incontinence.

PHYSICAL EXAMINATION

VITAL SIGNS: Pulse 76, blood pressure 90/60.

GENERAL: Well-developed, well-nourished, very thin white female who is awake, alert and oriented, no acute distress.

HEENT: Normocephalic, atraumatic. There are multiple piercings throughout the face to include the ears, nose and lip. There is some slight tenderness to palpation in the occipital regions bilaterally.

NECK: Supple without lymphadenopathy. There is some slight tightness into the left cervical paraspinal musculature and trapezia; however, there is nothing grossly or overtly noted in terms of spasms or trigger

Re: [REDACTED]

points.

BACK/SPINE: There is some slight tightness into the left rhomboid and levator scapula. But again, there are no overt trigger points noted.

EXTREMITIES: There is some notable dryness of the skin with scaling and flaking on the back of the hands. There is however, no overt joint swelling noted. There is some mild erythema of the skin, but again it appears to be more related to weathering and chaffing as opposed to frank erythema associated with the joints or swelling. Lower limbs without swelling or edema.

NEUROLOGIC/MENTAL STATUS: Awake, alert and oriented, fluent speech, follows commands. Strength - 5/5 throughout upper and lower limbs bilaterally. Sensory - Grossly intact to light touch throughout upper and lower limbs bilaterally. Reflexes - 1+ throughout upper and lower limbs bilaterally.

IMPRESSION

1. Chronic diffuse cervical pain. I am uncertain of the exact nature of the patient's pain. She has no overt abnormalities for findings on her magnetic resonance imaging. Her cervical range of motion is within functional limits. While the patient describes a variety of pain in the neck, I have no specific source of it at this time.
2. Myofascial pain. While there appears to be a myofascial pain overlay, there does not appear to be any frank trigger points or muscle spasms.
3. Consider the possibility of facet mediated pain. The patient however, again has good range of motion in the neck. There is no overt facet arthropathy noted on magnetic resonance imaging.
4. Consider the possibility of somatization disorder. While I always like to make this a diagnosis of exclusion, I am coming to the point where I do not have any really good diagnosis on which to base the significant amount of pain that the patient is describing. The patient has previously had, by her reports, a traumatic brain injury. This very well could be a contributing factor to her underlying perception.
5. Lumbosacral pain. Once again, I have no known source of her pain.
6. Consider the possibility of connective tissue disorder. The patient has expressed that she has been previously diagnosed with some type of unspecified vasculitis. Unfortunately, I have no records that account for this. I will not rule out the possibility of such a condition. The patient is notably thin. One must wonder if she does have some type of underlying connective tissue problem, rheumatological condition such as scleroderma.
7. Suboptimal response to conservative therapy. Again, I do not know specifically where to turn with the patient on this given her lack of tolerance to the multiple medications.

RECOMMENDATIONS

1. MRI of the lumbosacral spine. I would like to see what is going on with the patient at this time. I can not account for what is producing her lumbosacral pain or her lower limb radicular symptoms.
2. Referral to rheumatology. The patient has not pursued it at this time.
3. Obtain records from West Virginia. These supposedly account for all the patient's underlying medical conditions that have previously been problematic for her and yet may explain some of her symptoms.
4. Continue Zanaflex.
5. Consider intermittent trigger points; however, I do not necessarily want to pursue these aggressively without further diagnosis.
6. The patient is to continue other medications as previously prescribed.
7. The patient is to follow up with her PCP as previously scheduled.
8. The patient is to return to the clinic in approximately 8 weeks for nurse followup visit and 16 weeks to see me.

Approximately 25 minutes were spent with the patient total.

D. Preston Grice, MS, MD

GRIDP/ProScript

Re:

D: 2/7/2008 7:41:00 AM EST
T: 2/9/2008 8:01:09 PM EST
J: 89-891875295

Electronically Signed/Signature on File: D Preston Grice MD 02/21/08 1229

Fishersville, VA 22939

Date: 7/5/08 Patient Name: [REDACTED] Acct #: [REDACTED]
BP: 90/60 Pulse: 76 Chief Complaint: Head pain

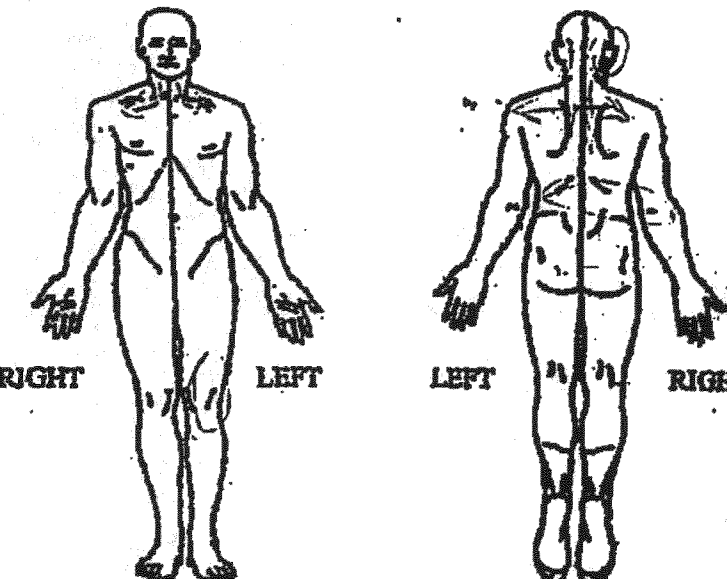
Pain Score Today: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain
Activity Level Today: No Limits Due to Pain 0 1 2 3 4 5 6 7 8 9 10 Severely Limited Due to Pain

Pain Description: ☒ Sharp ☒ Dull ☒ Throbbing ☐ Hot Burning
(“C” Constant “I” Intermittent) ☒ Stabbing ☒ Heavy ☒ Cramping ☒ Shooting
☒ Gnawing ☒ Aching ☐ Sickening ☐ Tiring/Exhausting
☐ Other

Do you have any weakness? ☐ No ☒ Yes Where? Hands and legs
What makes your pain better? Nothing
What makes your pain worse? Sitting for long periods of time, standing, laying down
Overall, how much pain relief have medications/treatments provided?
No Relief 10% 20% 30% 40% 50% 60% 70% 80% 90% Complete Relief

Do you have a driver available: ☐ No ☒ Yes ☐ N/A How many hours do you sleep a night? 5 hours

Where is your pain located? Circle area on body diagram



RIGHT LEFT LEFT RIGHT

List of Current Pain Medication(s)
Ibuprofen

Changes in Medication List? ☒ No ☐ Yes
Changes in Drug Allergies? ☐ No ☒ Yes

Comments:

Nurse/CMA Signature: P. W. [Signature]

New Problems: ☐ No ☒ Yes Head

OBC: ☐ None ☐ Yes Number 0 (Reference OBC description in front of chart)

Impression/Recommendation/Plan of Care:

Physician/Practitioner Signature: [Signature]

↑ muscle tightness cold weather

AUGUSTA PAIN MANAGEMENT CENTER

Medical Office Building, Suite 305
70 Medical Center Circle
Fishersville, Virginia 22939
Telephone (540) 932-5747
(540) 332-5747

Victor C. Lee, M.D.
Douglas DeGood, PhD
Darlinda M. Grice, M.D.
D. Preston Grice, M.D.
Mary M. Luebben, FNP

DATE: 01/16/08

PATIENT NAME: [REDACTED]

DOB: [REDACTED]

AMC #: [REDACTED]

Status of report is Signed

****Report is final only after physician signature****

DATE OF SERVICE: 01/07/2008

FOLLOWUP VISIT

REFERRING PHYSICIAN: Michael Plautz, MD

CHIEF COMPLAINT: Neck and shoulder pain.

HISTORY OF PRESENT ILLNESS: The patient is a 33-year-old white female who had been previously seen in the Pain Management Center for neck and shoulder pain, but had not been seen since October 2005. She was recently referred back to pain management following another motor vehicle accident in September 2007, when she was attempting to pull into a gas station, but could not turn her vehicle and ended up crashing her car. She sustained a facial injury and when her pain worsened, she developed some nasal problems and swallowing issues. She was referred to a local ENT specialist. Head CT and CT of the cervical spine from September 11, 2007 did not show any abnormalities in either her head or neck. She was then referred back to the patient management and was seen by Dr. Preston Grice on November 19, 2007. She returns today rating her pain at 10/10 on the NRS. Since her last visit she was sent for an MRI of the cervical spine that was done on January 2, 2008, that was a normal MRI examination of the cervical spine.

Today, she is complaining of pain in the posterior neck that radiates up to the base of the skull and then down into the shoulders and upper back. She has muscle spasms up into the back of her head, which will produce headaches. There is also pain that radiates down into the arm, mostly to the elbows that is worse in the left arm than the right. Her hands and legs intermittently go numb, especially when she is sitting or lying down. She has ongoing weakness in her arms, especially with gripping, as well as in her legs, mostly with lying or sitting. She denies any bowel or bladder incontinence. She notes that when she chews, she feels something poking into her throat and she hears a grinding noise when she moves her neck from side to side. She also complains of ongoing lower back pain. She has intermittent swelling into the lower extremities, especially if she has been on her feet for very long. This is from an undefined vasculitis, which she was previously treated for until her primary care physician in West Virginia died. She is from West Virginia, but attends Mary Baldwin College in Staunton and has not been established with any local physician, except for the one on campus. She has been involved in at least 6-8 motor vehicle accidents, as well as one bad snowboarding accident and has had ongoing complaints of neck, back and joint pain since about 1997.

In terms of medication, the patient is not currently taking any pain medications. She had been prescribed hydrocodone APAP after one of her emergency room visits, but is now out of them. Under Dr. Adelazo Mabadeje's care, she had been on fentanyl patch, which was fairly effective until she developed a skin reaction to the adhesive. She had been on Flexeril that was somewhat helpful. Dr. Grice did not want to prescribe any narcotics until the etiology of her pain could be determined.

ALLERGIES/ADVERSE DRUG REACTIONS: Penicillin, sulfa, valproic acid, preservatives, local

Re: [REDACTED]

anesthetics, Zonegran, fentanyl TTS, tramadol. The patient reports that she is gluten intolerant, but denies any allergies to iodine, shellfish, seafood, strawberries or IV contrast.

REVIEW OF SYSTEMS: The patient is complaining of neck, shoulder and head pain as per HPI. She has intermittent headaches, significant sleep disturbance, deficit in left eye vision and left ear hearing, easy bruising, cold and heat intolerance, intermittent diarrhea and knee pain. Otherwise, review of systems are negative.

PHYSICAL EXAMINATION

VITAL SIGNS: Blood pressure 108/58, pulse 60.

GENERAL: The patient is a well-developed, very thin, somewhat pale white female, who is awake, alert and oriented, and in no acute distress. The patient is friendly nondistended interactive.

HEENT: Head is normocephalic, atraumatic. The patient has noted tenderness through the occipital regions bilaterally. She has an upper partial dental plate. Otherwise, oropharynx is clear.

NECK: Cervical range of motion is within functional limits. She has significant tightness in the cervical paraspinal musculature and into the upper trapezia and levator scapula.

LUNGS: Clear to auscultation bilaterally.

HEART: Regular rate and rhythm.

ABDOMEN: Soft and nontender.

EXTREMITIES: Lower limbs without outstanding edema, although she does have some slight brawny discoloration over the shins bilaterally and has very thin tapering fingers with skin dryness of the hands.

BACK/SPINE: There is tenderness to palpation in the levator scapula and rhomboids bilaterally. There is some tenderness along the spinous processes at approximately T8-9, as well as along the spinous processes at about the L5 level. Seated straight leg raise is negative bilaterally.

NEUROLOGIC/MENTAL STATUS: Awake, alert and oriented, fluent speech, follows commands. Strength is 5/5 throughout upper and lower limbs bilaterally. Reflexes are difficult to elicit in the upper extremities, 1+ throughout lower limbs bilaterally. Sensory is grossly intact to light touch total in both upper and lower limbs bilaterally.

IMPRESSION

1. Subacute cervical pain with recent exacerbation following another motor vehicle accident.
2. ? Upper limb radicular pain.
3. Notable myofascial pain with significant tightness today through the cervical paraspinal muscles and into the upper trapezia.
4. Unspecified vasculitis, currently not undergoing any treatment. The patient has not been seen by rheumatology.
5. Multiple medication intolerances.
6. Occipital neuralgia.
7. Unspecified endocrine problem.

RECOMMENDATIONS

1. After discussion with Dr. Preston Grice the patient was scheduled for some trigger point injections with Dr. Grice to include some occipital nerve blocks.
2. Trial of baclofen 5 mg, 1-2 p.o. up to t.i.d. p.r.n. for muscle spasms.
3. Referral to rheumatology since she appears to have some underlying autoimmune condition.

