

CICERO, FRANCE, BARCH & ALEXANDER, P.C.

A Professional Corporation
Attorneys at Law
6323 EAST RIVERSIDE BOULEVARD
ROCKFORD, ILLINOIS 61114

PAUL R. CICERO
JOHN W. FRANCE
RONALD A. BARCH
CHARLES P. ALEXANDER
CHANTEL R. BIELSKIS

ANDREW T. SMITH

RECD SEP O

September 4, 20

2012

TEL: (815) 226-7700

SEP 19 2012

SEP 3 8 3 8

Release of Information/Medical Records Custodian c/o Centegra Northern Illinois Medical Center 4201 Medical Center Drive McHenry, IL 60050

And the second

Paul Dulberg y. Carolyn McGuire and Bill McGuire

McHenry County Case No. 12 LA 178 Records of: Paul Dulberg (B/D: 3/19/70)

Dear Medical Records Custodian:

Enclosed with this letter is a Subpoena for Deposition, a HIPAA Records Release Authorization and a check in the amount of \$20.00, the legal witness fee.

Please be advised that your appearance on the date indicated is <u>not</u> necessary. You may comply with the subpoena by mailing legible copies of all medical records, <u>medical statements for services</u> and medical reports of Paul Dulberg for the dates requested in the subpoena, in your possession or subject to your control.

Please note that we represent Carolyn McGuire and Bill McGuire in this case and not your patient. Since we do not represent the patient, we cannot discuss the substance of your care or the pending lawsuit with you outside the presence of your patient's attorney. If you have questions about how to comply with the subpoena, you may call my secretary, but neither she nor I can talk to you about any aspect of the lawsuit or the patient's medical treatment. Thank you in advance for your professional cooperation.

Very truly yours,

Cicero, France, Barch & Alexander, P.C.

RONALD A. BARCH

COPIED BY

SEP 14 2012

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RB:mj/subltr.records encls.

OHOIS.

cc: Attorney Hans A. Mast

Northern Illinois Medical Center TAX ID# 362338884 4201 Medical Center Dr McHenry, IL 60050 (815) 338-2544

F/C:SI P/T:EDB

DULBERG, PAUL R

11179-00323

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APIWAT W FORD

PAUL R DULBERG 4606 HAYDEN CT

601067 PAUL DULBERG/ACCIDENT

MCHENRY IL 60051-7918 99999 999999999 09/14/12

| | CODE ***250 | DESCRIPTION PHARMACY | QTY |
|-------|----------------|-----------------------------------|----------|
| 06/28 | 000196 | CEFADROXIL MONOH 500MG, CAPSUL | 1 19.00 |
| 06/28 | 002870 | HYDROCODONE-AC 10-325MG, TABLE | 1 7.50 |
| 06/28 | 000630 | BUPIVACAINE HCL 0. 0.25%,30 M | 1 26.50 |
| 33,20 | | AREA TOTAL *** | 53.00 |
| | ***258 | PHARMACY IV SOLUTIONS | |
| 06/28 | 012251 | SODIUM CHLORIDE 0.9% 1000ML IRRIG | 2 184.00 |
| • | | AREA TOTAL *** | 184.00 |
| | ***272 | STERILE SUPPLIES | |
| 06/28 | 012458 | TRAY LACERATION | 1 125.00 |
| | | AREA TOTAL *** | 125.00 |
| | ***320 | RADIOLOGY | |
| 06/28 | 010135 | FOREARM XR | 1 225.00 |
| | | AREA TOTAL *** | 225.00 |
| | ***450 | EMERGENCY DEPARTMENT | |
| 06/28 | 012004 | REPAIR SIMPLE 12.5 CM | 1 271.25 |
| 06/28 | 019283 | ED LEVEL III | 1 310.00 |
| | | AREA TOTAL *** | 581.25 |
| | ***636 | QUANTIFIED DRUGS | |
| 06/28 | 003507 | DIPHTHERIA-PERTUSSIS-TE, . 5 ML | 1 155,50 |
| | | AREA TOTAL *** | 155.50 |
| | | | |
| | | TOTAL CHARGES | 1,323.75 |
| | | TOTAL PAYMENTS/ADJUSTMENTS | 0.00 |
| | | | |

Northern Illinois Medical Center TAX 1D# 362338884 4201 Medical Center Dr McHenry, IL 60050 (815) 338-2544

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PAUL R DULBERG

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| | 250 | PHARMACY | 53,00 | |
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| | 272 | STERILE SUPPLIES | 125.00 | |
| | 320 | RADIOLOGY | 225.00 | |
| | 450 | EMERGENCY DEPARTMENT | 581.25 | |
| | 636 | QUANTIFIED DRUGS | 155.50 | |
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| | TOTAL | CHARGES | 1,323.75 | |
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| | TOTAL | PAYMENTS/ADJUSTMENTS | 0.00 | |

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| CODE | DESCRIPTION | QTY |
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| | Total Charges: | |
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| | 258 PHARMACY IV SOLUTIONS | 184.00 |
| | 272 STERILE SUPPLIES | 125.00 |
| | 320 RADIOLOGY | 225.00 |
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| Insurance Benefits | 601067 COB. 1 | | |
|---|----------------------------|------------------|--------------------------|
| Total Charges Non-Covered Chgs Deductibles/Co-Ins | 1,323.75 0.00 0.00 | | Patient |
| COB/Plan Amt Due | 1,323.75 | | 0.00 |
| Payments Adjs/Refunds Balance Transfers | 0.00 0.00 1,323.75CR | | 0.00 0.00 1,323.75 |
| Balance Due | 0.00 | | 1,323.75 |
| Third Party Excess Account Balance | | 0.00 1,323.75 | |

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++**Centegra**HealthSystem

Centegra Northern Illinois Medical Center 4201 Medical Center Drive McHenry, IL 60050 815-344-5000

| State of Illinois |) | |
|-------------------|---|----|
| |) | SS |
| County of McHenry |) | |

CERTIFICATION

The affiants, being duly sworn, do hereby state and certify that

- 1. Vicki Wheaton is employed by Centegra Health System, as Director of the Health Information Services.
- 2. Vicki Wheaton, as part of her employment duties in Medical Records Department, is authorized by the hospital to certify and/or testify concerning the hospital's medical record-keeping procedures, including customary practices and the completeness, accuracy, and/or authenticity of any original or copy of a hospital medical record.
- 3. The documents enclosed are medical records made in the regular course of the business of Centegra Health System and that it was in the regular course of such business to make such records, at the time of the act, transaction, occurrence, or event, or within a reasonable time thereafter.
- 4. With the exception of any documents excluded pursuant to court order, the documents enclosed are any and all records within our possession responsive to the subpoena under which the documents are being released.

Subscribed to and sworn before me this / Bday of Tanuary, a-DIO.

Notary

OFFICIAL SEAL
SUSAN HENN
NOTARY PUBLIC-STATE OF ILLINOIS
MY COMMISSION EXPIRES 01/05/13

Vicki Wheaton, RHIT

Director, HIS

Centegra Health System

| CENTEGRA | | | | | | | ` | | | | | DISCHARGE | IME |
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| ACCIDENT | DULBERG, PAT | | | , | | | | | | | | DOB. | |
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RESTRICTIONS / RELEASE FORM

| Emergency Department | Memorial Medical Center 3701 Doty Rd. Woodstock, Illinois 60098 (815) 334-3900 |
|---|---|
| PHYSICIAN SIGNATURE May return to work school gym without restriction. May not return to work school gym for day(s). May return to school with the following restrictions: Gym/Sports restrictions are day(s). May return to work with the following restrictions: No lifting greater than lbs. for day(s). | |
| ☐ Machinery/Driving restriction while on medication that can cause drow ☐ No continuous ☐ standing ☐ sitting for day(s). | siness. |
| ☐ Must keep | LIMITED WORK WITH NO WORK WITH Right Left Hand Hand Arm Arm Foot Foot Leg Leg For Days |
| All patients are referred to their personal physicians or a doctor on the staff of be obtained from that doctor and not the Emergency Department. I (or responsible person) have/has received and understand(s) the instruction Patient signature (or responsible person): PRINTED BY: MRV01/17 DATE 09/14/2012 EMCARE, INC | |

MEDICAL RECORDS COPY

Patient; PAUL DULBERG, Med. Rec. #: B0000109381, Visit #: B1117900323, Date: 06/28/2011 Time: 17:02

Home Care Instructions

IMPORTANT: We examined and treated you today on an emergency basis only. This was not a substitute for, or an effort to provide, complete medical care. In most cases, you must let your doctor check you again. Tell your doctor about any new or lasting problems. We cannot recognize and treat all injuries or illnesses in one Emergency Department visit. If you had special tests, such as EKG's or X-rays, we will review them again within 24 hours. We will call you if there are any new suggestions. You were treated today by: Ford, Apiwat W...

After your visit to our Emercency Department, you may receive a survey in the mail. We want to be sure we have given you yery good care and we ask that you please fill out the survey and return it in the mail.

After you leave, please follow the instructions below.

This information is About Your Follow Up Care

Call as soon as possible to make an appointment to see your doctor in 10 days for suture removal. You can reach your doctor by calling their clinic phone number.

Please return to the Emergency Department in 10 days for suture removal if you would prefer to have the sutures removed in the ER. We do recommend that you lollow-up with your Primary Care Physician but you can return to the ER for removal of your stitches if you choose...

This Information is About Your Illness and Diagnosis

WOUND CARE (with stitches)

Your wound was closed with stitches. These are small threads that keep the skin closed to help it heal. You have 3 internal and 11 external stitches. These should be removed in 10 days.

At home, please follow these instructions:

- Wash your hands before touching the dressing or wound.
- · Keep the wound clean and dry.
- · After 2 days, wash the wound gently with warm water and soap. Pat it dry.
- · Put a light dressing on it if it rubs or there is drainage.

