Fill in this information to identify the case:

Debtor IEH Auto Parts Holding LLC

United States Bankruptcy Court for the: Southern District of Texas (State)

Case number 23-90054

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Do not use this form to make a request for payment of an administrative expense. Make such a request according to 11 U.S.C. § 503.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. **Do not send original documents;** they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to $500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed. That date is on the notice of bankruptcy (Form 309) **that you received.**

Part 1: Identify the Claim

1. **Who is the current creditor?**

Adrienne Green
Name of the current creditor (the person or entity to be paid for this claim)

Other names the creditor used with the debtor

2. **Has this claim been acquired from someone else?**

☑ No
☐ Yes. From whom?

3. **Where should notices and payments to the creditor be sent?**

Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)

Where should notices to the creditor be sent?	**Where should payments to the creditor be sent?** (if different)
Adrienne Green 1104 Sandy Stone Rd, Apt L Essex, MD 21221	Kandel and Associates, P.A. 1001 N. Calvert Street Baltimore, MD 21202, United States
Contact phone 410-776-4405 Contact email adriennegreene28@yahoo.com	Contact phone 410- 837-0646 Contact email kandelpa@erols.com

Uniform claim identifier for electronic payments in chapter 13 (if you use one):

4. **Does this claim amend one already filed?**

☑ No
☐ Yes. Claim number on court claims registry (if known) _____ Filed on _____ MM / DD / YYYY

5. **Do you know if anyone else has filed a proof of claim for this claim?**

☑ No
☐ Yes. Who made the earlier filing?

23900542303151039580102O5

Part 2: Give Information About the Claim as of the Date the Case Was Filed

6. **Do you have any number you use to identify the debtor?**

☑ No

☐ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: ___ ___ ___ ___

7. **How much is the claim?** $ 40,000.00 . **Does this amount include interest or other charges?**

☐ No

☑ Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. **What is the basis of the claim?**

Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card.

Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).

Limit disclosing information that is entitled to privacy, such as health care information.

Personal Injury, Deductible and Car Rental

9. **Is all or part of the claim secured?**

☑ No

☐ Yes. The claim is secured by a lien on property.

Nature or property:

☐ Real estate: If the claim is secured by the debtor's principle residence, file a *Mortgage Proof of Claim Attachment* (Official Form 410-A) with this *Proof of Claim*.

☐ Motor vehicle

☐ Other. Describe: _____

Basis for perfection: _____

Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)

Value of property: $_____

Amount of the claim that is secured: $_____

Amount of the claim that is unsecured: $_____ (The sum of the secured and unsecured amount should match the amount in line 7.)

Amount necessary to cure any default as of the date of the petition: $_____

Annual Interest Rate (when case was filed)_____%

☐ Fixed

☐ Variable

10. **Is this claim based on a lease?**

☑ No

☐ Yes. **Amount necessary to cure any default as of the date of the petition.** $_____

11. **Is this claim subject to a right of setoff?**

☑ No

☐ Yes. Identify the property: _____

23900542303151039580102 05

12. **Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?**

A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the amount entitled to priority.

☑ No

☐ Yes. *Check all that apply:*

	Amount entitled to priority
☐ Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	$_____
☐ Up to $3,350* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	$_____
☐ Wages, salaries, or commissions (up to $15,150*) earned within 180 days before the bankruptcy petition is filed or the debtor's business ends, whichever is earlier. 11 U.S.C. § 507(a)(4).	$_____
☐ Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	$_____
☐ Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	$_____
☐ Other. Specify subsection of 11 U.S.C. § 507(a)(__) that applies.	$_____

* Amounts are subject to adjustment on 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☑ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

Part 3: Sign Below

The person completing this proof of claim must sign and date it. FRBP 9011(b).

If you file this claim electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what a signature is.

A person who files a fraudulent claim could be fined up to $500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Check the appropriate box:

☐ I am the creditor.

☑ I am the creditor's attorney or authorized agent.

☐ I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.

☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 04/13/2023
MM / DD / YYYY

/s/Robin Lates
Signature

Print the name of the person who is completing and signing this claim:

Name: Robin Lates
First name Middle name Last name

Title: Paralegal

Company: Kandel and Associates, P.A.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address

Contact phone _____ Email _____

23900542303151039580102O5

KCC ePOC Electronic Claim Filing Summary

For phone assistance: Domestic (888) 802-7207 | International (781) 575-2107

Debtor:
23-90054 - IEH Auto Parts Holding LLC
District:
Southern District of Texas, Houston Division

Creditor:
Adrienne Green
1104 Sandy Stone Rd, Apt L
Essex, MD, 21221
Phone:
410-776-4405
Phone 2:
Fax:
Email:
adriennegreene28@yahoo.com

Has Supporting Documentation:
Yes, supporting documentation successfully uploaded
Related Document Statement:

Has Related Claim:
No
Related Claim Filed By:

Filing Party:
Authorized agent

Disbursement/Notice Parties:
Kandel and Associates, P.A.
1001 N. Calvert Street
Baltimore, MD, 21202
United States
Phone:
410- 837-0646
Phone 2:
Fax:
410-783-8974
E-mail:
kandelpa@erols.com
DISBURSEMENT ADDRESS

Other Names Used with Debtor:

Amends Claim:
No
Acquired Claim:
No

Basis of Claim:
Personal Injury, Deductible and Car Rental

Last 4 Digits:
No

Uniform Claim Identifier:

Total Amount of Claim:
40,000.00

Includes Interest or Charges:
Yes

Has Priority Claim:
No

Priority Under:

Has Secured Claim:
No
Amount of 503(b)(9):
No
Based on Lease:
No
Subject to Right of Setoff:
No

Nature of Secured Amount:
Value of Property:
Annual Interest Rate:
Arrearage Amount:
Basis for Perfection:
Amount Unsecured:

Submitted By:
Robin Lates on 13-Apr-2023 12:14:22 p.m. Eastern Time
Title:
Paralegal
Company:
Kandel and Associates, P.A.

VN: A732823C2C5AF04DDE68F18B91819A86

KANDEL & ASSOCIATES P.A.

LAW OFFICES

1001 NORTH CALVERT STREET, BALTIMORE, MARYLAND 21202

E-MAIL: KANDELPA@EROLS.COM
FAX: 410-783-8974
TEL: 410-837-0646

April 11, 2023

SENT VIA EMAIL: CHARTLINE@pcigc.com
Ms. Christine Hartline
Property Casualty Insurance Guaranty Corp.
P.O. Box 10619
Towson, MD 21285

Re: Client: Adrienne Greene
Claim No.: Corvel Claim No.: 1245A-L230300052
D/A: January 18, 2023

Dear Ms Hartline:

Enclosed please find the following:

1. Franklin Square Hospital (1/18/23)	$793.54
2. Franklin Square Physicians' (1/18/23)	$410.00
3. Maryland Physicians Associates (1/23-3/09/23)	$1,046.00
4. Maryland Healthcare Clinics (10/14-11/15/22)	$5,818.00

Total: $8,067.54

Out of Pocket Expense:

1. Enterprise Rent-a-Car (1/24-3/1/23)	$887.73
2. Enterprise Rent-a-Car (3/2-3/31/23)	$884.08

Total: $1,771.81

Kindly evaluate these medicals and contact us to discuss settlement of this claim. Thank you.

Very truly yours,

KANDEL & ASSOCIATES, P.A.

Nelson R Kandel

BY: NELSON R. KANDEL

NRK/rl
Enclosure

Gmail Robin Lates <jrl.kandelpa@gmail.com

\drienne Greene

message

:obin Lates <jrl.kandelpa@gmail.com> Tue, Apr 11, 2023 at 10:18 Al
o: chartline@pcigc.com

Dear Ms. Hartline:

Please see attached Demand for our client **Adrienne Greene**. Ms. Greene has sent letters as well as our firm in reference to Corel's Bankruptsy. I hope that you and your company can come up with a resolution to this matter. Our client is eager to move forward and put this behind her. Please evaluate and access this Demand and get back to us in a timely manner. If you need further documnentation please do not hesitate to ask.

Thanks,

Robin Lates
Paralegal
Kandel & Associates, P.A.
1001 N. Calvert Street
Baltimore, MD 21202
Telephone: 410-837-0646
Facsimile: 410-783-8974
Email: jrl.kandelpa@gmail.com

20230411102150993.pdf
4051K

HCI # 12 1 I

MEDSTAR FRANKLIN SQUARE
PO BOX 418923
BOSTON, MA 02241-8923
410 933-2424
FEI # 520608007

PAGE NO. 1

TYPE OF BILL	DATE OF BILL	PREV.BILL DATE
CYCLE INS.	01/24/23	

BIRTH-DATE 03/04/72

HOSP NO. 573515

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS	
S E GREENE ,ADRIENNE EVETTE	3046326272	F		01/18/23			OUT PATIENT

GUARANTOR NAME AND ADDRESS	C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
ADRIENNE EVETTE GREENE PO BOX 1123 EDGEWOOD MD 21040	1	SELF PAY POS INS		

~~CHARBONNEAU, STEPHEN G~~

AMOUNT OF PAYMENT $

DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
DETAIL OF CURRENT CHARGES, PAYMENTS AND ADJUSTMENTS								
01/18	001 CHEST 2 VIEW	32100323	113.72					113.72
01/18	001 KNEE 3 VWS	32100992	159.24					159.24
01/18	001 TIBIA + FIBU	32101057	136.52					136.52
DEPARTMENT 32	SUBTOTAL---		409.48					409.48
01/18	001 B CATEGORY L	45650033	220.36					220.36
01/18	001 B CATEGORY M	45650074	110.19					110.19
DEPARTMENT 45	SUBTOTAL---		330.55					330.55
01/18	001 SENSOR PULSE	62002472	21.33					21.33
DEPARTMENT 62	SUBTOTAL---		21.33					21.33
01/18	002 *ACETAMINOPH	63700124						
01/18	001 *IBUPROFEN 8	63707541						
DEPARTMENT 63	SUBTOTAL---							
01/18	001 EKG	73030009	32.18					32.18
DEPARTMENT 73	SUBTOTAL---		32.18					32.18
SUMMARY OF CURRENT CHARGES								
	EMERGENCY ROOM		330.55					330.55
	MED/SURG SUPPLIES		21.33					21.33
	IMAGING/X-RAY		409.48					409.48
	CARDIOLOGY		32.18					32.18
SUB-TOTAL OF CURR. CHARGES			793.54					793.54
EMPLOYER INFORMATION:								
	EKISON SENIOR LIVING							
T O T A L S			793.54					793.54

PATIENT NUMBER 3046326272

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

MEDSTAR FRANKLIN SQUARE

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI # 12 1 I

MEDSTAR FRANKLIN SQUARE
PO BOX 418923
BOSTON, MA 02241-8923
410 933-2424
FEI # 520608007

PAGE NO. 2

TYPE OF BILL	DATE OF BILL	PREV.BILL DATE
CYCLE INS.	01/24/23	

BIRTH-DATE 03/04/72

HOSP.NO. 573515

OUT PATIENT

S	E	PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
		GREENE ,ADRIENNE EVETTE	3046326272	F		01/18/23		

GUARANTOR NAME AND ADDRESS

ADRIENNE EVETTE GREENE
PO BOX 1123
EDGEWOOD MD 21040

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	SELF PAY POS INS		

CHARBONNEAU, STEPHEN G

AMOUNT OF PAYMENT $

DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
	ACC DATE: 01/18/23 TYPE: A TIME: 10:00 AM PLACE: EMPL REL: N							
	DIAGNOSIS: M25.561							
	M25.561							
	T O T A L S		793.54					793.54

3046326272
PATIENT NUMBER

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES

MEDSTAR FRANKLIN SQUARE
BOSTON, MA

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

MedStar Health

MEDSTAR HEALTH
PHYSICIANS BILL SERVICES
CUSTOMER SERVICE DIVISION
P.O BOX 418597
BOSTON, MA 02241-8597
CXD305

MedStar Health

ADRIENNE EVETTE GREENE 0.00

02/21/23 000454319

CAREFIRST BLUE CHOICE POS

ADRIENNE EVETTE GREENE
PO BOX 1123
EDGEWOOD,MD 21040

02/21/23 ADRIENNE EVETTE GREENE 000454319 CAREFIRST BLUE CHOICE POS

01/18/23 44361256 K GUILLEN,PA - EMERGENCY MEDICINE
EMERGENCY DEPT VISIT $410.00 410.00

MEDSTAR HEALTH
PHYSICIANS BILL SERVICES
CUSTOMER SERVICE DIVISION
P.O BOX 418597
BOSTON, MA 02241-0597
CXD305

MedStar Health

MedStar Health

*****

GREENE,ADRIENNE EVETTE M/R #000454319 ,7930454,,801474292,,700082058,,,5995604 03/04/1972 F
SSN: XXX-XX-3968
PO BOX 1123 EDGEWOOD,MD 21040 410-776-4405
Patient's employer: EKISON SENIOR LIVING

PR	FSC	CERT/GROU/PLAN	REL	SUBSCRIBER	EFF DATE
1	644 CCH	LHS813098750/001901812MD10016/1		GREENE,ADRIENNE EVET	11/01/2022

ACCOUNTS IN GROUPS: 20 30 50
Registered on: 06/14/2016 By: VMA101EAD
Last Updated: 02/21/2023 By: CXD305EAD
Current Statement balance: 0.00
Last Statement Run# 0 Balance: 0.00 Date: Dun Level: Cycle: 3
Open Cases: 0 Closed Cases: 0 Archived Cases: 0
No cases on file for this account.

Invoice	ADM/Vis	Disch	Patient	MD	Loc	Hos Ba	Charges	FSC	Balance
44361256	01/18/2023		ADRIENNE K GUI	ER	FSH	WFE	410.00	CCH	410.00
		Total:					410.00		410.00

Invoice	ADM/Vis	Disch	Patient	MD	Loc	Hos Ba	Charges	FSC	Balance
44361256	01/18/2023		ADRIENNE K GUI	ER	FSH	WFE	410.00	CCH	410.00

	Posted	Service	Description	Payments	Adjust	Charges	FSC	Batch
1)	01/27/23	01/18/23	99285 EMERGENCY DEPARTMENT VISIT, LEVEL 5 (1)			410.00	CCH	942734
2)	01/30/23		70 CHANGE FSC (INVOICE) From SPI To CCH CLM:Y BLLD ACTIVE INS					943193
3)	01/31/23		348 ECOM-BCBS-837P-B GE CLM FORM PREPARED 1 ON TAPE RUN: 4551					

R07.89 OTHER CHEST PAIN~R07.89
M25.561 PAIN IN RIGHT KNEE~M25.561
V43.52XA CAR DRIVER INJURED IN COLLISION WITH OTHER TYPE CAR IN TRAFFIC ACCIDENT, INITIAL ENCOUNTER~V43.52XA
Y92.89 OTHER SPECIFIED PLACES AS THE PLACE OF OCCURRENCE OF THE EXTERNAL CAUSE~Y92.89
Y93.89 ACTIVITY, OTHER SPECIFIED~Y93.89
Division: EMERGENCY MEDICINE MWHC
Ref Phys: SELF-REFERRED
Invoice FSC List: 644,1

Maryland Physicians Associates

5 Park Center Court, Suite 200
Owings Mills, MD 21117
(888)570-0088
Fed Tax ID: 521995807

Patient: ADRIENNE GREENE
1104 Sandy Stone Road,
Essex, MD 21221
SSN#: ***-**-3968
DOB: 03/04/1972

Travelers
P.O. Box 430
Buffalo 14240
(800)252-4633
Policy#: IQC1880

Diagnoses: S13.4XXA, S43.499A, S80.10XA

The charges for all of the patient's care and treatment are fair and reasonable and are in accordance with the current annual regional edition of the **Customized Fee Analyzer** published by Optum, a nationally recognized healthcare information company.

Date	Description	Procedure	Units	Charge
01/23/2023	First visit comprehensive (30 min.)	99203	1	$374.00
02/01/2023	Cervical spine; 2 or 3 views	72040	1	$142.00
02/01/2023	Shoulder; complete, minimum of 2 views	73030	1	$137.00
03/02/2023	Established patient management(office or other outpatient visit)	99213	1	$245.00
03/09/2023	Final visit (10 min.)	99212	1	$148.00

Service provided at: Parkville/Carney
8113 Harford Road, Suite 200
Parkville, MD 21234
Phone: (888)570-0088
Fax: (410)732-6112

Current Charges:	$1,046.00
Total Balance:	$1,046.00

Travelers
P.O. Box 430
Buffalo, 14240

HEALTH INSURANCE CLAIM FORM

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

PICA | PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): IQC1880

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

3. PATIENT'S BIRTH DATE MM DD YY: 03 04 1972 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 1104 Sandy Stone Road,

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

7. INSURED'S ADDRESS (No., Street): 1104 Sandy Stone Road,

CITY: Essex | STATE: MD

8. RESERVED FOR NUCC USE

CITY: Essex | STATE: MD

ZIP CODE: 21221 | TELEPHONE (Include Area Code): (410) 776-4405

ZIP CODE: 21221 | TELEPHONE (Include Area Code): (410) 776-4405

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

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

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

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

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY: 03 04 1972 SEX M [ ] F [X]

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME: Travelers

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: SIGNATURE ON FILE DATE: 01/25/2023

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 01 18 2023 QUAL. Inj

15. OTHER DATE QUAL. MM DD YY: NA

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. S134XXA B. S43499A C. S8010XA D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 First visit comprehensive (30 min.) 01 23 23	01 23 23	11		99203			374 00	1		NPI	1952406043
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 521995807

26. PATIENT'S ACCOUNT NO.: GREAD009

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

28. TOTAL CHARGE: $ 374 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use: 374 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Benedicto S. Garin, M DATE 01/25/2023

32. SERVICE FACILITY LOCATION INFORMATION
Parkville/Carney
8113 Harford Road; Suite 200
Parkville, MD 21234

a. b.

33. BILLING PROVIDER INFO & PH # (888) 570-0088
Maryland Physicians Associates
5 Park Center Court, Suite 200
Owings Mills, MD 21117

a. 1407970601 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Travelers
P.O. Box 430
Buffalo, 14240

HEALTH INSURANCE CLAIM FORM

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

PICA | PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): IQC1880

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

3. PATIENT'S BIRTH DATE MM DD YY: 03 04 1972 | SEX M ( ) F (X)

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

5. PATIENT'S ADDRESS (No., Street): 1104 Sandy Stone Road,

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

7. INSURED'S ADDRESS (No., Street): 1104 Sandy Stone Road,

CITY: Essex | STATE: MD

8. RESERVED FOR NUCC USE

CITY: Essex | STATE: MD

ZIP CODE: 21221 | TELEPHONE (Include Area Code): (410) 776-4405

ZIP CODE: 21221 | TELEPHONE (Include Area Code): (410) 776-4405

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

a. INSURED'S DATE OF BIRTH MM DD YY: 03 04 1972 | SEX M ( ) F (X)

b. RESERVED FOR NUCC USE:

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

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES ( ) NO (X)

c. INSURANCE PLAN NAME OR PROGRAM NAME: Travelers

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: SIGNATURE ON FILE | DATE: 02/02/2023

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 01 18 2023 QUAL. Inj

15. OTHER DATE QUAL. | MM DD YY: NA

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ( ) NO (X) $ CHARGES

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

A. S134XXA B. S43499A C. S8010XA D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	Cervical spine; 2 or 3 views 02 01 23 | 02 01 23	11		72040			142 00	1		NPI	1407970601
2	Shoulder; complete, minimum of 2 views 02 01 23 | 02 01 23	11		73030			137 00	1		NPI	1407970601
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ( ) EIN (X): 521995807

26. PATIENT'S ACCOUNT NO.: GREAD009

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

28. TOTAL CHARGE: $ 279 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use: 279 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED SIGNATURE ON FILE DATE 02/02/2023

32. SERVICE FACILITY LOCATION INFORMATION
Parkville/Carney
8113 Harford Road; Suite 200
Parkville, MD 21234

a. | b.

33. BILLING PROVIDER INFO & PH # (888) 570-0088
Maryland Physicians Associates
5 Park Center Court, Suite 200
Owings Mills, MD 21117

a. 1407970601 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Travelers
P.O. Box 430
Buffalo, 14240

HEALTH INSURANCE CLAIM FORM

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

PICA | PICA

CARRIER

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): IQC1880

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

3. PATIENT'S BIRTH DATE MM DD YY: 03 04 1972 SEX M ☐ F ☒

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

5. PATIENT'S ADDRESS (No., Street): 1104 Sandy Stone Road,

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): 1104 Sandy Stone Road,

CITY: Essex | STATE: MD

8. RESERVED FOR NUCC USE

CITY: Essex | STATE: MD

ZIP CODE: 21221 | TELEPHONE (Include Area Code): (410) 776-4405

ZIP CODE: 21221 | TELEPHONE (Include Area Code): (410) 776-4405

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY: 03 04 1972 SEX M ☐ F ☒

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES ☒ NO ☐ PLACE (State):

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: Travelers

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: SIGNATURE ON FILE DATE: 03/06/2023

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 01 18 2023 QUAL. Inj

15. OTHER DATE QUAL. MM DD YY: NA

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☒ $ CHARGES

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

A. S134XXA B. S43499A C. S8010XA D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 Established patient management (office or other outpatient visit) 03 02 23	03 02 23	11		99213			245 00	1		NPI	1306868773
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☒: 521995807

26. PATIENT'S ACCOUNT NO.: GREAD009

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

28. TOTAL CHARGE: $ 245 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use: 245 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Daniel John, M.D. DATE 03/06/2023

32. SERVICE FACILITY LOCATION INFORMATION
Parkville/Carney
8113 Harford Road; Suite 200
Parkville, MD 21234

a. b.

33. BILLING PROVIDER INFO & PH # (888) 570-0088
Maryland Physicians Associates
5 Park Center Court, Suite 200
Owings Mills, MD 21117

a. 1407970601 b.