Mary Luebben, FNP D. Preston Grice, MS, MD

LUEMM/ProScript

D: 1/8/2008 7:56:00 PM EST

T: 1/9/2008 11:53:33 AM EST

J: 89-891856071

Re: [REDACTED]

Electronically Signed/Signature on File: Mary Luebben NP 01/17/08 1819
D Preston Grice MD 01/18/08 1352

Augusta Pain Management Cente.
70 Medical Center Circle, Suite 305
Fishersville, VA 22939

PATIENT ASSESSMENT

Date: 11/7/00 Patient Name: [REDACTED] Acct #: [REDACTED]
BP: 100/58 Pulse: 60 Chief Complaint: Cervical & LBP

Pain Score Today: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain
Activity Level Today: No Limits Due to Pain 0 1 2 3 4 5 6 7 8 9 10 Severely Limited Due to Pain
Pain Description: ☒ Sharp ☒ Dull ☐ Throbbing ☐ Hot Burning
(☐ Constant ☐ Intermittent) ☒ Stabbing ☒ Heavy ☐ Cramping ☒ Shooting
☐ Gnawing ☒ Aching ☐ Sickening ☐ Tiring/Exhausting
☐ Other

Do you have any weakness? ☒ No ☐ Yes Where?

What makes your pain better?

What makes your pain worse? Sitting standing heavy down

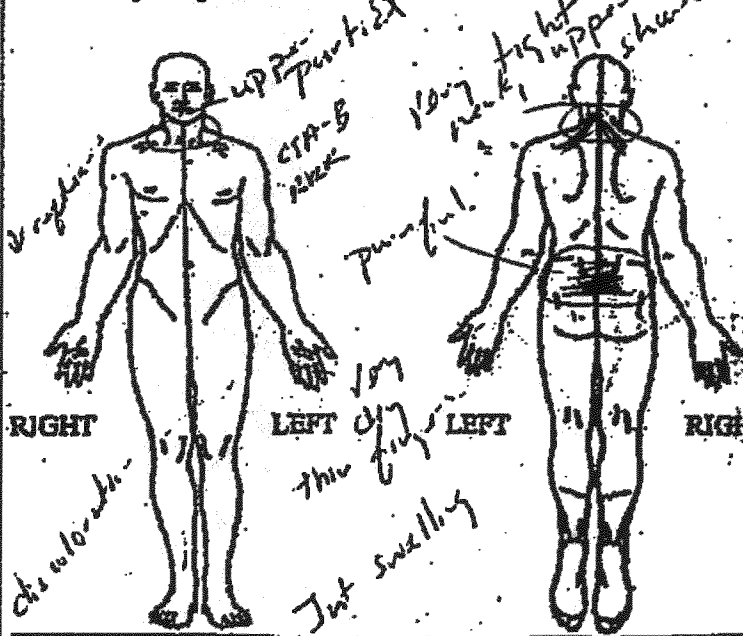
Overall, how much pain relief have medications/treatments provided?

No Relief 10% 20% 30% 40% 50% 60% 70% 80% 90% Complete Relief

Do you have a driver available: ☐ No ☒ Yes ☐ N/A

How many hours do you sleep a night? 4

Where is your pain located? Circle area on body diagram



List of Current Pain Medication(s)

None

When chews feels something poking

into throat.

vasculitis.

Changes in Medication List? ☐ No ☐ Yes

Changes in Drug Allergies? ☒ No ☐ Yes

Comments:

Has to be careful to diet -

diabetes -

Nurse/CMA Signature:

KHANMCCIN PCR

New Problems: ☒ No ☐ Yes

OBC: ☒ None ☐ Yes Number (Reference OBC description in front of chart)

Impression/Recommendation/Plan of Care:

1856011

Trial Barafen

Rheum Ref.

TP1's

Physician/Practitioner Signature: W. J. Smith

Not taking any medicine.

Numbers across / legs when laying down.

AUGUSTA PAIN MANAGEMENT CENTER

Medical Office Building, Suite 305
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Victor C. Lee, M.D.
Douglas DeGood, PhD
Darinda M. Grice, M.D.
D. Preston Grice, M.D.
Mary M. Luebben, FNP

DATE: 11/19/07

PATIENT NAME: [REDACTED]

DOB: [REDACTED]

AMC #: [REDACTED]

Status of report is Signed

****Report is final only after physician signature****

REFERRING PHYSICIAN: Michael Plautz, MD

CHIEF COMPLAINT: Neck and shoulder pain.

HISTORY OF PRESENT ILLNESS: The patient is a 33-year-old white female who had been previously seen in the Pain Management Center for neck and shoulder pain. She has not been seen since October 2005. She had previously had a motor vehicle accident. She ended up being referred to the clinic here because of another motor vehicle accident she had. In September 2007, she notes she was attempting to pull into a gas station, when she could not turn her vehicle. She ended up crashing her car. She notes that her air bag did not work and she ended up sustaining a facial injury. She did not end up seeing a doctor back home in West Virginia; however, ended up being seen in the emergency room at AMC. She appears to have been there on 3 occasions. Her pain progressively got worse and worse, as well as some nasal problems and swallowing issues. She ended up being referred to a local ENT specialist. There was nothing specifically that could be done for her surgically. Subsequently, she was referred back to the Pain Management Center for further evaluation and treatment.

In terms of the patient's pain, she has quite an elaborate description of what happens with it. She says the pain goes principally from the neck, over into the shoulders. She then points in the area down to the rhomboids. She says it sounds like there is "sand grinding" in her neck. There is pain that also radiates down her back and into her legs. There is pain that also radiates up the neck, into the base of the skull. She says when it radiates up into her skull, it will produce muscle spasms in the back of her head and "knots." There is also pain that radiates down the arm, to the elbows. It is much worse on the left than the right. She notes that her hands and legs go numb, in particular when she is sitting or lying down. She says the hands notably go numb when she goes to sleep. Intermittently, she has some weakness into the arms, in particular, grip. Intermittently, the legs will go numb, principally with lying or sitting. She denies any bowel or bladder incontinence. Her pain is typically made worse with prolonged standing or sitting. Riding in a car will increase her pain, as well as riding a bicycle. Sweeping will increase her pain. Coughing, sneezing and bowel movements do not increase her pain. Her pain is made better with "moving certain ways." Ice does not help.

In terms of workup, the patient has had a CT of the cervical spine, which is negative. She has not had an MRI. She has had x-rays, which reveal no overt abnormalities. She has previously had an EMG in 1997; however, we do not have a copy of this. She has not had a triple phase bone scan. She has not been seen by a neurosurgeon or orthopedic spine surgeon. In terms of treatment, she has not undergone any physical therapy. She has previously used a TENS unit; however, currently does not have pads for it. She has not had any neuroaxial injections or trigger point injections since her last accident. She has not tried acupuncture or other alternative medicine therapy. She has not tried magnets and has not seen a chiropractor.

Re: [REDACTED]

Date of Service: 11/19/07

In terms of medications, she currently has been using some hydrocodone, which had been provided to her by the emergency room. She also admits to having taken some of her mother's hydrocodone. She has previously been on Ultram, which she said she no longer could tolerate. She had been on Flexeril, which she says helps somewhat. Zonegran in the past did not provide her with any benefit. She has not been on oral corticosteroids.

PAST MEDICAL/SURGICAL HISTORY: Hypoglycemia, unspecified jaw surgery, reactive airway disease, unspecified vasculitis, irritable bowel syndrome.

ALLERGIES/ADVERSE DRUG REACTIONS: Penicillin, sulfa, valproic acid, preservatives in local anesthetics, Zonegran, fentanyl TTS, tramadol. The patient denies any allergies to iodine, shellfish, seafood, strawberries or IV contrast.

MEDICATIONS: None.

SOCIAL HISTORY: The patient denies tobacco, ethanol or illicit substance use. She is single and currently resides in Hambleton, West Virginia. She commutes back and forth and intermittently will stay in Staunton, Virginia. She is currently attending Mary Baldwin College. She has recently changed her major and is expecting to be present for another approximately 3 years.

FAMILY HISTORY: Uncle - Diabetes. Grandmother - Diabetes. Mother - Hypertension. Aunt - Cancer. Great aunt - Cancer.

REVIEW OF SYSTEMS: The patient is complaining of neck, shoulder and head pain as per HPI. She is also complaining of some recent problems with epistaxis, sputum production, diarrhea, back pain, knee pain, deficits in left eye vision and left ear hearing, easy bruising, sleep disturbance, cold and heat intolerance. Otherwise, remainder of the review of systems are negative.

PHYSICAL EXAMINATION

VITAL SIGNS: Pulse 104, blood pressure 94/60.

GENERAL: Well-developed, well-nourished, thin white female who is awake, alert and oriented. No acute distress.

HEENT: Normocephalic, atraumatic. EOMI. The patient has noted tenderness through the occipital regions bilaterally. There are multiple piercings of the ears, lips, eyebrow and other facial features.

NECK: Range of motion is grossly within functional limits. There is some noted tenderness into the cervical paraspinal musculature and trapezia bilaterally. There is however, no significant tightness, cords or trigger points. Cervical loading produces lumbosacral pain.

LUNGS: Clear to auscultation bilaterally.

HEART: Regular rate and rhythm.

ABDOMEN: Nontender and nondistended, soft.

EXTREMITIES: Upper and lower limbs without swelling or edema. There is no overt atrophy into the upper or lower limbs.

BACK/SPINE: There is tenderness to palpation in the levator scapula and rhomboids bilaterally. Once again, there is no overt tightness noted. There is a tattoo in the upper back. There is tenderness to palpation along the spinous processes at approximately the T8-9 level. There is also tenderness along the spinous processes at approximately the L5 level. In general, the patient is notably thin and the spinous processes are quite pronounced in the lumbosacral spine.

SKIN: Tattoo as per above. There are multiple piercings as per above.

LYMPHATICS: Upper and lower limbs without swelling or edema. Without cervical lymphadenopathy.

NEUROLOGIC/MENTAL STATUS: Awake, alert and oriented, fluent speech, follows commands. Cranial nerves - Cranial nerves II through XII are grossly intact. Strength - 5/5 throughout upper and lower limbs bilaterally. Reflexes - Trace biceps and triceps bilaterally, 2+ throughout lower limbs bilaterally. Hoffmann

Re: [REDACTED]

Date of Service: 11/19/07

reflex is negative bilaterally. Sensory - Grossly Intact to light touch throughout upper and lower limbs bilaterally.

IMPRESSION

1. Subacute cervical pain. The patient has recently been involved in a motor vehicle accident, further exacerbating her neck problems.
2. Upper limb radicular pain.
3. Myofascial pain. Despite the fact the patient complains notably of pain, there does not appear to little, if any tightness or trigger points.
4. Upper limb radicular symptoms. I am very suspicious and concerned about the numbness the patient is complaining about.
5. Probable cervical disk herniation versus degenerative disk disease.
6. Otherwise, at this time, I do not have a good working idea of what specifically is going on in the patient's neck.
7. Multiple medication intolerances.
8. Previous issues with a variety of medications. Many of these the patient either did not tolerate or did they did not provide her with significant benefit.
9. Past medical history as per above.
10. Review of systems as per above.
11. Occipital neuralgia.

RECOMMENDATIONS

1. First and foremost, we need to figure out what is going on with the patient's neck. We need a much better working diagnosis.
2. MRI of the cervical spine.
3. Consider initiating physical therapy after cervical spine MRI.
4. Consider occipital nerve blocks. The patient appears to have a fairly obvious occipital neuralgia.
5. Consider an analgesic in the future. I however, want to see what the patient actually has. If there is no overt pathology, I am honestly not looking at prescribing a narcotic for this patient.
6. Consider cervical trigger point injections.
7. Consider cervical epidural steroid injection depending on the results.
8. Consider pain psychology.
9. The patient is to continue other medications as previously prescribed.
10. The patient is to follow up with her PCP as previously scheduled.
11. The patient is to return to the clinic in approximately 4-6 weeks for nurse followup visit and 12-16 weeks to see me.

Approximately 65 minutes were spent with the patient total.

D. Preston Grice, MS, MD

GRIDP/ProScript

D: 11/19/2007 6:29:00 PM EST

T: 11/20/2007 12:03:03 PM EST

J: 89-891827260

Electronically Signed/Signature on File: D Preston Grice MD 11/21/07 1705

1827268
 Augusta Pain Management Center
 70 Medical Center Circle, Suite 305
 Fishersville, VA 22939

PATIENT ASSESSMENT

Date: 11/19/07		Patient Name: [REDACTED]		Acct #: [REDACTED]	
BP: 110/70		Pulse: 104		Chief Complaint: (FEMORAL NEURITIS) (L. F. BACK PAIN)	
Pain Score Today:		No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain			
Activity Level Today:		No Limits Due to Pain 0 1 2 3 4 5 6 7 8 9 10 Severely Limited Due to Pain			
Pain Description:		<input checked="" type="checkbox"/> Sharp <input checked="" type="checkbox"/> Dull <input checked="" type="checkbox"/> Throbbing <input checked="" type="checkbox"/> Hot Burning ("C" Constant "I" Intermittent) <input checked="" type="checkbox"/> Stabbing <input checked="" type="checkbox"/> Heavy <input type="checkbox"/> Cramping <input checked="" type="checkbox"/> Shooting <input type="checkbox"/> Gnawing <input checked="" type="checkbox"/> Aching <input checked="" type="checkbox"/> Sickening <input type="checkbox"/> Tiring/Exhausting <input type="checkbox"/> Other			
Do you have any weakness? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes Where? Neck, lower back					
What makes your pain better? Nothing					
What makes your pain worse? Sitting, standing, sleeping on back, belly					
Overall, how much pain relief have medications/treatments provided?					
No Relief 10% 20% 30% 40% 50% 60% 70% 80% 90% Complete Relief					
Do you have a driver available: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> N/A			How many hours do you sleep a night? 5		
Where is your pain located? Circle area on body diagram			List of Current Pain Medication(s)		
			Nothing		
Changes in Medication List? <input type="checkbox"/> No <input type="checkbox"/> Yes			Changes in Drug Allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Comments:			When turning head to side she feels like she is clicking		
Nurse/CMA Signature:			K. Hamlin, PC		
New Problems: <input type="checkbox"/> No <input type="checkbox"/> Yes					
OBC: <input checked="" type="checkbox"/> None <input type="checkbox"/> Yes Number (Reference OBC description in front of chart)					
Impression/Recommendation/Plan of Care:					
Physician/Practitioner Signature: [Signature]					

Augusta Pain Management Patient Questionnaire

Thank you for taking the time to answer this questionnaire. Please bring it with you to your appointment.