Call your doctor if:

- · you have redness, pain, or swelling in the area of your stitches.
- · your wound drains pus.
- your stitches come out before your wound is healed.
- · you have any new or bothersome symptoms.

This is information About Your New Medications - Start taking as prescribed.

HYDROGODONE and ACETAMINOPHEN (Vicodin, Vicodin ES, Lorlab, Lorlab elixir, Zamicet, Norco, Zydone, Anexsia, Anolor, Bancap HC)

Take this medicine by mouth with food in the following dose: one 10mg/325mg tablet every 4 to 6 hours if needed for pain. Do not take more than as directed per day (24 hours).

This is a mixture of medicines (hydrocodone and acetaminophen) used to relieve moderate to severe pain. This medicine may be used for other reasons, as prescribed by your doctor.

Side effects may include:

- · sleepiness or dizziness
- upset stomach, nausea or vomiting
- constipation

Other side effects may occur, but are not as common. <u>Alleray would show up as:</u> rash or ltching, facial or throat swelling, wheezing or shortness of breath. This medicine can be habit forming if used for a long period of time.

Follow these instructions:

- Never take more of this medicine than prescribed. Too much acetaminophen in your body can cause liver damage.
- Read the labels of non-prescription medicines before taking them. Many contain acataminophen, To avoid an overdose, do not take any other medicines that contain acetaminophen.
- Talk to your doctor or pharmacist before taking medicines for sleep, colds or atlergies. Severe drowsiness may occur.
- Do not share this medicine with others as this medicine is a controlled-substance. Sharing this medicine with others is against the law.
- To avoid constipation while taking this medicine:
 - Drink plenty of liquids. Try to drink 8 to 10 eight-ounce glasses of water or juice each day.
 - · Include extra fiber in your diet.
 - · Exercise daily.
- Watch for signs of dependence:
 - · feeling that you "cannot live without this medicine".
 - you need more of this medicine than before to get the same relief.
- Do not drink alcohol, drive or operate machinery until you know how this
 medicine affects you.
- Store this medicine away from heat, moisture or direct light.
- If you are taking this on a regular schedule and you miss a dose, take it as soon as possible. If it is almost time for your next dose, skip the missed dose and return to your regular schedule. Do not double the doses.
- Talk with your doctor before taking any other medicines (including vitamins and herbals) as you may require additional monitoring.

Call your doctor if you have:

- any sign of dependence or allergy.
- increased pain not helped by the pain medicine.
- · slow, weak breathing,
- seizures,
- slow or irregular heart beat.
- a yellow-color to your skin or eyes, or dark urine.
- slomach pain.
- · unusual or extreme tiredness.
- · any new or severe symptoms.

CEFADROXIL (Duricef)

Take this medicine until gone in the following dose: 500 mg by mouth 2 times a day for 5 days,

Portions Copyrighted 1987-20PP, LOGICARE Corporation Page 1 of 2 DATE PRINTED PAUL R

Account Number, B1117900323

Cefadroxil is an antibiotic used to treat infections caused by bacteria. Antibiotics kill bacteria or prevent them from growing Inside your body. This medicine may be used for other reasons, as prescribed by your doctor.

Side effects may include:

- dlarrhea
- upset stomach, nausea or vomiting
- headache

Other side effects may occur, but are not as common. An upset stomach is not a sign of allergy. Allergy would show up as rash or itching, facial or throat swelling, wheezing or shortness of breath.

Follow these instructions:

- Space your medicine doses evenly throughout the day. This medicine works best if there is a constant amount in your blood.
- Take this medicine with food to avoid an upset stomach.
- Swallow the capsule and tablet form of this medicine whole with a full 8-ounce glass of water.
- For diabetics, this medicine can cause false test results when testing your urine for sugar. Talk with your doctor if you have questions.
- Store the tablet or capsule form of this medicine away from heat, moisture or direct light.
- Store the liquid form of this medicine in the refrigerator. Shake the liquid well before each use.
- If you miss a dose, take it as soon as possible. If it is almost time for your next dose, skip the missed dose. Do not double the doses,
- Talk with your doctor before taking any other medicines (including vitamins and herbals) as you may require additional monitoring.

Call your doctor if you have:

- any sign of allergy.
- no improvement after you've taken all the medicine.
- a seizure.
- any sign of a new infection (fever, general aches, chills, or unusual tiredness or weakness).
- ongoing nausea, vomiting or stomach pain.
- white patches in your mouth.
- women: itching in or change in discharge from your vagina.
- inflammation (pain and swelling) in your intestine during treatment or up to weeks after you've finished this medicine:
 - ongoing diarrhea
 - stomach pain or cramping
 - blood or mucus in your bowel movements
- any new or bothersome symptoms.

SMOKING CESSATION

Smoking is the nation's leading preventable cause of death. It significantly increases the risk of coronary heart disease, stroke and cancer. In fact, more than half of all smoking related deaths in America each year are from heart disease, stroke, or other cardiovascular diseases. The good news is, that one year after quitting, the risk of heart disease is cut in half. After five to fifteen smoke-free years, the risk is that of a person who never smoked!

If you or someone you love is interested in quitting, consider joining our "Freedom From Smoking "classes for adults. Centegra Health System and the McHenry County Department of Health have partnered together to bring you an effective program that will help you quit smoking. Call 877-CENTEGRA, (877-236-8347) for more information regarding this program. To speak with a counselor immediately, call the Illinois Tobacco line at 1-866-QUIT-YES.

PAIN MANAGEMENT AFTER DISCHARGE:

A person may feel less pain just by being in familiar surroundings. Here are some frequently asked questions about your pain management:

- What can I do to help my pain management? A person's level of relaxation and their environment can affect their pain. If you are tired, over stimulated (too many visitors) are anxious about your diagnosis, or a past experience with a hospitalization, your pain perception may be impacted and your tolerance decreased. Ask questions, and inform us about any problems or concerns that you may have, re: pain. Partner with your health team for your best pain management.
- What if the medication is not working? Tell your health-care provider: physician, home health nurse, etc. You may need a different dose or type of medicaton.
- What if I feel I'm not getting enough pain control? Talk to your physician or home health nurse about it. Together you may be able to develop a plan to prevent or ease your pain. Depending on the cause of your pain, your health-care provider may suggest exercise, use of heat/cold, massage, repositioning, immobilization of the affected part, or distraction such as music or rest.
- There are other methods of pain management. Let your health-care provider assist you in finding the best one for you.

Weight management is one step to help maintain a healthy lifestyle. For certain medical problems, such as congestive heart failure, weight should be monitored daily.

YOU ARE THE MOST IMPORTANT FACTOR IN YOUR RECOVERY.

Follow the above instructions carefully. Take your medicines as prescribed. Most important, see a doctor again as discussed.

If you have problems that we have not discussed, or your problem changes or gets worse. Call or visit your doctor right away, if you cannot reach your doctor, return to the Emergency Department Immediately.

Centegra Health System is very concerned about your safety and well being. As part of our efforts to always provide very good care, any medications you received during this visit were reconciled with medication you are currently taking. This reconciliation was based on the information you or your representative provided regarding your current medications and allergies.

"I have received this information and my questions have been answered. I have discussed any challenges I see with this plan with the nurse or physican."

PAUL DULBERG or Responsible Person.

PAUL DULBERG or Responsible Person has received this information and tells me that all questions have been answered

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DATE PSI的社和SOO PZUL R

Account Number, B1117900323

PAUL DULBERG was discharged on 06/28/2011 at 17:06 from the hospital. The following is a summary of the discharge instructions given to PAUL before discharge:

This Information Is About Your Follow Up Care

Call as soon as possible to make an appointment to see your doctor in 10 days for suture removal. You can reach your doctor by calling their clinic phone number.

Please return to the Emergency Department in 10 days for suture removal if you would prefer to have the sutures removed in the ER. We do recommend that you follow-up with your Primary Care Physician but you can return to the ER for removal of your stitches if you choose..

This Information Is About Your Illness and Diagnosis

WOUND CARE (with stitches)

This is Information About Your New Medications - Start taking as prescribed.

HYDROCODONE and ACETAMINOPHEN (Vicodin, Vicodin ES, Lortab, Lortab elixir, Zamicet, Norco, Zydone, Anexsia, Anolor, Bancap HC).

one 10mg/325mg tablet every 4 to 6 hours if needed for pain. Do not take more than as directed per day (24 hours).

CEFADROXIL (Duricef)

500 mg by mouth 2 times a day for 5 days.

- 1. How are you and/or your family doing today?
- 2. Is your pain/or symptoms better today?
- 3. Did you understand your discharge instructions?
- 4. Are you following up with a Doctor?

Portions Copyrighted 1987-2011, LOGICARE Corporation Page 1 of 2
PRINTED BY: MRV0127
Patient Name: PAUL R
Account Number, B1117900323

| 5. Comments: | |
|--------------|--|
|--------------|--|

| Signature | of | nurse | making | phone | call; |
|-----------|----|-------|--------|-------|-------|
| Date: | _ | | _Time; | | |

FORM GOES TO MEDICAL RECORDS

++**Centegra**HealthSystem T (COLUMNA) (MANAMATA ☐ CH~W 🖾 СН - М 1117900323 Other (Specify) DULBERG, PAUL R M 41Y 03/19/1970 06/28/2011 B 0000109381 GENERAL CONSENT AND ACKNOWLEDGMENT Account Number/Effective Date: CONSENT FOR MEDICAL TREATMENT I have come to Centegra Health System (CHS) for medical treatment and consent to the customary examinations, tests, and procedures performed on patients in my condition. I understand and consent that independent professionals (such as my attending physician, on-call physicians, emergency medicine physicians, radiologists, anesthesiologists, pathologists, surgeons, obstetricians, consultants, nurse practitioners, physician assistants, certified registered nurse anesthetists and other specialists) may participate in my care as deemed necessary. I agree to follow the Patient Rights & Responsibilities of CHS and to participate with independent professionals and CHS personnel in my care and treatment. I understand the practice of Medicine is not an exact science and, therefore, no guarantees have been made regarding

to those areas of CHS where I receive care.