PATIENT AND INSURED INFORMATION

Travelers
P.O. Box 430
Buffalo, 14240

HEALTH INSURANCE CLAIM FORM

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

CARRIER

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): IQC1880

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

3. PATIENT'S BIRTH DATE MM DD YY: 03 04 1972 SEX M ☐ F ☒

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

5. PATIENT'S ADDRESS (No., Street): 1104 Sandy Stone Road,

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): 1104 Sandy Stone Road,

CITY: Essex STATE: MD

8. RESERVED FOR NUCC USE

CITY: Essex STATE: MD

ZIP CODE: 21221 TELEPHONE (Include Area Code): (410) 776-4405

ZIP CODE: 21221 TELEPHONE (Include Area Code): (410) 776-4405

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY: 03 04 1972 SEX M ☐ F ☒

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ☒ NO ☐ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: Travelers

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: SIGNATURE ON FILE DATE: 03/15/2023

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 01 18 2023 QUAL. Inj

15. OTHER DATE QUAL. MM DD YY: NA

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☒ $ CHARGES

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

A. S134XXA B. S43499A C. S8010XA D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 Final visit (10 min.) 03 09 23	03 09 23	11		99212			148 00	1		NPI	1306868773
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☒: 521995807

26. PATIENT'S ACCOUNT NO.: GREAD009

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

28. TOTAL CHARGE: $ 148 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use: 148 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Daniel John, M.D. DATE 03/15/2023

32. SERVICE FACILITY LOCATION INFORMATION
Parkville/Carney
8113 Harford Road; Suite 200
Parkville, MD 21234

a. b.

33. BILLING PROVIDER INFO & PH # (888) 570-0088
Maryland Physicians Associates
5 Park Center Court, Suite 200
Owings Mills, MD 21117

a. 1407970601 b.

Maryland Healthcare Clinics
DBA MHC HealthCare
5 Park Center Court, Suite 200
Owings Mills, MD 21117
(888)570-0088
Fed Tax ID: 521521492

Patient: ADRIENNE GREENE
1104 Sandy Stone Road,
Essex, MD 21221
SSN#: ***-**-3968
DOB: 03/04/1972

Travelers
P.O. Box 430
Buffalo 14240
(800)252-4633
Policy#: IQC1880

Diagnoses: S13.4XXA, S43.499A, S80.10XA

The charges for all of the patient's care and treatment are fair and reasonable and are in accordance with the current annual regional edition of the **Customized Fee Analyzer** published by Optum, a nationally recognized healthcare information company.

Date	Description	Procedure	Units	Charge
02/01/2023	Physical Therapy Evaluation	97161	1	$279.00
02/06/2023	Hot/Cold Pack	97010	1	$46.00
02/06/2023	Traction,mechanical	97012	1	$63.00
02/06/2023	Electrical Stimulation	97014	1	$66.00
02/06/2023	CMT spinal, 1-2 regions	98940	1	$74.00
02/06/2023	Electrodes	A4556	1	$49.00
02/07/2023	Hot/Cold Pack	97010	1	$46.00
02/07/2023	Traction,mechanical	97012	1	$63.00
02/07/2023	Electrical Stimulation	97014	1	$66.00
02/07/2023	Exercise	97110	1	$103.00
02/07/2023	CMT spinal, 1-2 regions	98940	1	$74.00
02/09/2023	Hot/Cold Pack	97010	1	$46.00
02/09/2023	Traction,mechanical	97012	1	$63.00
02/09/2023	Electrical Stimulation	97014	1	$66.00
02/09/2023	CMT spinal, 1-2 regions	98940	1	$74.00
02/09/2023	Exercise	97110	2	$206.00
02/13/2023	Hot/Cold Pack	97010	1	$46.00
02/13/2023	Traction,mechanical	97012	1	$63.00
02/13/2023	Electrical Stimulation	97014	1	$66.00
02/13/2023	CMT spinal, 1-2 regions	98940	1	$74.00
02/13/2023	Exercise	97110	2	$206.00
02/17/2023	Hot/Cold Pack	97010	1	$46.00
02/17/2023	Traction,mechanical	97012	1	$63.00
02/17/2023	Electrical Stimulation	97014	1	$66.00
02/17/2023	CMT spinal, 1-2 regions	98940	1	$74.00
02/17/2023	Exercise	97110	2	$206.00
02/20/2023	Hot/Cold Pack	97010	1	$46.00
02/20/2023	Traction,mechanical	97012	1	$63.00
02/20/2023	Electrical Stimulation	97014	1	$66.00

Service provided at: Parkville/Carney
8113 Harford Road, Suite 200
Parkville, MD 21234
Phone: (888)570-0088
Fax: (410)732-6112

Current Charges: $2,469.00

Total Balance: $5,818.00

Maryland Healthcare Clinics
DBA MHC HealthCare
5 Park Center Court, Suite 200
Owings Mills, MD 21117
(888)570-0088
Fed Tax ID: 521521492

Patient: ADRIENNE GREENE
1104 Sandy Stone Road,
Essex, MD 21221
SSN#: ***-**-3968
DOB: 03/04/1972

Travelers
P.O. Box 430
Buffalo 14240
(800)252-4633
Policy#: IQC1880

Diagnoses: S13.4XXA, S43.499A, S80.10XA

The charges for all of the patient's care and treatment are fair and reasonable and are in accordance with the current annual regional edition of the **Customized Fee Analyzer** published by Optum, a nationally recognized healthcare information company.

Date	Description	Procedure	Units	Charge
02/20/2023	CMT spinal, 1-2 regions	98940	1	$74.00
02/20/2023	Exercise	97110	2	$206.00
02/21/2023	Hot/Cold Pack	97010	1	$46.00
02/21/2023	Traction,mechanical	97012	1	$63.00
02/21/2023	Electrical Stimulation	97014	1	$66.00
02/21/2023	CMT spinal, 1-2 regions	98940	1	$74.00
02/21/2023	Exercise	97110	2	$206.00
02/23/2023	Hot/Cold Pack	97010	1	$46.00
02/23/2023	Traction,mechanical	97012	1	$63.00
02/23/2023	Electrical Stimulation	97014	1	$66.00
02/23/2023	Extraspinal, 1 or more regions	98943	1	$60.00
02/23/2023	Exercise	97110	2	$206.00
02/27/2023	Hot/Cold Pack	97010	1	$46.00
02/27/2023	Traction,mechanical	97012	1	$63.00
02/27/2023	Electrical Stimulation	97014	1	$66.00
02/27/2023	Extraspinal, 1 or more regions	98943	1	$60.00
02/27/2023	Exercise	97110	2	$206.00
02/28/2023	Hot/Cold Pack	97010	1	$46.00
02/28/2023	Traction,mechanical	97012	1	$63.00
02/28/2023	Electrical Stimulation	97014	1	$66.00
02/28/2023	Extraspinal, 1 or more regions	98943	1	$60.00
02/28/2023	Exercise	97110	2	$206.00
03/02/2023	Hot/Cold Pack	97010	1	$46.00
03/02/2023	Traction,mechanical	97012	1	$63.00
03/02/2023	Electrical Stimulation	97014	1	$66.00
03/02/2023	Extraspinal, 1 or more regions	98943	1	$60.00
03/02/2023	Exercise	97110	2	$206.00
03/06/2023	Hot/Cold Pack	97010	1	$46.00
03/06/2023	Traction,mechanical	97012	1	$63.00

Service provided at: Parkville/Carney
8113 Harford Road, Suite 200
Parkville, MD 21234
Phone: (888)570-0088
Fax: (410)732-6112

Current Charges: $5,077.00

Total Balance: $5,818.00

Maryland Healthcare Clinics
DBA MHC HealthCare
5 Park Center Court, Suite 200
Owings Mills, MD 21117
(888)570-0088
Fed Tax ID: 521521492

Patient:	ADRIENNE GREENE 1104 Sandy Stone Road, Essex, MD 21221	Travelers P.O. Box 430 Buffalo 14240	
SSN#:	***-**-3968	(800)252-4633	
DOB:	03/04/1972	**Policy#:** IQC1880	

Diagnoses: S13.4XXA, S43.499A, S80.10XA

The charges for all of the patient's care and treatment are fair and reasonable and are in accordance with the current annual regional edition of the **Customized Fee Analyzer** published by Optum, a nationally recognized healthcare information company.

Date	Description	Procedure	Units	Charge
03/06/2023	Electrical Stimulation	97014	1	$66.00
03/06/2023	Exercise	97110	1	$103.00
03/06/2023	Extraspinal, 1 or more regions	98943	1	$60.00
03/07/2023	Hot/Cold Pack	97010	1	$46.00
03/07/2023	Traction,mechanical	97012	1	$63.00
03/07/2023	Electrical Stimulation	97014	1	$66.00
03/07/2023	Physical therapy Re-Evaluation	97164	1	$135.00
03/09/2023	Hot/Cold Pack	97010	1	$46.00
03/09/2023	Hydrotherapy Bed	97039	1	$82.00
03/09/2023	CMT spinal, 1-2 regions	98940	1	$74.00

Service provided at: Parkville/Carney
8113 Harford Road, Suite 200
Parkville, MD 21234
Phone: (888)570-0088
Fax: (410)732-6112

Current Charges:	$5,818.00
Total Balance:	$5,818.00

Travelers
P.O. Box 430
Buffalo, 14240

HEALTH INSURANCE CLAIM FORM

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

PICA | PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): IQC1880

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

3. PATIENT'S BIRTH DATE MM DD YY: 03 04 1972 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 1104 Sandy Stone Road,

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

7. INSURED'S ADDRESS (No., Street): 1104 Sandy Stone Road,

CITY: Essex | STATE: MD

8. RESERVED FOR NUCC USE

CITY: Essex | STATE: MD

ZIP CODE: 21221 | TELEPHONE (Include Area Code): (410) 776-4405

ZIP CODE: 21221 | TELEPHONE (Include Area Code): (410) 776-4405

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

a. INSURED'S DATE OF BIRTH MM DD YY: 03 04 1972 SEX M [ ] F [X]

b. RESERVED FOR NUCC USE:

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

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: Travelers

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: SIGNATURE ON FILE DATE: 02/07/2023

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 01 18 2023 QUAL.: Inj

15. OTHER DATE QUAL.: MM DD YY: NA

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. S134XXA B. S43499A C. S8010XA D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 Physical Therapy Evaluation											
02 01 23	02 01 23	11		97161	59		279 00	1		NPI	1356403331
2 Hot/Cold Pack											
02 06 23	02 06 23	11		97010			46 00	1		NPI	1356403331
3 Traction,mechanical											
02 06 23	02 06 23	11		97012			63 00	1		NPI	1356403331
4 Electrical Stimulation											
02 06 23	02 06 23	11		97014			66 00	1		NPI	1356403331
5 CMT spinal, 1-2 regions											
02 06 23	02 06 23	11		98940			74 00	1		NPI	1356403331
6 Electrodes											
02 06 23	02 06 23	11		A4556			49 00	1		NPI	1356403331

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 521521492

26. PATIENT'S ACCOUNT NO.: GREAD008

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

28. TOTAL CHARGE: $ 577 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use: 577 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Michael Welch, D.C. DATE 02/07/2023

32. SERVICE FACILITY LOCATION INFORMATION
Parkville/Carney
8113 Harford Road; Suite 200
Parkville, MD 21234

a. b.

33. BILLING PROVIDER INFO & PH # (888) 570-0088
Maryland Healthcare Clinics
DBA MHC HealthCare
5 Park Center Court, Suite 200
Owings Mills, MD 21117

a. 1043312036 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Travelers
P.O. Box 430
Buffalo, 14240

HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): IQC1880

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

3. PATIENT'S BIRTH DATE: 03 04 1972 SEX: M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 1104 Sandy Stone Road,

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

7. INSURED'S ADDRESS (No., Street): 1104 Sandy Stone Road,

CITY: Essex | STATE: MD

8. RESERVED FOR NUCC USE

CITY: Essex | STATE: MD

ZIP CODE: 21221 | TELEPHONE (Include Area Code): (410) 776-4405

ZIP CODE: 21221 | TELEPHONE (Include Area Code): (410) 776-4405

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH: 03 04 1972 SEX: M [ ] F [X]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: Travelers

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: SIGNATURE ON FILE DATE: 02/08/2023

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 01 18 2023 QUAL. Inj

15. OTHER DATE QUAL. MM NA DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. S134XXA B. S43499A C. S8010XA D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 Hot/Cold Pack	02 07 23	02 07 23	11		97010			46 00	1		NPI	1356403331
2 Traction,mechanical	02 07 23	02 07 23	11		97012			63 00	1		NPI	1356403331
3 Electrical Stimulation	02 07 23	02 07 23	11		97014			66 00	1		NPI	1356403331
4 Exercise	02 07 23	02 07 23	11		97110			103 00	1		NPI	1356403331
5 CMT spinal, 1-2 regions	02 07 23	02 07 23	11		98940			74 00	1		NPI	1356403331
6											NPI	

25. FEDERAL TAX I.D. NUMBER: 521521492 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: GREAD008

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

28. TOTAL CHARGE: $ 352 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use: 352 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Michael Welch, D.C. DATE 02/08/2023

32. SERVICE FACILITY LOCATION INFORMATION
Parkville/Carney
8113 Harford Road; Suite 200
Parkville, MD 21234

a. b.

33. BILLING PROVIDER INFO & PH # (888) 570-0088
Maryland Healthcare Clinics
DBA MHC HealthCare
5 Park Center Court, Suite 200
Owings Mills, MD 21117

a. 1043312036 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Travelers
P.O. Box 430
Buffalo, 14240

HEALTH INSURANCE CLAIM FORM

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

CARRIER

PICA | PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): IQC1880

PATIENT AND INSURED INFORMATION

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
GREENE, ADRIENNE	03 04 1972 M [ ] F [X]	GREENE, ADRIENNE
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
1104 Sandy Stone Road,	Self [X] Spouse [ ] Child [ ] Other [ ]	1104 Sandy Stone Road,
CITY: Essex / STATE: MD	8. RESERVED FOR NUCC USE	CITY: Essex / STATE: MD
ZIP CODE: 21221 / TELEPHONE (Include Area Code): (410) 776-4405		ZIP CODE: 21221 / TELEPHONE (Include Area Code): (410) 776-4405
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: 03 04 1972 M [ ] F [X]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME: Travelers
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 02/10/2023

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO MM DD YY
01 18 2023 QUAL. Inj	QUAL. NA	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

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

A. S134XXA B. S43499A C. S8010XA D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 Hot/Cold Pack: 02 09 23 02 09 23	11		97010			46 00	1		NPI	1356403331
2 Traction,mechanical: 02 09 23 02 09 23	11		97012			63 00	1		NPI	1356403331
3 Electrical Stimulation: 02 09 23 02 09 23	11		97014			66 00	1		NPI	1356403331
4 CMT spinal, 1-2 regions: 02 09 23 02 09 23	11		98940			74 00	1		NPI	1356403331
5 Exercise: 02 09 23 02 09 23	11		97110			206 00	2		NPI	1356403331
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
521521492 [ ] [X]	GREAD008	YES [X] NO [ ]	$ 455 00	$	455 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (888) 570-0088
SIGNED Michael Welch, D.C. DATE 02/10/2023	Parkville/Carney 8113 Harford Road; Suite 200 Parkville, MD 21234 a. b.	Maryland Healthcare Clinics DBA MHC HealthCare 5 Park Center Court, Suite 200 Owings Mills, MD 21117 a. 1043312036 b.

Travelers
P.O. Box 430
Buffalo, 14240

HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): IQC1880

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

3. PATIENT'S BIRTH DATE: 03 04 1972 SEX: M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 1104 Sandy Stone Road,

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

7. INSURED'S ADDRESS (No., Street): 1104 Sandy Stone Road,

CITY: Essex STATE: MD

8. RESERVED FOR NUCC USE

CITY: Essex STATE: MD

ZIP CODE: 21221 TELEPHONE (Include Area Code): (410) 776-4405

ZIP CODE: 21221 TELEPHONE (Include Area Code): (410) 776-4405

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH: 03 04 1972 SEX: M [ ] F [X]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: Travelers

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: SIGNATURE ON FILE DATE: 02/14/2023

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 01 18 2023 QUAL. Inj

15. OTHER DATE QUAL. MM NA DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. S134XXA B. S43499A C. S8010XA D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 Hot/Cold Pack 02 13 23	02 13 23	11		97010			46 00	1		NPI	1356403331
2 Traction,mechanical 02 13 23	02 13 23	11		97012			63 00	1		NPI	1356403331
3 Electrical Stimulation 02 13 23	02 13 23	11		97014			66 00	1		NPI	1356403331
4 CMT spinal, 1-2 regions 02 13 23	02 13 23	11		98940			74 00	1		NPI	1356403331
5 Exercise 02 13 23	02 13 23	11		97110			206 00	2		NPI	1356403331
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 521521492

26. PATIENT'S ACCOUNT NO.: GREAD008

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

28. TOTAL CHARGE: $ 455 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use: 455 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Michael Welch, D.C. DATE 02/14/2023

32. SERVICE FACILITY LOCATION INFORMATION
Parkville/Carney
8113 Harford Road; Suite 200
Parkville, MD 21234

a. b.

33. BILLING PROVIDER INFO & PH # (888) 570-0088
Maryland Healthcare Clinics
DBA MHC HealthCare
5 Park Center Court, Suite 200
Owings Mills, MD 21117

a. 1043312036 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Travelers
P.O. Box 430
Buffalo, 14240

HEALTH INSURANCE CLAIM FORM

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

PICA | PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): IQC1880

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

3. PATIENT'S BIRTH DATE MM DD YY: 03 04 1972 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 1104 Sandy Stone Road,

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

7. INSURED'S ADDRESS (No., Street): 1104 Sandy Stone Road,

CITY: Essex | STATE: MD

8. RESERVED FOR NUCC USE

CITY: Essex | STATE: MD

ZIP CODE: 21221 | TELEPHONE (Include Area Code): (410) 776-4405

ZIP CODE: 21221 | TELEPHONE (Include Area Code): (410) 776-4405

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

a. INSURED'S DATE OF BIRTH MM DD YY: 03 04 1972 SEX M [ ] F [X]

b. RESERVED FOR NUCC USE:

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

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: Travelers

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: SIGNATURE ON FILE DATE: 02/21/2023

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 01 18 2023 QUAL. Inj

15. OTHER DATE QUAL. MM DD YY: NA

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. S134XXA B. S43499A C. S8010XA D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 Hot/Cold Pack											
02 17 23	02 17 23	11		97010			46 00	1		NPI	1356403331
2 Traction,mechanical											
02 17 23	02 17 23	11		97012			63 00	1		NPI	1356403331
3 Electrical Stimulation											
02 17 23	02 17 23	11		97014			66 00	1		NPI	1356403331
4 CMT spinal, 1-2 regions											
02 17 23	02 17 23	11		98940			74 00	1		NPI	1356403331
5 Exercise											
02 17 23	02 17 23	11		97110			206 00	2		NPI	1356403331
6 Hot/Cold Pack											
02 20 23	02 20 23	11		97010			46 00	1		NPI	1356403331

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 521521492

26. PATIENT'S ACCOUNT NO.: GREAD008

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

28. TOTAL CHARGE: $ 501 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use: 501 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Michael Welch, D.C. DATE 02/21/2023

32. SERVICE FACILITY LOCATION INFORMATION
Parkville/Carney
8113 Harford Road; Suite 200
Parkville, MD 21234

a. b.

33. BILLING PROVIDER INFO & PH # (888) 570-0088
Maryland Healthcare Clinics
DBA MHC HealthCare
5 Park Center Court, Suite 200
Owings Mills, MD 21117

a. 1043312036 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Travelers
P.O. Box 430
Buffalo, 14240

HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): IQC1880

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

3. PATIENT'S BIRTH DATE: 03 04 1972 SEX: M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 1104 Sandy Stone Road,

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

7. INSURED'S ADDRESS (No., Street): 1104 Sandy Stone Road,

CITY: Essex | STATE: MD

8. RESERVED FOR NUCC USE

CITY: Essex | STATE: MD

ZIP CODE: 21221 | TELEPHONE (Include Area Code): (410) 776-4405

ZIP CODE: 21221 | TELEPHONE (Include Area Code): (410) 776-4405

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

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

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

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

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH: 03 04 1972 SEX: M [ ] F [X]

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME: Travelers

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: SIGNATURE ON FILE DATE: 02/21/2023

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 01 18 2023 QUAL. Inj

15. OTHER DATE QUAL. MM NA DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. S134XXA B. S43499A C. S8010XA D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 Traction,mechanical	02 20 23	02 20 23	11		97012			63 00	1		NPI 1356403331
2 Electrical Stimulation	02 20 23	02 20 23	11		97014			66 00	1		NPI 1356403331
3 CMT spinal, 1-2 regions	02 20 23	02 20 23	11		98940			74 00	1		NPI 1356403331
4 Exercise	02 20 23	02 20 23	11		97110			206 00	2		NPI 1356403331
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER: 521521492 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: GREAD008

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

28. TOTAL CHARGE: $ 409 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use: 409 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Michael Welch, D.C. DATE 02/21/2023

32. SERVICE FACILITY LOCATION INFORMATION
Parkville/Carney
8113 Harford Road; Suite 200
Parkville, MD 21234

a. b.

33. BILLING PROVIDER INFO & PH # (888) 570-0088
Maryland Healthcare Clinics
DBA MHC HealthCare
5 Park Center Court, Suite 200
Owings Mills, MD 21117

a. 1043312036 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Travelers
P.O. Box 430
Buffalo, 14240

HEALTH INSURANCE CLAIM FORM

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

PICA | PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): IQC1880

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

3. PATIENT'S BIRTH DATE (MM DD YY): 03 04 1972 SEX: M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 1104 Sandy Stone Road,

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

7. INSURED'S ADDRESS (No., Street): 1104 Sandy Stone Road,

CITY: Essex | STATE: MD

8. RESERVED FOR NUCC USE

CITY: Essex | STATE: MD

ZIP CODE: 21221 | TELEPHONE (Include Area Code): (410) 776-4405

ZIP CODE: 21221 | TELEPHONE (Include Area Code): (410) 776-4405

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH (MM DD YY): 03 04 1972 SEX: M [ ] F [X]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: Travelers

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: SIGNATURE ON FILE DATE: 02/22/2023

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM DD YY): 01 18 2023 QUAL. Inj

15. OTHER DATE QUAL. MM DD YY: NA

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. S134XXA B. S43499A C. S8010XA D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 Hot/Cold Pack	02 21 23	02 21 23	11		97010		A	46 00	1		NPI	1356403331
2 Traction,mechanical	02 21 23	02 21 23	11		97012		A	63 00	1		NPI	1356403331
3 Electrical Stimulation	02 21 23	02 21 23	11		97014		A	66 00	1		NPI	1356403331
4 CMT spinal, 1-2 regions	02 21 23	02 21 23	11		98940		A	74 00	1		NPI	1356403331
5 Exercise	02 21 23	02 21 23	11		97110		A	206 00	2		NPI	1356403331
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 521521492

26. PATIENT'S ACCOUNT NO.: GREAD008

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

28. TOTAL CHARGE: $ 455 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use: 455 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Michael Welch, D.C. DATE 02/22/2023

32. SERVICE FACILITY LOCATION INFORMATION
Parkville/Carney
8113 Harford Road; Suite 200
Parkville, MD 21234

a. b.