[illegible]

Who referred you to the pain clinic? _____ **Phone number** _____

Height 5'8 1/2 Weight 120

When did your pain problem begin and how did your pain problem first start? (motor vehicle accident, fall, job-related, following illness or surgery, it just began) LIST DATE AND TIME OF INJURY

If your pain is due to a specific accident or injury, have you ever had similar pain before that accident or injury?
Yes No Explain:

Describe your pain problem

Describe when your pain occurs (For example, is it constant, intermittent, only at night)

Number of visits to health care providers in the last year related to your pain problem? _____

Have you been hospitalized for your pain in the past? Yes _____ No X

If yes, how many times?

Have you had anesthesia/sedation in the past? Yes X No

If yes, for what?

Have you ever had any problems with anesthesia/sedation? Yes No ☒

If yes, what were they?

Is there a family history of problems with anesthesia/sedation? Yes _____ No X

If yes, what were they?

Please circle the level of your primary pain from 0 (no pain) to 10 (worst pain imaginable)

PRESENT level of pain:

0 1 2 3 4 5 6 7 8 9 10
(no pain) (mild) (discomforting) (distressing) (horrible) (worst pain)

WORST level of pain:

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst pain)

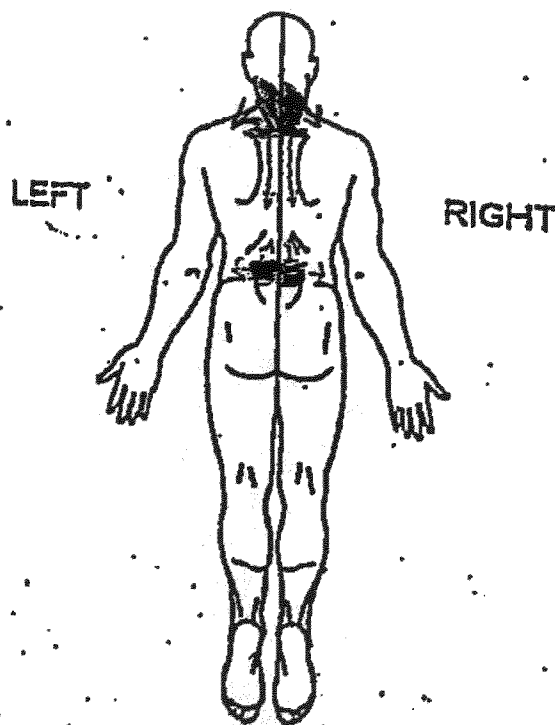
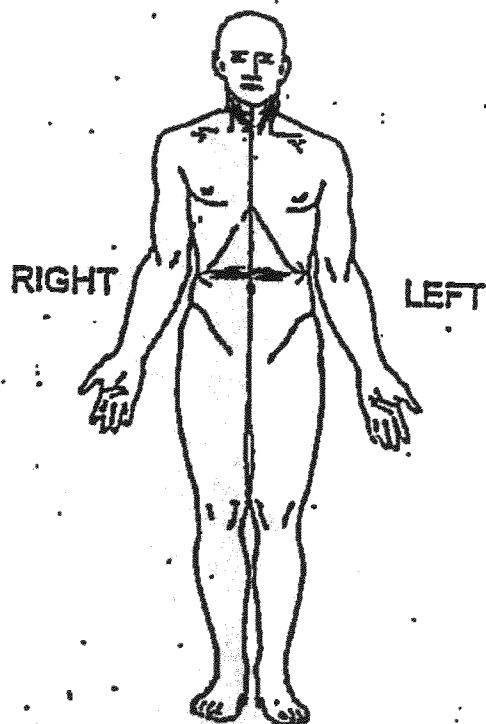
LEAST level of pain:

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst pain)

Using the same scale, what level of pain is ACCEPTABLE for you (the level at which you can function)?

0 1 2 3 4 5 6 7 8 9 10
(no pain) 3 No MORE Than 5 (worst pain)

Please shade in the areas below that represent your areas of pain (where do you hurt)? Use arrows to draw radiating pain or pain that moves around.



Describe your present use of pain medications:

Definitely increasing _____ Increasing slightly _____ Same as always _____
Decreasing slightly _____ Definitely decreasing _____ Not applicable _____

You should list ALL of your Current Medications on the back of the Yellow Patient Summary Sheet

[illegible][illegible]

PREVIOUS TREATMENT/PROCEDURES – Look at each treatment listed in the first column and choose the most appropriate answer for each.

TREATMENT TYPE	DATE TRIED	HELPFUL	NOT HELPFUL	COMMENTS
Surgery (list type)				
Nerve Block				
Steroid injection		✓		
Acupuncture				
Trigger-point injection			✓	
TENS unit				HELPED SOME
Heat/Ice treatment			✓	
Biofeedback				
Hypnosis				
Relaxation training				
Counseling				
Physical therapy			✓	
Chiropractor			✓	
Occupational therapy				
Massage				
Herbal therapies				
Traction				
Other				

?

Have you had the following tests?

TEST (LIST AREA OF BODY)	DATE	FACILITY WHERE DONE	RESULTS
XRAY		AMC	
CT SCAN			
MRI		AMC	
EMG			
MYELOGRAM			
LAB			

SLEEP (How does pain affect your sleep)

CONDITION	ALWAYS	SOMETIMES	NEVER
Trouble falling asleep	✓		
Medication needed to fall asleep			
Awakened by pain	✓		

Average Number of Hours of Sleep a Night: 5

Are there areas of your life that have been affected by your pain? Check all.

	SAME	LESS	MORE	COMMENTS
Sleep			✓	ASK ME
Appetite				Are You on a specific Diet?
Relationships				
Work				
Finances				
Physical activity			✓	
Happiness				
Use of alcohol				
Use of recreational drugs				
Emotions				
Concentration			✓	NOT ABLE TO CONCENTRATE IN CLASS
Sexual Relations				

Look at chart below. The first column lists treatments and activities, put an X in most appropriate response.

TREATMENT	RELIEVES	WORSENS	NO CHANGE	COMMENTS
Mild exercise			X	
Heavy exercise		X		
Walking		X		
Massage				
Sitting		X		
Standing		X		
Touch		X		
Heat pack			X	
Ice pack		X		
Hot temp			X	
Cold temp		X		
Weather		X		
Bright lights			X	
Eating			X	
Alcohol			X	
Emotional stress			X	
Urination			X	
Defecation			X	
Noise			X	
People (crowds)			X	
Music			X	
Sleeping			X	
Menstrual cycle			X	DONT GET ENOUGH
Rolling in bed				CONSTANT
Moving from standing to sitting				CONSTANT
Stairs		X		
Fatigue			X	

Current Marital Status

___ Single ☒ Living with significant other ___ Married ___ Divorced ___ Widowed ___ Separated

Marital Status When Pain Problem Began

___ Single ☒ Living with significant other ___ Married ___ Divorced ___ Widowed ___ Separated

Number of Children 0 Ages _____ Are you Pregnant? _____

Level of Education College Senior

Names of people living with you Savanna Cooper

Are you currently working? ___ YES ☒ NO Occupation: College Student

Is this the same occupation you had when the pain started? ☒ YES ___ NO

If not working, did you stop working because of pain? ___ YES ___ NO

What type of job did you do before your pain started? College Student

IS THERE ANYTHING ELSE YOU WOULD LIKE TO SHARE THAT MAY BENEFIT YOUR TREATMENT?

NEED SOMETHING THAT WILL TAKE THIS PAIN AWAY
LIKE TO HAVE A SOME WHAT NORMAL LIFE

*** TRANSMISSION REPORT ***

SID : AUGUSTA PAIN MGMT

Number L1 : 5403325748
Number L2 :

Date : 10-25-87 12:35

Date/Time	10-25 12:34
Dialled number	7011
Subscriber	540 245 7011
Durat.	0'17"
Mode	PHOTO
Pages	1
On	Line 1
Status	Correct

AUGUSTA PAIN MANAGEMENT CENTER
70 MEDICAL CENTER CIRCLE, SUITE 303
FISHERSVILLE, VA 22039
(540) 932-5747 or (540) 332-5747
FAX (540) 932-5748

INITIAL EVALUATION CONFIRMATION

THE FOLLOWING PATIENT HAS BEEN SCHEDULED IN TO SEE OUR
PHYSICIAN HERE AT AUGUSTA PAIN MANAGEMENT CENTER PER YOUR
REQUEST:

PATIENT: [REDACTED]

DATE OF BIRTH: [REDACTED]

REFERRED BY: Michael Plautz, MD

DATE & CHECK IN TIME OF SCHEDULED APPT:
Feb 4, 2008 check in 9:50 AM

CONSULTING PHYSICIAN: Preston Grace, MD



"PLEASE BE AWARE THAT WE DO NOT CONTACT THE PATIENT
WITH THIS INFORMATION. INFORM PATIENT THAT A PACKET OF
INFORMATION WILL BE MAILED TO THEM TO FULLY COMPLETE
AND BRING IN THIS DATE. ALSO INSTRUCT THEM TO BRING IN
INSURANCE CARDS AND ALL PAIN MEDICATIONS THAT THEY ARE
CURRENTLY TAKING."

THANK YOU FOR YOUR COOPERATION.

AUGUSTA PAIN MANAGEMENT CENTER

Victor C. Lee, MD
D. Preston Grice, MD
Darlinda Grice, MD
Mary Luebben, NP
Douglas DeGood, PhD

70 Medical Center Circle, Suite 305
Fishersville, VA 22939
Telephone: (540)332-5747
Fax Number: (540)332-5748

New Patient Referral Request

DATE: 10-17-07

REFERRING PHYSICIAN NAME: Michael Plautz, MD

OFFICE TELEPHONE: 245-7010 FAX: 245-7011

ADDRESS: 70 Medical Center Circle Ste 104

PATIENT'S NAME: [REDACTED]

DIAGNOSIS/REASON FOR CONSULT: Chronic neck, back, extremity pain -
no multiple MRIs - previous w/o being treated at any pain clinic

Are you aware if the patient is being seen or has been seen at any other pain clinic before yes

Is the patient on any pain medications Pt denies

Have you prescribed the patient any pain medications No

These questions must be completed before patient is seen

APPT. TYPE: ☒ Referral for Evaluation and Treatment ☐ Consultation Only
☒ First Available Physician ☐ Specified physician only
☐ Psychological Evaluation with Dr. DeGood
☐ Referral for Procedure Type

*SIGNATURE OF REFERRING PHYSICIAN: [Signature] M. PLAUTZ

ADDITIONAL INFORMATION:

Patient's SS#: [REDACTED] Patient's DOB: [REDACTED]

Patient's Phone Number: [REDACTED]

Patient's Address: [REDACTED]

Hambleton, WV [REDACTED]

Type of Insurance: State Farm Auto Name of PCP: [REDACTED]

Claim
Please send a copy of patients Insurance card/ workers comp information

Policy #: see attached Group#: [REDACTED]

DOCTOR Preston Grice, MD

Appointment Date and Time: 2-4-08 1020

Augusta Pain Management will mail the Patient an Information Pack Completed? Yes No 10-25-07

**IF ALL NEEDED INFORMATION IS NOT RECEIVED AT TIME OF REFERRAL, A
DELAY IN SCHEDULING THE APPOINTMENT WILL OCCUR.** Packet

Mailed.
A. Young

Augusta Pain Management

Pain Management Spreadsheet

Name [REDACTED]

DOB 7/15/74

1. Today's Pain

7/15/24 7/16/24 7/17/24 7/18/24 7/19/24 7/20/24 7/21/24 7/22/24 7/23/24

2	6-7	10	2-4	5	3	3	10	
---	-----	----	-----	---	---	---	----	--

2. Average Pain

10	5-6	0	8-9	4	6	3	10	
----	-----	---	-----	---	---	---	----	--

3. Average Sleep

7	10	9	7	9	10	0	10	
---	----	---	---	---	----	---	----	--

4. Average Mood

5	5-9	1	4	2	4	1	4	
---	-----	---	---	---	---	---	---	--

5. Average Activity

8	9	6	8	8	6	6-7	9	
---	---	---	---	---	---	-----	---	--

6. Average Energy

3	6-7	0	0	9	1	2-3	0	
---	-----	---	---	---	---	-----	---	--

AUGUSTA PAIN MANAGEMENT CENTER

Medical Office Building, Suite 305
70 Medical Center Circle
Fishersville, Virginia 22939
Telephone (540) 932-5747
(540) 332-5747

Victor C. Lee, M.D.
Darlinda Grice, M.D.
D. Preston Grice, M.D.
Mary Luebben, FNP
Holly Robedeau, Psy. D

PATIENT NAME: [REDACTED]

DOB: [REDACTED]

AMC #: [REDACTED]

Status of report is Signed

****Report is final only after physician signature****

DATE OF SERVICE: 05/28/2008

Due to time restrictions the Psychosocial Evaluation will be completed after the patient's next visit.