I understand the language in this Consent guides and controls all other forms and consents I may sign during my treating of the consent of this document, treating of the consent with terms of this document.

I understand this General Consent and Acknowledgement will remain in effect for this episode of care and will be provided

the likelihood of success or outcomes of any diagnosis, treatment, test, surgery or examination performed at CHS.

PATIENT ACKNOWLEDGMENT OF INDEPENDENT PHYSICIANS

I acknowledge the independent professional(s) who provide services to me at CHS are not employees or agents of CHS, but are independent medical practitioners who have been permitted to use its facilities for the care and treatment of their patients. They include but are not limited to, my attending physician, on-call physicians, emergency medicine physicians, radiologists, anesthesiologists, pathologists, surgeons, obstetricians, consultants, nurse practitioners, physician assistants, certified registered nurse anesthetists and other specialists. My decision to seek care is not based upon any representation or advertisement of the independent professionals and I understand they are not employees or agents of CHS. CHS bills do not include physician, surgeon, or other independent professional services and I understand I will receive a separate bill directly from the independent professional. I have read and understand the above terms and confirm I am the patient or am authorized to sign on the patient's behalf.

PATIENT ACKNOWLEDGMENT OF INDEPENDENT SERVICES

During the course of my hospital stay, my physician may determine I require care at another medical facility, or I may request care at an alternate facility. I acknowledge that all transportation services provided in connection with my transfer to another facility are provided by an independent third party and I will receive a separate bill directly from the service provider for which I may be responsible.

USE AND DISCLOSURE OF HEALTH INFORMATION

Unless I request otherwise, CHS will provide my room location or telephone number to visitors and callers. I understand CHS will use and disclose my health information for the purposes of treatment, payment, and health care operations, as permitted by law as described in the CHS Notice of Privacy Practices. Certain information can be used without obtaining my consent. I fully understand that the use or disclosure of my health information may include history, diagnosis and /or diagnostic treatment of mental health/ developmental disabilities conditions, alcohol or drug abuse and Acquired Immune Deficiency Syndrome (AIDS/ HIV).

I understand that if I refuse to allow disclosure of my health information to process my insurance claim, I may be financially responsible for all costs incurred by me for treatment. I agree to release and hold harmless CHS, its agents, and employees from any liability that may arise from the use or disclosure of my health information.

PICTURES/IMAGES

Initials

I understand photographs, videotapes or other Images may be taken to document my care. These images may be kept by CHS and/or by the independent professional involved in my care. I understand I have the right to view or obtain copies of these materials which are in possession of CHS upon written request. It is my responsibility to confirm if such photographs, videotapes or other images have been taken. I understand images identifying me will only be released as allowable under law or with my written authorization.

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ADC10000-00 01/07 01/08 10/08 04/09. *3CNTG*

DATE 09/14/2012
GENERAL CONSENT AND ACKNOWLEDGMENT
Page 1 of 2



++**Centegra**HealthSystem

111,000323 111,000323 DULBERG, PAUL R M 541Y 03/19/19/0 06/28/2011 B 0000109381

RELEASE FROM LIABILITY FOR VALUABLES

I understand my belongings are my responsibility and I have been advised to send any items of value home. I release CHS from any liability for the loss, damage to, or theft of any of my belongings. Safes or lockers are available at the hospital facilities and may be used to store valuables.

PATIENT PRE-CERTIFICATION RESPONSIBILITY

PATIENT INFORMATION OFFERED

I understand I am responsible for the notification to my insurance company to obtain authorization before service is rendered. I further understand that if I do not pre-certify I may incur a reduction or loss of paid benefits to the hospital for which I will be liable.

ASSIGNMENT OF BENEFITS/ AGREEMENT FOR PAYMENT

I hereby authorize payment to be made directly to CHS and to the independent professional(s) for all insurance benefits otherwise payable to me. I understand I am financially responsible to CHS and independent professionals for all charges incurred. Patient "out-of-pocket" amounts will be requested prior to or upon discharge. In the event of default or non-payment, CHS shall be entitled to the right of recovery of all collection expenses, including court costs and reasonable attorney's fees for the purpose of securing payment. It is further agreed that any credit balance may be applied on any other account owed CHS by the guarantor/responsible party, or any open account for his/her dependent family.

| Patient Rights/Responsibilities | Yes Declined | If Nie. Tourielms | |
|--|---|---------------------------------------|---|
| Advance Directive Information | Yes Declined | If No Explain: | |
| Notice of Privacy Practices | | If No. Explain: | |
| Patient Billing Information | Yes Declined | If No, Explain: | |
| PATIENT CERTIFICATION | | | |
| Du olembar this Conord Conord and Asim | | 111 | · · · · · · · · · · · · · · · · · · · |
| By signing this General Consent and Ackno contained in this form and accept its terms | owiedgement Form, i . I also acknowledge | acknowledge i na I have received a | copy of this form for my records. |
| NPATIENTS ONLY: | | | |
| TRICARE (Military) Insurance PATIENTS | Yes, I have rec | elved TRICARE "Imp | ortant Message" |
| | • | | |
| Patient/Authorized Person | Relationsh | ip | Date (0 0 8 1 |
| Witness | | | |
| l, | , have in | terpreted/translate | d the above form to the patient. The |
| patient has informed me he/she fully unde | rstands and agrees to | o the terms set ou | In this consent form. |
| | | | |
| Interpreter/Translator (Please Print Name) | Language | Interpret | ation/Translation Provider (Company name or Relationship to Patient) |
| | | | |

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GENERAL CONSEND AND ADMICWLEDGMENT

Page 2 of 2

Northern Illinois Medical Center

Patient Name: DULBERG, PAUL R Account Number: B1117900323 NIMC Radiology

Northern Illinois Medical Center

06/28/2011

10135 RIGHT FOREARM 2139703

HISTORY:

Chain saw versus forearm, forearm laceration.

IMPRESSION:

Right forearm films demonstrate no fracture or radiopaque foreign body. There is deep soft tissue laceration along the ventral surface of the mid

forearm.

FINDINGS:

This exam consists of two views of the right forearm which demonstrate deep laceration on the ventral aspect of the mid forearm as best visualized on the lateral view. No fracture or radiopaque foreign body is identified.

cc:

Apiwat W. Ford, D.O. Donald R Kennard, M.D. Frank Sek, M.D.

Electronically Authenticated Donald R Kennard, M.D. 06/28/2011 18:18 815-759-4683

D 06/28/2011 T 06/28/2011 5:19 P / LBA Northern Illinois Medical Center

NIMC Radiology

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DATE 09/14/2012

Centegra Health System
Centegra Hospital - McHenry



B1117900323 DULBERG, PAUL R M 41Y 03/19/1970 06/28/2011 0000109381

| <u>EME</u> | RGE | <u>NCY AD</u> | <u>MISSIC</u> | <u>ON ASSES</u> | <u>SMENT</u> | | | | | |
|---------------------------------------|---|--|---|--|---|--|--------------------------------------|--|----------------|---|
| ED BED EXPRES ESI: (3 Primar | # C ss seo # 1 [] 2027 v Physic | 33405 | Sek | BROUGHT BY: Self OF Police DV Other Ambulance: GCS:\RTS | rlend | 12.V | Stretcher Carried Malked | TREATMENT PTA | ne of Ir | B Patient Band applied ☐ Hand Off Communication Band applied ☐ Security watch njury: n air ☐ O₂ Pain Level: |
| Chief | compl | aint/reaso | n for visi | = 5+a; | rez Tez | <u>ch</u> | elo elo | teeling | R-1 | htheades |
| CUR | RENT M | EDS DQer | nies | | | | Triage ALLERGIES Medications: | |), 3 (,? | REACTION |
| | | | | | | | Food: | | | |
| Langu. Do you | u foel saf | ier □ Yes fe at home? | XIYes □ | iter Name/ATT N No Is there anyo | ne in your lit | fo that th | Othe preatens, Intimid | ate D Family D Alone | y way | sing home D Group home 7 D Yes No Time: |
| al History 🛚 None | ☐ AstI ☐ Bac ☐ Bloc ☐ Car ☐ Car ☐ CHI LMP:_ | k problems od disorders ncor diovascular F | ☐ Endoc ☐ GI pro ☐ GU P ☐ Glauc ☐ HEEN ☐ Heart ☐ Norm | iblems roblems oma IT problems murmur al | □ Hea □ Hyp □ Mus □ Nou □ Psy | d inj pa ertensio sculoSke iro probl choSoci | letal problems | Yes Pressure Ulcer Recent exposure Reproductive proble Rospiratory problem Soizures Skin problems Vision problems | ms | Yes Infactious diseases MRSA VRE Chicken Pox Measles Shingles Strep Throat Other: |
| Past Medical History | Expai | nded/surgic | al history: | <u></u> | -CW | 274 | | Hip DAICD DOther | ; | |
| TB His | tory | □ Bloody | Ever had a sputum s signs & s | □ Weight loss I | ? ☐ Yes █ ☐ Night swe | No □S ats □1 | elf-history of TE oss of appetite | 3 □ Family history of Ti D □ Fatigue □ Recent | B C interna | 1 Cough □ Fever tional travel |
| Vac | ccine | □ Flu | Tetanus E | N/A SQUP to d | ate 🛭 >5 yes | ırs 🗆 U | nsure F | ediatric immunization [| J Up to | date 🗆 No 🗅 Unsure |