33. BILLING PROVIDER INFO & PH # (888) 570-0088
Maryland Healthcare Clinics
DBA MHC HealthCare
5 Park Center Court, Suite 200
Owings Mills, MD 21117

a. 1043312036 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Travelers
P.O. Box 430
Buffalo, 14240

HEALTH INSURANCE CLAIM FORM

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

CARRIER

PICA | PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): IQC1880

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

3. PATIENT'S BIRTH DATE MM DD YY: 03 04 1972 | SEX: M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 1104 Sandy Stone Road,

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

7. INSURED'S ADDRESS (No., Street): 1104 Sandy Stone Road,

CITY: Essex | STATE: MD

8. RESERVED FOR NUCC USE

CITY: Essex | STATE: MD

ZIP CODE: 21221 | TELEPHONE (Include Area Code): (410) 776-4405

ZIP CODE: 21221 | TELEPHONE (Include Area Code): (410) 776-4405

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH MM DD YY: 03 04 1972 | SEX: M [ ] F [X]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: Travelers

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: SIGNATURE ON FILE | DATE: 02/24/2023

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 01 18 2023 QUAL.: Inj

15. OTHER DATE QUAL.: | MM DD YY: NA

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. S134XXA B. S43499A C. S8010XA D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 Hot/Cold Pack	02 23 23	02 23 23	11		97010		46 00	1		NPI	1356403331
2 Traction,mechanical	02 23 23	02 23 23	11		97012		63 00	1		NPI	1356403331
3 Electrical Stimulation	02 23 23	02 23 23	11		97014		66 00	1		NPI	1356403331
4 Extraspinal, 1 or more regions	02 23 23	02 23 23	11		98943		60 00	1		NPI	1356403331
5 Exercise	02 23 23	02 23 23	11		97110		206 00	2		NPI	1356403331
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 521521492 [ ] [X]

26. PATIENT'S ACCOUNT NO.: GREAD008

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

28. TOTAL CHARGE: $ 441 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use: 441 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Michael Welch, D.C. DATE 02/24/2023

32. SERVICE FACILITY LOCATION INFORMATION
Parkville/Carney
8113 Harford Road; Suite 200
Parkville, MD 21234

a. | b.

33. BILLING PROVIDER INFO & PH # (888) 570-0088
Maryland Healthcare Clinics
DBA MHC HealthCare
5 Park Center Court, Suite 200
Owings Mills, MD 21117

a. 1043312036 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Travelers
P.O. Box 430
Buffalo, 14240

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE [ ] (ID#/DOD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [X] (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): IQC1880
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): GREENE, ADRIENNE	3. PATIENT'S BIRTH DATE MM DD YY: 03 04 1972 SEX M [ ] F [X]	4. INSURED'S NAME (Last Name, First Name, Middle Initial): GREENE, ADRIENNE
5. PATIENT'S ADDRESS (No., Street): 1104 Sandy Stone Road,	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street): 1104 Sandy Stone Road,
CITY: Essex STATE: MD	8. RESERVED FOR NUCC USE	CITY: Essex STATE: MD
ZIP CODE: 21221 TELEPHONE (Include Area Code): (410) 776-4405		ZIP CODE: 21221 TELEPHONE (Include Area Code): (410) 776-4405
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER:
a. OTHER INSURED'S POLICY OR GROUP NUMBER:	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY: 03 04 1972 SEX M [ ] F [X]
b. RESERVED FOR NUCC USE:	b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State):	b. OTHER CLAIM ID (Designated by NUCC):
c. RESERVED FOR NUCC USE:	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME: Travelers
d. INSURANCE PLAN NAME OR PROGRAM NAME:	10d. CLAIM CODES (Designated by NUCC):	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 02/28/2023

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 01 18 2023 QUAL.: Inj	15. OTHER DATE QUAL.: MM DD YY: NA	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.
A. S134XXA B. S43499A C. S8010XA D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 Hot/Cold Pack 02 27 23 02 27 23	11		97010			46 00	1		NPI	1356403331
2 Traction,mechanical 02 27 23 02 27 23	11		97012			63 00	1		NPI	1356403331
3 Electrical Stimulation 02 27 23 02 27 23	11		97014			66 00	1		NPI	1356403331
4 Extraspinal, 1 or more regions 02 27 23 02 27 23	11		98943			60 00	1		NPI	1356403331
5 Exercise 02 27 23 02 27 23	11		97110			206 00	2		NPI	1356403331
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
521521492 [ ] [X]	GREAD008	YES [X] NO [ ]	$ 441 00	$	441 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (888) 570-0088
SIGNED Michael Welch, D.C. DATE 02/28/2023	Parkville/Carney 8113 Harford Road; Suite 200 Parkville, MD 21234 a. b.	Maryland Healthcare Clinics DBA MHC HealthCare 5 Park Center Court, Suite 200 Owings Mills, MD 21117 a. 1043312036 b.

Travelers
P.O. Box 430
Buffalo, 14240

HEALTH INSURANCE CLAIM FORM

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

CARRIER

PICA | PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE ☐ (ID#/DOD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☒ (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
	IQC1880	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
GREENE, ADRIENNE	03 | 04 | 1972 M ☐ F ☒	GREENE, ADRIENNE
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
1104 Sandy Stone Road,	Self ☒ Spouse ☐ Child ☐ Other ☐	1104 Sandy Stone Road,
CITY / STATE: Essex / MD	8. RESERVED FOR NUCC USE	CITY / STATE: Essex / MD
ZIP CODE / TELEPHONE (Include Area Code): 21221 / (410) 776-4405		ZIP CODE / TELEPHONE (Include Area Code): 21221 / (410) 776-4405
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO	a. INSURED'S DATE OF BIRTH SEX: 03 | 04 | 1972 M ☐ F ☒
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☒ YES ☐ NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☒ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: Travelers
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 03/01/2023

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 01 | 18 | 2023 QUAL. Inj	15. OTHER DATE QUAL. MM DD YY: NA	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.
A. S134XXA B. S43499A C. S8010XA D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 Hot/Cold Pack: 02 28 23 02 28 23	11		97010		46 00	1		NPI	1356403331
2 Traction,mechanical: 02 28 23 02 28 23	11		97012		63 00	1		NPI	1356403331
3 Electrical Stimulation: 02 28 23 02 28 23	11		97014		66 00	1		NPI	1356403331
4 Extraspinal, 1 or more regions: 02 28 23 02 28 23	11		98943		60 00	1		NPI	1356403331
5 Exercise: 02 28 23 02 28 23	11		97110		206 00	2		NPI	1356403331
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
521521492 ☐ ☒	GREAD008	☒ YES ☐ NO	$ 441 00	$	441 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (888) 570-0088
SIGNED Michael Welch, D.C. DATE 03/01/2023	Parkville/Carney 8113 Harford Road; Suite 200 Parkville, MD 21234 a. b.	Maryland Healthcare Clinics DBA MHC HealthCare 5 Park Center Court, Suite 200 Owings Mills, MD 21117 a. 1043312036 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Travelers
P.O. Box 430
Buffalo, 14240

HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): IQC1880

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

3. PATIENT'S BIRTH DATE: 03 04 1972 SEX: M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 1104 Sandy Stone Road,

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

7. INSURED'S ADDRESS (No., Street): 1104 Sandy Stone Road,

CITY: Essex | STATE: MD

8. RESERVED FOR NUCC USE

CITY: Essex | STATE: MD

ZIP CODE: 21221 | TELEPHONE (Include Area Code): (410) 776-4405

ZIP CODE: 21221 | TELEPHONE (Include Area Code): (410) 776-4405

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH: 03 04 1972 SEX: M [ ] F [X]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: Travelers

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: SIGNATURE ON FILE DATE: 03/03/2023

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 01 18 2023 QUAL. Inj

15. OTHER DATE QUAL. MM DD YY: NA

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. S134XXA B. S43499A C. S8010XA D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 Hot/Cold Pack 03 02 23	03 02 23	11		97010			46 00	1		NPI	1356403331
2 Traction,mechanical 03 02 23	03 02 23	11		97012			63 00	1		NPI	1356403331
3 Electrical Stimulation 03 02 23	03 02 23	11		97014			66 00	1		NPI	1356403331
4 Extraspinal, 1 or more regions 03 02 23	03 02 23	11		98943			60 00	1		NPI	1356403331
5 Exercise 03 02 23	03 02 23	11		97110			206 00	2		NPI	1356403331
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 521521492

26. PATIENT'S ACCOUNT NO.: GREAD008

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

28. TOTAL CHARGE: $ 441 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use: 441 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Michael Welch, D.C. DATE 03/03/2023

32. SERVICE FACILITY LOCATION INFORMATION
Parkville/Carney
8113 Harford Road; Suite 200
Parkville, MD 21234

a. b.

33. BILLING PROVIDER INFO & PH # (888) 570-0088
Maryland Healthcare Clinics
DBA MHC HealthCare
5 Park Center Court, Suite 200
Owings Mills, MD 21117

a. 1043312036 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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Buffalo, 14240

HEALTH INSURANCE CLAIM FORM

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

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3. PATIENT'S BIRTH DATE MM DD YY: 03 04 1972 SEX M ☐ F ☒

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

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6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): 1104 Sandy Stone Road,

CITY: Essex | STATE: MD

8. RESERVED FOR NUCC USE

CITY: Essex | STATE: MD

ZIP CODE: 21221 | TELEPHONE (Include Area Code): (410) 776-4405

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY: 03 04 1972 SEX M ☐ F ☒

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ☒ NO ☐ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: Travelers

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: SIGNATURE ON FILE DATE: 03/07/2023

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 01 18 2023 QUAL. Inj

15. OTHER DATE QUAL. MM DD YY: NA

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☒ $ CHARGES

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

A. S134XXA B. S43499A C. S8010XA D.
E. F. G. H.
I. J. K. L.

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1 Hot/Cold Pack 03 06 23	03 06 23	11		97010			46 00	1		NPI	1356403331
2 Traction,mechanical 03 06 23	03 06 23	11		97012			63 00	1		NPI	1356403331
3 Electrical Stimulation 03 06 23	03 06 23	11		97014			66 00	1		NPI	1356403331
4 Exercise 03 06 23	03 06 23	11		97110			103 00	1		NPI	1356403331
5 Extraspinal, 1 or more regions 03 06 23	03 06 23	11		98943			60 00	1		NPI	1356403331
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☒: 521521492

26. PATIENT'S ACCOUNT NO.: GREAD008

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

28. TOTAL CHARGE: $ 338 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use: 338 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Michael Welch, D.C. DATE 03/07/2023

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8113 Harford Road; Suite 200
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a. b.

33. BILLING PROVIDER INFO & PH # (888) 570-0088
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DBA MHC HealthCare
5 Park Center Court, Suite 200
Owings Mills, MD 21117

a. 1043312036 b.

CARRIER

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

3. PATIENT'S BIRTH DATE MM DD YY: 03 04 1972 SEX M ☐ F ☒

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

5. PATIENT'S ADDRESS (No., Street): 1104 Sandy Stone Road,

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): 1104 Sandy Stone Road,

CITY: Essex STATE: MD

8. RESERVED FOR NUCC USE

CITY: Essex STATE: MD

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10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY: 03 04 1972 SEX M ☐ F ☒

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ☒ NO ☐ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: Travelers

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: SIGNATURE ON FILE DATE: 03/08/2023

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 01 18 2023 QUAL.: Inj

15. OTHER DATE QUAL.: MM: NA DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

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17b. NPI

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20. OUTSIDE LAB? YES ☐ NO ☒ $ CHARGES

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A. S134XXA B. S43499A C. S8010XA D.
E. F. G. H.
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1 Hot/Cold Pack 03 07 23 03 07 23	11		97010			46 00	1		NPI	1356403331
2 Traction,mechanical 03 07 23 03 07 23	11		97012			63 00	1		NPI	1356403331
3 Electrical Stimulation 03 07 23 03 07 23	11		97014			66 00	1		NPI	1356403331
4 Physical therapy Re-Evaluation 03 07 23 03 07 23	11		97164			135 00	1		NPI	1356403331
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☒: 521521492

26. PATIENT'S ACCOUNT NO.: GREAD008

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

28. TOTAL CHARGE: $ 310 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use: 310 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Michael Welch, D.C. DATE 03/08/2023

32. SERVICE FACILITY LOCATION INFORMATION
Parkville/Carney
8113 Harford Road; Suite 200
Parkville, MD 21234

a. b.

33. BILLING PROVIDER INFO & PH # (888) 570-0088
Maryland Healthcare Clinics
DBA MHC HealthCare
5 Park Center Court, Suite 200
Owings Mills, MD 21117

a. 1043312036 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

Travelers
P.O. Box 430
Buffalo, 14240

HEALTH INSURANCE CLAIM FORM

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

PICA

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a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH: 03 04 1972 SEX: M [ ] F [X]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: Travelers

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

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SIGNED: SIGNATURE ON FILE DATE: 03/10/2023

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SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 01 18 2023 QUAL. Inj

15. OTHER DATE QUAL. MM DD YY: NA

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

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2 Hydrotherapy Bed 03 09 23	03 09 23	11		97039			82 00	1		NPI	1356403331
3 CMT spinal, 1-2 regions 03 09 23	03 09 23	11		98940			74 00	1		NPI	1356403331
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 521521492 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: GREAD008

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

28. TOTAL CHARGE: $ 202 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use: 202 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Michael Welch, D.C. DATE 03/10/2023

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DBA MHC HealthCare
5 Park Center Court, Suite 200
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a. 1043312036 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

MedStar Health

MedStar Franklin Square Medical Center

9000 Franklin Square Drive
Baltimore, MD 21237
Phone: 443-777-7000

Patient:	**GREENE, ADRIENNE EVETTE**		
Med Rec #:	FSH-000801474292	Admit/Discharge:	1/18/2023 / 1/18/2023
Account #:	FSH-03046326272	Admitting Doctor:	Charbonneau,MD,Stephen G
Date of Birth:	3/4/1972 Age: 50 years Sex: Female	Ordering Doctor:	n/a
Location:	Franklin Square Hospital Center		MFSH EDPT

Emergency Documentation

DOCUMENT NAME:	Triage Note
PERFORM INFORMATION:	Fernando,RN,Emily Marie A (1/18/2023 16:50 EST)
RESULT STATUS:	Modified
SERVICE DATE/TIME:	1/18/2023 16:50 EST
SIGN INFORMATION:	Fernando,RN,Emily Marie A (1/18/2023 17:36 EST); Fernando,RN,Emily Marie A (1/18/2023 16:50 EST)

ED Triage Adult Entered On: 01/18/2023 16:54 EST
Performed On: 01/18/2023 16:50 EST by Fernando, RN, Emily Marie A

COVID-19 Screening
Is the patient experiencing any symptoms consistent with COVID-19? : No
Positive/Diagnosed COVID19 past 10 days : No
COVID19 Close Contact past 10 days : No
COVIDScrnCalc : 2
ISONLY COVID Healthcare CALC : 2

Fernando, RN, Emily Marie A - 01/18/2023 16:50 EST

MedStar ED Adult Triage
Chief Complaint/Mechanism of Injury : Pt belted driver in MVC around 1150 today. Pt driving 35 mph and was hit on passenger side. +AB. -LOC. Pt reports R sided 7/10 CP and R side knee pain. Bruising noted to side of R knee. SOB resolved PTA. -cspine tenderness. Ambulatory on scene.
Preferred Language For Discussing Healthcare : English
Interpreter Used : N/A
Demonstrates Signs,Symptoms of Condition : None
Recent Travel Internationally : No
Location family or close friend travel : None
Lynx Mode of Arrival - Modified : Walk-in
Arrived From for ED : Home
Mode of Arrival : Walk-in

Fernando, RN, Emily Marie A - 01/18/2023 16:50 EST

Behavioral/Domestic Concerns
BehHlth/Subst Abuse Reason for Care : No
Domestic Concerns : None
Homicide/Assault Ideation : None

Fernando, RN, Emily Marie A - 01/18/2023 16:50 EST

MedStar Franklin Square Medical Center

Patient: **GREENE, ADRIENNE EVETTE**
Med Rec #: FSH-000801474292
Account #: FSH-03046326272
Date of Birth: 3/4/1972 Age: 50 years Sex: Female
Location: MFSH EDPT

Admit/Discharge: 1/18/2023 / 1/18/2023
Admitting Doctor: Charbonneau,MD,Stephen G
Ordering Doctor: n/a

Emergency Documentation

Dosing Height/Weight v1
Dosing Weight/Height History RTF : Weight Dosing Wt Height/Length Height
Date/Time Facility Dosing Method Dosing Method BMI Dosing
01/26/22 15:36 Bariatrics and Su 117.5 kg 163 cm 44.22 kg/m2
Dosing Height Method : Estimated
Height/Length Dosing : 163 cm(Converted to: 5 ft 4 in)
Abnormal Height Validation (Dosing) : Documented height is WITHIN reference range
Dosing Weight Method : Estimated
Weight Dosing : 117.5 kg(Converted to: 259 lb 1 oz)
Abnormal Weight Validation (Dosing) : Documented weight is WITHIN reference range
BSA Dosing : 2.19 m2
Body Mass Index Dosing : 44.22 kg/m2

Fernando, RN, Emily Marie A - 01/18/2023 16:50 EST

ED Vital Signs/Pain Assessment Adult V6
ED Tech Triage Vital Signs - ST : ED Triage VS
Temperature Oral: 37 DegC (01/18/23 16:37:29)
Peripheral Pulse Rate: 86 bpm (01/18/23 16:37:49)
Respiratory Rate: 16 BR/min (01/18/23 16:37:35)
Systolic BP, Automated: 141 mmHg High (01/18/23 16:37:39)
Diastolic BP, Automated: 85 mmHg (01/18/23 16:37:39)
SpO2: 99 % (01/18/23 16:37:49)
ED Triage VS Completed : Yes
Pain Present : Yes actual or suspected pain
Preferred Pain Tool : Numeric rating scale
Numeric Pain Score : 7
Numeric Pain Scale Acceptable Intensity : 2

Fernando, RN, Emily Marie A - 01/18/2023 16:50 EST

ESI
Does The Patient Require Immediate Life-Saving Intervention? : No
Is This a High Risk Situation Where The Patient is Confused/Lethargic/Disoriented or in Severe Pain/Distress? : No
How Many Different Resources Will This Patient Need? : Many
Recommended ESI Level : 3

Fernando, RN, Emily Marie A - 01/18/2023 16:50 EST
Fernando, RN, Emily Marie A - 01/18/2023 16:50 EST

DCP GENERIC CODE
Tracking Group : ED FSHC Tracking

Fernando, RN, Emily Marie A - 01/18/2023 16:50 EST

Tracking Acuity : 3V

Fernando, RN, Emily Marie A - 01/18/2023 17:36 EST
~~{ [3H] - previously charted by Fernando, RN, Emily Marie A at 01/18/2023 16:50 EST};~~

Allergies/Home Meds

(As Of: 01/18/2023 16:54:36 EST)

MedStar Franklin Square Medical Center

Patient: **GREENE, ADRIENNE EVETTE**
Med Rec #: FSH-000801474292
Account #: FSH-03046326272
Date of Birth: 3/4/1972 Age: 50 years Sex: Female
Location: MFSH EDPT

Admit/Discharge: 1/18/2023 / 1/18/2023
Admitting Doctor: Charbonneau,MD,Stephen G
Ordering Doctor: n/a

Emergency Documentation

Allergies (Active)

Latex — *Estimated Onset Date:* Unspecified ; *Reactions:* Itching, reddness ; *Created By:* JENNIFER RICE/SMITH, RN; *Reaction Status:* Active ; *Category:* Other ; *Substance:* Latex ; *Type:* Allergy ; *Updated By:* JENNIFER RICE/SMITH, RN; *Reviewed Date:* 01/26/2022 15:36 EST

Medication List

(As Of: 01/18/2023 16:54:36 EST)

Prescription/Discharge Order

liraglutide — : liraglutide ; *Status:* Prescribed ; *Ordered As Mnemonic:* Saxenda 18 mg/3 mL subcutaneous solution ; *Simple Display Line:* See Instructions, Week 1 0.6 mg Subcut Daily; Week 2 1.2 mg Subcut Daily; Week 3 1.8 mg Subcut Daily; Week 4 2.4 mg Subcut Daily; Week 5 3.0 mg Subcut Daily, 15 mL, 0 Refill(s) ; *Ordering Provider:* You, MD, Christopher Jamyn; *Catalog Code:* liraglutide ; *Order Dt/Tm:* 01/26/2022 15:53:07 EST

cholecalciferol — : cholecalciferol ; *Status:* Prescribed ; *Ordered As Mnemonic:* Vitamin D3 2000 intl units oral tablet ; *Simple Display Line:* 2,000 Intl_Unit, 1 tab, PO, Daily, 90 tab, 1 Refill(s) ; *Ordering Provider:* Karen L. Wheeler, CRNP; *Catalog Code:* cholecalciferol ; *Order Dt/Tm:* 02/16/2021 16:37:36 EST

hydroCHLOROthiazide — : hydroCHLOROthiazide ; *Status:* Prescribed ; *Ordered As Mnemonic:* hydrochlorothiazide 25 mg oral tablet ; *Simple Display Line:* 25 mg, 1 tab, PO, Daily, 30 tab, 0 Refill(s) ; *Ordering Provider:* Karen L. Wheeler, CRNP; *Catalog Code:* hydroCHLOROthiazide ; *Order Dt/Tm:* 05/26/2020 09:38:48 EDT

famotidine — : famotidine ; *Status:* Prescribed ; *Ordered As Mnemonic:* famotidine 20 mg oral tablet ; *Simple Display Line:* 20 mg, 1 tab, PO, 2x/day, PRN: heartburn/indigestion, 180 tab, 0 Refill(s) ; *Ordering Provider:* Karen L. Wheeler, CRNP; *Catalog Code:* famotidine ; *Order Dt/Tm:* 11/04/2019 15:59:34 EST

levonorgestrel — : levonorgestrel ; *Status:* Prescribed ; *Ordered As Mnemonic:* Mirena 52 mg intrauteral device ; *Simple Display Line:* 52 mg, 1 ea, intraUTERAL, One Time, 1 ea, 0 Refill(s) ; *Ordering*