Presenting Information: [REDACTED] is a 33-year-old single, white female. She is currently in a relationship with a significant other whose name is [REDACTED] age 19. The women live together in an apartment here in Augusta County. The patient was raised in West Virginia and lived there until 4 years ago when she moved to Augusta County, Virginia to attend Mary Baldwin College. She is pursuing a Bachelor's degree in marketing with a minor in environmental science and biology. The patient was referred by Dr. Preston Grice here at Augusta Pain Management Center for Psychological Services for assistance in pain and stress management. [REDACTED] appeared for the interview dressed in long shorts and T-shirt. She stated that she weighs 120 pounds and is 5 feet 9-1/2 inches tall. She is lean and thin. Multiple piercings with pins decorate her body in her ears, lip, chin, and eyebrow, along with tattoos. Her hair is trimmed short and spiked with streaks. The patient is a friendly, cooperative person with good communication skills.

Past Developmental & Social History: The patient's mother and father are alive and reside in her hometown of Parsons, West Virginia, where her elder half-sister, [REDACTED] age 48, lives with her 2 children. Her father is age 65, and the patient describes him as disabled as a result of a job-related injury. Her mother, age 66, still works as a custodian in the local grade school and as well takes in 2 people, one with mental illness, and the other with an amputated leg, for care within the home. The patient described her mother as a workaholic and extremely supportive.

[REDACTED] attended high school in her hometown until she transferred in her senior year to another high school which had "better schooling" in business and computers. She graduated from high school with a 3.5 average and attended the local community college, Davidson Elkins College, where she studied business administration and biology for a year and a half. At that point, her education was interrupted by the first of several motor vehicle accidents. The patient subsequently moved to Augusta County 4 years ago to attend Mary Baldwin College in pursuit of a degree in marketing with environmental science and biology as her minors. The patient reported that completion of this degree has been interrupted by additional motor vehicle accidents. The patient expects to graduate in June 2008, if she is granted permission by Dr. Grice to return to school. The patient noted, "Dr. Grice says he is not ready to release me to return back to school." She expressed an interest in returning to school this September 2008, if she is medically approved. The patient notes that her goals for a career are within the field of environmental sciences, i.e. freshwater testing within the government. But she is also interested in animal care and may become a Veterinarian.

The patient noted that due to a head injury in her first and subsequent accidents, her mother manages most of her financial obligations. The patient is on full Social Security disability, and her checks go to her mother, who then takes care of paying most of her bills. The patient does manage her apartment rental and food, etc. Ms. Lambert advised that she is not considered capable of taking care of her bills due to her difficulty in recall and staying on task. She was active in high school as a member of the high school

Re: [REDACTED]

basketball team and softball team. The patient reports no marriages, nor pregnancies. She denies any current legal issues. However, she is in discussion with General Motors over her most recent accident in September 2007, where she reports that the steering function of her Chevy Cobalt would not operate, thus resulting in her driving into a building.

Cognitive & Emotional Functioning: The patient was alert and oriented with good eye contact during the session. Speech was extremely pressured. She appeared above average in intelligence. Deficits in thought processes included difficulty staying on task, some evidence of circumstantiality and tangentiality. No hallucinations or delusions were reported. There were deficits in memory and recall in a number of areas including previous medical treatments. Attention deficits were present during the interview. She presented with psychomotor agitation; but this could be due to discomfort as a result of pain and/or hyperactivity. Mood was stable during the interview with some apprehension. Affect was varied. The patient did not appear to be emotionally overwhelmed.

[REDACTED] denied any previous or present suicidal ideation or plans. The patient noted that she was previously seen for psychiatric treatment in Morgantown, West Virginia after her first accident in 1995. She indicated that she was diagnosed as PTSD with brain damage which included short-term and long-term memory loss. She also noted a bipolar diagnosis. She notes that she does not take any medication for the bipolar diagnosis because she was "allergic to the medication and manages fine without it."

Later in the interview [REDACTED] recalled that she had been diagnosed with obsessive-compulsive disorder in West Virginia in the late 1990s. The patient went on to describe that in her life she has always had lot of energy and "even now" is extremely active despite her pain. She noted that she scrubs the floors regularly to make sure that there is no dirt and organizes her closet and her partner's closet and does all the cooking and repairs in the home. The patient denied that she has ever been diagnosed with ADHD. However, it is recommended that she be evaluated for ADHD. This may be contributing to her pressured speech, psychomotor agitation, difficulty attending, and issues in recall.

Cognitive issues described above prompt the recommendation that Ms. Lambert be evaluated by a Psychiatrist for evaluation and centralization of her psychiatric services.

50 minutes were spent in the session with the patient today.

Due to time restrictions, a complete Psychosocial Evaluation will be completed at our next appointment in 1 week.

Holly Robedeau, Psy.D
Staff Psychologist
Augusta Pain Management Center

ROBHG/ProScript
D: 5/28/2008 1:13:00 PM EST
T: 5/28/2008 3:01:06 PM EST
J: 89-891948742

Electronically Signed/Signature on File: Holly G Robedeau Psy.D. 06/10/08 1514

AUGUSTA PAIN MANAGEMENT CENTER

70 Medical Center Circle, Suite 305 • Fishersville, VA 22939 • Phone (540)332-5747 or (540)932-5747 • Fax (540)332-5748

Holly G Robedeau, Psy.D.

Account #: 71000000000000000000	Patient: [REDACTED]	Ticket#: [REDACTED]	Today's Charge: [REDACTED]
Date/Time: 05/26/06 1100	SS#: [REDACTED] DOB: [REDACTED]	MR#: H0257215	Payment: [REDACTED]
Pat Phone: [REDACTED]	Addr: [REDACTED] HANBLETON, WV [REDACTED]		Refer Dr: Plautz, Michael R. MD
Patient Balance: 115.00	Last Chg On: 05/19/06	Type: APHFS	PCP Name: MARY BALDWIN COLLEGE

INS1 Self Pay 7/1/06 1015 Auth# [REDACTED] INS2 Auth# [REDACTED] Injury Date/Time: 9/7/07	DX1 475.28 DX2 475.46 DX3 475.46 DX4 475.46 DX5 475.46 DX6 475.46	Code Code Code Code Code Code *** MODIFIERS *** 21 Prolonged E&M 22 Unusual Procedure 24 E&M During Global 25 Separate E&M Proc 26 Professional Comp 50 Bilateral Proc 51 Multiple Proc 53 Discontinued Procedure 58 Staged Procedure 59 Distinct Proc Service LT Side RT Side GA Waiver of Liability GT Medicare Exclusion
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NEXT APPT TIME LAB & OTHER TESTS NEEDED NEXT APPT:

NEW VISIT	Mins	INJECTIONS/NERVE BLOCKS	EMG/NERVE CONDUCTION STUDIES
99201PM Problem Focused	10	90772PM Therapeutic Inj - SC IN	95860PM EMG 1 Extremity
99202PM Expanded	20	90774PM Therapeutic Inj - IV	95861PM EMG 2 Extremities
99203PM Detailed	30	20605PM Joint Inj Interned (Wrist/Elbow)	95863PM EMG 3 Extremities
99204PM Comprehensve I	45	20610PM Joint Inj Major (Shoulder/Hip)	95864PM EMG 4 Extremities
99205PM Comprehensve II	60	20550PM TPI Single Tendon Sheath/Ligament	95867PM EMG Cranial: Unilateral
NEW CONSULT		20551PM TPI Single Tendon Origin	95868PM EMG Cranial: Bilateral
99241PM Problem Focused	10	20552PM TPI 1-2 Sites	95869PM EMG Thoracic Paraspinal
99242PM Expanded	20	20553PM TPI 3- Sites	95870PM EMG Other
99243PM Detailed	30	64415PM Brachial Plexus	95900PM Nerve Conduct Motor
99244PM Comprehensve I	45	64405PM Greater Occipital Nerve	95903PM Nerve Conduct Motor FNAVE
99245PM Comprehensve II	60	64425PM Ilioinguinal Nerve	95904PM Nerve Conduct Sensory
ESTAB VISIT		64400PM Trigeminal	95925PM SSEP Short Lat UE
99211PM Nurse Visit	5	64412PM Spinal Accessory	95926PM SSEP Short Lat LE
99212PM Problem Focused	10	64418PM Suprascapular	95933PM Blink Reflex
99213PM Expanded	15	64420PM Intercostal - Single	95934PM H-Reflex: GCS Muscle
99214PM Detailed	25	64421PM Intercostal - Multiple	95936PM H-Reflex: Other
99215PM Comprehensive	40	64430PM Pudendal	
PSYC SERVICES		11900PM Interlesional up to 7 sites	
90801PM Eval w/o Test	30-60	64450PM Other Peripheral	
90804PM Therapy Outpt	25-30		MEDICATIONS (Specify #Units)
90806PM Therapy Outpt	45-50		J0475PM Baclofen 10mg/U
90808PM Therapy Outpt	75-90		J0476PM Baclofen Intra Trial 50mcg
90901PM Biofeedback Train	30		J0702PM Botulinum toxin per 3mg/U
90875PM Therapy/Biofdbk	25-30		J0735PM Clonidine 1mg/U
90876PM Therapy/Biofdbk	45-50		J1200PM Diphenhydramine up to 50mg
90846PM Therapy/Fan w/o Pt	30	IMPLANTABLE THERAPY	J3010PM Fentanyl 0.1mg/U
90947PM Therapy/Fan w/Pt	30	01996PM Catheter Maintenance	J1170PM Hydromorphone up to 4mg
OTHER		95970PM Stim Analysis w/o Prog	80892PM Hydromorphone 250mg
97810PM Acupuncture 1st 15		62367PM Pump Analysis w/o Prog	J1885PM Ketorolac per 15mg/U
97811PM Acupuncture ea addt 15		62368PM Pump Analysis w/Prog	J0670PM Mepivacaine per 10ml/U
97813PM Acupuncture E-S 1st 15		95990PM Pump Refill, Nurse	J1020PM Methylprednisolone 20mg
97814PM Acupuncture E-S addt 15		95911PM Pump Refill, Physician	J1030PM Methylprednisolone 40mg
99359PM Case Mgr Conf: 30-60			J2250PM Midazolam per 1mg/U
99359PM Case Mgr Conf add: 30			J2271PM Morphine 100mg/U
99372PM Phone Conference 15		OTHER	80930PM Morphine 500mg/U
99373PM Phone Conference 30-		99075APM Deposition - 1 hour	J7040PM Normal Saline 500ml/U
99080PM Reports per/unit 15			J34902PM Phenol Aqueous 6%
99455PM Work/Dis Exam per/hr			J34900PM Phenol 89.
99456PM Work/Dis Exam non/treat			J2550PM Promethazine up to 50mg/U
99075PM Med Testimony per unit			J3490PM Sufentanil 0.35mg/U
99075APM Deposition in office 50			J3302PM Triamcinolone - Aristocort per 3mg/U
99456PM DE			J3303PM Triamcinolone - Aristospan per 3mg/U
			J3301PM Triamcinolone - Kenalog per 10mg/U

Augusta Pain Management
Patient Follow up Sheet

DATE: 5/2/00

[] Telephone or Walk In Patient

PATIENT NAME:

SS#:

PATIENT'S DATE OF BIRTH:

PHONE NUMBER:

SA LEVEL

Schedule Patient Return to Office in 1 Weeks [] First Available [] Priority [] Work In

Schedule with: [] Lee [] P. Grice [] D. Grice [] Lucbben [x] Robedeau [] Nurse

Schedule this type appt: Follow up [] 20 min [] 40 min [x] 60 min
TPI [] 20 min [] 40 min [] 60 min
EMG [] 60 min [] 90 min
ESI [] 40 min [] 60 min
[] Pump Fill/Reprogram [] Other
[] Nurse Visit Reason:

Discuss/Evaluate for:

Cancel or Reset other appointments

Request Schedule Fluoro appointment in Weeks [] First Available [] Priority [] Work In

Schedule with: [] Lee [] P. Grice [] D. Grice

Schedule ESI [] Cervical [] Thoracic [] Lumbar [] Caudal
Facet [] Cervical [] Thoracic [] Lumbar
SNRB [] Cervical [] Thoracic [] Lumbar
min/hr Denervation [] Cervical [] Thoracic [] Lumbar
[] Other