EDN10000-00 07/08 10/08 03/09 12/09 03/10

'3EDRN'

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DATE

09/14/2012



CentegraHealthSystem



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| ADMISSION ASSESSMENT | Mark drawing with number: 1. Abrasion |
|--|--|
| Do you currently have pain? Developed (1-10) Developed Fyes Type of pain: Burning Dull Pressure Decramping Developed Other: | 2. Amputation 3. Avulsion 4. Bleeding eavy □ Sharp □ Achy 5. Burn 2. Amputation 5. Avulsion 4. Bleeding 5. Burn |
| Pain Scale used; ☐ Wong Baker ☐ FLACC ☐ Numeric | 6. Bruise 7. Deformity |
| ALCOHOL INTAKE: Never | 8. Fracture 9. GSW 10. Hernatoma 11. Leceration 12. Pein 13. Stab wound 14. Foreign body 15. Pressure ulcer 16. Leg ulcer |
| Neurological NA Cardiac/Greulatory: NA LOC Yes No Pink Warm Dry Gardiac/Greulatory: NA Dusky Ashen Dusky Dusky Ashen Dusky Dusky Ashen Dusky Dus | Describe: Desc |
| ANY POSITIVE ANSWER INDICATES ENHANCED FALL RISK IN | 5 FO And Mary Mario Sales |
| laceration July (h | MASON 40 (R) ASSONS 100 - 24 |
| Quet to year, 15 | OS, It Godes in ER# (8, |
| Dona att conte | 1600 (1500) (It medicated |
| Cleaned Dr Fr | 1 10 × 81 trus 180 (1713) DIC- |
| instructions to at | Oall questions assessed |
| He verbalized ilm | west online |
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| | |
| Associate Signature/Initials: | Associate Signature/Initials: |

PRINTED BY: May 2014

DATE

09/14/2012

CentegraHealthSystem



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ADMISSION ASSESSMENT

| □ ABG | MD/DO initials | ' | _ab | Time MD/DO Initial | | Lab | | Orde Time MD/ Initia | B DO | | _ | | Order Time MD/DO Initial |
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| | | □ PTT | | | □ WOL | ind culture | | | | | Spine | | |
| ☐ Amylase | | RSV | | | | | | | | □LS | Spine | | |
| □ Blood Culture | | ☐ Salicyla | ite | | | | | | | 🗆 Ultr | asound- | | |
| □ BMP | | ☐ Sputum | r culture | | | | | | | | Scan-Brain | | - |
| □ BNP | } | □ Strep | | | | | | | | | Scan-C Spli | | |
| ☐ CBC w/diff | } | , 🗆 Trichim | | | | | | | | | Scan-Chest | | |
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| ☐ Digoxin Level | | □ Туре & | screen | | | 3 Time Acqu | ired | 1 | | □ MR | | | |
|] ETOH | | □ Туре & | | | Time f | | ,, | 1 | | | ST Scan | | |
| □ GC/Chlamydia | | of uni | ts | | | 3 Time Acqu | ired | | | | Preg Ltd US | | <u> </u> |
| □ Hepalic Panel | | □ UA | | | Time I | | | <u> </u> | | | Preg follow | | |
| ☐ HCG Qualitative | | □ UA/Ref | lex culture | | Medi | cal Imag | ing | | | □ ED | Pelvis Ltd L | JS | |
| ☐ HCG Quantitative | | □ Urine C | Culture | | | est PA/Lat | | 1 | | □ ED | Abd Aorta L | JS | Ī |
| 1 Influenza Screen | 1 | | rug Screen | - | | st Port | • | 1 | | CIED | Doppler pel | vis | |
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| MRSA | | C) Urine D | ip □ POC | 1 | □ X-1 | able | | | | | Trauma tran | ns echo | |
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| | | iop IV | Solution & A | mount | Warm Y/N | Additive | es | Site | Calh | Size | Rate | Amt Infused | Initials |
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| Time of the state | ime Sto | ne S | Medication | | Dosage | | Site | | lals | Time | Effects | Pain Scale | Initials |
| 12 1 | 1200 | | NOR | 22 | 1600 | (2) | } | 1/27 | We | 10 | 2018/100 | 12 | WIM |
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| Td 0.5mL 🗖 Tdap | 0.5mL □ | | | | □ Vitals | Reviewe | ed | | | | Reconcili | | |
| ech: | | Initia | als: | Tow | Tech: | ian: | hit | ox. | _ | ··· | Initials Initials | Ta | 2/2 |

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DATEMERGENDY/ADM/SSIGN ASSESSMENT Page 3 of 4

B1117900323 DULBERG, PAUL R M 41Y 03/19/1970 06/28/2011 0000109381

:: Centegra Health System

EMERGENCY ADMISSION ASSESSMENT

| Time | Blood pressure | Pulse | Resp | Temp | SpO2 | 02 | GCS E/VIM | Monitor | Intake | Output |
|---|---|----------------|------------------------------------|---------------------------------------|---|--|--|---|---|--------|
| | | | | <u> </u> | | | 1 1 | | **** | |
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| | | | · | | | | | | · | |
| | Orthostatic Lying | 9: | Sitting: | · · · · · · · · · · · · · · · · · · · | Standing: | | | | | |
| ☐ O₂ The ☐ Chost t ☐ NG tub ☐ Lumba ☐ Pelyic t Blood Glut Normal Va | ts/Procedures: rapy: ubo: e # @ r puncture: exam: cose value: iluos Age 50 or more due: Age newboin to | (80-99 n | _ Time: ng/dl), 13-60 yi | By: _ r. (75-99), 1 | mo13 yr. (| 60-99) C rl | □ Cor tical Value less th | itinuous Cardia ian 40 or more | Cont Pulse Ox nent sheet unt: c Monitoring than 400 | |
| ✓ Wound □ Irrigatio | Care UtV | NS | □ Dressing: □ | | | | | □ Crutches | own crutches | |
| 🗆 Soak: | | | □ Adaptic | □ E | evate Time; | | _ 🛘 Sling | ☐ Crutch wa | ilking instr/ret de | êmo |
| htisep | tic Wash | | □ 4X4 | | | | _ 🗆 Tubi Grip | | olint: | |
| D Other: | | | □ Kling | | nee immobili | | | | mold: | |
| | | • | ☐ Tube gauze | | houlder imm | | _ | | | |
| | | | | | | 00112.01 | | | | |
| | | | □ Steristrip | | e Wrap | | | | | |
| isolation | Туре: | | □ Burn dressi | ng USI | MV's after in | ımobilizatio | n | C) Longth:_ | | |
| LEFT WIT Discha Discha Discha Discha | TION: MHome acility: AIC NOWalk □ Car. H: □ Solf □ Family rge instructions give rgo Pain Level: Yital Signs: Summery | NO Frien | _ id □ Police ses understand | ina | □ Mod □ ER h □ To u □ No o □ Disc | e: nold from nlt/room #_ Id chart harge Pain GCS: | Servation □ Surging Time: to □ Old chart in E Level: RTS: □ Yes □ No (se | Accompani D □ Chart to flo (0-10) | or . | |
| RN: (KO) | POOLO A | Phil | Initia Initia | als: 22) | P) RN:_ | | | Ir | ritials: | |

EMERGENCY ADMISSION ASSESSMENT PRINTED BY: MB/6/13/247

DATE

09/14/2012

| | Contagna Hospital-N | испенту | 7 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 |
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| © 1996 - 2006 T-System, Inc. Co | rcle or check affirmatives, backslash () negatives. | | B1117900323 |
| 06 +Canta | gra HealthSystem | | DULBERG, PAUL R M 412 03/19/1970 |
| | Y PHYSICIAN RECORD | | 06/28/2011 0000109381 |
| The state of the s | xtremity Injury (4) | | Sem Lorcent |
| · · · · · · · · · · · · · · · · · · · | |] | REMORE FARM BON |
| DATE: 6/28/// ROOM: /8 | TIME: | FOREARM / ELBOW | tenderness soft-tissue / bony |
| EMS treatments ordered | Erib Affindi | nml inspection | swelling / ecchymosis |
| HISTORIAN: Patient | | non-tender fiml ROM* | limited ROM deformity |
| HX /EXAM LÌMFTED | ВУ: | ARM / | |
| | iry to: /right./left | SHOULDER | tenderness soft-tissue / bony |
| 1 | wrist forearm elbow arm | inspection inspection | swelling / ecchymosis |
| shoulder | collar-bone area | Amil ROM* | deformity |
| duration / occurred: | where: home school | | 111 |
| today | neighbor's park | | |
| yesterday | | | |
| severity of pain: | days ago | | 1 \ |
| | evere pain intermittent / lasting | |) |
| context: fall blo | | | |
| | | | \ // \ \ \ \ \ \ |
| associated symptoms | tingling / numbness distally | | |
| ROS | | | (\mathcal{E}_{i}) |
| suspected F8 (skin lac) loss feeling / power arms / | legs trouble breathing / chest pain | | |
| headacho / neck pain | recent fever / illness | | , , , , , , |
| double vision / hearing loss | other Injuries | | |
| nausea / vomiting | **************** | • | |
| SOCIAL HX smoker | drug use / abuse | | |
| recent ETOH | lives alone | | |
| FAMILY HXnegative | lives in nursing home | | |
| | | (| 1/11/1 |
| PAST HX negative diabetes Type 1 Type 2 | diet / oral / insulin | \ | 7/ |
| HTN heart disease | DEGONSIUM INTEDI | 5C | {/ ' ' \} { |
| Meds- none see nu Allergies- NKDA se | rses notee nurses note | l | - (ab) |
| | | ' | WY, ' ' , PW |
| PHYSICAL EXAM | wed Vitals Reviewed Tetanus Immun. UTD | To You days as DeT. Date | Tenderness S-Swelling E-Ecchymosis B-Burn C-Contusion |
| | ICE c-collar (PTA / In ED) / backboard | L=1,acerutlos | A=Ahrasian M=Muscle spaim PW=Puncture Wound |
| no acute distress | mild Cmoderate / severe distress | | without m=mild mod=moderate rv=severe) ample: Trv = Tenderness on palpudon (revere) |
| EXTREMITIES | anxious | NEURO / VASC / | TENDON |
| | _see diagram | sensation intact | sensory / motor deficit |
| nml inspection non-tender | _tenderness soft-tissue / bonyswelling / ecchymosis | motor intact no vascular | |
| | _deformity | compromise | pallor / cool skin / abnml cap rofili |
| WRIST | _see diagramtenderness _soft-tissue / bony | <u>tendon function</u> | pulse deficit radial ulnor |
| non-tender | tenderness in anatomical snuff box | (IACIII) | deficit in tendon function |
| | _wrist pain on axial thumb load swelling / occhymosis | | |
| _ | _limited ROM | | |
| _ | _deformityDDINTED_BV. MOX | 70 1 2 7 | |
| *3EDTSN* / Rev. 08 / 07 | PRINTED BY: MRY Upper Extremit | iy`irljúr√-06 NIMC MentonEn | |
| | DATE 09/1 5 | でたいして | A NU DIRAW REFUNDIN DELLA DE |