MedStar Franklin Square Medical Center

Patient: **GREENE, ADRIENNE EVETTE**
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Account #: FSH-03046326272
Date of Birth: 3/4/1972 Age: 50 years Sex: Female
Location: MFSH EDPT

Admit/Discharge: 1/18/2023 / 1/18/2023
Admitting Doctor: Charbonneau,MD,Stephen G
Ordering Doctor: n/a

Emergency Documentation

Provider: Karen L. Wheeler, CRNP; *Catalog Code:* levonorgestrel ; *Order Dt/Tm:* 02/23/2018 16:11:56 EST

Home Meds

Non Formulary : Non Formulary ; *Status:* Documented ; *Ordered As Mnemonic:* Bariatric Advantage Ultra Solo Multivitamin without iron ; *Simple Display Line:* 1 tab, Daily, 0 Refill(s) ; *Catalog Code:* Non Formulary ; *Order Dt/Tm:* 05/26/2020 09:57:48 EDT

Non Formulary : Non Formulary ; *Status:* Documented ; *Ordered As Mnemonic:* Iron infusion under direction of Dr. Chen prn ; *Simple Display Line:* 0 Refill(s) ; *Catalog Code:* Non Formulary ; *Order Dt/Tm:* 02/21/2019 09:27:02 EST

Non Formulary : Non Formulary ; *Status:* Documented ; *Ordered As Mnemonic:* B-100 Complex ; *Simple Display Line:* Every Other Day, 0 Refill(s) ; *Catalog Code:* Non Formulary ; *Order Dt/Tm:* 04/24/2018 15:44:48 EDT

Non Formulary : Non Formulary ; *Status:* Documented ; *Ordered As Mnemonic:* Calcium citrate ; *Simple Display Line:* 3x/day, 0 Refill(s) ; *Catalog Code:* Non Formulary ; *Order Dt/Tm:* 06/02/2017 11:00:10 EDT

Problem List/Nursing Diagnosis

(As Of: 01/18/2023 16:54:36 EST)

Problems(Active)

Anemia, iron deficiency (SNOMED CT :145104011) *Name of Problem:* Anemia, iron deficiency ; *Recorder:* Wheeler, CRNP, Karen L.; *Confirmation:* Confirmed ; *Classification:* Medical ; *Code:* 145104011 ; *Contributor System:* PowerChart ; *Last Updated:* 09/14/2017 09:57 EDT ; *Life Cycle Date:* 09/14/2017 ; *Life Cycle Status:* Active ; *Responsible Provider:* Wheeler, CRNP, Karen L.; *Vocabulary:* SNOMED CT

Bariatric surgery status (SNOMED CT :251850013) *Name of Problem:* Bariatric surgery status ; *Recorder:* Wheeler, CRNP, Karen L.; *Confirmation:* Confirmed ; *Classification:* Medical ; *Code:* 251850013 ; *Contributor*

MedStar Franklin Square Medical Center

Patient: GREENE, ADRIENNE EVETTE
Med Rec #: FSH-000801474292
Account #: FSH-03046326272
Date of Birth: 3/4/1972 Age: 50 years Sex: Female
Location: MFSH EDPT

Admit/Discharge: 1/18/2023 / 1/18/2023
Admitting Doctor: Charbonneau,MD,Stephen G
Ordering Doctor: n/a

Emergency Documentation

	System: PowerChart ; *Last Updated:* 05/26/2020 09:27 EDT ; *Life Cycle Date:* 05/26/2020 ; *Life Cycle Status:* Active ; *Responsible Provider:* Wheeler, CRNP, Karen L.; *Vocabulary:* SNOMED CT
Body mass index (BMI) of 40.0 to 44.9 in adult (SNOMED CT :2160062010)	*Name of Problem:* Body mass index (BMI) of 40.0 to 44.9 in adult ; *Recorder:* You, MD, Christopher Jamyn; *Confirmation:* Confirmed ; *Classification:* Medical ; *Code:* 2160062010 ; *Contributor System:* PowerChart ; *Last Updated:* 01/26/2022 15:48 EST ; *Life Cycle Date:* 01/26/2022 ; *Life Cycle Status:* Active ; *Responsible Provider:* You, MD, Christopher Jamyn; *Vocabulary:* SNOMED CT
HTN (hypertension) (SNOMED CT :1215744012)	*Name of Problem:* HTN (hypertension) ; *Recorder:* Combs, RN, Melissa B; *Confirmation:* Confirmed ; *Classification:* Medical ; *Code:* 1215744012 ; *Contributor System:* PowerChart ; *Last Updated:* 05/03/2017 15:06 EDT ; *Life Cycle Date:* 03/27/2017 ; *Life Cycle Status:* Active ; *Vocabulary:* SNOMED CT
Hyperlipidemia (SNOMED CT :92826017)	*Name of Problem:* Hyperlipidemia ; *Recorder:* Wheeler, CRNP, Karen L.; *Confirmation:* Confirmed ; *Classification:* Medical ; *Code:* 92826017 ; *Contributor System:* PowerChart ; *Last Updated:* 05/26/2020 09:27 EDT ; *Life Cycle Date:* 05/26/2020 ; *Life Cycle Status:* Active ; *Responsible Provider:* Wheeler, CRNP, Karen L.; *Vocabulary:* SNOMED CT
Morbid obesity (SNOMED CT :356968010)	*Name of Problem:* Morbid obesity ; *Recorder:* SYSTEM, SYSTEM; *Confirmation:* Probable ; *Classification:* Medical ; *Code:* 356968010 ; *Last Updated:* 02/13/2018 10:54 EST ; *Life Cycle Date:* 02/13/2018 ; *Life Cycle Status:* Active ; *Vocabulary:* SNOMED CT
Vitamin D deficiency (SNOMED CT :57937016)	*Name of Problem:* Vitamin D deficiency ; *Recorder:* Wheeler, CRNP, Karen L.; *Confirmation:* Confirmed ; *Classification:* Medical ; *Code:* 57937016 ; *Contributor System:* PowerChart ; *Last Updated:* 05/26/2020 09:27 EDT ; *Life Cycle Date:* 05/26/2020 ; *Life Cycle Status:* Active ; *Responsible Provider:* Wheeler, CRNP, Karen L.; *Vocabulary:* SNOMED CT

Diagnoses(Active)

MedStar Franklin Square Medical Center

Patient: **GREENE, ADRIENNE EVETTE**
Med Rec #: FSH-000801474292
Account #: FSH-03046326272
Date of Birth: 3/4/1972 Age: 50 years Sex: Female
Location: MFSH EDPT

Admit/Discharge: 1/18/2023 / 1/18/2023
Admitting Doctor: Charbonneau,MD,Stephen G
Ordering Doctor: n/a

Emergency Documentation

MVC (motor vehicle collision)	*Date:* 01/18/2023 ; *Diagnosis Type:* Reason For Visit ; *Confirmation:* Complaint of ; *Clinical Dx:* MVC (motor vehicle collision) ; *Classification:* Nursing ; *Clinical Service:* Non-Specified ; *Code:* ICD-10-CM ; *Probability:* 0 ; *Diagnosis Code:* V87.7XXA
Right-sided chest pain	*Date:* 01/18/2023 ; *Diagnosis Type:* Reason For Visit ; *Confirmation:* Complaint of ; *Clinical Dx:* Right-sided chest pain ; *Classification:* Nursing ; *Clinical Service:* Non-Specified ; *Code:* ICD-10-CM ; *Probability:* 0 ; *Diagnosis Code:* R07.9

Safety Assessment
Historical Concerns Regarding Staff Safety : None at this time
Concerns Regarding Staff Safety : None at this time

Fernando, RN, Emily Marie A - 01/18/2023 16:50 EST

Electronically signed by:
Fernando, RN, Emily Marie A on: 01.18.2023 16:50 EST

Electronically signed by:
Fernando, RN, Emily Marie A on: 01.18.2023 17:36 EST

DOCUMENT NAME: ED Note-Nursing
PERFORM INFORMATION: Owuamana,LPN,Charlene (1/18/2023 19:18 EST)
RESULT STATUS: Auth (Verified)
SERVICE DATE/TIME: 1/18/2023 19:18 EST
SIGN INFORMATION: Owuamana,LPN,Charlene (1/18/2023 19:18 EST)

ED Assessment Adult Entered On: 01/18/2023 19:24 EST
Performed On: 01/18/2023 19:18 EST by Owuamana, LPN, Charlene

Documented ESI
DCP GENERIC CODE
Tracking Acuity : 3V
Tracking Group : ED FSHC Tracking

Owuamana, LPN, Charlene - 01/18/2023 19:18 EST

ED TB Risk Factor/Symptoms
TB Symptoms Grid

MedStar Franklin Square Medical Center

Patient: **GREENE, ADRIENNE EVETTE**
Med Rec #: FSH-000801474292
Account #: FSH-03046326272
Date of Birth: 3/4/1972 Age: 50 years Sex: Female
Location: MFSH EDPT

Admit/Discharge: 1/18/2023 / 1/18/2023
Admitting Doctor: Charbonneau,MD,Stephen G
Ordering Doctor: n/a

Emergency Documentation

Fever : No
Chills : No
Persistent Cough Greater Than 2 Weeks : No
Weight Loss Greater Than 10lbs : No

Owuamana, LPN, Charlene - 01/18/2023 19:18 EST

Neurological
Orientation Assessment : Oriented x 4
Affect/Behavior : Anxious, Appropriate, Calm
Aspiration Risk : None
Level of Consciousness : Alert, Responsive
Loss of Consciousness : No

Owuamana, LPN, Charlene - 01/18/2023 19:18 EST

Procedure History
Extremity restriction, wt bearing/other : No

Owuamana, LPN, Charlene - 01/18/2023 19:18 EST

Procedure History

(As Of: 01/18/2023 19:24:14 EST)

Procedure Dt/Tm: 1995 ; *Anesthesia Minutes:* 0 ; *Procedure Name:* Cesarean delivery ; *Procedure Minutes:* 0

Procedure Dt/Tm: 2013 ; *Anesthesia Minutes:* 0 ; *Procedure Name:* Breast reduction, bilateral ; *Procedure Minutes:* 0

Procedure Dt/Tm: 2017 ; *Anesthesia Minutes:* 0 ; *Procedure Name:* Upper GI endoscopy ; *Procedure Minutes:* 0

Procedure Dt/Tm: 05/18/2017 ; *Anesthesia Minutes:* 0 ; *Procedure Name:* Sleeve Gastrectomy ; *Procedure Minutes:* 0

Procedure Dt/Tm: 11/27/2017 ; *Anesthesia Minutes:* 0 ; *Procedure Name:* Endometrial Biposy ; *Procedure Minutes:* 0

Procedure Dt/Tm: 02/23/2018 ; *Anesthesia Minutes:* 0 ; *Procedure Name:* Hysteroscopy, Dilation and Curettage, Mirena IUD insertion ; *Procedure Minutes:* 0

Social History
Tobacco Use : Never Used

MedStar Franklin Square Medical Center

Patient:	**GREENE, ADRIENNE EVETTE**		
Med Rec #:	FSH-000801474292	Admit/Discharge:	1/18/2023 / 1/18/2023
Account #:	FSH-03046326272	Admitting Doctor:	Charbonneau,MD,Stephen G
Date of Birth:	3/4/1972 Age: 50 years Sex: Female	Ordering Doctor:	n/a
Location:	MFSH EDPT		

Emergency Documentation

Smoking Status : Never smoker
Preferred Language For Discussing Healthcare : English
Preferred Communication Mode : Verbal
Interpreter Used : N/A
Cultural/Spiritual Practices to Continue : No

Owuamana, LPN, Charlene - 01/18/2023 19:18 EST

Social History

(As Of: 01/18/2023 19:24:14 EST)

Tobacco/Nicotine:

Use: Denies. (Last Updated: 12/29/2016 11:35:09 EST by Strom, RD, Kerry L.)

Substance Use:

Use: Denies. (Last Updated: 12/29/2016 11:35:04 EST by Strom, RD, Kerry L.)

Alcohol:

Use: Current. Frequency of Intake: 1-2 times per year. Average Drinks per episode in last year: 1. (Last Updated: 12/29/2016 11:35:33 EST by Strom, RD, Kerry L.)

Employment/School:

Status: Employed. Work/School description: Home Health Aide, works 3-11pm. (Last Updated: 04/04/2017 14:40:31 EDT by Strom, RD, Kerry L.)

Exercise:

Duration per Episode (Avg # of Minutes) 20. Frequency: 3-4 times/week. Self assessment: Fair condition. Exercise type: Walking, stationary bike. Comments: 12/05/2017 12:37 - Lynne Parry: trying to do more. 12/29/2016 11:36 - Strom, RD, Kerry L.: Does not exercise (Last Updated: 12/05/2017 12:37:44 EST by Lynne Parry)

Home/Environment:

Lives with Children, Spouse. Living situation: Home/Independent. Home Equipment: None. (Last Updated: 05/03/2017 15:06:34 EDT by Coleman-Reed, MA, Dina)

Nutrition/Health:

MedStar Franklin Square Medical Center

Patient: **GREENE, ADRIENNE EVETTE**
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Date of Birth: 3/4/1972 Age: 50 years Sex: Female
Location: MFSH EDPT

Admit/Discharge: 1/18/2023 / 1/18/2023
Admitting Doctor: Charbonneau,MD,Stephen G
Ordering Doctor: n/a

Emergency Documentation

Diet Description: low calorie high protein. Type of Diet: Calorie restricted. Sleeping Concerns No. Feels highly stressed: No.
(Last Updated: 12/05/2017 12:38:04 EST by Lynne Parry)

General
Tetanus Vaccine Date RTF : No qualifying data available in Immunization Record for the past 10 years.
Influenza Vaccine Date RTF : No qualifying data available in Immunization Record for the past year.
Pneumococcal Vaccine Date RTF : No qualifying data available in Immunization Record for the past 5 years.
Lines or Tubes Present on Admission : None
Patient on Dialysis : None
Does patient have a preferred name? : No
Does patient have preferred pronouns? : No
Does the patient receive any form of Dialysis? : None
BehHlth/Subst Abuse Reason for Care : No
Homicide/Assault Ideation : None

Owuamana, LPN, Charlene - 01/18/2023 19:18 EST

ED Morse Fall Risk Assessment
History of Fall in Last 3 Months Morse : No
Presence of Secondary Diagnosis Morse : No
Use of Ambulatory Aid Morse : None, bedrest, wheelchair, nurse
IV/Heparin Lock Fall Risk Morse : No
Gait Weak or Impaired Fall Risk Morse : Normal, bedrest, immobile
Mental Status Fall Risk Morse : Oriented to own ability
Morse Fall Risk Score : 0
Morse Calculated With : Patient

Owuamana, LPN, Charlene - 01/18/2023 19:18 EST

Safety Assessment
Historical Concerns Regarding Staff Safety : None at this time
Concerns Regarding Staff Safety : None at this time

Owuamana, LPN, Charlene - 01/18/2023 19:18 EST

Electronically signed by:

Owuamana, LPN, Charlene on: 01.18.2023 19:18 EST

DOCUMENT NAME: ED Note-Clinician
PERFORM INFORMATION: Gribbin,PA-C,Delys Vernetta (1/18/2023 17:00 EST)
RESULT STATUS: Auth (Verified)
SERVICE DATE/TIME: 1/18/2023 16:57 EST
SIGN INFORMATION: Gribbin,PA-C,Delys Vernetta (1/18/2023 17:00 EST)

MedStar Franklin Square Medical Center

Patient: GREENE, ADRIENNE EVETTE

Med Rec #:	FSH-000801474292	Admit/Discharge:	1/18/2023 / 1/18/2023
Account #:	FSH-03046326272	Admitting Doctor:	Charbonneau,MD,Stephen G
Date of Birth:	3/4/1972 Age: 50 years Sex: Female	Ordering Doctor:	n/a
Location:	MFSH EDPT		

Emergency Documentation

This is a brief Emergency Department triage note. Please refer to the ED clinician note for complete documentation.

Clinician Assign
Time Seen:
Gribbin, PA-C, Delys Vernetta / 01/18/2023 16:56 - ED Triage Clinician
Preferred Language/Interpretation Services
Preferred Language Discussing Healthcare: English
Interpreter Used: N/A

Chief Complaint

As per Triage RN:
Pt belted driver in MVC around 1150 today. Pt driving 35 mph and was hit on passenger side. +AB. -LOC. Pt reports R sided 7/10 CP and R side knee pain. Bruising noted to side of R knee. SOB resolved PTA. -cspine tenderness. Ambulatory on scene.

History of Present Illness
50-year-old nontoxic, afebrile female seatbelted driver presents emergency room status post MVC this morning at 1150. Patient states was driving approximately 35 miles an hour and was hit on the passenger side. Patient reports ambulatory at scene, complains of right sided 7/10 chest pain, and bruising/pain to lateral right lower extremity, had some shortness of breath at the time of MVC but states has since resolved, as per ED triage RN no C-spine tenderness.

Physical Exam

Vitals:
Initial Vitals
T: 37 degC (Oral) **HR:** 86 (Peripheral) **RR:** 16 **BP:** 141/85 (Automated) **SpO2:** 99%
Gen: Well appearing. Nontoxic. Appears comfortable in triage
Psych: Awake and alert
Resp: Nonlabored breathing
CV: Appears well perfused
GI: Not vomiting
Neuro: Moving extremities independently

Assessment and Plan/Medical Decision Making

After my evaluation of the patient, further care with testing and in-person evaluation is indicated for patient's musculoskeletal pain to rule out life- or limb-threatening causes of their symptoms or need for emergency surgery, and I initiated care that will be completed by the care team within the department.

MedStar Franklin Square Medical Center

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Admitting Doctor: Charbonneau,MD,Stephen G
Ordering Doctor: n/a

Emergency Documentation

Attestation
I evaluated the patient via a live, two-way secure video portal. Presentation of the patient was performed by the nursing staff. Additional history was acquired from the patient. I have reviewed available records relevant to this presentation.

Electronically signed by:

Gribbin, PA-C, Delys Vernetta on: 01.18.2023 17:00 EST

DOCUMENT NAME: ED Note - Clinician Co-Sign
PERFORM INFORMATION: Sellers,PA-C,Kallie Marie (1/18/2023 22:36 EST)
RESULT STATUS: Auth (Verified)
SERVICE DATE/TIME: 1/18/2023 22:29 EST
SIGN INFORMATION: Charbonneau,MD,Stephen G (1/20/2023 06:37 EST); Sellers,PA-C,Kallie Marie (1/18/2023 22:36 EST)

Clinician Assign
Time Seen:
Gribbin, PA-C, Delys Vernetta / 01/18/2023 16:56 - ED Triage Clinician
Sellers, PA-C, Kallie Marie / 01/18/2023 21:02 - ED PA/NP
Charbonneau, MD, Stephen G / 01/18/2023 21:47 - ED Attending
Preferred Language/Interpretation Services
Preferred Language Discussing Healthcare: English
Interpreter Used: N/A

Sources reviewed:

Initial nursing notes reviewed.

Chief Complaint

As per Triage RN:
Pt belted driver in MVC around 1150 today. Pt driving 35 mph and was hit on passenger side. +AB. -LOC. Pt reports R sided 7/10 CP and R side knee pain. Bruising noted to side of R knee. SOB resolved PTA. -cspine tenderness. Ambulatory on scene.

History of Present Illness
Patient is a 50-year-old female past medical history of hypertension, gastric sleeve in 2017 presenting with complaints of right knee pain and right-sided chest pain after being involved in MVC around noon today. Patient reports she was driving about 35 mph when another vehicle was making a U-turn and hit her passenger side and reports airbag deployment. Denies any head injury, LOC and was ambulatory on scene and wearing her seatbelt. She does note some bruising to her right knee and a burn right

Problem List/Past Medical History
Ongoing
- Anemia, iron deficiency
- Bariatric surgery status
- Body mass index (BMI) of 40.0 to 44.9 in adult
- HTN (hypertension)
- Hyperlipidemia
- Morbid obesity
- Vitamin D deficiency

Historical
- Gastric erosion
- GERD (gastroesophageal reflux disease)
- Heartburn
- Hiatal hernia
- Low serum prealbumin
- Morbid obesity
- Vitamin A deficiency

Surgical History
- HYSTEROSCOPY BX ENDOMETRIUM&/POLYPC W/WO D&C (02/23/2018)
- Hysteroscopy, Dilation and Curettage, Mirena IUD insertion (02/23/2018)

MedStar Franklin Square Medical Center

Patient: GREENE, ADRIENNE EVETTE
Med Rec #: FSH-000801474292
Account #: FSH-03046326272
Date of Birth: 3/4/1972 Age: 50 years Sex: Female
Location: MFSH EDPT

Admit/Discharge: 1/18/2023 / 1/18/2023
Admitting Doctor: Charbonneau,MD,Stephen G
Ordering Doctor: n/a

Emergency Documentation

shin from the airbag. Denies any neck pain, back pain, headache, dizziness, lightheadedness, shortness of breath, abdominal pain, nausea, vomiting, or pain to her upper extremities.

Relevant Social Determinants of Health
Denies tobacco, alcohol, or illicit drug use. Currently works as a CRNA and lives with her husband.

Review of Systems
General- vitals reviewed
Eyes- denies decreased vision, double vision, and eye pain
ENT: Denies hearing loss, throat injury
CV- denies chest pain, fainting, shortness of breath
Resp- denies cough and wheezing
GI- denies nausea and vomiting, abdominal pain
MS- As per HPI
Derm-Denies rash
Neuro- denies headache, dizziness, numbness, weakness, and LOC.