Request Procedure Follow-up in 2 Weeks with: [] Lee [] P. Grice [] D. Grice [] Lucbben
[] Do Not schedule separate procedure Follow up [] Do Telephone Procedure Follow up

DATE/TIME OF SCHEDULED OR APPOINTMENT

DATE/TIME OF FOLLOW UP VISIT

Date and Name Or Notified (4284)

Purple Instruction Sheet [] Given to patient [] Reviewed over the telephone

Other

Refer to

Reason

☐ Copy Put in/given to:

6-4-08

AUGUSTA PAIN MANAGEMENT CENTER

70 Medical Center Circle, Suite 305 • Fishersville, VA 22039 • Phone (540)332-5747 or (540)832-5747 • Fax (540)332-5748

D Preston Grice, MD

Account #	Patient:	Ticket#	Today's Charge
Date/Time: 05/19/08 1:20	SS#: 07/15/1974	MR# M3257215	Payment
Pat Phone:	Addr: HANNALETOWN, WV		Refer Dr: Grice, Darlinda M. MD
Patient Balance: 0.00	Last Chg On: 05/15/07	Type: AMKID	DCP Name: Grice, Darlinda M. MD

INS1	DX1 726.94	Code	*** MODIFIERS ***
Auth#	DX2 723.9	Code	21 Prolonged E&M
INS2	DX3	Code	22 Unusual Procedure
Auth#	DX4 729.1	Code	24 E&M During Global
Injury Date/Time	DX5	Code	25 Separate E&M Proc
	DX6	Code	26 Professional Comp
			50 Bilateral Proc
			51 Multiple Proc
			53 Discontinued Procedure
			58 Staged Procedure
			59 Distinct Proc Service
			LT Side
			RT Side
			GA Waiver of Liability
			OT Medicare Exclusion

NEXT APPT TIME LAB & OTHER TESTS NEEDED NEXT APPT:

NEW VISIT 99201PM Problem Focused 10 99202PM Expanded 20 99203PM Detailed 30 99204PM Comprehensive I 45 99205PM Comprehensive II 60 NEW CONSULT 99201PM Problem Focused 10 99202PM Expanded 20 99203PM Detailed 30 99204PM Comprehensive I 45 99205PM Comprehensive II 60 ESTAB VISIT 99211PM Nurse Visit 5 99212PM Problem Focused 10 99213PM Expanded 15 99214PM Detailed 25 99215PM Comprehensive 40 PSYC SERVICES 90411PM Eval w/o Test 30-60 90404PM Therapy Outpt 25-30 90406PM Therapy Outpt 45-60 90408PM Therapy Outpt 75-90 90411PM Biofeedback Train 30 90415PM Therapy/Biofbk 25-30 90416PM Therapy/Biofbk 45-60 90416PM Therapy/Fam w/o Pt 30 90417PM Therapy/Fam w/Pt 30 OTHER 97810PM Acupuncture 1st 15 97811PM Acupuncture ea addt 15 97813PM Acupuncture E-S 1st 15 97814PM Acupuncture E-S addt 15 99358PM Case Mgr Conf 30-60 99359PM Case Mgr Conf addt 30 99372PM Phone Conference 15 99373PM Phone Conference 30- 99408PM Reports per/unit 15 99435PM Work/Dia Exam per/hr 99466PM Work/Dia Exam non/treat 99075PM Med Testimony per unit 99075PM Deposition in office 60 99416PM DXE	INJECTIONS/NERVE BLOCKS 90772PM Therapeutic Inj - SC IM 90774PM Therapeutic Inj - IV 20602PM Joint Inj Intermed (Wrist/Elbow) 20610PM Joint Inj Major (Shoulder/Hip) 20350PM TPI Single Tendon Sheath/Ligament 20511PM TPI Single Tendon Origin 20502PM TPI 1-2 Sites 20563PM TPI 3+ Sites 64415PM Brachial Plexus 64405PM Greater Occipital Nerve 64415PM Iliioinguinal Nerve 64400PM Trigeminal 64412PM Spinal Accessory 64418PM Suprascapular 64410PM Intercostal - Single 64411PM Intercostal - Multiple 64430PM Pudendal 11301PM Interlesional up to 7 sites 64410PM Other Peripheral IMPLANTABLE THERAPY 01996PM Catheter Maintenance 95970PM Stim Analysis w/o Prog 95971PM Stim Analysis w/Prog 62367PM Pump Analysis w/o Prog 62368PM Pump Analysis w/Prog 95990PM Imp Refill, Nurse 95911PM Pump Refill, Physician OTHER 99075PM Deposition - 1 hour	EMG/NERVE CONDUCTION STUDIES 95960PM EMG 1 Extremity 95961PM EMG 2 Extremities 95963PM EMG 3 Extremities 95964PM EMG 4 Extremities 95967PM EMG Cranial Unilateral 95968PM EMG Cranial Bilateral 95969PM EMG Thoracic Paraspinal 95970PM EMG Other 95980PM Nerve Conduct Motor 95981PM Nerve Conduct Motor FNAVE 95984PM Nerve Conduct Sensory 95925PM SSEP Short Lat UE 95926PM SSEP Short Lat LE 95933PM Blink Reflex 95934PM H-Reflex: GCS Muscle 95936PM H-Reflex: Other MEDICATIONS (Specify #Units) J0475PM Baclofen 10mg/U J0476PM Baclofen Intra Tral 50mg J0702PM Betamethasone per 3mg/U J0735PM Clonidine 1mg/U J1200PM Diphenhydramine up to 50mg J3010PM Fentanyl 0.1mg/U J1170PM Hydrocodone up to 4mg 90092PM Hydromorphone 250mg J1885PM Ketorolac per 15mg/U J0670PM Ketivacaine per 10ml/U J1020PM Methylprednisolone 20mg J1030PM Methylprednisolone 40mg J2250PM Midazolam per 1mg/U J2271PM Morphine 10mg/U 90930PM Morphine 500mg/U J7040PM Normal Saline 500ml/U J3490PM Phenol 89% J2551PM Promethazine up to 50mg/U J3490PM Sufentanil 0.5mg/U J3302PM Triamcinolone - Aristocort per 1mg/U J3303PM Triamcinolone - Aristocort per 5mg/U J3301PM Triamcinolone - Kenalog per 10mg/U
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**Augusta Pain Management
Patient Follow up Sheet**

DATE: 5/15/08

☐ Telephone or Walk In Patient

PATIENT NAME: [REDACTED]

SS#: _____

PATIENT'S DATE OF BIRTH: [REDACTED]

PHONE NUMBER: _____

SA LEVEL 2

Schedule Patient Return to Office in 16 Weeks ☐ First Available ☐ Priority ☐ Work In

Schedule with: ☐ Lee ☒ P. Grice ☐ D. Grice ☒ Luebben ☐ DeGood ☒ Nurse

Schedule this type appt: Follow up ☒ 20 min ☐ 40 min ☒ 60 min
 TPI ☐ 20 min ☐ 40 min ☐ 60 min
 EMG ☐ 60 min ☐ 90 min
 ESI ☐ 40 min ☐ 60 min
☐ Pump Fill/Reprogram ☐ Other _____
☐ Nurse Visit Reason: _____

Discuss/Evaluate for: IV

Cancel or Reset other appointments _____

Request Schedule Fluoro appointment in _____ Weeks ☐ First Available ☐ Priority ☐ Work In
 Schedule with: ☐ Lee ☐ P. Grice ☐ D. Grice

Schedule	ESI	<input type="checkbox"/> Cervical	<input type="checkbox"/> Thoracic	<input type="checkbox"/> Lumbar	<input type="checkbox"/> Caudal
	Facet	<input type="checkbox"/> Cervical	<input type="checkbox"/> Thoracic	<input type="checkbox"/> Lumbar	
	SNRB	<input type="checkbox"/> Cervical	<input type="checkbox"/> Thoracic	<input type="checkbox"/> Lumbar	
_____ min/hr	Denervation	<input type="checkbox"/> Cervical	<input type="checkbox"/> Thoracic	<input type="checkbox"/> Lumbar	

☐ Other _____

Request Procedure Follow-up in 2 Weeks with: ☐ Lee ☐ P. Grice ☐ D. Grice ☐ Luebben
☐ Do Not schedule separate procedure Follow up ☐ Do Telephone Procedure Follow up

DATE/TIME OF SCHEDULED OR APPOINTMENT _____

DATE/TIME OF FOLLOW UP VISIT _____

Date and Name Or Notified (4284) _____
 Purple Instruction Sheet ☐ Given to patient ☐ Reviewed over the telephone

Refer to _____ Other _____

Reason _____
☐ Copy Put in/given to: _____

5-28-08 / 7-14-08 / 9-8-08

**AUGUSTA PAIN MANAGEMENT CENTER
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

(Patient Name) _____
(Street Address) _____
(City, State, Zip code) Hambledon, WV _____

(Patient Name) _____
(Street Address) _____
(City, State, Zip code) _____

At the request of the individual, I _____, do hereby authorize _____ to release:
(Patient's Name) (Name of Facility)

DATES OF: _____

<input type="checkbox"/> DISCHARGE SUMMARY	<input type="checkbox"/> BILLING INFORMATION	<input type="checkbox"/> EMERGENCY REPORTS
<input type="checkbox"/> HISTORY & PHYSICAL	<input type="checkbox"/> LABORATORY REPORTS	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> PROGRESS NOTES	<input type="checkbox"/> RADIOLOGY REPORTS	(please specify) _____
<input type="checkbox"/> OPERATIVE NOTES	<input type="checkbox"/> EKG/EEG/CARDIAC CATH	_____

☐ I do ☐ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: **AUGUSTA PAIN MANAGEMENT CENTER**
70 MEDICAL CENTER CIRCLE
SUITE 305
FISHERSVILLE, VA 22939

PURPOSE OF DISCLOSURE:

☐ REFERRAL TO SPECIALIST ☐ INSURANCE ☐ WORKERS COMP ☐ CHANGE OF DOCTOR
☐ LEGAL INVESTIGATION ☐ PERSONAL ☐ CONTINUING CARE ☐ DISABILITY DETERMINATION
OTHER (specify) _____

Please provide current telephone number in the event we need to contact you: _____

If I have questions about disclosure of my health information, I can contact Augusta Pain Management @ 932.5747 or 332.5747.

Upon request, I will be given a copy of this authorization form, after signing.

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification by that it will not effect any information; released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized may not condition its treatment of me on whether or not I sign the authorization.

Signature of individual or guardian or
Personal Representative of patient's estate

2/5/08
Date

Average turn-around-time is 15 days.

Note: There may be a charge for a personal copy of your records. Augusta Pain Management will invoice you directly.

MEDICAL INFORMATION RELEASED BY AUGUSTA PAIN MANAGEMENT CENTER

ENTIRE _____ LAB _____ EKG _____
DS _____ HP _____ OP _____
BIL _____ RAD _____ IMMUNIZATIONS _____
OTHER _____

RECORDS SPECIALIST

DATE

AUGUSTA PAIN MANAGEMENT CENTER

70 Medical Center Circle, Suite 305 • Fishersville, VA 22939 • Phone (540)332-5747 or (540)932-5747 • Fax (540)332-5748

D Preston Grice, MD

193437

Account #: [REDACTED]	Patient: [REDACTED]	Ticket#: [REDACTED]	Today's Charge: <u>115</u>
Date/Time: 02/05/08 1100	DOB: 07/15/1974	MR#: [REDACTED]	Payment: [REDACTED]
Pat Phone: [REDACTED]	CELL Addr: [REDACTED]	Refer Dr: Miller, Theresa MD	
Patient Balance:	Last Chg On: 01/24/08	Type: APC0	PCP Name: MARY BALDWIN COLLEGE

INS1 STATE FARM INSURANCE	DX1 <u>726.90</u>	Code	*** MODIFIERS ***
Auth#	DX2 <u>323.9</u>	Code	21 Prolonged E&M
	DX3 <u>323.9</u>	Code	22 Unusual Procedure
INS2	DX4 <u>323.9</u>	Code	24 E&M During Global
Auth#	DX5 <u>324.4</u>	Code	25 Separate E&M Proc
	DX6	Code	26 Professional Comp
Injury Date/Time			50 Bilateral Proc
			51 Multiple Proc
			53 Discontinued Procedure
			58 Staged Procedure
			59 Distinct Proc Service
			LT Side
			RT Side
			GA Waiver of Liability
			GY Medicare Exclusion

NEXT APPT: _____ TIME: _____ LAB & OTHER TESTS NEEDED NEXT APPT: _____

NEW VISIT

99201PM Problem Focused	10
99202PM Expanded	20
99203PM Detailed	30
99204PM Comprehensive I	45
99205PM Comprehensive II	60

NEW CONSULT

99241PM Problem Focused	10
99242PM Expanded	20
99243PM Detailed	30
99244PM Comprehensive I	45
99245PM Comprehensive II	60

ESTAB VISIT

99211PM Nurse Visit	5
99212PM Problem Focused	10
99213PM Expanded	20
99214PM Detailed	30
99215PM Comprehensive	40