__diaphoretic / cool / cyanotic___

SKIN



B1117900323 DULBERG, PAUL R M 417 03/19/1970

| _warm, dry | | | DULBERG, P | AUL R |
|--|---|---|---|--|
| HEAD / ENT | tendernoss | | M 41Y 0 06/28/2011 | 3/19/1970 |
| _nml inspection | swelling / ecchymosis | | 000010938 | 1 |
| pharynx nml | | | 3550,5555 | • |
| NECK / BACK | tenderness | | | |
| nml inspection | _swelling / ecchymosis | | | |
| non-tender | | XRAYS [Interp. | by me Reviewed by me | Discad w/ radiologist |
| RESPIRATORY | tenderness | | forearm elbow hum | |
| thest non-tender | swelling / acchymosis / abrasions | normal / NAD | D D | inina attorium |
| breath snds nml | crepitus / subcutaneous emphysema | polracture | 0.1 | |
| • | decreased breath sounds | nml alignment | soft-tissue swelling | |
| | wheezes / raies / rhonchi | no foreign body | positive anterior fat-pad | sign |
| CVS | tachycardia / bradycardia | | positive posterior fat-pag | |
| neart sounds nml | | | foreign body | *************************************** |
| GI (ABDOMEN) | tenderness / guarding | | fracture non-displaced | |
| non-tender | | | | mminuted angulated |
| no organomegaly | | | impacted torus | |
| nml bowel snds* | | (1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1- | H - al Hestes E cap an act twee mt m our blomave at my my referenced at | |
| PROCEDURES | *************************************** | Other study: | | ······ |
| Wanted Described | | See separate repor | t | |
| tongth Vision | on / Repair Processes Bielly | PROGRESS | | |
| linear irregul | ar flao stellate | Time | unchanged improved | re-examined |
| superficial subcu | | | , | |
| contused tissue- | lip-lacegation | * | , | |
| | nated minimally moderately / heavily | | | |
| with | | initial fracture care o | rovided: follow-up on | *************************************** |
| distal NVT: neuro | & vascular status intact no tendon injury | Rx given | TOTALEGE TOTAL TOTAL TOTAL | |
| anesthesia: local | LET / tetracaine / adrenaline / cocaine /5 ml. : | referred to / discuss | ed with Dr | |
| marcaine 0.25% 0.5% | 6 lidoc 1% 2% epi/bicarb digital/metacarpal block | will see patient in: | ED / hospital / office in | doys |
| moderate sedation re | equired; see attached 23d template | CLINICAL II | MPRESSION Fall | ll Alleged Assault |
| prep: | RURCLENS TOTAL | | | |
| Betadine / scrub trigated / washed w/ | Saliner 12 Maddabridge | | | ist |
| minimal / mod. / * | extensive (minimg) mod, / */ *extensive | Hematoma | arm elbow hand | |
| wound explored | undermined | Sprain / Strain | | |
| foreign material remo | · · · · · · · · · · · · · · · · · · · | Dislocation | | |
| partially complete | | Laceration | | |
| minimal / mod. / * | | Fracture R / L | radius distai/shaft/pro: | |
| no foreign body ident | | | ulna distal / shaft / proxim | |
| | | | humerus distal/shaft/p Colles (racture stabilize | roximal / supracondylor d / restorative |
| | ind closed with: wound adhesive / steri-strips | | Colles tracture scoolized | a v testorative |
| skin- # <u>/</u> | | DISPOSITION- | ransferred home admit | |
| inte +SUBCUT-# | rupted rynning simple mattress (h/v) F-0 (vieryi / chromic) | | MA | rea []expirea |
| | 3 4-0 (vicry) / chromic (h/v) | | ood 🛮 fair 🗌 poor 🔲 critica | al Dimproved |
| OTHER # | -0 material | П | table unchanged | |
| . | rrupted running simple mattress (h/y) | · | | |
| | e repair may indicate complex repair | | , DECINEL | T / PA / NP SIGNATURE |
| andian With Committee | | ATTEMPIMO | | , , CA / ME SIGNATUKE |
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Northern Illinois Medical Center

NIMC Radiology

Patient Name: DULBERG, PAUL R Account Number: B1117900323

Northern Illinois Medical Center

06/28/2011

10135 RIGHT FOREARM 2139703

HISTORY:

Chain saw versus forearm, forearm laceration.

IMPRESSION:

Right forearm films demonstrate no fracture or radiopaque foreign body. There is deep soft tissue laceration along the ventral surface of the mid

forearm.

FINDINGS:

This exam consists of two views of the right forearm which demonstrate deep laceration on the ventral aspect of the mid forearm as best visualized on the lateral view. No fracture or radiopaque foreign body

is identified.

cc:

Apiwat W. Ford, D.O. Donald R Kennard, M.D. Frank Sek, M.D.

Electronically Authenticated Donald R Kennard, M.D. 06/28/2011 18:18 815-759-4683

D 06/28/2011 T 06/28/2011 5:19 P / LBA Northern Illinois Medical Center

NIMC Radiology

PRINTED BY: SJS0422
DATE 12/08/2011



CentegraHealthSystem

Centegra Hospital - McHenry

B1117900323 DULBERG, PAUL R M 41Y 03/19/1970 06/28/2011 0000109381

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| TB His | tory | ☐ None Ever had a ☐ Bloody sputum ☐ Denies signs & sy | □ Weight loss □ N | lYes DWo □ S light sweats □ I | elf-history of TB ∟oss of appetite | ☐ Family history of TB ☐ Fatigue ☐ Recent into | □ Cough □ Fever prnational travel |
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12/08/2011



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| ADMISSION ASSESSMEN | lT | | 1. Abrasion | Φ |
|--|--|---|---|---|
| Type of pain: Burning Dull Other: Pain Scale used: Wong Bake ALCOHOL INTAKE: Never Type: Amount: STREET/REC DRUCS: Amount: | ☐ Occasionally ☐ DAILY Last Drink: Occasionally ☐ DAILY Last Used: | Chronic □ New Onset Sharp □ Achy | 2. Amputation 3. Avuision 4. Bleeding 5. Burn 6. Bruise 7. Deformity 6. Fracture 9. GSW 10. Hematoma 11. Laceration 12. Pain 13. Stab wound 14. Foreign bod 15. Pressure uk 16. Leg ulcer | Right |
| Neurological DNA LOC DYes No Conscious Dunconscious D Alert D Orlented X D Crying D Lethargic DMAE D Sturred speech D Irritable D Combative Pupils DNA DPERL R L Reactive D D Sluggish D D Nonreactivo Pupil size AVPU DA DV P D U GCS: FALL RISK ASSESMENT D Medically unsafe to be Independently mobile D Unaware or forgetful of physical limitations D Recent history of falls | Absent □ □ Cap Refill □ 2Sec □ >2 Sec Ankle edema □ Yes □ No Monitor: Respiratory □ NA □ Distress □ None □ Mild □ Moderate □ Severe □ Stridor □ Nasal Flaring □ Retractions □ Productive cough: □ Unproductive cough | ☐ Correction Ear Drainage: ☐ Y Describe: Epistaxis: ☐ NA R Controlled ☐ Uncontrolled ☐ THROAT: ☐ Diff. swallowing ☐ Diff. speaking ☐ Drooling | 6 0 0 0 0 0 | Gl/Abdominal: NA Denies NSoft Distended Firm Nontender Tender Bowel sounds: Present Absent Hyporactive Last BM: Denies Denies Vomiting x Denies Nausea Yes No Last oral intake: Comments: NA Denies University Denies University NA Denies University NA Denies University NA Denies University University |
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| Associate Signature/Ini | tlais: //////////////////////////////////// | Assoclate Signat | ure/Initials:_ | |

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ADMISSION ASSESSMENT

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DATEMERGENCY/ADMISSION ASSESSMENT Page 3 of 4