Denies etoh use
Denies anticoagulants
Denies head injury

Physical Exam

Vitals:
Initial Vitals
T: 37 degC (Oral) **HR:** 86 (Peripheral) **RR:** 16 **BP:** 141/85 (Automated) **SpO2:** 99%
Vital Sign(s) Noted
General: Well developed, well nourished. No acute distress.
Head: Normocephalic, atraumatic. Hearing intact.
ENT: PERRLA. EOM's intact. Normal TM's. Hearing intact
Neck: Supple, non-tender, with full range of motion.
Lungs: No respiratory distress. Lungs are clear to auscultation with good air exchange.
Cardiovascular: Normal rate, regular rhythm, no murmur, gallop or rub. There is no peripheral edema. Distal pulses strong and equal in all limbs. No chest wall pain.
Abdomen: Soft, supple, non-distended. No tenderness to palpation. No bruising or ecchymosis to the abdomen.
Musculoskeletal: No gross deformity of extremities. All extremities move well with full range of motion and 5/5 strength, no tenderness or swelling. Normal reflexes throughout.
Skin: Skin is warm, dry and pink. No rashes or lesions. No seatbelt sign.
Neuro: A & O x 4. Normal gait.

Assessment and Plan/Medical Decision Making
History Obtained from: Patient

This is a 50-year-old well-appearing female presenting with right-sided chest pain and right knee/shin pain after being involved in MVC with airbag hit on the passenger side.

- INSERTION INTRAUTERINE DEVICE IUD (02/23/2018)
- Endometrial Biposy (11/27/2017)
- EXCISION OF STOMACH, PERCUTANEOUS ENDOSCOPIC APPROACH, VERT (05/18/2017)
- ROBOTIC ASSISTED PROCEDURE OF TRUNK, PERC ENDO APPROACH (05/18/2017)
- Sleeve Gastrectomy (05/18/2017)
- EGD TRANSORAL BIOPSY SINGLE/MULTIPLE (03/27/2017)
- Upper GI endoscopy (2017)
- Breast reduction, bilateral (2013)
- Cesarean delivery (1995)

Allergies
Latex (reddness, itching)

Medication Administration
Administered:
Medications:
acetaminophen, 1000 mg, PO (01/18/2023 17:09 EST)
ibuprofen, 800 mg, PO (01/18/2023 17:09 EST)

Home Medications
B-100 Complex, Every Other Day
Bariatric Advantage Ultra Solo Multivitamin without iron, 1 tab, Daily
Calcium citrate, 3x/day
famotidine 20 mg oral tablet, 20 mg= 1 tab, PO, 2x/day, PRN
hydrochlorothiazide 25 mg oral tablet, 25 mg= 1 tab, PO, Daily
Iron infusion under direction of Dr. Chen prn
Mirena 52 mg intrauteral device, 52 mg= 1 ea, IntraUTERAL, One Time
Saxenda 18 mg/3 mL subcutaneous solution, See Instructions, Week 1 0.6 mg Subcut Daily; Week 2 1.2 mg Subcut Daily; Week 3 1.8 mg Subcut Daily; Week 4 2.4 mg Subcut Daily; Week 5 3.0 mg Subcut Daily
Vitamin D3 2000 intl units oral tablet, 2000 Intl_Unit= 1 tab, PO, Daily, 1 refills

MedStar Franklin Square Medical Center

Patient: **GREENE, ADRIENNE EVETTE**
Med Rec #: FSH-000801474292
Account #: FSH-03046326272
Date of Birth: 3/4/1972 Age: 50 years Sex: Female
Location: MFSH EDPT

Admit/Discharge: 1/18/2023 / 1/18/2023
Admitting Doctor: Charbonneau,MD,Stephen G
Ordering Doctor: n/a

Emergency Documentation

On exam patient is amatory with a steady gait, moving all of her extremities, lungs are clear to auscultation, with no signs of any head injury or trauma.
I personally reviewed patient's x-rays of her right knee, chest, right tib-fib that shows no acute pathology or signs of any fracture. Patient has no tenderness to her ribs and low suspicion for a fracture or pneumothorax at this time as patient has no shortness of breath and vitals are stable and lungs are clear to auscultation. Discussed with patient her chest discomfort can be from the airbags deploying and hitting her chest and is likely musculoskeletal in nature. She has no risk factors concerning for ACS at this time. In regards to her right knee pain likely secondary to a contusion and her airbags in her legs. Recommended ice and taking ibuprofen and Tylenol and to follow-up with her PCP. Provided patient with a note off work and she is otherwise stable to be discharged home.

Discussion of management: Physician Dr. Charbonneau

ED EKG/Rhythm/Imaging Interpretation
- Completed
-- One Time, Stop Date 01/18/23 16:57:25 EST, 01/18/23 16:57:25 EST
Normal sinus rhythm rate of 89 bpm. No acute ST elevations or depressions. QT interval 438

Diagnostic Results
(01/18/2023 17:41 EST XR Chest PA and LAT 2 View)
*** Final Report ***

Reason For Exam
Chest Pain

REPORT
Exam: XR Knee 3 View Right, XR Chest PA and LAT 2 View, XR Tibia and Fibula Right

History: Trauma

Technique: Frontal lateral view right tibia and fibula frontal view notch view lateral view right knee frontal lateral view chest

Findings: 2 views chest no evidence of trauma. The right knee minimal DJD. Right tibia and fibula no evidence of trauma

IMPRESSION: NO ACUTE PATHOLOGY

Impression/Disposition

ED Diagnosis:
Acute pain of right knee M25.561
Chest wall pain R07.89
Encounter for examination following motor vehicle collision (MVC) Z04.1
Patient Disposition

Immunizations
Immunizations: No qualifying data available

Social History
Smoking Status
Never smoker
Alcohol
Use: Current. Frequency of Intake: 1-2 times per year. Average Drinks per episode in last year: 1.
Employment/School
Status: Employed. Work/School description: Home Health Aide, works 3-11pm.
Exercise
Duration per Episode (Avg # of Minutes) 20. Frequency: 3-4 times/week. Self assessment: Fair condition. Exercise type: Walking, stationary bike.
Home/Environment
Lives with Children, Spouse. Living situation: Home/Independent. Home Equipment: None.
Nutrition/Health
Diet Description: low calorie high protein. Type of Diet: Calorie restricted. Sleeping Concerns No. Feels highly stressed: No.
Substance Use
Use: Denies.
Tobacco/Nicotine
Use: Denies.
Smoking Status
Tobacco Use: Never Used (01/18/23)

Family History
Cancer: Mother and Grandmother.
Diabetes.....: Father and Grandmother.
High blood pressure: Mother and Father.

MedStar Franklin Square Medical Center

Patient:	**GREENE, ADRIENNE EVETTE**		
Med Rec #:	FSH-000801474292	Admit/Discharge:	1/18/2023 / 1/18/2023
Account #:	FSH-03046326272	Admitting Doctor:	Charbonneau,MD,Stephen G
Date of Birth:	3/4/1972 Age: 50 years Sex: Female	Ordering Doctor:	n/a
Location:	MFSH EDPT		

Emergency Documentation

Discharge Patient - Ordered
– 01/18/23 21:52:00 EST, Home

Discharge Prescriptions:
No documented discharge medications

Attending Physician Note:

I have discussed with the Advance Practice Provider and agree with the findings and plan as documented in their notes. I was present and available when this patient was in the ED.

[1] XR Chest PA and LAT 2 View; Burnstein, MD, Mark Ian 01/18/2023 17:41 EST

Electronically signed by:

Sellers, PA-C, Kallie Marie on: 01.18.2023 22:36 EST

Electronically signed by:

Charbonneau, MD, Stephen G on: 01.20.2023 06:37 EST

DOCUMENT NAME:	ED Patient Education Note
PERFORM INFORMATION:	Owuamana,LPN,Charlene (1/18/2023 22:26 EST)
RESULT STATUS:	Modified
SERVICE DATE/TIME:	1/18/2023 22:26 EST
SIGN INFORMATION:	Owuamana,LPN,Charlene (1/18/2023 22:26 EST); Sellers, PA-C,Kallie Marie (1/18/2023 21:52 EST); Sellers,PA-C,Kallie Marie (1/18/2023 21:40 EST); Sellers,PA-C,Kallie Marie (1/18/2023 21:39 EST); Sellers,PA-C,Kallie Marie (1/18/2023 21:39 EST)

ED Patient Education Note

Motor Vehicle Collision Injury, Adult

After a car accident (motor vehicle collision), it is common to have injuries to your head, face, arms, and body. These injuries may include:

- Cuts.
- Burns.

Emergency Documentation

- Bruises.
- Sore muscles or a stretch or tear in a muscle (strain).
- Headaches.

You may feel stiff and sore for the first several hours. You may feel worse after waking up the first morning after the accident. These injuries often feel worse for the first 24–48 hours. After that, you will usually begin to get better with each day. How quickly you get better often depends on:

- How bad the accident was.
- How many injuries you have.
- Where your injuries are.
- What types of injuries you have.
- If you were wearing a seat belt.
- If your airbag was used.

A head injury may result in a concussion. This is a type of brain injury that can have serious effects. If you have a concussion, you should rest as told by your doctor. You must be very careful to avoid having a second concussion.

Follow these instructions at home:

Medicines

- Take over-the-counter and prescription medicines only as told by your doctor.
- If you were prescribed antibiotic medicine, take or apply it as told by your doctor. **Do not** stop using the antibiotic even if your condition gets better.

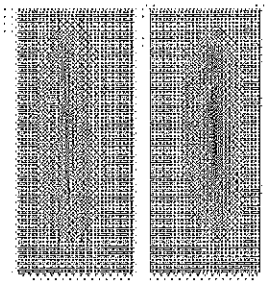
If you have a wound or a burn:

MedStar Franklin Square Medical Center

Patient: GREENE, ADRIENNE EVETTE
Med Rec #: FSH-000801474292
Account #: FSH-03046326272
Date of Birth: 3/4/1972 Age: 50 years Sex: Female
Location: MFSH EDPT

Admit/Discharge: 1/18/2023 / 1/18/2023
Admitting Doctor: Charbonneau,MD,Stephen G
Ordering Doctor: n/a

Emergency Documentation



Normal wound | Infected wound

- Clean your wound or burn as told by your doctor.
  - —46 Wash it with mild soap and water.
  - —46 Rinse it with water to get all the soap off.
  - —46 Pat it dry with a clean towel. **Do not** rub it.
  - —46 If you were told to put an ointment or cream on the wound, do so as told by your doctor.
- Follow instructions from your doctor about how to take care of your wound or burn. Make sure you:
  - —46 Know when and how to change or remove your bandage (dressing).
  - —46 Always wash your hands with soap and water before and after you change your bandage. If you cannot use soap and water, use hand sanitizer.
  - —46 Leave stitches (sutures), skin glue, or skin tape (adhesive) strips in place, if you have these. They may need to stay in place for 2 weeks or longer. If tape strips get loose and curl up, you may trim the loose edges. **Do not** remove tape strips completely unless your doctor says it is okay.
- **Do not:**
  - —46 Scratch or pick at the wound or burn.
  - —46 Break any blisters you may have.
  - —46 Peel any skin.
- Avoid getting sun on your wound or burn.

MedStar Franklin Square Medical Center

Patient:	**GREENE, ADRIENNE EVETTE**		
Med Rec #:	FSH-000801474292	Admit/Discharge:	1/18/2023 / 1/18/2023
Account #:	FSH-03046326272	Admitting Doctor:	Charbonneau,MD,Stephen G
Date of Birth:	3/4/1972 Age: 50 years Sex: Female	Ordering Doctor:	n/a
Location:	MFSH EDPT		

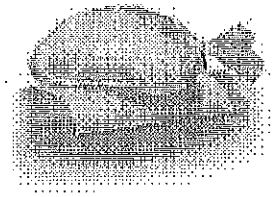
Emergency Documentation

- Raise (elevate) the wound or burn above the level of your heart while you are sitting or lying down. If you have a wound or burn on your face, you may want to sleep with your head raised. You may do this by putting an extra pillow under your head.
- Check your wound or burn every day for signs of infection. Check for:
  - —46 More redness, swelling, or pain.
  - —46 More fluid or blood.
  - —46 Warmth.
  - —46 Pus or a bad smell.

Activity

- Rest. Rest helps your body to heal. Make sure you:
  - —46 Get plenty of sleep at night. Avoid staying up late.
  - —46 Go to bed at the same time on weekends and weekdays.
- Ask your doctor if you have any limits to what you can lift.
- Ask your doctor when you can drive, ride a bicycle, or use heavy machinery. **Do not** do these activities if you are dizzy.
- If you are told to wear a brace on an injured arm, leg, or other part of your body, follow instructions from your doctor about activities. Your doctor may give you instructions about driving, bathing, exercising, or working.

General instructions



MedStar Franklin Square Medical Center

Patient: GREENE, ADRIENNE EVETTE
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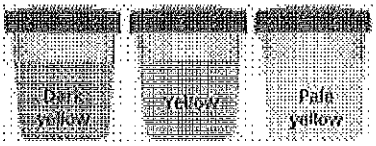
Account #: FSH-03046326272 Admitting Doctor: Charbonneau,MD,Stephen G
Date of Birth: 3/4/1972 Age: 50 years Sex: Female Ordering Doctor: n/a
Location: MFSH EDPT

Emergency Documentation



- If told, put ice on the injured areas.
  - —46 Put ice in a plastic bag.
  - —46 Place a towel between your skin and the bag.
  - —46 Leave the ice on for 20 minutes, 2–3 times a day.
- Drink enough fluid to keep your pee (urine) pale yellow.
- **Do not** drink alcohol.
- Eat healthy foods.
- Keep all follow-up visits as told by your doctor. This is important.

Contact a doctor if:

- Your symptoms get worse.
- You have neck pain that gets worse or has not improved after 1 week.
- You have signs of infection in a wound or burn.
- You have a fever.
- You have any of the following symptoms for more than 2 weeks after your car accident:
  - —46 Lasting (chronic) headaches.
  - —46 Dizziness or balance problems.
  - —46 Feeling sick to your stomach (nauseous).
  - —46 Problems with how you see (vision).
  - —46 More sensitivity to noise or light.
  - —46 Depression or mood swings.
  - —46 Feeling worried or nervous (anxiety).
  - —46 Getting upset or bothered easily.

—46 Memory problems.
—46 Trouble concentrating or paying attention.
—46 Sleep problems.
—46 Feeling tired all the time.

Get help right away if:

- You have:
  - —46 Loss of feeling (numbness), tingling, or weakness in your arms or legs.
  - —46 Very bad neck pain, especially tenderness in the middle of the back of your neck.
  - —46 A change in your ability to control your pee or poop (stool).
  - —46 More pain in any area of your body.
  - —46 Swelling in any area of your body, especially your legs.
  - —46 Shortness of breath or light-headedness.
  - —46 Chest pain.
  - —46 Blood in your pee, poop, or vomit.
  - —46 Very bad pain in your belly (abdomen) or your back.
  - —46 Very bad headaches or headaches that are getting worse.
  - —46 Sudden vision loss or double vision.
- Your eye suddenly turns red.
- The black center of your eye (pupil) is an odd shape or size.

Summary

- After a car accident (motor vehicle collision), it is common to have injuries to your head, face, arms, and body.
- Follow instructions from your doctor about how to take care of a wound or burn.
- If told, put ice on your injured areas.

MedStar Franklin Square Medical Center

Patient:	**GREENE, ADRIENNE EVETTE**		
Med Rec #:	FSH-000801474292	Admit/Discharge:	1/18/2023 / 1/18/2023
Account #:	FSH-03046326272	Admitting Doctor:	Charbonneau,MD,Stephen G
Date of Birth:	3/4/1972 Age: 50 years Sex: Female	Ordering Doctor:	n/a
Location:	MFSH EDPT		

Emergency Documentation

- Contact a doctor if your symptoms get worse.
- Keep all follow-up visits as told by your doctor.

This information is not intended to replace advice given to you by your health care provider. Make sure you discuss any questions you have with your health care provider.

Document Revised: 03/24/2022 Document Reviewed: 03/24/2022

DOCUMENT NAME:	ED Patient Summary
PERFORM INFORMATION:	Owuamana,LPN,Charlene (1/18/2023 22:26 EST)
RESULT STATUS:	Modified
SERVICE DATE/TIME:	1/18/2023 22:26 EST
SIGN INFORMATION:	Owuamana,LPN,Charlene (1/18/2023 22:26 EST); Sellers, PA-C,Kallie Marie (1/18/2023 21:52 EST); Sellers,PA-C,Kallie Marie (1/18/2023 21:40 EST)

ED Patient Summary

MedStar Franklin Square Medical Center

9000 Franklin Square Drive Baltimore, MD 21237
Phone: (443) 777-7000
www.franklinsquare.org

Emergency Department

New Prescription Summary For GREENE, ADRIENNE EVETTE

No prescriptions sent Electronically or Printed this visit.

MedStar Franklin Square Medical Center

Patient:	**GREENE, ADRIENNE EVETTE**		
Med Rec #:	FSH-000801474292	Admit/Discharge:	1/18/2023 / 1/18/2023
Account #:	FSH-03046326272	Admitting Doctor:	Charbonneau,MD,Stephen G
Date of Birth:	3/4/1972 Age: 50 years Sex: Female	Ordering Doctor:	n/a
Location:	MFSH EDPT		

Emergency Documentation

MedStar Franklin Square Medical Center
9000 Franklin Square Drive Baltimore, MD 21237
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Emergency Department

Work/School Note

To whom it may concern:
This certifies that GREENE, ADRIENNE EVETTE was a patient in the MedStar Franklin Square Medical Center Emergency Department from 01/18/23 16:29:00 until 01/18/23 22:25:59

Status:Return to work/school no restrictions
Return to Work/School Date:01/23/23 00:00:00

NOTE: This note is **only** to show your employer/school that you were seen by a physician and/or physician's assistant in evaluation of an acute illness or injury.

Complete days off are provided only for a severe medical illness. The Emergency Department staff cannot decide whether or not you can work due to an injury. If you were assigned "light duty (partial disability)", the note above describes what type of physical activity is limited. Your work supervisor needs to determine if there is light duty available or make other arrangements for you. If you feel a need for additional days in light duty status, you will need to contact and follow up with another clinician as noted in your discharge instructions.
If you feel that you need additional days off due to illness, you will need to contact and follow up with another clinician as noted in your discharge instructions.
The Emergency Department staff does NOT determine total disability due to injury.

MedStar Franklin Square Medical Center

Patient:	**GREENE, ADRIENNE EVETTE**		
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Account #:	FSH-03046326272	Admitting Doctor:	Charbonneau,MD,Stephen G
Date of Birth:	3/4/1972 Age: 50 years Sex: Female	Ordering Doctor:	n/a
Location:	MFSH EDPT		

Emergency Documentation

Electronically Signed by: Sellers, PA-C, Kallie Marie

MedStar Franklin Square Medical Center
9000 Franklin Square Drive Baltimore, MD 21237
Phone: (443) 777-7000
www.franklinsquare.org

Emergency Department

Patient Discharge Instructions For GREENE, ADRIENNE EVETTE

MedStar Franklin Square Medical Center would like to thank you for allowing us to assist you with your healthcare needs. We are committed to providing the very best in safety, quality and service. Within the next few weeks, you may receive a mail, email, or text survey from Press Ganey asking about your experience while you were here. Your feedback helps us identify ways we can better address your needs and continually improve your overall experience. We appreciate you taking the time to participate in the survey and share your feedback about your experience.â€If you need help getting a follow up appointment, copies of your imaging tests or records, or any other concerns please call our patient experience navigator at (443)777-2534. Please return to the emergency department if worsening symptoms or pain, trouble breathing, or any other concerns.

Need immediate emotional support or have thoughts of harming yourself? Call or text the National Suicide Crisis lifeline at **988** to connect to a trained professional who can help. Confidential care is available 24/7. Because we all need help sometimes.
Please note, the previous Lifeline phone number (1-800-273-8255) will remain available.

Access your information on line by registering for MYMEDSTAR, our patient portal, at www.mymedstar.org.

Patient Information

Name: **GREENE, ADRIENNE EVETTE**	Arrival Date and Time: **01/18/2023 16:29**

MedStar Franklin Square Medical Center

Patient:	**GREENE, ADRIENNE EVETTE**		
Med Rec #:	FSH-000801474292	Admit/Discharge:	1/18/2023 / 1/18/2023
Account #:	FSH-03046326272	Admitting Doctor:	Charbonneau,MD,Stephen G
Date of Birth:	3/4/1972 Age: 50 years Sex: Female	Ordering Doctor:	n/a
Location:	MFSH EDPT		

Emergency Documentation

Date of Birth: **03/04/1972**	Discharge Date and Time: **01/18/2023 22:25**
Patient ID: **454319**	

Healthcare Provider Information

Clinician(s):
Gribbin, PA-C, Delys Vernetta
Sellers, PA-C, Kallie Marie
Charbonneau, MD, Stephen G

Information About Hospital Visit

Diagnoses: **Encounter for examination following motor vehicle collision (MVC); Acute pain of right knee; Chest wall pain**

Follow Up Instructions

You must call each Provider to make/verify your appointment.

PHYSICIAN/PROVIDER	DETAILS
Rashida Nesbit	**When: In 1 week 01/25/2023** **Address: 1245 Eastern Blvd** **Essex MD 21221** **(410)558-4700(Ph)**

Laboratory or Other Results This Visit (last charted value for your 01/18/2023 visit)

Diagnostic Radiology

01/18/23 17:41:33

XR Tibia and Fibula Right: XR Tibia and Fibula Right
XR Knee 3 View Right: XR Knee 3 View Right
XR Chest PA and LAT 2 View: XR Chest PA and LAT 2 View
Radiology Image: Radiology Image

MedStar Franklin Square Medical Center

Patient:	**GREENE, ADRIENNE EVETTE**		
Med Rec #:	FSH-000801474292	Admit/Discharge:	1/18/2023 / 1/18/2023
Account #:	FSH-03046326272	Admitting Doctor:	Charbonneau,MD,Stephen G
Date of Birth:	3/4/1972 Age: 50 years Sex: Female	Ordering Doctor:	n/a
Location:	MFSH EDPT		

Emergency Documentation

Allergies and Immunizations

Allergies

Latex (reddness) (itching)

Current Medication List as of 01/18/23 22:25:59

MedStar Franklin Square Medical Center ED Physicians are providing you with a complete list of medications post discharge. If you have been instructed to stop taking a medication please ensure you also follow up with this information to your Primary Care Provider.