PSYC SERVICES

90801PM Eval w/o Test	30-60
90804PM Therapy Outpt	25-30
90806PM Therapy Outpt	45-50
90808PM Therapy Outpt	75-80
90901PM Biofeedback Train	30
90875PM Therapy/Biofbk	25-30
90876PM Therapy/Biofbk	45-50
90846PM Therapy/Fam w/o Pt	30
90847PM Therapy/Fam w/Pt	30

OTHER

97810PM Acupuncture	1st 15
97811PM Acupuncture ea addt	15
97813PM Acupuncture E-S	1st 15
97814PM Acupuncture E-S addt	15
99358PM Case Mgr Confl	30-60
99359PM Case Mgr Confl addt	30
99372PM Phone Conference	15
99373PM Phone Conference	30+
99080PM Reports per/unit	15
99455PM Work/Dia Exam per/hr	
99456PM Work/Dia Exam non/treat	
99075PM Med Testimony per unit	
99075APM Deposition in office	60
99456PM IME	

INJECTIONS/NERVE BLOCKS

90773PM Therapeutic Inj - SC IM	
90774PM Therapeutic Inj - IV	
20605PM Joint Inj Interned (Wrist/Elbow)	
20613PM Joint Inj Major (Shoulder/Hip)	
20550PM TPI Single Tendon Sheath/Ligament	
20551PM TPI Single Tendon Origin	
20552PM TPI 1-2 Sites	
20553PM TPI 3+ Sites	
64415PM Brachial Plexus	
64405PM Greater Occipital Nerve	
64425PM Ilioinguinal Nerve	
64400PM Trigeminal	
64412PM Spinal Accessory	
64418PM Suprascapular	
64420PM Intercostal - Single	
64421PM Intercostal - Multiple	
64430PM Pudendal	
11900PM Interlesional up to 7 sites	
64450PM Other Peripheral	

IMPLANTABLE THERAPY

01996PM Catheter Maintenance	
95970PM Stin Analysis w/o Prog	
95971PM Stin Analysis w/Prog	
62367PM Pump Analysis w/o Prog	
62368PM Pump Analysis w/Prog	
95990PM Pump Refill, Nurse	
95911PM Pump Refill, Physician	

OTHER

99075APM Deposition - 1 hour	
------------------------------	--

EMG/NERVE CONDUCTION STUDIES

95860PM EMG 1 Extremity	
95861PM EMG 2 Extremities	
95863PM EMG 3 Extremities	
95864PM EMG 4 Extremities	
95867PM EMG Cranial Unilateral	
95869PM EMG Cranial Bilateral	
95869PM EMG Thoracic Paraspinal	
95870PM EMG Other	
95900PM Nerve Conduct Motor	
95903PM Nerve Conduct Motor FMAVE	
95904PM Nerve Conduct Sensory	
95925PM SSEP Short Lat UE	
95926PM SSEP Short Lat LE	
95933PM Blink Reflex	
95934PM H-Reflex: GCS Muscle	
95936PM H-Reflex: Other	

MEDICATIONS (Specify #Units)

J0475PM Baclofen 10mg/U	
J0476PM Baclofen Intra Trial 50mcg	
J0702PM Botanehasone per 3mg/U	
J0735PM Clonidine 1mg/U	
J1200PM Diphenhydramine up to 50mg	
J3010PM Fentanyl 0.1mg/U	
J1170PM Hydromorphone up to 4mg	
50092PM Hydromorphone 250mg	
J1885PM Ketorolac per 15mg/U	
J0670PM Mepivacaine per 10ml/U	
J1020PM Methylprednisolone 20mg	
J1030PM Methylprednisolone 40mg	
J2250PM Midazolam per 1mg/U	
J2271PM Morphine 100mg/U	
80930PM Morphine 500mg/U	
J7040PM Normal Saline 500ml/U	
J3490PM Phenol Aqueous 64	
J3490PM Phenol 891	
J2550PM Promethazine up to 50mg/U	
J3490PM Sufentanil 0.05mg/U	
J3302PM Triamcinolone - Aristocort per 5mg/U	
J3303PM Triamcinolone - Aristospan per 5mg/U	
J3301PM Triamcinolone - Kenalog per 10mg/U	

Augusta Pain Management
Patient Follow up Sheet

DATE: 2/5/08

☐ Telephone or Walk In Patient

PATIENT NAME: [REDACTED] SS#: _____

PATIENT'S DATE OF BIRTH: [REDACTED] PHONE NUMBER: _____

SA LEVEL 2 16 Weeks ☐ First Available ☐ Priority ☐ Work In

Schedule Patient Return to Office in _____ Weeks

Schedule with: ☐ Lee ☐ P. Grice ☐ D. Grice ☐ Luebben ☐ DeGood ☐ Nurse

Schedule this type appt:

Follow up	<input checked="" type="checkbox"/> 20 min	<input type="checkbox"/> 40 min	<input type="checkbox"/> 60 min
TPI	<input type="checkbox"/> 20 min	<input type="checkbox"/> 40 min	<input type="checkbox"/> 60 min
EMG	<input type="checkbox"/> 60 min	<input type="checkbox"/> 90 min	
ESI	<input type="checkbox"/> 40 min	<input type="checkbox"/> 60 min	
<input type="checkbox"/> Pump Fill/Reprogram	<input type="checkbox"/> Other		
<input type="checkbox"/> Nurse Visit Reason:			

Discuss/Evaluate for: _____

Cancel or Reset other appointments _____

Request Schedule Fluoro appointment in _____ Weeks ☐ First Available ☐ Priority ☐ Work In

Schedule with: ☐ Lee ☐ P. Grice ☐ D. Grice

Schedule

ESI	<input type="checkbox"/> Cervical	<input type="checkbox"/> Thoracic	<input type="checkbox"/> Lumbar	<input type="checkbox"/> Caudal
Facet	<input type="checkbox"/> Cervical	<input type="checkbox"/> Thoracic	<input type="checkbox"/> Lumbar	
SNRB	<input type="checkbox"/> Cervical	<input type="checkbox"/> Thoracic	<input type="checkbox"/> Lumbar	
_____ min/hr Denervation	<input type="checkbox"/> Cervical	<input type="checkbox"/> Thoracic	<input type="checkbox"/> Lumbar	

☐ Other _____

Request Procedure Follow-up in 2 Weeks with: ☐ Lee ☐ P. Grice ☐ D. Grice ☐ Luebben

☐ Do Not schedule separate procedure Follow up ☐ Do Telephone Procedure Follow up

DATE/TIME OF SCHEDULED OR APPOINTMENT _____

DATE/TIME OF FOLLOW UP VISIT _____

Date and Name Or Notified (4284) _____

Purple Instruction Sheet ☐ Given to patient ☐ Reviewed over the telephone

Refer to _____ Other _____

Reason _____

☐ Copy Put in/given to: _____

*** TRANSMISSION REPORT ***

SID : AUGUSTA PAIN MGMT

Number L1 : 5403325740
Number L2 :

Date : 01-24-08 13:04

Date/Time	1-24 13:03
Dialled number	92457171
Subscriber	540 245 7171
Durat.	0' 45"
Mode	NORMAL
Pages	4
On	Line 2
Status	Correct

AUGUSTA RHEUMATOLOGY AND OSTEOPORESIS
 11 Scott Heywood
 70 Medical Center Circle, Suite 108
 Fishersville, VA 22938
 Telephone: (540) 443-1170
 Fax Number: (540) 245-7171

New Patient Referral Request

DATE: 1/17/08

REFERRING PHYSICIAN: D. Gordon Price, MD

OFFICE TELEPHONE: 5747 FAX: 5749

ADDRESS: 70 Medical Center Circle, Suite 108

PATIENT'S NAME: [REDACTED]

DATE OF BIRTH: [REDACTED] with history of
 ? YACHTING and DIVERS Therapy. Vase evaluation of function!

APPT TYPE: ☐ Referral for Evaluation and Treatment ☒ Consult Only

SIGNATURE OF REFERRING PHYSICIAN: [Signature]

ADDITIONAL SIGNATURE: [REDACTED]

Patient's SSN: [REDACTED] Patient's DOB: [REDACTED]

Patient's Phone Number: [REDACTED]

Patient's Address: [REDACTED] Hambleton, WV [REDACTED]

Type of Insurance: State Farm Ins Name of PCP: Theresa Miller MD

Please send a copy of patient's insurance card and group information

Policy #: [REDACTED] Group/Vol: [REDACTED]

Please send all pertinent records

*Vase Records sent: TL&ML

Appointment Date and Time: [REDACTED]

Augusta Rheumatology and Osteoporosis will send the Patient an Information Pack

State Farm Ins
 PO Box 953
 Frederick, MD 21705
 nfc: 866-891-3658
 fax 888-613-3759

claim th [REDACTED]
 POL 9/1/07
 Claim representative
 Carol Englebrecht ext 7939

AUGUSTA RHEUMATOLOGY AND OSTEOPOROSIS

M. Scott Hogenmiller
70 Medical Center Circle, Suite 108
Fishersville, VA 22939
Telephone: (540) 245-7170
Fax Number: (540) 245-7171

New Patient Referral Request

DATE: 11/7/08

REFERRING PHYSICIAN NAME: D. Preston Price, MD

OFFICE TELEPHONE: 5747 FAX: 5748

ADDRESS: 70 Medical Center Circle Suite 305

PATIENT'S NAME: [REDACTED]

DIAGNOSIS/REASON FOR CONSULT: 33 y/o female with history of
? vasculitis and DMARD therapy. for evaluation of treatment.

APPT TYPE: ☐ Referral for Evaluate and Treatment ☒ Consult Only

*SIGNATURE OF REFERRING PHYSICIAN: [Signature]

ADDITIONAL INFORMATION:

Patient's SSN: [REDACTED] Patient's DOB: [REDACTED]

Patient's Phone Number: [REDACTED]

Patient's Address: [REDACTED] Hambleton, WV [REDACTED]

Type of Insurance: State Farm INS Name of PCP: Theresa Miller MD

Please send a copy of patients Insurance card/ workers comp Information

Policy #: _____ Group# Visits: _____

Please send all pertinent records

*Were Records Sent: YES/NO DOCTOR: _____

Appointment Date and Time: _____

Augusta Rheumatology and Osteoporosis will mail the Patient an Information Pack

Completed? Yes/No

State Farm INS
PO Box 953
Frieda, KY, MD 21705
ofc. 866-891-3658
fax 888-613-3964

claim # [REDACTED]
PCT. 9/7/07
claim representative
Carol Englebrecht ext 7939

AUGUSTA PAIN MANAGEMENT CENTER

70 Medical Center Circle, Suite 305 • Fishersville, VA 22938 • Phone (540)332-5747 or (540)932-5747 • Fax (540)332-5748

Mary NP Luebben

Account #: XXXXXXXXXX	Patient: XXXXXXXXXX	Ticket: XXXXXXXXXX	Today's Charge: XXXXXXXXXX
Date/Time: 01/24/08 1140	SSN: XXXXXXXXXX DOB: 07/15/1974	MR# M0257215	Payment: XXXXXXXXXX
Pat Phone: XXXXXXXXXX	CELL Addr: XXXXXXXXXX HAMBLETON, WV XXXXXXXXXX	Type: APMTPI20	Refer Dr: XXXXXXXXXX
Patient Balance:	Last Chg On: 01/07/08		PCP Name: MARY BALDWIN COLLEGE

INS1 STATE FARM INSURANCE	DX1 <u>726.90</u>	Code	
Auth#	DX2 <u>723.9</u>	Code	21 Prolonged ECM 53 Discontinued Procedure
	DX3 <u>723.9</u>	Code	22 Unusual Procedure 58 Staged Procedure
INS2	DX4 <u>724.1</u>	Code	24 ECM During Global 59 Distinct Proc Service
Auth#	DX5 <u>724.1</u>	Code	25 Separate ECM Proc LT Side
	PXS <u>724.1</u>	Code	26 Professional Comp RT Side
Injury Date/Time			30 Bilateral Proc GA Waiver of Liability
			31 Multiple Proc GY Medicare Exclusion

NEXT APPT: _____ TIME: _____ LAB & OTHER TESTS NEED NEXT APPT: _____

NEW VISIT

99201PM Problem Focused	10
99202PM Expanded	20
99203PM Detailed	30
99204PM Comprehensive I	45
99205PM Comprehensive II	60

NEW CONSULT

99241PM Problem Focused	10
99242PM Expanded	20
99243PM Detailed	30
99244PM Comprehensive I	45
99245PM Comprehensive II	60

ESTAB VISIT

99211PM Nurse Visit	5
99212PM Problem Focused	10
99213PM Expanded	15
99214PM Detailed	25
99215PM Comprehensive	40

PSYC SERVICES

90901PM Eval w/o Test	30-60
90804PM Therapy Outpt	25-30
90806PM Therapy Outpt	45-50
90808PM Therapy Outpt	75-80
90901PM Biofeedback Train	30
90875PM Therapy/Biofbk	25-30
90876PM Therapy/Biofbk	45-50
90846PM Therapy/Fan w/o Pt	30
90847PM Therapy/Fan w/Pt	30