B1117900323 DULBERG, PAUL R M 41Y 03/19/1970 06/28/2011 0000109381

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EMERGENCY ADMISSION ASSESSMENT

| Time | Blood pressure | Pulse | Resp | Temp | SpO2 | O2 | GCS E/V\M | Monitor | Intako | Output |
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| □ Chest t | rapy: ube: e # @ puncture: exam: | - Intai | ☐ Time Out: | : | Respiratory i Eve irrigation | 16911U6111; | □ Ear | irrigation: | Cont Fuise Ox . | |
| ∐ NG tub | e#CD | | Character | | | □ Castric | : lavane: | | | - |
| 🗆 Lumbai | puncture: | ···· •································ | Ţ | ime Out: | | | □ See | neuro assessm | ent sheet | |
| ⊔ ⊬elγic e Blood Chic | r puncture: exam: cose value: luos Age 60 or more lue: Age newborn to | | Sirai | ight Cath/C Rvi | υD @ | | , ⊔,Blac | ider scan Amor tinuous Cardiac | Monitorina | - |
| Vormal Va | lues Age 60 or more | (80-99 n | ig/dl), 13-60 yr | . (75-99), 1 | mo13 yr. (| 60-99) Crit | cal Value less th | an 40 or more | than 400 | |
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| r ⊐ Irrigation | Care | NS | ☐ Antibiotic | | | | | ☐ Patient's o | wn crutches | |
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| | ge Paln Level: # | | | <u>-</u> 13 | ľ | | RTS: □ Yes □ No (se | | n) | |
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| ecn: | IDUCA # | Ulla | Initia | Is ZZO | | ., | | | | • |

EMERGENCY ADMISSION ASSESSMENT PRINTED BY: \$45642

DATE

12/08/2011

| | Centegra Hospital-N | AcHenry | |
|--|--|--|---|
| ROOM: EJ EMS treatments ordered EJ | HealthSystem VSICIAN RECORD ity Injury (4) SAGARIVOI SE paramedics | FOREARM / ELBOWnml inspectionnon-tenderfiml ROM* ARM / SHOULDERmfil inspectionmfon-tendermfil ROM* | B1117900323 DULBERG, PAUL R M 41Y 03/19/1970 06/28/2011 0000109381 See diagram tenderness soft-tissue / bony swelling / ecchymosis limited ROM deformity see diagram tenderness soft-tissue / bony swelling / ecchymosis limited ROM deformity swelling / ecchymosis |
| just prior to arrival today yesterday days ago severity of pain: mild moderate severe context: fail blow inc associated symptoms: tinglin ROS suspacted FB (skin lac) loss feeling / power arms / legs | home school neighbor's park work street worse / persistent since pain intermittent / lasting ised crushed burn g / numbness distally | | |
| SOCIAL HX smoker recent ETOH lives at home FAMILY HX negative PAST HX negative R diabetes Type 1 Type 2 diet / on HTN heart disease Mads-none / see nurses note Allorgins-NKDA / see nurses | drug use / abuselives alonelives in nursing homelives in nursing homelives in nursing homel/ L HANDED prior injury at / insulin | sc- | |
| Selert anxlous EXTREMITIES HAND see diag nml inspection swelling deformi WRIST see diag nml inspection tender non-tender tendern non-tender tendern nml ROM* wrist pa swelling | ram_ess soft-tissue / bony_ess in anatomical snuff box_in on axial thumb load_/ecchymosis_ROM_ | NEURO / VASC / Sensation intact motor intact no vascular compromise tendon function normal | i Tenderaess S-Swelling E-Ecchymosis B-Burn C-Contusion A-Abrasion M=Muscle spann PW=Puncture Wound without memild modernoderate re-severe) ample. Two Tenderness on polpution (severe) TENDONsensory / motor deficitpallor / cool skin / abnml cap refillpulse deficit rodial ulnurdeficit in tendon function |
| *3EDTSN* / Rev. 08 / 07 | PRINTED UPW EXECUTED DATE 12/05/2 | | |



B1117900323 DULBERG, PAUL R

| <u>\$KIN</u> warm, dry | diaphoretic / cool / cyanotic | | | B111790032 DULBERG, PA | |
|---|--|--|---|--|--|
| | **** | | | M 41Y 03 | /19/1970 |
| HEAD / ENT | tenderness | | | 06/28/2011 | |
| nml inspection | swelling / ecchymosis | | | 0000109381 | • |
| pharynx nml | | 1 | | | |
| NECK / BACK | tenderness | ! ! | | | |
| _nml inspection | swelling / ecchymosis | XRAYS Inter | | ln 1 11 . [| True 1 / Production |
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| RESPIRATORY | tenderness | RL hand wris | | ri⊶elbow humi | rus shoulder |
| thest non-tender | swelling / ecchymosis / abrasions | normal / NAD | _DJD | | |
| breath snds nml | crepitus / subcutaneous emphysema | polracture | dislocat | don | |
| 1 | decreased breath sounds | nml alignment | _soft-tiss | sue swelling | · · · · · · · · · · · · · · · · · · · |
| • | wheezes / rales / rhonchi | no foreign body | positive | anterior fat-pad si | gn |
| cvs | tachycardia / bradycardia | | positive | posterior fat-pad | sign |
| heart sounds nml | | ! | foreign | body | |
| GI (ABDOMEN) | tenderness / guarding | ! | | e non-displaced o | |
| non-tender | Solitori France / Barria Alt (8) | | transve | e rse ablique co m | minuted angulated |
| no organomegaly | | } | impact | ted torus | 1 |
| nml bowel snds* | | | | INTO TRANSPORTED IN COLUMN 2 I | FildNat 419(144) includable in Francisco (include in Fildnatis) |
| , <u>, , , , , , , , , , , , , , , , , , </u> | | Other study: | | | |
| PROCEDURES | | See separate repo | ort | | |
| Wound Description | on / Repair RECREAREN BULL | | | ************************************** | |
| length XV Mcm | Incation DFORGARM DULL | PROGRESS | | | |
| linear irrogul | ar flap stellate | Time | unchanged | d improved | re-examined |
| superficial subci | | · ——— | | | |
| contused tissue | lip laceration | | | | |
| | nated minimally I moderately / *heavily | · | | ***************** | |
| With | The state of the s | initial fracture care | provided: f | ollow-up on | |
| | & vascular status intact no tendon injury | Rx given | | | |
| | LET / tetracaine / adrenaline / cocaine /5. ml. | referred to / discus | ssed with Dr. | | |
| marcaine 0.25% 0.59 | 6 Ildoc 1% 2% epi/bicarb digital/metacarps/block | will see patient in: | | pital/office in | days |
| moderate sedation r | equired: see attached 23d template | CLINICAL | | | |
| prep; SA | MURCLENS TOTAL | 1 | | | Alleged Assault |
| Betadine / scrub | | Contusion (B) | イL should | ler (lorearm wri | it |
| trigated washed wh | Saline 14 MAGGebrided | Hematoma | arm | elbow hand | |
| minimal / mod. / * | extensive minimal 4-mod. / * 'nextensive | Sprain / Strain | | | |
| wound explored | undermined | Dislocation | | | |
| foreign material remo | oved minimal / mod. / *extensive | Laceration | | | |
| partially complet | ely "wound margins revised | | L. radius | distal / shaft / proxi | mal |
| ! minimal / mod. / * | | ! I accure K / I | | istal / shaft / praxim | |
| no foreign body ident | | <u> </u> | | | oximal / supracondylar |
| i | | ; [| Colles fra | actura stabilized | / restorative |
| | und dosed with: wound adhesive / steri-strips | ¦ | Contra | | 10310141110 |
| ; SKIN- # <u>/</u> | | DISPOSITION: | | | |
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| +SUBCUT-# | 3 4-0 (vicry) / chromic | | | poor critical | Dimonwad |
| | urupted running simple mattress (h/v) | | stable 🔲 un | | / Improvisor |
| OTHER # | | չ | Table Time | . es sent 16 A A | |
| | errupted running simple mattress (h/v) te repair may indicate complex repair | ! } | | | |
| terrerenene incinicular | A PART AND THE CONTRACT CONTRA | · | | RESIDENT | / PA / NP SIGNATURE |
| splint Vekro OCL/ | Ortho-glass / Plaster Aluminum-foam | ATTENDING NO | TE: | | |
| | mb spica Ulnar Wrist Sugar-Tong Cock-up Colles | | | wed, patient interview | wed and examined. |
| applied by ED Ph | ysician / Orthopedist / Tech | Briefly, pertinent HPI i | | | ., |
| • | olint application NV intect olignment good | My personal exam of p Assessment and plan r | atient reveals | I | - b - a d - a ullia |
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| * equivalent or minimum | n system required for organ system RamNTED BY: SJS | 0422 | iere Mud | SINUMAL LANGE | |
| | A6 Page 2 of 2 TATE : 9 12 (408) | | | | |
| anar tevrenmitti İniver | DE BONGTATION DE CITATION | 2647 1 1 6" 3" | 4 600.00 | | |

RESTRICTIONS / RELEASE FORM

| Emergency Department 4201 Medical Center Drive McHenry, Illinois 60050 (815) 344–5000 | 3701 Doty Rd. Woodstock, Illinois 60098 (815) 334-3900 | |
|--|--|----|
| PHYSICIAN SIGNATURE May return to work school gym without restriction. May not return to work school gym for day(s). May return to school with the following restrictions: Gym/Sports restrictions are Must take prescription medication for day(s). May return to work with the following restrictions: | DATE U 28 ZeM 1117900323 OULBERG, PAUL R M 11Y 03/18/1970 OB/28/2011 B D000109381 forday(s). | |
| ☐ No lifting greater than lbs. for day(s). | | |
| ☐ Machinery/Driving restriction while on medication that can cause drov | wsiness. | |
| ☐ No continuous ☐ standing ☐ sitting for day(s). | | |
| ☐ Must keep elevated forday(s). ☐ Sedentary work only for day(s). | ☐ LIMITED WORK WITH ☐ NO WORK WITH | |
| ☐ Must use crutches for day(s). ☐ No overhead work for day(s). ☐ No bending or twisting for day(s). ☐ Must wear immobilizer for day(s). | ☐ Right ☐ Left ☐ Hand ☐ Hand ☐ Arm ☐ Arm ☐ Foot ☐ Foot ☐ Leg ☐ Leg ☐ Days | |
| ☐ No climbing on ladder or stairs for day(s). | | |
| Other days for reevaluation. | | |
| All patients are referred to their personal physicians or a doctor on the staff of be obtained from that doctor and not the Emergency Department. | this hospital. Release from restriction must | |
| I (or responsible person) have/has received and understand(s) the instruction Patient signature (or responsible person): | ns to follow as noted above. | |
| PRINTED BY: SJS04/2 DATE 12/08/2011 EMCARE, INC | ED 102 NIMC/Mi | 10 |

MEDICAL RECORDS COPY

Patient: PAUL DULBERG, Med. Rec. #: 80000109381, Visit #: 81117900323, Date: 06/28/2011 Time: 17:02

Home Care Instructions

IMPORTANT: We examined and treated you today on an emergency basis only. This was not a substitute for, or an effort to provide, complete medical care. In most cases, you must let your doctor check you again. Tell your doctor about any new or lasting problems. We cannot recognize and treat all injuries or illnesses in one Emergency Department visit. If you had special tests, such as EKG's or X-rays, we will review them again within 24 hours. We will call you if there are any new suggestions. You were treated today by: Ford, Apiwat W.,

After your visit to our Emergency Department, you may receive a survey in the mail. We want to be sure we have given you yery good care and we ask that you please fill out the survey and return it in the mail.