Unless otherwise noted, you will continue to take medications as prescribed prior to the Emergency Room visit. Any specific questions regarding your chronic medications and dosages should be discussed with your Primary Care Provider and Pharmacy.

cholecalciferol (Vitamin D3 2000 intl units oral tablet)
Directions:1 tablet by mouth every day
Take Next Dose:_____

famotidine 20 mg oral tablet
Directions: 1 tablet by mouth 2 times a day as needed for heartburn/indigestion
Take Next Dose:_____

hydroCHLOROthiazide (hydrochlorothiazide 25 mg oral tablet)
Directions: 1 tablet by mouth every day
Take Next Dose:_____

levonorgestrel (Mirena 52 mg intrauteral device)
Directions: 1 each intrauteral one time
Take Next Dose:_____

liraglutide (Saxenda 18 mg/3 mL subcutaneous solution)
Directions:See Instructions inject. Prescribed for the treatment of Weight gain; adjunct
Special Instructions: Week 1 0.6 mg Subcut Daily; Week 2 1.2 mg Subcut Daily; Week 3 1.8 mg Subcut Daily; Week 4 2.4 mg Subcut Daily; Week 5 3.0 mg Subcut Daily
Take Next Dose:_____

Non Formulary (Calcium citrate)

MedStar Franklin Square Medical Center

Patient:	**GREENE, ADRIENNE EVETTE**		
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Account #:	FSH-03046326272	Admitting Doctor:	Charbonneau,MD,Stephen G
Date of Birth:	3/4/1972 Age: 50 years Sex: Female	Ordering Doctor:	n/a
Location:	MFSH EDPT		

Emergency Documentation

Directions: Use as previously directed by your prescribing physician
Take Next Dose:_____

Non Formulary (B-100 Complex)
Directions: Use as previously directed by your prescribing physician
Take Next Dose:_____

Non Formulary (Iron infusion under direction of Dr. Chen prn)
Directions: Use as previously directed by your prescribing physician
Take Next Dose:_____

Non Formulary (Bariatric Advantage Ultra Solo Multivitamin without iron)
Directions: 1 tablet every day
Take Next Dose:_____

Physician(s) who completed Medication Reconciliation
Sellers, PA-C, Kallie Marie (01/18/2023 21:39)

Patient and Medication Education

Motor Vehicle Collision Injury, Adult

After a car accident (motor vehicle collision), it is common to have injuries to your head, face, arms, and body. These injuries may include:

- **Cuts.**
- **Burns.**
- **Bruises.**
- **Sore muscles or a stretch or tear in a muscle (strain).**

MedStar Franklin Square Medical Center

Patient:	**GREENE, ADRIENNE EVETTE**		
Med Rec #:	FSH-000801474292	Admit/Discharge:	1/18/2023 / 1/18/2023
Account #:	FSH-03046326272	Admitting Doctor:	Charbonneau,MD,Stephen G
Date of Birth:	3/4/1972 Age: 50 years Sex: Female	Ordering Doctor:	n/a
Location:	MFSH EDPT		

Emergency Documentation

- **Headaches.**

You may feel stiff and sore for the first several hours. You may feel worse after waking up the first morning after the accident. These injuries often feel worse for the first 24–48 hours. After that, you will usually begin to get better with each day. How quickly you get better often depends on:

- **How bad the accident was.**
- **How many injuries you have.**
- **Where your injuries are.**
- **What types of injuries you have.**
- **If you were wearing a seat belt.**
- **If your airbag was used.**

A head injury may result in a concussion. This is a type of brain injury that can have serious effects. If you have a concussion, you should rest as told by your doctor. You must be very careful to avoid having a second concussion.

Follow these instructions at home:

Medicines

- **Take over-the-counter and prescription medicines only as told by your doctor.**
- **If you were prescribed antibiotic medicine, take or apply it as told by your doctor. Do not stop using the antibiotic even if your condition gets better.**

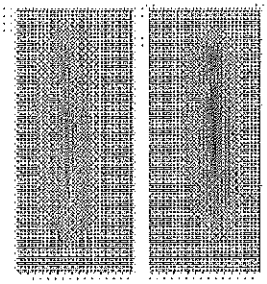
If you have a wound or a burn:

MedStar Franklin Square Medical Center

Patient: GREENE, ADRIENNE EVETTE
Med Rec #: FSH-000801474292
Account #: FSH-03046326272
Date of Birth: 3/4/1972 Age: 50 years Sex: Female
Location: MFSH EDPT

Admit/Discharge: 1/18/2023 / 1/18/2023
Admitting Doctor: Charbonneau,MD,Stephen G
Ordering Doctor: n/a

Emergency Documentation



Normal wound | Infected wound

- **Clean your wound or burn as told by your doctor.**
  - —46 **Wash it with mild soap and water.**
  - —46 **Rinse it with water to get all the soap off.**
  - —46 **Pat it dry with a clean towel. Do not rub it.**
  - —46 **If you were told to put an ointment or cream on the wound, do so as told by your doctor.**
- **Follow instructions from your doctor about how to take care of your wound or burn. Make sure you:**
  - —46 **Know when and how to change or remove your bandage (dressing).**
  - —46 **Always wash your hands with soap and water before and after you change your bandage. If you cannot use soap and water, use hand sanitizer.**
  - —46 **Leave stitches (sutures), skin glue, or skin tape (adhesive) strips in place, if you have these. They may need to stay in place for 2 weeks or longer. If tape strips get loose and curl up, you may trim the loose edges. Do not remove tape strips completely unless your doctor says it is okay.**
- **Do not:**
  - —46 **Scratch or pick at the wound or burn.**
  - —46 **Break any blisters you may have.**
  - —46 **Peel any skin.**

MedStar Franklin Square Medical Center

Patient:	**GREENE, ADRIENNE EVETTE**		
Med Rec #:	FSH-000801474292	Admit/Discharge:	1/18/2023 / 1/18/2023
Account #:	FSH-03046326272	Admitting Doctor:	Charbonneau,MD,Stephen G
Date of Birth:	3/4/1972 Age: 50 years Sex: Female	Ordering Doctor:	n/a
Location:	MFSH EDPT		

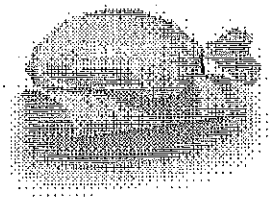
Emergency Documentation

- **Avoid getting sun on your wound or burn.**
- **Raise (elevate) the wound or burn above the level of your heart while you are sitting or lying down. If you have a wound or burn on your face, you may want to sleep with your head raised. You may do this by putting an extra pillow under your head.**
- **Check your wound or burn every day for signs of infection. Check for:**
  - **—46 More redness, swelling, or pain.**
  - **—46 More fluid or blood.**
  - **—46 Warmth.**
  - **—46 Pus or a bad smell.**

Activity

- **Rest. Rest helps your body to heal. Make sure you:**
  - **—46 Get plenty of sleep at night. Avoid staying up late.**
  - **—46 Go to bed at the same time on weekends and weekdays.**
- **Ask your doctor if you have any limits to what you can lift.**
- **Ask your doctor when you can drive, ride a bicycle, or use heavy machinery. Do not do these activities if you are dizzy.**
- **If you are told to wear a brace on an injured arm, leg, or other part of your body, follow instructions from your doctor about activities. Your doctor may give you instructions about driving, bathing, exercising, or working.**

General instructions



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Patient:	**GREENE, ADRIENNE EVETTE**		
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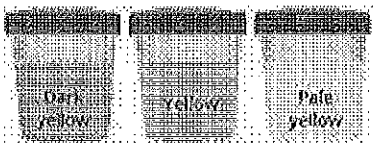
Emergency Documentation



- **If told, put ice on the injured areas.**
  - **—46 Put ice in a plastic bag.**
  - **—46 Place a towel between your skin and the bag.**
  - **—46 Leave the ice on for 20 minutes, 2–3 times a day.**
- **Drink enough fluid to keep your pee (urine) pale yellow.**
- **Do not drink alcohol.**
- **Eat healthy foods.**
- **Keep all follow-up visits as told by your doctor. This is important.**

Contact a doctor if:

- **Your symptoms get worse.**
- **You have neck pain that gets worse or has not improved after 1 week.**
- **You have signs of infection in a wound or burn.**
- **You have a fever.**
- **You have any of the following symptoms for more than 2 weeks after your car accident:**
  - **—46 Lasting (chronic) headaches.**
  - **—46 Dizziness or balance problems.**
  - **—46 Feeling sick to your stomach (nauseous).**
  - **—46 Problems with how you see (vision).**
  - **—46 More sensitivity to noise or light.**
  - **—46 Depression or mood swings.**
  - **—46 Feeling worried or nervous (anxiety).**

—46 Getting upset or bothered easily.

—46 Memory problems.

—46 Trouble concentrating or paying attention.

—46 Sleep problems.

—46 Feeling tired all the time.

Get help right away if:

- You have:
  - —46 Loss of feeling (numbness), tingling, or weakness in your arms or legs.
  - —46 Very bad neck pain, especially tenderness in the middle of the back of your neck.
  - —46 A change in your ability to control your pee or poop (stool).
  - —46 More pain in any area of your body.
  - —46 Swelling in any area of your body, especially your legs.
  - —46 Shortness of breath or light-headedness.
  - —46 Chest pain.
  - —46 Blood in your pee, poop, or vomit.
  - —46 Very bad pain in your belly (abdomen) or your back.
  - —46 Very bad headaches or headaches that are getting worse.
  - —46 Sudden vision loss or double vision.
- Your eye suddenly turns red.
- The black center of your eye (pupil) is an odd shape or size.

Summary

- After a car accident (motor vehicle collision), it is common to have injuries to your head, face, arms, and body.
- Follow instructions from your doctor about how to take care of a wound or burn.

MedStar Franklin Square Medical Center

Patient:	**GREENE, ADRIENNE EVETTE**		
Med Rec #:	FSH-000801474292	Admit/Discharge:	1/18/2023 / 1/18/2023
Account #:	FSH-03046326272	Admitting Doctor:	Charbonneau,MD,Stephen G
Date of Birth:	3/4/1972 Age: 50 years Sex: Female	Ordering Doctor:	n/a
Location:	MFSH EDPT		

Emergency Documentation

- **If told, put ice on your injured areas.**
- **Contact a doctor if your symptoms get worse.**
- **Keep all follow-up visits as told by your doctor.**

This information is not intended to replace advice given to you by your health care provider. Make sure you discuss any questions you have with your health care provider.

End of Discharge Education and Instructions

Patient Visit Summary

Diagnoses: **Encounter for examination following motor vehicle collision (MVC); Acute pain of right knee; Chest wall pain**

I, GREENE, ADRIENNE EVETTE, have received the attached patient education materials/instructions and have verbalized understanding.

Patient/Patient Representative Signature Date/Time

Relationship to Patient

Nurse Signature **Date/Time**

***Hospital has retained last page for medical records**

Patient Visit Summary

Diagnoses: **Encounter for examination following motor vehicle collision (MVC); Acute pain of right knee; Chest wall pain**

I, GREENE, ADRIENNE EVETTE, have received the attached patient education materials/instructions and have verbalized understanding.

MedStar Franklin Square Medical Center

Patient:	**GREENE, ADRIENNE EVETTE**		
Med Rec #:	FSH-000801474292	Admit/Discharge:	1/18/2023 / 1/18/2023
Account #:	FSH-03046326272	Admitting Doctor:	Charbonneau,MD,Stephen G
Date of Birth:	3/4/1972 Age: 50 years Sex: Female	Ordering Doctor:	n/a
Location:	MFSH EDPT		

Emergency Documentation

Patient/Patient Representative Signature **Date/Time**

Relationship to Patient

Nurse Signature **Date/Time**

ADCINSTR

DOCUMENT NAME:	ED Clinical Summary
PERFORM INFORMATION:	Owuamana,LPN,Charlene (1/18/2023 22:25 EST)
RESULT STATUS:	Modified
SERVICE DATE/TIME:	1/18/2023 22:25 EST
SIGN INFORMATION:	Owuamana,LPN,Charlene (1/18/2023 22:25 EST); Sellers, PA-C,Kallie Marie (1/18/2023 21:52 EST); Sellers,PA-C,Kallie Marie (1/18/2023 21:40 EST)

MedStar Franklin Square Medical Center

Patient:	**GREENE, ADRIENNE EVETTE**		
Med Rec #:	FSH-000801474292	Admit/Discharge:	1/18/2023 / 1/18/2023
Account #:	FSH-03046326272	Admitting Doctor:	Charbonneau,MD,Stephen G
Date of Birth:	3/4/1972 Age: 50 years Sex: Female	Ordering Doctor:	n/a
Location:	MFSH EDPT		

Emergency Documentation

ED Clinical Summary

MedStar Franklin Square Medical Center

9000 Franklin Square Dr Baltimore, MD 21237
(443) 777-7068

Emergency Department Clinical Summary

PERSON INFORMATION

Name GREENE, ADRIENNE EVETTE
Sex Female

Language English

Marital Status Single
ED Arrival Date and Time 01/18/2023 04:29 PM
Depart Date and Time 01/18/2023 10:25 PM

Age 50 Years
Race African American
Phone (410)776-4405

MRN FSH-000801474292
Acuity 3V

Discharge Disposition Disch to home or self care-Routine

DOB 03/04/1972
Ethnicity Non-Hispanic

PCP Nesbit, CRNP, Rashida Khadijah
Acct# FSH-03046326272
LOS 000 05:56

Patient Address:

PO BOX 1123 EDGEWOOD MD 21040

Patient Stated Complaint: Right-sided chest pain; MVC (motor vehicle collision); MVC/CHEST/LEG PAIN

Details of the patient encounter not listed in this Clinical Discharge Summary can be accessed from the patient record via the MedStar Clinician Portal or by contacting Medical Records at 443-777-7266.

MedStar Franklin Square Medical Center

Patient:	**GREENE, ADRIENNE EVETTE**		
Med Rec #:	FSH-000801474292	Admit/Discharge:	1/18/2023 / 1/18/2023
Account #:	FSH-03046326272	Admitting Doctor:	Charbonneau,MD,Stephen G
Date of Birth:	3/4/1972 Age: 50 years Sex: Female	Ordering Doctor:	n/a
Location:	MFSH EDPT		

Emergency Documentation

DIAGNOSIS

Acute pain of right knee; Chest wall pain; Encounter for examination following motor vehicle collision (MVC)

Procedures

No Procedures Documented

Provider Information:
Primary Provider:
Stephen G Charbonneau, MD
Secondary Provider:
Sellers, PA-C, Kallie Marie

Admitting Physician: Unassigned, Unassigned
Consulting Physician(s):

Referring Physician

Measurements	Latest	Date/Time
Weight Dosing	117.5 kg	01/18/2023 16:50:00
Height/Length Dosing	163 cm	01/18/2023 16:50:00
Body Mass Index Dosing	44.22 kg/m2	01/18/2023 16:50:00

Vital Sign	Triage	Triage Date/Time	Latest	Latest Date/Time

MedStar Franklin Square Medical Center

Patient: **GREENE, ADRIENNE EVETTE**
Med Rec #: FSH-000801474292
Account #: FSH-03046326272
Date of Birth: 3/4/1972 Age: 50 years Sex: Female
Location: MFSH EDPT

Admit/Discharge: 1/18/2023 / 1/18/2023
Admitting Doctor: Charbonneau,MD,Stephen G
Ordering Doctor: n/a

Emergency Documentation

Temperature Oral	37 DegC	01/18/2023 16:37:29	36.5 DegC	01/18/2023 20:43:00
O2 Sat	99 %	01/18/2023 16:37:49	100 %	01/18/2023 20:43:00
Respiratory Rate	16 BR/min	01/18/2023 16:37:35	16 BR/min	01/18/2023 16:37:35
Peripheral Pulse Rate	86 bpm	01/18/2023 16:37:49	71 bpm	01/18/2023 20:43:00
Blood Pressure, Automated	141/85 mmHg	01/18/2023 16:37:39	106/68 mmHg	01/18/2023 20:43:00
MAP, Automated	103 mmHg	01/18/2023 16:37:39	81 mmHg	01/18/2023 20:43:00

Cognitive and Functional Status:Oriented x 4,

MEDICAL INFORMATION

Problems

Active

- Body mass index (BMI) of 40.0 to 44.9 in adult
- Hyperlipidemia
- Vitamin D deficiency
- Bariatric surgery status
- Morbid obesity
- Anemia, iron deficiency
- HTN (hypertension)

Resolved

- GERD (gastroesophageal reflux disease)
- Heartburn
- Vitamin A deficiency
- Low serum prealbumin
- Hiatal hernia
- Morbid obesity
- Gastric erosion

MedStar Franklin Square Medical Center

Patient:	**GREENE, ADRIENNE EVETTE**		
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Account #:	FSH-03046326272	Admitting Doctor:	Charbonneau,MD,Stephen G
Date of Birth:	3/4/1972 Age: 50 years Sex: Female	Ordering Doctor:	n/a
Location:	MFSH EDPT		

Emergency Documentation

Allergies
Latex (reddness) (itching)

Immunizations
No Immunizations Documented This Visit

Smoking Status: **Never smoker**

Laboratory or Other Results This Visit (last charted value for your 01/18/2023 visit)

Diagnostic Radiology

01/18/23 17:41:33

XR Tibia and Fibula Right: XR Tibia and Fibula Right
XR Knee 3 View Right: XR Knee 3 View Right
XR Chest PA and LAT 2 View: XR Chest PA and LAT 2 View
Radiology Image: Radiology Image

Cardiology Orders

Name	Status	Details
Electrocardiogram	Ordered	01/18/23 16:56:00 EST, Chest Pain - R07.9, One Time, Stat, 24

Comment:

Current Medication List as of 01/18/23 22:25:57
cholecalciferol (Vitamin D3 2000 intl units oral tablet)
Directions:1 tablet by mouth every day
Take Next Dose:_____

famotidine 20 mg oral tablet
Directions: 1 tablet by mouth 2 times a day as needed for heartburn/indigestion
Take Next Dose:_____

MedStar Franklin Square Medical Center

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Date of Birth:	3/4/1972 Age: 50 years Sex: Female	Ordering Doctor:	n/a
Location:	MFSH EDPT		

Emergency Documentation

hydroCHLOROthiazide (hydrochlorothiazide 25 mg oral tablet)
Directions: 1 tablet by mouth every day
Take Next Dose:_____

levonorgestrel (Mirena 52 mg intrauteral device)
Directions: 1 each intrauteral one time
Take Next Dose:_____

liraglutide (Saxenda 18 mg/3 mL subcutaneous solution)
Directions:See Instructions inject. Prescribed for the treatment of Weight gain; adjunct
Special Instructions: Week 1 0.6 mg Subcut Daily; Week 2 1.2 mg Subcut Daily; Week 3 1.8 mg Subcut Daily; Week 4 2.4 mg Subcut Daily; Week 5 3.0 mg Subcut Daily
Take Next Dose:_____

Non Formulary (Calcium citrate)
Directions: Use as previously directed by your prescribing physician
Take Next Dose:_____

Non Formulary (B-100 Complex)
Directions: Use as previously directed by your prescribing physician
Take Next Dose:_____

Non Formulary (Iron infusion under direction of Dr. Chen prn)
Directions: Use as previously directed by your prescribing physician
Take Next Dose:_____

Non Formulary (Bariatric Advantage Ultra Solo Multivitamin without iron)
Directions:1 tablet every day
Take Next Dose:_____

Physician(s) who completed Medication Reconciliation
Sellers, PA-C, Kallie Marie (01/18/2023 21:39)

MedStar Franklin Square Medical Center

Patient:	**GREENE, ADRIENNE EVETTE**		
Med Rec #:	FSH-000801474292	Admit/Discharge:	1/18/2023 / 1/18/2023
Account #:	FSH-03046326272	Admitting Doctor:	Charbonneau,MD,Stephen G
Date of Birth:	3/4/1972 Age: 50 years Sex: Female	Ordering Doctor:	n/a
Location:	MFSH EDPT		

Emergency Documentation

PATIENT EDUCATION INFORMATION

Follow up:

You must call each Provider to make/verify your appointment.

PHYSICIAN/PROVIDER	DETAILS
Rashida Nesbit	**When: In 1 week 01/25/2023** **Address: 1245 Eastern Blvd** **Essex MD 21221** **(410)558-4700(Ph)**

Care Plan & Goals:

For this information, please review the details within this full Summary of Care document. For information not listed elsewhere, please refer to the patient medical record.

Printed Education Given To Patient:

Motor Vehicle Collision Injury, Adult, Easy-to-Read

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INITIAL VISIT

RE: Adrienne Greene
DATE OF INJURY: January 18, 2023
DATE OF VISIT: January 23, 2023

HISTORY OF PRESENT ILLNESS

Ms. Greene is a 50-year-old right-handed female who was involved in an auto accident on January 18, 2023. The history, obtained from the patient via secure telehealth connection, is as follows:

Ms. Greene was a seat-belted driver in a moving car which collided with a van. The airbags deployed. The police, ambulance and fire department arrived at the scene of the accident and her car was towed. Upon impact her body moved forward and backward and was thrown from side to side. She injured her cervical spine, right shin, right shoulder and right trapezius muscle. The onset of pain resulting from the injuries began at the scene of this collision. She visited MedStar Franklin Square Medical Center. Following an initial evaluation and X-ray examination, she was discharged. Upon discharge the patient was given a disability certificate from 01.18.2023 until 01.23.2023. Persisting pain in the injured areas caused Ms. Greene to visit this clinic seeking medical assistance. Pain is aggravated by reaching for something.

Due to these problems Ms. Greene states she is unable to work. Ms. Greene states these injuries have restricted her ability to perform domestic duties.

SUBJECTIVE FINDINGS:

The patient was asked to assess the pain level of the injured areas on a scale of 0-10. Ms. Greene states that pain in the injured areas is at #7-8. Ms. Greene states that she did not have these complaints prior to this accident.

PAST MEDICAL HISTORY:

SURGERY: Patient denies any previous surgeries.
INJURY: Patient denies any previous injuries.
ILLNESSES/CONDITIONS: Patient denies major past medical illnesses.
MEDICATIONS: Hydrochlorothiazide.
ALLERGIES: Latex.
REVIEW OF SYSTEMS: No active medical problems.

SOCIAL/EMPLOYMENT HISTORY:

The patient is employed. She is single.

FAMILY HISTORY:

Non-contributory.