OTHER

97810PM Acupuncture 1st 15
97811PM Acupuncture ea addt 15
97813PM Acupuncture E-S 1st 15
97814PM Acupuncture E-S addt 15
99359PM Case Mgr Confl 30-60
99359PM Case Mgr Confl addt 30
99372PM Phone Conference 15
99373PM Phone Conference 30-
99080PM Reports per/unit 15
99455PM Work/Dis Exam per/hr
99456PM Work/Dis Exam non/treat
99075PM Med Testimony per unit
99075PM Deposition in office 60
99456PM IME

INJECTIONS/NERVE BLOCKS

90772PM Therapeutic Inj - SC IM
90774PM Therapeutic Inj - IV
20605PM Joint Inj Intermed (Wrist/Elbow)
20610PM Joint Inj Major (Shoulder/Hip)
20550PM TPI Single Tendon Sheath/Ligament
20551PM TPI Single Tendon Origin
20552PM TPI 1-2 Sites
20553PM TPI 3+ Sites
64425PM Brachial Plexus
64405PM Greater Occipital Nerve
64425PM Ilioinguinal Nerve
64400PM Trigeminal
64412PM Spinal Accessory
64418PM Suprascapular
64420PM Intercostal - Single
64421PM Intercostal - Multiple
64430PM Pudendal
11900PM Interlesional up to 7 sites
64450PM Other Peripheral

IMPLANTABLE THERAPY

01996PM Catheter Maintenance
95970PM Stim Analysis w/o Prog
95971PM Stim Analysis w/Prog
62367PM Pump Analysis w/o Prog
62368PM Pump Analysis w/Prog
95990PM Pump Refill, Nurse
95911PM Pump Refill, Physician

OTHER

99075PM Deposition - 1 hour

EMG/NERVE CONDUCTION STUDIES

95860PM EMG 1 Extremity
95861PM EMG 2 Extremities
95863PM EMG 3 Extremities
95864PM EMG 4 Extremities
95867PM EMG Cranial Unilateral
95868PM EMG Cranial Bilateral
95869PM EMG Thoracic Paraspinal
95870PM EMG Other
95900PM Nerve Conduct Motor
95903PM Nerve Conduct Motor FNAVE
95904PM Nerve Conduct Sensory
95925PM SSEP Short Lat UE
95926PM SSEP Short Lat LE
95933PM Blink Reflex
95934PM H-Reflex: GCS Muscle
95936PM H-Reflex: Other

MEDICATIONS (Specify Units)

J0475PM Baclofen 10mg/U
J0476PM Baclofen Intra Trial 50mcg
J0702PM Betamethasone per 3mg/U
J0735PM Clonidine 1mg/U
J1200PM Diphenhydramine up to 50mg
J3010PM Fentanyl 0.1mg/U
J1170PM Hydromorphone up to 4mg
90092PM Hydromorphone 250mg
J1885PM Ketorolac per 15mg/U
J0870PM Mepivacaine per 10ml/U
J1020PM Methylprednisolone 20mg
J1030PM Methylprednisolone 40mg
J2250PM Midazolam per 1mg/U
J2271PM Morphine 100mg/U
50930PM Morphine 500mg/U
J7040PM Normal Saline 500ml/U
J3490PM Phenol Aqueous 6%
J3490PM Phenol 89%
J3350PM Promethazine up to 50mg/U
J3490PM Sufentanil 0.05mg/U
J3302PM Triamcinolone - Aristocort per 5mg/U
J3303PM Triamcinolone - Aristospan per 5mg/U
J3301PM Triamcinolone - Kenalog per 10mg/U

C. Luebben 1/26

11

Mary NP Luebben

115

INS1	Self Pay	DX1	723.4	Code
	Auth#	DX2	723.4	Code
		DX3	726.10	Code
INS2		DX4	726.19	Code
	Auth#	DX5	+26.19	Code
		DX6		Code
Injury Date/Time	1/11/7		723.1	

*** MODIFIERS ***	
21 Prolonged E&M	53 Discontinued Procedure
22 Unusual Procedure	58 Staged Procedure
24 E&M During Global	59 Distinct Proc Service
25 Separate E&M Proc	LT Side
26 Professional Comp	RT Side
50 Bilateral Proc	GA Waiver of Liability
51 Multiple Proc	GY Medicare Exclusion

NEW VISIT		mins
99201PM	Problem Focused	10
99202PM	Expanded	20
99203PM	Detailed	30
99204PM	Comprehensive I	45
99205PM	Comprehensive II	60
NEW CONSULT		
99241PM	Problem Focused	10
99242PM	Expanded	20
99243PM	Detailed	30
99244PM	Comprehensive I	45
99245PM	Comprehensive II	60
ESTAB VISIT		
99211PM	Nurse Visit	5
99212PM	Problem Focused	10
99213PM	Expanded	15
99214PM	Detailed	25
99215PM	Comprehensive	40

EMG/NERVE CONDUCTION STUDIES

95860PM	EMG 1 Extremity
95861PM	EMG 2 Extremities
95863PM	EMG 3 Extremities
95864PM	EMG 4 Extremities
95867PM	EMG Cranial Unilateral
95868PM	EMG Cranial Bilateral
95869PM	EMG Thoracic Paraspinal
95870PM	EMG Other
95900PM	Nerve Conduct Motor
95903PM	Nerve Conduct Motor FNAVE
95904PM	Nerve Conduct Sensory
95925PM	SSEP Short Lat UE
95926PM	SSEP Short Lat LE
95933PM	Blink Reflex
95934PM	H-Reflex: GCS Muscle
95936PM	H-Reflex: Other

IMPLANTABLE THERAPY

___ 01996PM Catheter Maintenance

___ 95970PM Stim Analysis w/c Prog

___ 95971PM Stim Analysis w/Prog

___ 62367PM Pump Analysis w/c Prog

___ 62368PM Pump Analysis w/Prog

___ 95990PM Pump Refill, Nurse

___ 95911PM Pump Refill, Physician

=====

OTHER

___ 99075APM Deposition - 1 hour

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MEDICATIONS (Specify #Units)

__ J0475PM Baclofen 10mg/U

__ J0476PM Baclofen Intra Trial 50mcg

__ J0702PM Betamethasone per 3mg/U

__ J0735PM Clonidine 1mg/U

__ J1200PM Diphenhydramine up to 50mg

__ J3010PM Fentanyl 0.1mg/U

__ J1170PM Hydromorphone up to 4mg

__ S0092PM Hydromorphone 250mg

__ J1885PM Ketorolac per 15mg/U

__ J0670PM Mepivacaine per 10ml/U

__ J1020PM Methylprednisolone 20mg

__ J1030PM Methylprednisolone 40mg

__ J2250PM Midazolam per 1mg/U

__ J2271PM Morphine 100mg/U

__ S0930PM Morphine 500mg/U

__ J0400PM Normal Saline 500ml/U

__ J3490APM Phenol Aqueous 6%

__ J34900PM Phenol 89%

__ J2550PM Promethazine up to 50mg/U

__ J3490PM Sufentanil 0.05mg/U

__ J3302PM Triamcinolone - Aristocort per 5mg/U

__ J3303PM Triamcinolone - Aristocort per 5mg/U

__ J3301PM Triamcinolone - Kenalog per 10mg/U

**Augusta Pain Management
Patient Follow up Sheet**

DATE: 11/7/08

☐ Telephone or Walk In Patient

PATIENT NAME: [REDACTED] SS#:

PATIENT'S DATE OF BIRTH: [REDACTED] PHONE NUMBER:

SA LEVEL

Schedule Patient Return to Office in Weeks ☐ First Available ☐ Priority ☐ Work In

Schedule with: ☐ Lee ☒ P. Grice ☐ D. Grice ☐ Luebben ☐ DeGood ☐ Nurse

Schedule this type appt: *Over book.*

Follow up	<input type="checkbox"/> 20 min	<input type="checkbox"/> 40 min	<input type="checkbox"/> 60 min
TPI	<input checked="" type="checkbox"/> 20 min	<input type="checkbox"/> 40 min	<input type="checkbox"/> 60 min
EMG	<input type="checkbox"/> 60 min	<input type="checkbox"/> 90 min	
ESI	<input type="checkbox"/> 40 min	<input type="checkbox"/> 60 min	
<input type="checkbox"/> Pump Fill/Reprogram	<input type="checkbox"/> Other <u> </u>		
<input type="checkbox"/> Nurse Visit Reason: <u> </u>			

Discuss/Evaluate for:

Cancel or Reset other appointments

Request Schedule Fluoro appointment in Weeks ☐ First Available ☐ Priority ☐ Work In

Schedule with: ☐ Lee ☐ P. Grice ☐ D. Grice

Schedule	ESI	<input type="checkbox"/> Cervical	<input type="checkbox"/> Thoracic	<input type="checkbox"/> Lumbar	<input type="checkbox"/> Caudal
	Facet	<input type="checkbox"/> Cervical	<input type="checkbox"/> Thoracic	<input type="checkbox"/> Lumbar	
	SNRB	<input type="checkbox"/> Cervical	<input type="checkbox"/> Thoracic	<input type="checkbox"/> Lumbar	
<u> </u> min/hr	Denervation	<input type="checkbox"/> Cervical	<input type="checkbox"/> Thoracic	<input type="checkbox"/> Lumbar	
<input type="checkbox"/> Other <u> </u>					

Request Procedure Follow-up in 2 Weeks with: ☐ Lee ☐ P. Grice ☐ D. Grice ☐ Luebben

☐ Do Not schedule separate procedure Follow up ☐ Do Telephone Procedure Follow up

DATE/TIME OF SCHEDULED OR APPOINTMENT

DATE/TIME OF FOLLOW UP VISIT

Date and Name Or Notified (4284)

Purple Instruction Sheet ☐ Given to patient ☐ Reviewed over the telephone

Other

Refer to

Reason

☐ Copy Put in/given to:

D Preston Grice, MD

Account #: [REDACTED]	Patient: [REDACTED]	Ticket# [REDACTED]	Today's Charge <u>3K</u>
Date/Time: 11/19/07 1020	SSN: [REDACTED] DOB: 07/15/1974	ESI [REDACTED]	Payment [REDACTED]
Pat Phone: [REDACTED]	CELL Addr: [REDACTED] HANBLETON, WV	[REDACTED]	Refer Dr: Plautz, Michael R. MD
Patient Balance: 0.00	Last Chg On: 11/04/05	Type: IV	PCP Name: Miller, Theresa MD

INS1 STATE FARM INSURANCE	DX1 7.23.4	Code	*** MODIFIERS *** 21 Prolonged E&M 53 Discontinued Procedure 22 Unusual Procedure 58 Staged Procedure 24 E&M During Global 59 Distinct Proc Service 25 Separate E&M Proc LT Side 26 Professional Comp RT Side 50 Bilateral Proc GA Waiver of Liability 51 Multiple Proc GY Medicare Exclusion
Auth# [REDACTED]	DX2 9.22.4	Code	
	DX3 7.26.14	Code	
INS2	DX4 7.26.14	Code	
Auth# [REDACTED]	DX5 7.22.1	Code	
	DX6 [REDACTED]	Code	
Injury Date/Time 9/17/07			

NEXT APPT _____ TIME _____ LAB & OTHER TESTS NEEDED NEXT APPT:

NEW VISIT

99201PM Problem Focused	10
99202PM Expanded	20
99203PM Detailed	30
99204PM Comprehensive I	45
99205PM Comprehensive II	60

NEW CONSULT

99241PM Problem Focused	10
99242PM Expanded	20
99243PM Detailed	30
99244PM Comprehensive I	45
99245PM Comprehensive II	60

ESTAB VISIT

99211PM Nurse Visit	5
99212PM Problem Focused	10
99213PM Expanded	15
99214PM Detailed	25
99215PM Comprehensive	40

PSYC SERVICES

90801PM Eval w/o Test	30-60
90804PM Therapy Outpt	25-30
90806PM Therapy Outpt	45-50
90808PM Therapy Outpt	75-80
90901PM Biofeedback Train	30
90875PM Therapy/Biofdbk	25-30
90876PM Therapy/Biofdbk	45-50
90846PM Therapy/Fam w/o Pt	30
90847PM Therapy/Fam w/Pt	30

OTHER

97810PM Acupuncture 1st 15
97811PM Acupuncture ea addt 15
97813PM Acupuncture E-S 1st 15
97814PM Acupuncture E-S addt 15
99358PM Case Mgr Conf: 30-60
99359PM Case Mgr Conf addt 30
99372PM Phone Conference 15
99373PM Phone Conference 30+
99080PM Reports per/unit 15
99455PM Work/Dia Exam per/hr
99456PM Work/Dia Exam non/treat
99075PM Med Testimony per unit
99075APM Deposition in office 60
99456PM INE