After you leave, please follow the instructions below.

This Information is About Your Follow Up Care

Call as soon as possible to make an appointment to see your doctor in 10 days for suture removal. You can reach your doctor by calling their clinic phone number.

Please return to the Emergency Department in 10 days for suture removal if you would prefer to have the sutures removed in the ER. We do recommend that you follow-up with your Primary Care Physician but you can return to the ER for removal of your stitches if you choose...

This Information is About Your lilness and Diagnosis

WOUND CARE (with stitches)

Your wound was closed with stitches. These are small threads that keep the skin closed to help it heal. You have 3 Internal and 11 external stitches. These should be removed in 10 days.

At home, please follow these instructions:

- Wash your hands before touching the dressing or wound.
- · Keep the wound clean and dry.
- After 2 days, wash the wound gently with warm water and soap. Pat it dry.
- · Put a light dressing on it if it rubs or there is drainage.

Call your doctor if:

- you have redness, pain, or swelling in the area of your stitches.
- your wound drains pus.
- your stitches come out before your wound is healed.
- · you have any new or bothersome symptoms.

This is information About Your New Medications - Start taking as prescribed.

HYDROCODONE and ACETAMINOPHEN (Vicodin, Vicodin ES, Lortab, Lortab elixir, Zamicet, Norco, Zydone, Anexsia, Anolor, Bancap HC)

Take this medicine by mouth with food in the following dose: one 10mg/325mg tablet every 4 to 6 hours if needed for pain, Do not take more than as directed per day (24 hours).

This is a mixture of medicines (hydrocodone and acetaminophen) used to relieve moderate to severe pain. This medicine may be used for other reasons, as prescribed by your doctor.

Side effects may include:

- · sleepiness or dizziness
- · upset stomach, nausea or vomiting
- constipation

Other side effects may occur, but are not as common. <u>Alteray would show up as:</u> rash or ltching, facial or throat swelling, wheezing or shortness of breath. This medicine can be habit forming if used for a long period of time.

Follow these instructions:

- Never take more of this medicine than prescribed. Too much acetaminophen in your body can cause liver damage.
- Read the labels of non-prescription medicines before taking them, Many contain acetaminophen. To avoid an overdose, do not take any other medicines that contain acetaminophen.
- Talk to your doctor or pharmacist before taking medicines for sleep, colds or allergies. Severe drowsiness may occur.
- Do not share this medicine with others as this medicine is a controlled-substance. Sharing this medicine with others is against the law
- To avoid constipation while taking this medicine:
 - Drink plenty of liquids. Try to drink 8 to 10 eight-ounce glasses of water or juice each day.
 - · Include extra fiber in your diet.
 - Exercise daily.
- Watch for signs of dependence:
 - · feeling that you "cannot live without this medicine".
 - you need more of this medicine than before to get the same relief.
- Do not drink alcohol, drive or operate machinery until you know how this
 medicine affects you.
- Store this medicine away from heat, moisture or direct light.
- If you are taking this on a regular schedule and you miss a dose, take it as soon as possible. If it is almost time for your next dose, skip the missed dose and return to your regular schedule. Do not double the doses.
- Talk with your doctor before taking any other medicines (including vitamins and herbais) as you may require additional monitoring.

Call your doctor if you have:

- · any sign of dependence or allergy.
- · increased pain not helped by the pain medicine.
- · slow, weak breathing.
- seizures.
- slow or irregular heart beat.
- a yellow-color to your skin or eyes, or dark urine.
- stomach pain.
- · unusual or extreme tiredness.
- · any new or severe symptoms.

CEFADROXIL (Duricef)

Take this medicine until gone in the following dose: 500 mg by mouth 2 times a day for 5 days.

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DATE PAIGNAGO PAUL R

Cefadroxil is an antibiotic used to treat infections caused by bacteria. Antibiotics kill bacteria or prevent them from growing inside your body. This medicine may be used for other reasons, as prescribed by your doctor. Side effects may include:

- diarrhea
- upset stomach, nausea or vomiting
- headache

Other side effects may occur, but are not as common. An upset stomach is not a sign of allergy. Allergy would show up as rash or itching, facial or throat swelling, wheezing or shortness of breath.

Follow these instructions:

- Space your medicine doses evenly throughout the day. This medicine works best if there is a constant amount in your blood.
- Take this medicine with food to avoid an upset stomach.
- Swallow the capsule and tablet form of this medicine whole with a full 8-ounce glass of water.
- For diabetics, this medicine can cause false test results when testing your urine for sugar. Talk with your doctor if you have questions.
- Store the tablet or capsule form of this medicine away from heat, moisture or direct light.
- Store the liquid form of this medicine in the refrigerator. Shake the liquid well before each use
- If you miss a dose, take it as soon as possible. If it is almost time for your next dose, skip the missed dose. Do not double the doses,
- Talk with your doctor before taking any other medicines (including vitamins and herbais) as you may require additional monitoring.

Call your doctor if you have:

- any sign of allergy.
- no improvement after you've taken all the medicine.
- a seizure.
- any sign of a new infection (fever, general aches, chills, or unusual tiredness or weakness).
- ongoing nausea, vomiting or stomach pain.
- white patches in your mouth.
- women: itching in or change in discharge from your vagina.
- inflammation (pain and swelling) in your intestine during treatment or up to weeks after you've finished this medicine:
 - ongoing diarrhea
 - stomach pain or cramping
 - blood or mucus in your bowel movements
- any new or bothersome symptoms.

SMOKING CESSATION

Smoking is the nation's leading preventable cause of death. It significantly increases the risk of coronary heart disease, stroke and cancer. In fact, more than half of all smoking related deaths in America each year are from heart disease, stroke, or other cardiovascular diseases. The good news is, that one year after quitting, the risk of heart disease is cut in half. After five to fifteen smoke-free years, the risk is that of a person who never smoked!

If you or someone you love is interested in quitting, consider joining our "Freedom From Smoking "classes for adults. Centegra Health System and the McHenry County Department of Health have partnered together to bring you an effective program that will help you quit smoking. Call 877-CENTEGRA, (877-236-8347) for more information regarding this program. To speak with a counselor immediately, call the !llinois Tobacco line at 1-866-QUIT-YES.

PAIN MANAGEMENT AFTER DISCHARGE:

A person may feel less pain just by being in familiar surroundings. Here are some frequently asked questions about your pain management:

- What can I do to help my pain management? A person's level of relaxation and their environment can affect their paln. If you are tired, over stimulated (too many visitors) are anxious about your diagnosis, or a past experience with a hospitalization, your pain perception may be impacted and your tolerance decreased. Ask questions, and inform us about any problems or concerns that you may have, re: pain. Partner with your health team for your best pain management.
- What if the medication is not working? Tell your health-care provider; physician, home health nurse, etc. You may need a different dose or type of medicaton.
- What if I feel I'm not getting enough pain control? Talk to your physician or home health nurse about it. Together you may be able to develop a plan to prevent or ease your pain. Depending on the cause of your pain, your health-care provider may suggest exercise, use of heat/cold, massage, repositioning, immobilization of the affected part, or distraction such as music or rest.
- There are other methods of pain management. Let your health-care provider assist you in finding the best one for you.

Weight management is one step to help maintain a healthy lifestyle. For certain medical problems, such as congestive heart failure, weight should be monitored daily.

YOU ARE THE MOST IMPORTANT FACTOR IN YOUR RECOVERY.

Follow the above instructions carefully. Take your medicines as prescribed. Most important, see a doctor again as discussed.

If you have problems that we have not discussed, or your problem changes or gets worse. Call or visit your doctor right away. If you cannot reach your doctor, return to the Emergency Department immediately.

Centegra Health System is very concerned about your safety and well being. As part of our efforts to always provide very good care, any medications you received during this visit were reconciled with medication you are currently taking. This reconciliation was based on the information you or your representative provided regarding your current medications and allergies.

"I have received this information and my questions have been answered. I have discussed any clicklenges i see with this plan with the nurse or physician."/

PAUL DULBERG or Responsible Person

PAUL DULBERG or Responsible Person has received this information and tells me that all questions have been answered

Portion Topy Agmed 1967-2517 NoticaRE Corporation Page 2 of

Panathana Paul R Account Number, B1117900323

DATE

PAUL DULBERG was discharged on 06/28/2011 at 17:06 from the hospital. The following is a summary of the discharge instructions given to PAUL before discharge:

This Information Is About Your Follow Up Care

Call as soon as possible to make an appointment to see your doctor in 10 days for suture removal. You can reach your doctor by calling their clinic phone number.