PATIENT EVALUATION:

OBJECTIVE: 50-year-old female.
VITAL SIGNS: BP-125/86, PR-76, Wt-257 lb., Ht-5' 4".
GENERAL APPEARANCE: There is a bruise on the right shin.
NEUROLOGICAL STATUS: Mental status examination shows that she is alert and oriented.
HEAD: There are no signs of injury to the head.
EYES: The eyelids and globes are intact. The extra-ocular movements are intact.
EARS: There are no signs of injury to the ears.
NOSE: There is no blood or abnormal discharge.
MOUTH: There are no signs of injury to the mouth or teeth.
JAW: There is no discomfort of the TM-joints.
NECK: Patient states there is discomfort and pain of the paravertebral muscles. The range of motion is limited: extension - to 30°, rotation to the left - to 70°, rotation to the right - to 70°, tilt to the left - to 20°, tilt to the right - to 20°. There is discomfort of the right trapezius muscle.
CHEST: Patient states there is no discomfort of the chest.
UPPER AND MIDDLE BACK: Patient states there is no discomfort and pain of the upper- and mid-thoracic paravertebral muscles.

ABDOMEN: Patient states there is no discomfort of the abdominal wall.

LOWER BACK: Patient states there is no discomfort and pain of the paravertebral muscles. The range of motion is normal and without pain.

UPPER EXTREMITIES: Patient states there is discomfort of the right shoulder. The range of motion of the right shoulder is limited. Perfusion and pulses are adequate.

LOWER EXTREMITIES: Patient states there is discomfort of the right shin. There is a normal range of active and passive motion of all other areas encompassed by the lower extremities without pain. Perfusion and pulses are adequate.

ASSESSMENT:

Ms. Greene sustained injuries of the cervical spine, right shin, right shoulder and right trapezius muscle in the auto accident on January 18, 2023. The patient's complaints and objective findings are consistent with the mechanisms of the injuries caused by the accident.

DIAGNOSES:

1. Acute ligamentous injury of the right shoulder.
2. Acute sprain/strain of the cervical spine.
3. Acute sprain of the right trapezius muscle.
4. Contusion of the right shin.

TREATMENT PLAN:

1. Physical therapy evaluation and treatment.
2. Obtain medical record and results of X-ray examinations from MedStar Franklin Square Medical Center.
3. Naproxen 500 mg, # 30, P.O., BID, PRN.
4. Cyclobenzaprine 10 mg, # 30, P.O., QHS, PRN.
5. X-ray examinations of the right shoulder and cervical spine.
6. Follow up in two weeks or as needed.

Ms. Greene is unable to perform work duties from January 23, 2023 until January 25, 2023, return to work on January 26, 2023.

It is my opinion to a reasonable degree of medical certainty that the patient's injuries are causally related to the accident, that the treatments recommended are medically necessary, and the bills are fair, reasonable and comparable with like charges for this geographic area.

Patient has been evaluated by:

Benedicto S. Garin, M.D.

Kay O'Hara, D.C.

Report is generated based on physician's evaluation, PT evaluation and patient's input. EM

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FOLLOW UP VISIT

RE: Adrienne Greene
DATE OF INJURY: January 18, 2023
DATE OF VISIT: March 02, 2023

Ms. Greene returned for her follow up visit today. A severe hypolordosis of cervical spine is noted. X-ray examinations of the right shoulder and cervical spine revealed no evidence of fracture or dislocation. She still complains of ongoing pain in the injured areas upon physical exertion. After a physical therapy evaluation, the patient continues the prescribed physical therapy treatment with adequate response.

PHYSICAL EXAMINATION:

OBJECTIVE: 50-year-old female.
GENERAL APPEARANCE: There is a healing bruise on the right shin.
NECK: There is tenderness and spasm of the paravertebral muscles. The range of motion is limited with mild pain. There is tenderness of the right trapezius muscle.
UPPER EXTREMITIES: There is tenderness of the right shoulder. The range of motion of the right shoulder is limited with mild pain.
LOWER EXTREMITIES: There is tenderness of the right shin.

DIAGNOSES:

1. Acute ligamentous injury of the right shoulder.
2. Acute sprain/strain of the cervical spine.
3. Acute sprain of the right trapezius muscle.
4. Contusion of the right shin.

TREATMENT PLAN:

1. Continue physical therapy treatment.
2. Continue taking prescribed medications.
3. Follow up in two weeks or as needed.

It is my opinion to a reasonable degree of medical certainty that the patient's injuries are causally related to the accident, that the treatments recommended are medically necessary, and the bills are fair, reasonable and comparable with like charges for this geographic area.

Patient has been examined by:

Daniel John, M.D.

Report is generated based on physician's examination, test data, specialist's reports (when applicable) and PT Notes. EM

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SUMMARY REPORT

RE: Adrienne Greene
DATE OF INJURY: January 18, 2023
DATE: March 09, 2023

Ms. Greene's condition has substantially stabilized.

PHYSICAL EXAMINATION:

OBJECTIVE: 51-year-old female.
GENERAL APPEARANCE: Bruise on the right shin has healed.
NECK: There is no tenderness or spasm of the paravertebral muscles. The range of motion is normal and without pain.
UPPER EXTREMITIES: There is no tenderness of the right shoulder. The range of motion of the right shoulder is normal and without pain.

DIAGNOSES:

1. Acute ligamentous injury of the right shoulder, improved.
2. Acute sprain/strain of the cervical spine, improved.
3. Acute sprain of the right trapezius muscle, improved.
4. Contusion of the right shin, improved.

TREATMENT PLAN / DISPOSITION:

1. Discontinue physical therapy.
2. Stop taking medications.

COURSE / PROGNOSIS:

Ms. Greene's injuries of the right shin, right shoulder, right trapezius muscle and cervical spine have improved. Ms. Greene's condition is sufficient to discontinue therapy at this time. The patient was advised to return to this office for further treatment if any flare-ups occur.

ASSESSMENT:

Based on the patient's complaints, review of the clinical course, medical records and the results of my examination I have concluded, within a reasonable degree of medical certainty, that all of the patient's injuries were caused by the accident of January 18, 2023. The care and treatment rendered to the patient were medically necessary for the injuries sustained by Ms. Greene in the above accident. The charges for all of the patient's care and treatment are fair, reasonable and comparable to the prevailing charges in this geographic area.

Patient has been examined by:

Daniel John, M.D.

Report is generated based on physician's examination, test data, specialist's reports (when applicable) and PT Notes. EM

X-RAY REPORT

Ordering Physician Benedicto S. Garin, M.D. ***Office*** Essex/Middle River ***Service Provided at*** Essex/Middle River

CERVICAL SPINE

NORMAL FINDINGS

ALL ☑ No fractures, pathologies or severe dislocations are displayed.
☑ The bone structures of the spine(s) are essentially normal.
☑ The disc spaces appear well maintained
☑ There is no evidence of instability
A-P ☑ The A-P spine is generally in good alignment.
☑ The vertebral bodies and posterior elements are normal
A-P/LAT ☑ The discs and discovertebral relationships are normal
LAT ☐ The lateral spine is generally in normal alignment

ABNORMAL FINDINGS

A-P/LAT FLX ☐ An approximation of the atlas on the axis is revealed indicating a possible tearing of the alar ligament.
A-P ☐ A Left concave curvature is displayed of the spine from _____
☐ A Right concave curvature is displayed of the spine from _____
☐ A Left convex curvature is displayed of the spine from _____
☐ A Right convex curvature is displayed of the spine from _____
☐ A transitional vertebrae of _____ is displayed.
☐ A lumbarization of _____ is displayed.
☐ A sacralization of _____ is displayed.
☐ Multilevel diffuse degenerative changes are visible
At the anterior aspect of the: _____
At the posterior aspect of the: _____
At the superior aspect of the: _____
At the inferior aspect end plate(s) of the: _____
At the facets of the: _____
☐ A ☐ Small ☐ Medium ☐ Large osteophytes are present on the ☐ anterior ☐ posterior ☐ lateral aspect of the _____
☐ Osteoporosis is displayed.
☐ Spina bifida occulta is noted at the _____ vertebral level(s).
LAT ☑ A ☑Hypolordosis (severe) ☐Hyperlordosis ☐Hypokyphosis ☐Hyperkyphosis of the Spine is noted.
cervical
☐ There is a reversal of the ☐Cervical ☐Lumbar spine.
☐ Intervertebral disc thinning is noted at the _____ vertebral level(s).
☐ A limbus formation is noted
at the superior aspect of the end plate of the _____
at the inferior aspect of the end plate of the _____
☐ A compression fracture of _____ is visible.
☐ Schmorl's nodes are suggested at the _____ vertebral level(s).
☐ A ☐ Congenital ☐ Surgical fusion is in evidence at the _____ vertebral level.
LAT/OBL ☐ Foraminal encroachment is displayed at the _____ vertebral level (on the L/R).
☐ Spondylolisthesis of the ☐ Retro-listhesis ☐ Antero listhesis is noted.
☐ A grade _____ ☐spondylolisthesis ☐retro/antero-listhesis of _____ is noted.
ALL ☑ Miscellaneous X-ray findings: small area of calcification of the ALL between C5-6
right lateral tilting of the head

Impression marked cervical hypolordosis with lateral tilting of the head

Read by Doctor: Kay O'Hara ***License #*** S01499 ***Signature*** Kay O'Hara PC
(Name)

Reviewed by: Benedicto S. Garin ***License #*** D12724 ***Signature*** B.S. Garin, MD
(Name)

 GREENE, ADRIENNE (D.O.B: 3/4/1972, D.O.I: 1/18/2023, D.O.S: 2/1/2023)

X-RAY EXTREMITY

Ordering Physician Benedicto S. Garin, M.D. ***Office*** Essex/Middle River ***Service Provided at*** Essex/Middle River

SHOULDER (RIGHT)

NORMAL FINDINGS

☑ No fractures, pathologies or severe dislocations are displayed.
☑ The bone structures are essentially normal.
☑ The joint spaces appear well maintained
☑ There is no evidence of instability
☑ There is generally good alignment.
☑ The soft tissues are normal
☑ no degenerative changes
☑ No destructive bony lesion is identified

ABNORMAL FINDINGS

☐ There is a fracture ☐ Alignment ☐ Approximation
☐ A compression fracture of _____ is visible.
☐ A loss of joint space is displayed.
☐ Diffuse degenerative changes are visible
☐Small ☐Medium ☐Large osteophytes are present on the ☐anterior ☐posterior ☐inferior aspect of the _____
☐ Osteoporosis is displayed.
☐ congenital ☐ surgical fusion is in evidence at the: _____
☐ A prothesis present and in normal aligment
☐ Miscellaneous X-ray findings: _____

Impression normal study

Read by Doctor: Kay O'Hara ***License #*** S01499 ***Signature*** Kay B O'Hara PC
(Name)

Reviewed by: Benedicto S. Garin ***License #*** D12724 ***Signature*** B.S. Garin, MD
(Name)

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Information: (888)570-0088 Fax: (410)732-6112
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Date: 1/23/2023

Date of injury: 1/18/2023

This is to certify that ADRIENNE GREENE has been under my professional care and is unable to perform work duties from 1/23/2023 to 1/25/2023, return to work on 1/26/2023.

Benedicto S. Garin,
M.D.

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℞

Date: 1/23/2023

Date of injury: 1/18/2023

Patient`s Name: ADRIENNE GREENE DOB: 3/4/1972

Address: 1104 Sandy Stone Road, Essex MD 21221

LABEL AS TO CONTENTS

☑ Naproxen 500 mg

Tablets: 30 Direction: P.O., BID, PRN

Patient`s Signature:

B.S. Garin, MD

Benedicto S. Garin, M.D.

(NPI: 1952406043)

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℞

Date: 1/23/2023

Date of injury: 1/18/2023

Patient's Name: ADRIENNE GREENE DOB: 3/4/1972

Address: 1104 Sandy Stone Road, Essex MD 21221

LABEL AS TO CONTENTS

☑ Cyclobenzaprine 10 mg

Tablets: 30 Direction: P.O., QHS, PRN

Patient's Signature: _____

B.S. Garin, M.D.

Benedicto S. Garin, M.D.

(NPI: 1952406043)

Physical Therapy Treatment Notes

PATIENT	GREENE, ADRIENNE	DOA: 01/18/2023
DX	Acute sprain of cervical spine. Acute sprain of shoulder right. Acute sprain of trapezius right. Contusion of shin right	
PT/DC	Kay O'Hara, D.C.[PT/DC # S01499], Michael Welch, D.C.[PT/DC # S03804]	
PTA/CA		

Modality Date	Initial eval 97161	Re-Eval 97164	Hot/Cold pack all areas 97010	ElectricalST all areas 97014	Mech. Traction all areas 97012	Massage 9 min. 97124	Man. Therapy Tqs. 9 min. 97140	Exercise 9 min 97110	Hydrotherapy Bed 97039				PROGRESS NOTES	Signatures: PT/DC;PTA/CA; Patient
02/01/23	C/S Shin (R) Shldr(R) Trapezius(R)												**S** Initial Eval performed (see report) **O** Initial Eval performed (see report) **A** Withheld until next visit **P** Continue Tx plan as tolerated	[illegible] [illegible]

Physical Therapy Treatment Notes

PATIENT	GREENE, ADRIENNE	**DOA:** 01/18/2023
DX	Acute sprain of cervical spine. Acute sprain of shoulder right. Acute sprain of trapezius right. Contusion of shin right	
PT/DC	Kay O'Hara, D.C.[PT/DC # S01499], Michael Welch, D.C.[PT/DC # S03804]	
PTA/CA		

Modality / Date	Initial eval 97161	Re-Eval 97164	Hot/Cold pack all areas 97010	ElectricalST all areas 97014	Mech. Traction all areas 97012	Massage 9 min. 97124	Man. Therapy Tqs. 9 min. 97140	Exercise 9 min 97110	Hydrotherapy Bed 97039	Electrodes 2pairs A4556	CMT spinal, one or two regions 98940		PROGRESS NOTES	Signatures: PT/DC;PTA/CA; Patient
02/06/23			C/S	C/S	C/S					C/S	C/S		**S** Feels about the same today **O** No change in tenderness/spasm **A** Patient tolerated treatment well **P** Continue Tx plan as tolerated	

Physical Therapy Treatment Notes

PATIENT	GREENE, ADRIENNE	DOA: 01/18/2023
DX	Acute sprain of cervical spine. Acute sprain of shoulder right. Acute sprain of trapezius right. Contusion of shin right	
PT/DC	Kay O'Hara, D.C.[PT/DC # S01499], Michael Welch, D.C.[PT/DC # S03804]	
PTA/CA		

Modality Date	Initial eval 97161	Re-Eval 97164	Hot/Cold pack all areas 97010	ElectricalST all areas 97014	Mech. Traction all areas 97012	Massage 9 min. 97124	Man. Therapy Tqs. 9 min. 97140	Exercise 9 min 97110	Hydrotherapy Bed 97039	CMT spinal, one or two regions 98940			PROGRESS NOTES	Signatures: PT/DC;PTA/CA; Patient
02/07/23			C/S	C/S	C/S			C/S		C/S			**S** Aching sharp pains with movement **O** Cont. joint restriction in all areas **A** Patient tolerated treatment well **P** Continue Tx plan as tolerated	
02/09/23			C/S Shldr(R) Trapezius(R)	C/S Trapezius(R)	C/S			C/S Shldr(R) Trapezius(R) 2 UNITS min 23 minutes		C/S			**S** Aching sharp pains with movement **O** Cont. joint restriction in all areas **A** Patient tolerated treatment well **P** Continue Tx plan as tolerated	
02/13/23			C/S Shldr(R) Trapezius(R)	C/S Trapezius(R)	C/S			C/S Shldr(R) Trapezius(R) 2 UNITS min 23 minutes		C/S			**S** Pt complains of tightness in CS that varies in intensity with activity **O** Mtpl TrPs w/jt dysf in areas of complt **A** Patient tolerated treatment well **P** Continue Tx plan as tolerated	

Physical Therapy Treatment Notes

PATIENT	GREENE, ADRIENNE	DOA: 01/18/2023
DX	Acute sprain of cervical spine. Acute sprain of shoulder right. Acute sprain of trapezius right. Contusion of shin right	
PT/DC	Kay O'Hara, D.C.[PT/DC # S01499], Michael Welch, D.C.[PT/DC # S03804]	
PTA/CA		

Modality Date	Initial eval 97161	Re-Eval 97164	Hot/Cold pack all areas 97010	ElectricalST all areas 97014	Mech. Traction all areas 97012	Massage 9 min. 97124	Man. Therapy Tqs. 9 min. 97140	Exercise 9 min 97110	Hydrotherapy Bed 97039	CMT spinal, one or two regions 98940			PROGRESS NOTES	Signatures: PT/DC;PTA/CA; Patient
02/17/23			C/S Shldr(R) Trapezius(R)	C/S Trapezius(R)	C/S			C/S Shldr(R) Trapezius(R) 2 UNITS min 23 minutes		C/S			S Frequent aching and stiffness in the: CS shoulder O Cont. joint restriction in: CS shoulder A Patient tolerated treatment well P Continue Tx plan as tolerated	
02/20/23			C/S Shldr(R) Trapezius(R)	C/S Trapezius(R)	C/S			C/S Shldr(R) Trapezius(R) 2 UNITS min 23 minutes		C/S			S Shoulder and CS soreness O Paraspinal spasm and tenderness on mild palpation A Patient tolerated treatment well P Continue Tx plan as tolerated	
02/21/23			C/S Shldr(R) Trapezius(R)	C/S Trapezius(R)	C/S			C/S Shldr(R) Trapezius(R) 2 UNITS min 23 minutes		C/S			S Feels about the same today O No change in tenderness/spasm A No change noted P Continue Tx plan as tolerated	

Physical Therapy Treatment Notes

PATIENT	GREENE, ADRIENNE	DOA: 01/18/2023
DX	Acute sprain of cervical spine. Acute sprain of shoulder right. Acute sprain of trapezius right. Contusion of shin right	
PT/DC	Kay O'Hara, D.C.[PT/DC # S01499], Michael Welch, D.C.[PT/DC # S03804]	
PTA/CA		

Modality Date	Initial eval 97161	Re-Eval 97164	Hot/Cold pack all areas 97010	ElectricalST all areas 97014	Mech. Traction all areas 97012	Massage 9 min. 97124	Man. Therapy Tqs. 9 min. 97140	Exercise 9 min 97110	Hydrotherapy Bed 97039	Extraspinal, 1>regions 98943			PROGRESS NOTES	Signatures: PT/DC;PTA/CA; Patient
02/23/23			C/S Shldr(R) Trapezius(R)	C/S Trapezius(R)	C/S			C/S Shldr(R) Trapezius(R) 2 UNITS min 23 minutes		Shldr(R)			S Decreased pain in all areas O Decreased spasm A Improving slowly P Continue Tx plan as tolerated	
02/27/23			C/S Shldr(R) Trapezius(R)	C/S Trapezius(R)	C/S			C/S Shldr(R) Trapezius(R) 2 UNITS min 23 minutes		Shldr(R)			S No change since last visit, continued soreness in the shoulder and CS O Cont. joint restriction in: CS A Patient tolerated treatment well P Continue Tx plan as tolerated	
02/28/23			C/S Shldr(R) Trapezius(R)	C/S Trapezius(R)	C/S			C/S Shldr(R) Trapezius(R) 2 UNITS min 23 minutes		Shldr(R)			S Feels about the same today O No marked changes A Patient tolerated treatment well P Continue Tx plan as tolerated	

Physical Therapy Treatment Notes

PATIENT	GREENE, ADRIENNE	DOA: 01/18/2023
DX	Acute sprain of cervical spine. Acute sprain of shoulder right. Acute sprain of trapezius right. Contusion of shin right	
PT/DC	Kay O'Hara, D.C.[PT/DC # S01499], Michael Welch, D.C.[PT/DC # S03804]	
PTA/CA		

Modality Date	Initial eval 97161	Re-Eval 97164	Hot/Cold pack all areas 97010	ElectricalST all areas 97014	Mech. Traction all areas 97012	Massage 9 min. 97124	Man. Therapy Tqs. 9 min. 97140	Exercise 9 min 97110	Hydrotherapy Bed 97039	Extraspinal, 1>regions 98943			PROGRESS NOTES	Signatures: PT/DC;PTA/CA; Patient
03/02/23			C/S Shldr(R) Trapezius(R)	C/S Trapezius(R)	C/S			C/S Shldr(R) Trapezius(R) 2 UNITS min 23 minutes		Shldr(R)			S Feels about the same today O No change in tenderness/spasm A Patient tolerated treatment well P Continue Tx plan as tolerated	
03/06/23			C/S Shldr(R) Trapezius(R)	C/S Trapezius(R)	C/S			C/S Shldr(R) Trapezius(R)		Shldr(R)			S CS and shoulder soreness O Cont. joint restriction in: CS shoulder(R) A Patient tolerated treatment well P Continue Tx plan as tolerated	
03/07/23		C/S Shin (R) Shldr(R) Trapezius(R)	C/S Shldr(R) Trapezius(R)	C/S Trapezius(R)	C/S								S Re-Eval performed (see report) O Re-Eval performed (see report) A Patient tolerated treatment well P Continue Tx plan as tolerated	

Physical Therapy Treatment Notes

PATIENT	GREENE, ADRIENNE	DOA: 01/18/2023
DX	Acute sprain of cervical spine. Acute sprain of shoulder right. Acute sprain of trapezius right. Contusion of shin right	
PT/DC	Kay O'Hara, D.C.[PT/DC # S01499], Michael Welch, D.C.[PT/DC # S03804]	
PTA/CA		

Modality Date	Initial eval 97161	Re-Eval 97164	Hot/Cold pack all areas 97010	ElectricalST all areas 97014	Mech. Traction all areas 97012	Massage 9 min. 97124	Man. Therapy Tqs. 9 min. 97140	Exercise 9 min 97110	Hydrotherapy Bed 97039	CMT spinal, one or two regions 98940			PROGRESS NOTES	Signatures: PT/DC;PTA/CA; Patient
03/09/23			C/S Shldr(R) Trapezius(R)						C/S Shldr(R) Trapezius(R)	C/S			S Decreased pain in all areas O ROM improving A Patient tolerated treatment well P Continue Tx plan as tolerated	

MHC HealthCare

Physical Therapy Evaluation/Chiropractic Examination

Patient: GREENE, ADRIENNE **Date:** 02/01/2023 **DOB:** 03/04/1972 **Sex:** **DOI:** 01/18/2023

PT/DC: Kay O'Hara, D.C. [PT/DC # S01499]

☑ **Initial Evaluation** ☐ **Re-Evaluation**

Diagnosis: Acute sprain of cervical spine; Acute sprain of shoulder right; Acute sprain of trapezius right; Contusion of shin right