INJECTIONS/NERVE BLOCKS

90772PM Therapeutic Inj - SC IM
90774PM Therapeutic Inj - IV
20605PM Joint Inj Intermed (Wrist/Elbow)
20610PM Joint Inj Major (Shoulder/Hip)
20550PM TPI Single Tendon Sheath/Ligament
20551PM TPI Single Tendon Origin
20552PM TPI 1-2 Sites
20553PM TPI 3+ Sites
64415PM Brachial Plexus
64405PM Greater Occipital Nerve
64425PM Ilioinguinal Nerve
64400PM Trigeminal
64412PM Spinal Accessory
64418PM Suprascapular
64420PM Intercostal - Single
64421PM Intercostal - Multiple
64430PM Pudendal
11900PM Interlesional up to 7 sites
64450PM Other Peripheral

IMPLANTABLE THERAPY

01996PM Catheter Maintenance
95970PM Stim Analysis w/o Prog
95971PM Stim Analysis w/Prog
62367PM Pump Analysis w/o Prog
62368PM Pump Analysis w/Prog
95990PM Pump Refill, Nurse
95911PM Pump Refill, Physician

OTHER

99075APM Deposition - 1 hour

EMG/NERVE CONDUCTION STUDIES

95860PM EMG 1 Extremity
95861PM EMG 2 Extremities
95863PM EMG 3 Extremities
95864PM EMG 4 Extremities
95867PM EMG Cranial Unilateral
95868PM EMG Cranial Bilateral
95869PM EMG Thoracic: Paraspinal
95870PM EMG Other
95900PM Nerve Conduct Motor
95903PM Nerve Conduct Motor FNAVE
95904PM Nerve Conduct Sensory
95925PM SSEP Short Lat UE
95926PM SSEP Short Lat LE
95933PM Blink Reflex
95934PM H-Reflex: GCS Musculo
95936PM H-Reflex: Other

MEDICATIONS (Specify #Units)

J0475PM Baclofen 10mg/U
J0476PM Baclofen Intra Triaal 50mcg
J0700PM Betamethasone per 3mg/U
J0735PM Clonidine 1mg/U
J1200PM Diphenhydramine up to 50mg
J3010PM Fentanyl 0.1mg/U
J1170PM Hydromorphone up to 4mg
80092PM Hydromorphone 250mg
J1885PM Ketorolac per 15mg/U
J0670PM Mepivacaine per 10ml/U
J1020PM Methylprednisolone 20mg
J1030PM Methylprednisolone 40mg
J2250PM Midazolam per 1mg/U
J2271PM Morphine 100mg/U
50930PM Morphine 500mg/U
J7040PM Normal Saline 500ml/U
J3490BPM Phenol Aqueous 6%
J3490BPM Phenol 89%
J2550PM Promethazine up to 50mg/U
J3490PM Sufentanil 0.05mg/U
J3302PM Triamcinolone - Aristocort per 5mg/U
J3303PM Triamcinolone - Aristospan per 5mg/U
J3301PM Triamcinolone - Kenalog per 10mg/U

**Augusta Pain Management
Patient Follow up Sheet**

DATE: 11/16/10

☐ Telephone or Walk In Patient

PATIENT NAME: [REDACTED] SS#: _____

PATIENT'S DATE OF BIRTH: [REDACTED] PHONE NUMBER: _____

SA LEVEL 1

12-16

Schedule Patient Return to Office in _____ Weeks ☐ First Available ☐ Priority ☐ Work In

Schedule with: ☐ Lee ☒ P. Grice ☐ D. Grice ☐ Luebben ☐ DeGood ☐ Nurse

Schedule this type appt:

Follow up	<input checked="" type="checkbox"/> 20 min	<input type="checkbox"/> 40 min	<input type="checkbox"/> 60 min
TPI	<input type="checkbox"/> 20 min	<input type="checkbox"/> 40 min	<input type="checkbox"/> 60 min
EMG	<input type="checkbox"/> 60 min	<input type="checkbox"/> 90 min	
ESI	<input type="checkbox"/> 40 min	<input type="checkbox"/> 60 min	
<input type="checkbox"/> Pump Fill/Reprogram	<input type="checkbox"/> Other _____		
<input type="checkbox"/> Nurse Visit Reason: _____			

Discuss/Evaluate for: _____

Cancel or Reset other appointments _____

Request Schedule Fluoro appointment in _____ Weeks ☐ First Available ☐ Priority ☐ Work In

Schedule with: ☐ Lee ☐ P. Grice ☐ D. Grice

Schedule

ESI	<input type="checkbox"/> Cervical	<input type="checkbox"/> Thoracic	<input type="checkbox"/> Lumbar	<input type="checkbox"/> Caudal
Facet	<input type="checkbox"/> Cervical	<input type="checkbox"/> Thoracic	<input type="checkbox"/> Lumbar	
SNRB	<input type="checkbox"/> Cervical	<input type="checkbox"/> Thoracic	<input type="checkbox"/> Lumbar	
min/hr Denervation	<input type="checkbox"/> Cervical	<input type="checkbox"/> Thoracic	<input type="checkbox"/> Lumbar	

☐ Other _____

Request Procedure Follow-up in 2 Weeks with: ☐ Lee ☐ P. Grice ☐ D. Grice ☐ Luebben
☐ Do Not schedule separate procedure Follow up ☐ Do Telephone Procedure Follow up

DATE/TIME OF SCHEDULED OR APPOINTMENT _____

DATE/TIME OF FOLLOW UP VISIT _____

Date and Name Or Notified (4284) _____

Purple Instruction Sheet ☐ Given to patient ☐ Reviewed over the telephone

Other

Refer to _____

Reason _____

☐ Copy Put in/given to: _____

State Farm®
Providing Insurance and Financial Services
Home Office, Bloomington, Illinois 61710



September 10, 2007

[REDACTED]
[REDACTED]
HAMBLETON, WV [REDACTED]

Frederick PIP Office
PO Box 953
Frederick, MD 21705

RE: Claim Number: [REDACTED]
Date of Loss: 9/7/2007
Our Insured: [REDACTED]

Dear [REDACTED]

It has been reported that you were injured in a motor vehicle accident on 9/7/2007. You are entitled to Medical Payments coverage based on the terms of State Farm® policy number [REDACTED]

For the bodily injury caused by the motor vehicle accident, we will pay reasonable expenses incurred for medical services if the medical services are provided within one year immediately following the date of the accident, up to the coverage limit of \$25,000.00. Medical services means treatments, procedures and other services that are necessary to achieve maximum medical improvement, rendered by a licensed healthcare provider, commonly recognized throughout the medical profession, primarily designed to serve a medical purpose and not experimental and not for research. Reasonable expenses mean the lowest of usual and customary fees charged by a majority of healthcare providers who provide similar medical services in the geographic area in which the charges were incurred.

We have the right to obtain and use utilization reviews, peer reviews and medical bill reviews to determine if the incurred charges are reasonable expenses.

Under the terms of the policy, any person making a claim under the Medical Payments coverage shall be examined by physicians chosen and paid for by us, as often as we reasonably may require. A copy of the report will be sent to the person upon written request. The person, or his or her legal representative, shall authorize us to obtain all medical reports and records.

The policy requires you to reimburse us for payments made under the Medical Payments coverage if the same expenses were paid under the liability coverage of a person also insured with State Farm (includes State Farm Mutual Automobile Insurance Company and its affiliated companies). The policy requires you pass your rights of recovery to us or hold in trust and reimburse us for any recovery from other parties not insured by State Farm.

If you wish to present a claim, we will need your medical information, reports, and bills. Please complete and sign the enclosed Medical Authorization and return it to us in the envelope

provided. This authorization will allow your medical providers to furnish State Farm with the medical information we need to process your claim.

It is likely one claim team will be assigned to handle your Medical Payments Coverage and, if applicable, any other claim presented under this policy would be assigned to a different handler. To expedite the handling of your claim or claims, your signed Medical Authorization may be used to evaluate your claim for Medical Payments coverage, as well as any other claim presented under this policy. However, if you prefer that this authorization not be used for other claims under this policy, please advise us in writing.

Please retain this letter for your personal records, as it identifies your claim number and the representative handling the Medical Payments coverage portion of your claim. If you wish to submit medical bills or other correspondence, include your name and claim number, and mail them to the address at the top of this letter.

Please provide this address to your medical providers in the event they wish to submit their bills directly to us. Please be advised we may pay the injured person or any other person or organization performing the services.

The Medical Payments coverage has other terms and conditions not listed in this letter. For further details of the coverage, please refer to your policy.

If you have any questions, please contact us at (866) 891-3658 x7939.

Sincerely,
Carol Englebrecht
Claim Representative for Claim Processor Unit P4
Phone: (866) 891-3658 x7939
Fax: (888) 613-3969

State Farm Mutual Automobile Insurance Company

Enclosures: Medical Authorization
Postage Paid Return Envelope



AUTHORIZATION FOR RELEASE OF INFORMATION

NOTE: Property and Casualty insurance is excluded from the definition of "health plan" in the privacy rules developed pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is not a covered entity. However, this authorization meets the core elements criteria set forth in the HIPAA privacy rule, Section 164.508 (c).

Name of Injured Person: [REDACTED] (hereinafter referred to as the "Injured Person")

Social Security Number of Injured Person: [REDACTED] (needed to locate records)

Date of birth of Injured Person: [REDACTED] (needed to locate records)

State Farm Claim No.: [REDACTED]

I authorize:

- (1) any medical, psychological, psychiatric, osteopathic or chiropractic physician, dentist, any other medical practitioner or healthcare provider, hospital, clinic, rehabilitation facility, nursing home, or any other healthcare facility to disclose information from the medical and healthcare records of the Injured Person. I understand that the specific type of information to be disclosed includes, but is not limited to, medical and healthcare records and any other information including any history, treatment records, diagnosis, prognosis, narrative reports, and billing records. This authorization also permits my medical providers to discuss in person, by telephone, electronically, or by mail, medical options, conclusions, treatment plans and other information; and
- (2) any firm, employer, or insurance company to furnish information about the earnings, loss of earnings, work history, workers' compensation claim, and other medical information in its/their possession concerning the Injured Person, as well as, Event Data Recorder (EDR) information, photographs and other information about the physical damage to the vehicle(s) involved in the accident; and
- (3) any educational organization to furnish the school records of the Injured Person to

State Farm Mutual Automobile Insurance Company, its subsidiaries and affiliates, its claim associates, and legal representatives (hereinafter referred to collectively as "State Farm").

I authorize the use of the above information to permit State Farm to investigate, process, and determine the amount payable, if any, for all claims made under any State Farm property and casualty insurance policy that applies to the accident or occurrence on 9/7/2007. I understand as part of the claim handling process, State Farm may disclose medical or other information obtained by this authorization to physicians, dentists, other medical or healthcare providers or other professionals for their review and professional opinion. This information may also be released to other insurance companies for their use in connection with insurance transactions, or as required or permitted by law. Information obtained pursuant to this authorization may later be redisclosed and may not be protected under the HIPAA privacy rule. I understand that I may refuse to authorize disclosure of all or some of the requested information, but that refusal may potentially cause a delay in processing, or result in the denial of, insurance benefits for the pending injury claim(s).

This authorization may be revoked at any time, except to the extent that State Farm has taken action in reliance on this authorization prior to notice of revocation. Such revocation must be in writing, dated, signed, and include the claim number referenced above. I understand that revocation of this authorization may potentially cause a delay in processing, or result in the denial of, insurance benefits for the pending injury claim(s).

This authorization is valid for the duration of the claim referenced above, and a photocopy is as valid as the original. This authorization specifically applies to records made before, during, and after the date of signing this authorization for as long as the authorization is in effect.

I have read the authorization and signed this document as a free and voluntary act for the purposes noted above. I understand that I may obtain a copy of this authorization upon written request submitted to State Farm.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Date: _____

Signature of individual or personal representative _____

Description of personal representative's authority or relationship to patient _____

Augusta Pain Management Center
Insurance Referral/Preauthorization Flow Sheet

Patient's Name:

Referring Physician:

Insurance:

State Farm Ins

PCP:

Address:

PO Box 953

Claim Number:

Frederick, MD 21705

Date of Injury:

9/7/07

Case Manager/Adjuster Name & Number:

claim representative

Date

Documentation

Staff Initials

11/14/07

Spoke to Supriya @ State Farm Claims

unit gave me address to send claims to
& phone #

PA called & said to make appt for MRI & send bill to State Farm
2/11/08 called for Auth for MRI SE said to do MRI send Bills
& report to them. PE

5/23/08 spoke to Jamie @ State Farm ins CO. She
approved Evaluation depending on if tx is in relation
to injury for further Auth. S. Tutwell

5

ESIS/GM Central Claims Unit
P.O. Box 300
Mail Code 482 C19 B61
Detroit, MI 48265-3000

800.888.0164 *tel*
313.665.0911 *fax*

August 11, 2008

[REDACTED]
Hambleton, WV [REDACTED]

RE: Date of Event: September 7, 2007
 File Number: 652566
 Client: General Motors Corporation

Dear [REDACTED]

As you know, ESIS provides claims handling services to General Motors involving product liability claims.

This letter is a follow up to our conversation of August 11, 2008.

A review of your claim involving a 2005 Chevrolet Cobalt has been completed.

ESIS must respectfully deny your claim for any damages.

Sincerely,

Tiffini Hails