Presenting Problems:
This patient was the driver of a car that collided with a van. During the accident she was jolted and the air bags deployed. She was evaluated at Franklin Square hospital

Vital Signs: BP was 125/86, pulse 76

Pain Quality:
achy, stiff and sore

Pain Radiation/Refferal: none

Pain Severity: Trapezius(R) 8/10; Shldr(R) 8/10; C/S 8/10; Shin (R) 8/10

Observation/General Appearance: some brusing on the right shin

Palpation: multiple areas of tenderness and hypertonicity in the paracervical and upper trapezius mm. Tender right periscap mm. Tender right shin

Special Tests: **Cervical Spine.** Shoulder Depression Test: Positive Bilaterally
Cervical Spine. Jackson's Compression Test: Positive Bilaterally

Assessment: Ue sensation was wnl

Short-Term Goals:
reduce pain and inflammation

Long-Term Goals:
support healing

Treatment Plan:

Hot/Cold pack all areas:	C/S **PRN**; Shin (R) **PRN**; Shldr(R) **PRN**; Trapezius(R) **PRN**
Mech. Traction all areas:	C/S **PRN**
ElectricalST all areas:	C/S **PRN**; Shldr(R) **PRN**; Trapezius(R) **PRN**
Hydrotherapy Bed:	C/S **PRN**; Shldr(R) **PRN**; Trapezius(R) **PRN**
Exercise 9 min:	C/S **PRN**; Shldr(R) **PRN**; Trapezius(R) **PRN**
Man. Therapy Tqs. 9 min.:	C/S **PRN**; Shldr(R) **PRN**; Trapezius(R) **PRN**

Treatment frequency 2-3 times a week for 4-5 weeks

Maryland Healthcare Clinics

Physical Therapy Evaluation Form - Page 2

Name: GREENE, ADRIENNE **Date:** 02/01/2023 **DOB:** 03/04/1972 **Sex:** **DOI:** 01/18/2023

Cervical Spine:	Normal	Tested	w/pain
Flexion	55	60	+
Extension	45	30	+
Left Rotation	90	70	+
Right Rotation	90	70	+
Left Bending	40	20	+
Right Bending	40	20	+

Thoracic Spine:	Normal	Tested	w/pain
Flexion	45	-	-
Extension	30	-	-
Left Rotation	25	-	-
Right Rotation	25	-	-
Left Bending	20	-	-
Right Bending	20	-	-

Lumbar Spine:	Normal	Tested	w/pain
Flexion	90	-	-
Extension	30	-	-
Left Rotation	25	-	-
Right Rotation	25	-	-
Left Bending	30	-	-
Right Bending	30	-	-

Hip:	Normal	Left	Right	w/pain
Flexion	120-125	-	-	-
Extension	45-50	-	-	-
Abduction	45	-	-	-
Adduction	20	-	-	-
Int. Rotation	30	-	-	-
Ext. Rotation	50	-	-	-

Knee:	Normal	Left	Right	w/pain
Flexion	135-140	-	-	-
Extension	0	-	-	-

Reflexes:	Left	Right
C5 (Biceps)	2+	2+
C6 (Brachioradialis)	2+	2+
C7 (Triceps)	2+	2+
L4 (Patellar)	-	-
S1 (Achilles)	-	-

Pathologic Reflexes:	Left	Right
Hoffmann's	-	-
Forced Ankle Flexion	-	-
Other:-	-	-

Shoulder:	Normal	Left	Right	w/pain
Flexion	180	-	180	-
Extension	45	-	45	-
Int. Rotation	90	-	90	-
Ext. Rotation	90	-	90	-
Abduction	180	-	180	-
Adduction	45	-	-	-

Elbow:	Normal	Left	Right	w/pain
Flexion	135-145	-	-	-
Extension	0	-	-	-
Supination	80-90	-	-	-
Pronation	70-90	-	-	-

Wrist:	Normal	Left	Right	w/pain
Dorsiflexion	55	-	-	-
Palmar flexion	70-80	-	-	-
Radial deviation	20-35	-	-	-
Ulnar deviation	40-75	-	-	-

Ankle:	Normal	Left	Right	w/pain
Dorsiflexion	20-30	-	-	-
Plantar flexion	45-55	-	-	-
Inversion	50	-	-	-
Eversion	20	-	-	-

Upper Extremity Strength:	Left	Right
C5 (deltoid)	5	5
C6 (biceps)	-	-
C7 (triceps)	-	-
C8 (hand)	-	-
T1 (fingers)	-	-

Lower Extremity Strength:	Left	Right
L2 (iliopsoas)	-	-
L3 (Adductors, quadriceps)	-	-
L4 (tibialis anterior/inversion)	-	-
L5 (hallux extension)	-	-
S1 (peroneus longus/eversion)	-	-

PT\DC Signature: Kelly B Ohm PC

License #: S01499

Patient Signature:

MHC HealthCare

Physical Therapy Evaluation/Chiropractic Examination

Patient: GREENE, ADRIENNE **Date:** 03/07/2023 **DOB:** 03/04/1972 **Sex:** **DOI:** 01/18/2023

PT/DC: Michael Welch, D.C. [PT/DC # S03804]

☐ **Initial Evaluation** ☑ **Re-Evaluation**

Diagnosis: Acute sprain of cervical spine; Acute sprain of shoulder right; Acute sprain of trapezius right; Contusion of shin right

Presenting Problems:
Patient is improving with decreases in pain in all areas.

Vital Signs:

Pain Quality:

Pain Radiation/Refferal:

Pain Severity: Shin (R) 1/10; C/S 2/10; Trapezius(R) 1/10; Shldr(R) 3/10

Observation/General Appearance: x3 Alerted and oriented

Palpation: Mild trigger points in the areas of complaint

Special Tests: **Cervical Spine.** Maximal Foraminal Compression: Positive

Assessment: Patient is improving and would likely benefit from a continued course of conservative care

Short-Term Goals:
Strengthen

Long-Term Goals:
Return to pre-accident condition

Treatment Plan:

Hot/Cold pack all areas:	C/S **PRN**; Shin (R) **PRN**; Shldr(R) **PRN**; Trapezius(R) **PRN**
Mech. Traction all areas:	C/S **PRN**
ElectricalST all areas:	C/S **PRN**; Shldr(R) **PRN**; Trapezius(R) **PRN**
Hydrotherapy Bed:	C/S **PRN**; Shldr(R) **PRN**; Trapezius(R) **PRN**
Exercise 9 min:	C/S **PRN**; Shldr(R) **PRN**; Trapezius(R) **PRN**
Man. Therapy Tqs. 9 min.:	C/S **PRN**; Shldr(R) **PRN**; Trapezius(R) **PRN**

Treatment frequency 3-4 times a week for 4-5 weeks

Maryland Healthcare Clinics

Physical Therapy Evaluation Form - Page 2

Name: GREENE, ADRIENNE **Date:** 03/07/2023 **DOB:** 03/04/1972 **Sex:** **DOI:** 01/18/2023

Cervical Spine:	Normal	Tested	w/pain
Flexion	55	40	-
Extension	45	40	-
Left Rotation	90	85	-
Right Rotation	90	70	-
Left Bending	40	35	-
Right Bending	40	30	+

Thoracic Spine:	Normal	Tested	w/pain
Flexion	45	-	-
Extension	30	-	-
Left Rotation	25	-	-
Right Rotation	25	-	-
Left Bending	20	-	-
Right Bending	20	-	-

Lumbar Spine:	Normal	Tested	w/pain
Flexion	90	-	-
Extension	30	-	-
Left Rotation	25	-	-
Right Rotation	25	-	-
Left Bending	30	-	-
Right Bending	30	-	-

Hip:	Normal	Left	Right	w/pain
Flexion	120-125	-	-	-
Extension	45-50	-	-	-
Abduction	45	-	-	-
Adduction	20	-	-	-
Int. Rotation	30	-	-	-
Ext. Rotation	50	-	-	-

Knee:	Normal	Left	Right	w/pain
Flexion	135-140	-	-	-
Extension	0	-	-	-

Reflexes:	Left	Right
C5 (Biceps)	-	-
C6 (Brachioradialis)	-	-
C7 (Triceps)	-	-
L4 (Patellar)	-	-
S1 (Achilles)	-	-

Pathologic Reflexes:	Left	Right
Hoffmann's	-	-
Forced Ankle Flexion	-	-
Other:-	-	-

Shoulder:	Normal	Left	Right	w/pain
Flexion	180	-	180	-
Extension	45	-	45	-
Int. Rotation	90	-	90	-
Ext. Rotation	90	-	90	-
Abduction	180	-	180	-
Adduction	45	-	40	-

Elbow:	Normal	Left	Right	w/pain
Flexion	135-145	-	-	-
Extension	0	-	-	-
Supination	80-90	-	-	-
Pronation	70-90	-	-	-

Wrist:	Normal	Left	Right	w/pain
Dorsiflexion	55	-	-	-
Palmar flexion	70-80	-	-	-
Radial deviation	20-35	-	-	-
Ulnar deviation	40-75	-	-	-

Ankle:	Normal	Left	Right	w/pain
Dorsiflexion	20-30	-	-	-
Plantar flexion	45-55	-	-	-
Inversion	50	-	-	-
Eversion	20	-	-	-

Upper Extremity Strength:	Left	Right
C5 (deltoid)	-	-
C6 (biceps)	-	-
C7 (triceps)	-	-
C8 (hand)	-	-
T1 (fingers)	-	-

Lower Extremity Strength:	Left	Right
L2 (iliopsoas)	-	-
L3 (Adductors, quadriceps)	-	-
L4 (tibialis anterior/inversion)	-	-
L5 (hallux extension)	-	-
S1 (peroneus longus/eversion)	-	-

PT\DC Signature:

License #: S03804

Patient Signature:

Exercise form

Patient: GREENE, ADRIENNE DOB: 03/04/1972 Sex: DOA: 01/18/2023

	CERVICAL/THORACIC SPINE												UPPER EXTREMITIES												LUMBAR SPINE												LOW EXTREMITIES														
									ACTIVE ROM												ACTIVE ROM SHOULDER ELBOW WRIST/ HAND																								ACTIVE ROM HIP, KNEE, ANKLE, FOOT														
EQUIPMENT USED						BIKE												PULLEYS/WHEEL	THERABAND	FREE WEIGHTS		THERAPATTY								TREAD MILL	BIKE												TREAD MILL	BIKE	FREE WEIGHTS										
DATE	UPPER TRAPEZIUS STRETCH	CORNER STRETCH	ISOMETRICS	SHOULDER SHRUG	SHOULDER ROLLS	BIKE	WHOLE BODY VIBRATION	POSTURAL ALIGNMENT	ROTATION L/R	SIDE BENDING L/R	FLEXION	EXTENSION	BIKE	PENDULUM MOVEMENTS	WAND EXERCISES	PULLEYS/WHEELING EXERCISES	THERABAND STRENGTHENING (Y,R,G,B)*	FREE WEIGHTS (1#),(2#),(3#),(4#)	THERAPATTY	DIGIFLEXORS	ISOMETRICS	ROTATION L/R	SIDE BENDING L/R	FLEXION	EXTENSION	LOW TRUNK ROTATION	SINGLE KNEE-CHEST	HAMSTRING STRETCH	PIRIFORMIS STRETCH	PRONE ON ELBOWS	CURL UPS	PELVIC TILT	SEATED LOW BACK STRETCH	BRIDGING	TREAD MILL	BIKE	WHOLE BODY VIBRATION	POSTURAL ALIGNMENT	ALTERNATE ARM AND LEG EXTENSION	WOBLE CHAIR	ISOMETRICS	SHORT ARC QUADS/LONG ARC QUADS	CALF STRETCH	HEEL SLIDES	WALL SLIDES	TREAD MILL	BIKE	FREE WEIGHTS (1#),(2#),(3#),(4#),(5#)	ISOMETRICS	ROTATION L/R	SIDE BENDING L/R	FLEXION	EXTENSION	armbike; shoulder stretch; Core exercises; shoulder		PT / DC OR PTA / CA SIGNATURE
02/07/2023																																																X		
02/09/2023																																																X		
02/13/2023																																																X		
02/17/2023																																																X		
02/20/2023																																																X		

Exercise form

Patient: GREENE, ADRIENNE DOB: 03/04/1972 Sex: DOA: 01/18/2023

	CERVICAL/THORACIC SPINE												UPPER EXTREMITIES												LUMBAR SPINE												LOW EXTREMITIES														
								ACTIVE ROM												ACTIVE ROM SHOULDER ELBOW WRIST/ HAND																								ACTIVE ROM HIP, KNEE, ANKLE, FOOT														
EQUIPMENT USED					BIKE								BIKE		WAND	PULLEYS/WHEEL	THERABAND	FREE WEIGHTS	THERAPATTY									TREAD MILL	BIKE												TREAD MILL	BIKE	FREE WEIGHTS										
DATE	UPPER TRAPEZIUS STRETCH	CORNER STRETCH	ISOMETRICS	SHOULDER SHRUG	SHOULDER ROLLS	BIKE	WHOLE BODY VIBRATION	POSTURAL ALIGNMENT	ROTATION L/R	SIDE BENDING L/R	FLEXION	EXTENSION	BIKE	PENDULUM MOVEMENTS	WAND EXERCISES	PULLEYS/WHEELING EXERCISES	THERABAND STRENGTHENING (Y,R,G,B)*	FREE WEIGHTS (1#),(2#),(3#),(4#)	THERAPATTY	DIGIFLEXORS	ISOMETRICS	ROTATION L/R	SIDE BENDING L/R	FLEXION	EXTENSION	LOW TRUNK ROTATION	SINGLE KNEE-CHEST	HAMSTRING STRETCH	PIRIFORMIS STRETCH	PRONE ON ELBOWS	CURL UPS	PELVIC TILT	SEATED LOW BACK STRETCH	BRIDGING	TREAD MILL	BIKE	WHOLE BODY VIBRATION	POSTURAL ALIGNMENT	ALTERNATE ARM AND LEG EXTENSION	WOBLE CHAIR	ISOMETRICS	SHORT ARC QUADS/LONG ARC QUADS	CALF STRETCH	HEEL SLIDES	WALL SLIDES	TREAD MILL	BIKE	FREE WEIGHTS (1#),(2#),(3#),(4#),(5#)	ISOMETRICS	ROTATION L/R	SIDE BENDING L/R	FLEXION	EXTENSION	armbike; shoulder stretch; Core exercises; shoulder		PT / DC OR PTA / CA SIGNATURE
02/21/2023																																																X		
02/23/2023																																																X		
02/27/2023																																																X		
02/28/2023																																																X		
03/02/2023																																																X		

Exercise form

Patient: GREENE, ADRIENNE DOB: 03/04/1972 Sex: DOA: 01/18/2023

	CERVICAL/THORACIC SPINE												UPPER EXTREMITIES												LUMBAR SPINE												LOW EXTREMITIES														
									ACTIVE ROM												ACTIVE ROM SHOULDER ELBOW WRIST/ HAND																				ACTIVE ROM HIP, KNEE, ANKLE, FOOT														
EQUIPMENT USED						BIKE							BIKE		WAND	PULLEYS/WHEEL	THERABAND	FREE WEIGHTS	THERAPATTY										TREAD MILL	BIKE												TREAD MILL	BIKE	FREE WEIGHTS								
DATE	UPPER TRAPEZIUS STRETCH	CORNER STRETCH	ISOMETRICS	SHOULDER SHRUG	SHOULDER ROLLS	BIKE	WHOLE BODY VIBRATION	POSTURAL ALIGNMENT	ROTATION L/R	SIDE BENDING L/R	FLEXION	EXTENSION	BIKE	PENDULUM MOVEMENTS	WAND EXERCISES	PULLEYS/WHEELING EXERCISES	THERABAND STRENGTHENING (Y,R,G,B)*	FREE WEIGHTS (1#),(2#),(3#),(4#)	THERAPATTY	DIGIFLEXORS	ISOMETRICS	ROTATION L/R	SIDE BENDING L/R	FLEXION	EXTENSION	LOW TRUNK ROTATION	SINGLE KNEE-CHEST	HAMSTRING STRETCH	PIRIFORMIS STRETCH	PRONE ON ELBOWS	CURL UPS	PELVIC TILT	SEATED LOW BACK STRETCH	BRIDGING	TREAD MILL	BIKE	WHOLE BODY VIBRATION	POSTURAL ALIGNMENT	ALTERNATE ARM AND LEG EXTENSION	WOBLE CHAIR	ISOMETRICS	SHORT ARC QUADS/LONG ARC QUADS	CALF STRETCH	HEEL SLIDES	WALL SLIDES	TREAD MILL	BIKE	FREE WEIGHTS (1#),(2#),(3#),(4#),(5#)	ISOMETRICS	ROTATION L/R	SIDE BENDING L/R	FLEXION	EXTENSION	armbike; shoulder stretch; Core exercises; shoulder		PT / DC OR PTA / CA SIGNATURE
03/06/2023																																																		X		

File/s Attached with this email:

1) CP_8Q0MRZ_144000063451_20230410193637.pdf

RA #: 8Q0MRZ
Invoice #: 144000063451
Invoice Date: 03/06/2023
Reservation #: 8PV0BJ
ARMS Alt Res #: Y37TYS

enterprise
701 WEDEMAN AVE
21090-1415 LINTHICUM, UNITED STATES

BILLING DETAIL

Description	Qty	Period	Rate	Amount
Taxable Charges:				
TIME & DISTANCE	3	DAY	43.99	131.97
TIME & DISTANCE	16	DAY	40.69	655.84
MD VEHICLE LICENSE RECOVERY FEE	4	DAY	0.44	1.76
MD VEHICLE LICENSE RECOVERY FEE	15	DAY	0.44	6.60
		Taxable Subtotal:		796.17
Non-Taxable Charges:				
MARYLAND SALES TAX	796.17	%	11.50	91.56
		Non-Taxable Subtotal:		91.56
Total (USD)				887.73

PAYMENTS

Deposit	02/14/2023	VI	5222	0.50
Deposit	01/24/2023	VI	5222	5.00
Deposit	02/11/2023	VI	5222	143.62
Deposit	03/06/2023	VI	5222	277.17
Deposit	02/14/2023	VI	5360	0.50
Deposit	02/17/2023	VI	5360	183.78
Deposit	02/23/2023	VI	5360	277.16
Total Payments (USD)				887.73

Balance Due (USD) 0.00

Individual line item charges such as rental rates for Time and Distance, percentage based charges (e.g., sales taxes and fees or surcharges), and charges divided between multiple parties may be rounded up or down a whole cent to ensure that the charges equal the actual Total Amount Due and/or Base Fractional cents.

BILL TO

ADRIENNE GREEN
1104 SANDY STONE RD #L
ESSEX, MD, UNITED STATES 21221

RENTAL INFORMATION

Driver:	GREEN, ADRIENNE
Check Out:	01/24/2023 12:44
Location:	ESSEX
Check In:	03/01/2023 16:24
Location:	ESSEX
Reserved Car Class:	SCAR / SCAR
Charged Car Class:	ECAR / ECAR
Type:	VP
Rate Plan:	CORVEL - DALLAS / DEFAULT - RATES

RENTAL VEHICLES

#	Year	Make	Model	Series	Class	Reg. Date	Start	End
1	2022	MAZD	CX5	SPC4	IFDR		01/24	02/14
2	2021	CHEV	SPAR	SDLT	ECAR		02/14	02/17
3	2021	TOYO	CORO	LE	ICAR		02/17	03/01

#	Lic. Plate	MRP	CO2	Fuel	KM/M Beg. / End. / Total
1	1FG7657			UL	6203 / 6708 / 505
2	2FB0707			UL	32533 / 32806 / 273
3	6EW7695			UL	38660 / 39828 / 1168

#	VIN #	Eng.	HP	KW	Unit
1	JM3KFBEM2N1567804		0	0	7VJ265
2	KL8CD6SA6MC743169		98	72	7VTY30
3	5YFEPMAE7MP183833		139	102	7V148X

CLAIM INFORMATION

Claim#/PO#/RO#:

Repair Shop: TOTAL LOSS

Fed Tax Id : 26-4548300

FOR BILLING INQUIRIES

Tel#: 4104124820
BALTARADMIN@EHI.com

Thank You For Choosing Enterprise
Page 1 of 1

PDF document for the invoice Details.

Terms | Privacy Policy

enterprise

Rental Agreement # 92LTW8

Renter Information

Renter Name
ADRIENNE GREEN

Renter Address
ESSEX, MD 21221
USA

Vehicle Information

CORO
License #: 6EW7695
State/Province: MD
Unit #: 7V148X
Vehicle #: MP183833

Vehicle Class Driven
Midsize 2/4 door/Automatic/Air

Vehicle Class Charged
Midsize 2/4 door/Automatic/Air

Odometer Mileage/Kilometers
Starting: 39828 **Ending:** 41796
Total: 1,968

Fuel
Starting: 3/4 **Ending:** 3/16

Thank you for renting with Enterprise Rent-A-Car

We appreciate your business!
This email was automatically generated from an unattended mailbox, so please do not reply to this e-mail.
If you have any questions about your rental, please view our Frequently Asked Questions or send us a secured message by visiting our Support Center

Trip Information

Pickup
Thursday, March 2, 2023 12:01 AM
Start Charges
Thursday, March 2, 2023 4:24 PM
ESSEX
1601 EASTERN BLVD
ESSEX, MD 21221-2104
USA

Return
Friday, March 31, 2023 10:47 AM
ESSEX
1601 EASTERN BLVD
ESSEX, MD 21221-2104
USA

Bill-To: TRAVELERS-CUSTOMER PAY

Subtotal		$0.00

Renter Charges

Rental Rate	Time & Distance 30 Day at $25.99 / Day	$779.70
Mileage	Unlimited Mileage	Included
Taxes and Fees	Md Vehicle License Recovery Fee ($0.44 / Day)	$13.20
	Maryland Sales Tax (11.50%)	$91.18
Total		**$884.08**
(Subject to audit)		
Amount charged on March 23, 2023 to VISA (5360)		($604.61)
Amount charged on March 10, 2023 to VISA (5360)		($309.00)
APN: VISA DEBIT		
AID: A0000000031010		
Verified: Signature		
Entry: Chip		
TSI: 6800		
Amount charged on March 6, 2023 to VISA (5222)		($50.00)
Amount Due		**($70.53)**