Please return to the Emergency Department in 10 days for suture removal if you would prefer to have the sutures removed in the ER. We do recommend that you follow-up with your Primary Care Physician but you can return to the ER for removal of your stitches if you choose..

This Information Is About Your Illness and Diagnosis

WOUND CARE (with stitches)

This is Information About Your New Medications - Start taking as prescribed.

HYDROCODONE and ACETAMINOPHEN (Vicodin, Vicodin ES, Lortab, Lortab elixir, Zamicet, Norco, Zydone, Anexsia, Anolor, Bancap HC)

one 10mg/325mg tablet every 4 to 6 hours if needed for pain. Do not take more than as directed per day (24 hours).

CEFADROXIL (Duricef)

500 mg by mouth 2 times a day for 5 days.

- 1. How are you and/or your family doing today?
- 2. Is your pain/or symptoms better today?
- 3. Did you understand your discharge instructions?
- 4. Are you following up with a Doctor?

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Patient Name PAUL R

Account Number, B1117900323

5. Comments:

| Signature | of | nurse | making | phone | call; | | | | | | | |
|-----------|----|-------|--------|-------|-------|------|------|----|-------|----|------|------|
| Date: | | | Time; | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | FORM | GOES | TO | MEDIC | ΔI | RECO | JBDe |

CentegraHealthSystem

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1117800326 WELTER, KAITLYN 0 F 10Y 11/28/2000 06/28/2011 B 0000297787

| | RELEASE FROM LIABILITY FOR VALUABLES |
|----------|--------------------------------------|
| Initials | |

I understand my belongings are my responsibility and I have been advised to send any items of value home. I release CHS from any liability for the loss, damage to, or theft of any of my belongings. Safes or lockers are available at the hospital facilities and may be used to store valuables.

PATIENT PRE-CERTIFICATION RESPONSIBILITY

I understand I am responsible for the notification to my insurance company to obtain authorization before service is rendered. I further understand that if I do not pre-certify I may incur a reduction or loss of paid benefits to the hospital for which I will be liable.

ASSIGNMENT OF BENEFITS/ AGREEMENT FOR PAYMENT

I hereby authorize payment to be made directly to CHS and to the independent professional(s) for all insurance benefits otherwise payable to me. I understand I am financially responsible to CHS and independent professionals for all charges incurred. Patient "out-of-pocket" amounts will be requested prior to or upon discharge. In the event of default or non-payment, CHS shall be entitled to the right of recovery of all collection expenses, including court costs and reasonable attorney's fees for the purpose of securing payment. It is further agreed that any credit balance may be applied on any other account owed CHS by the guarantor/responsible party, or any open account for his/her dependent family.

| PATIENT INFORMATION OFFERED Patient Rights/Responsibilities | es Declined Declined | If No, Explain: | | |
|---|--|--|---|---|
| PATIENT CERTIFICATION | | | al a a al complemente production of the | the information |
| By signing this General Consent and Acknow contained in this form and accept its terms. | rledgement Form, I I also acknowledge | acknowledge i have real I have received a copy of | of this form for my | records. |
| INPATIENTS ONLY: TRICARE (Military) Insurance PATIENTS | Yes, I have rec | eived TRICARE "Important & | lessage" | |
| Patient/ Authorized Person | Relationsh | lL | 6/28/// Date | <u>/</u> |
| Witness | | | | |
| i, patient has informed me he/she fully unders | tands and agrees t | terpreted/translated the othe terms set out in thi | above form to the s consent form. | patient. The |
| Interpreter/Translator (Please Print Name) | Language | Interpretation/T | ranslation Provider(| Company name or Relationship to Patient) |

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TEENERAL CONSENTEND AND ACKNOWLEDGMENT
Page 2 of 2



WELTER, KAITLYN D 10Y 11/28/2000

| Centegra Health System CH - M | 06/28/2011 B | 0000297787 | |
|------------------------------------|--------------|------------|--|
| GENERAL CONSENT AND ACKNOWLEDGMENT | - | | |
| Account Number/Effective Date: | | | |

CONSENT FOR MEDICAL TREATMENT

I have come to Centegra Health System (CHS) for medical treatment and consent to the customary examinations, tests, and procedures performed on patients in my condition. I understand and consent that independent professionals (such as my attending physician, on-call physicians, emergency medicine physicians, radiologists, anesthesiologists, pathologists, surgeons, obstetricians, consultants, nurse practitioners, physician assistants, certified registered nurse anesthetists and other specialists) may participate in my care as deemed necessary.

I agree to follow the Patient Rights & Responsibilities of CHS and to participate with independent professionals and CHS

personnel in my care and treatment.

I understand the practice of Medicine is not an exact science and, therefore, no guarantees have been made regarding the likelihood of success or outcomes of any diagnosis, treatment, test, surgery or examination performed at CHS.

I understand this General Consent and Acknowledgement will remain in effect for this episode of care and will be provided to those areas of CHS where I receive care.

I understand the language in this Consent guides and controls all other forms and consents I may sign during my treatment with Centegra Health System and any inconsistencies shall be interpreted consistent with terms of this document.

MW PATIENT ACKNOWLEDGMENT OF INDEPENDENT PHYSICIANS

Initials I acknowledge the Independent professional(s) who provide services to me at CHS are not employees or agents of CHS, but are independent medical practitioners who have been permitted to use its facilities for the care and treatment of their patients. They include but are not limited to, my attending physician, on-call physicians, emergency medicine physicians, radiologists, anesthesiologists, pathologists, surgeons, obstetricians, consultants, nurse practitioners, physician assistants, certified registered nurse anesthetists and other specialists. My decision to seek care is not based upon any representation or advertisement of the independent professionals and I understand they are not employees or agents of CHS. CHS bills do not include physician, surgeon, or other independent professional services and I understand I will receive a separate bill directly from the Independent professional. I have read and understand the above terms and confirm I am the patient or am authorized to sign on the patient's behalf.

PATIENT ACKNOWLEDGMENT OF INDEPENDENT SERVICES

lhitials

During the course of my hospital stay, my physician may determine I require care at another medical facility, or I may request care at an alternate facility. I acknowledge that all transportation services provided in connection with my transfer to another facility are provided by an independent third party and I will receive a separate bill directly from the service provider for which I may be responsible.

USE AND DISCLOSURE OF HEALTH INFORMATION

Unless I request otherwise, CHS will provide my room location or telephone number to visitors and callers. I understand CHS will use and disclose my health information for the purposes of treatment, payment, and health care operations, as permitted by law as described in the CHS Notice of Privacy Practices. Certain information can be used without obtaining my consent. I fully understand that the use or disclosure of my health information may include history, diagnosis and /or diagnostic treatment of mental health/ developmental disabilities conditions, alcohol or drug abuse and Acquired Immune Deficiency Syndrome (AIDS/ HIV).

I understand that if I refuse to allow disclosure of my health information to process my insurance claim, I may be financially responsible for all costs incurred by me for treatment. I agree to release and hold harmless CHS, its agents, and

employees from any liability that may arise from the use or disclosure of my health information.

Oliv PICTURES/IMAGES

initials I understand photographs, videotapes or other images may be taken to document my care. These images may be kept by CHS and/or by the independent professional involved in my care. I understand I have the right to view or obtain copies of these materials which are in possession of CHS upon written request. It is my responsibility to confirm if such photographs, videotapes or other images have been taken. I understand images identifying me will only be released as allowable under law or with my written authorization.

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DATE

12/08/2011

GENERAL CONSENT AND ACKNOWLEDGMENT Page 1 of 2



++**Centegra**HealthSystem CH - M ☐ CH - W 1117900323 ☐ Other (Specify) DULBERG, PAUL R 41Y 03/19/1970 GENERAL CONSENT AND ACKNOWLEDGMENT

08/28/2011 B 0000109381

Account Number/Effective Date:

CONSENT FOR MEDICAL TREATMENT

I have come to Centegra Health System (CHS) for medical treatment and consent to the customary examinations, tests, and procedures performed on patients in my condition. I understand and consent that independent professionals (such as my attending physician, on-call physicians, emergency medicine physicians, radiologists, anesthesiologists, pathologists, surgeons, obstetricians, consultants, nurse practitioners, physician assistants, certified registered nurse anesthetists and other specialists) may participate in my care as deemed necessary.

Lagree to follow the Patient Rights & Responsibilities of CHS and to participate with independent professionals and CHS

personnel in my care and treatment.

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I understand this General Consent and Acknowledgement will remain in effect for this episode of care and will be provided

to those areas of OHS where I receive care.

I understand the language in this Consent guides and controls all other forms and consents I may sign during my treating with Centegra Health System and any inconsistencies shall be interpreted consistent with terms of this document.

PATIENT ACKNOWLEDGMENT OF INDEPENDENT PHYSICIANS

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PATIENT ACKNOWLEDGMENT OF INDEPENDENT SERVICES

Initials

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PICTURES/IMAGES

Lunderstand photographs, videotapes or other images may be taken to document my care. These images may be kept by CHS and/or by the independent professional involved in my care. I understand I have the right to view or obtain copies of these materials which are in possession of CHS upon written request. It is my responsibility to confirm if such photographs, videotapes or other images have been taken. I understand images identifying me will only be released as allowable under law or with my written authorization.

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DATE 12/08/2011
GENERAL CONSENT AND ACKNOWLEDGMENT Page 1 of 2



Centegral-lealthSystem



11179C0323 DULBERG, PAUL R M 11Y 03/19/19/0 06/28/2011 B 0000109381

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| Initials | 1 of the first first first first | I IZONI EN | ADILLI I | FUK V | ALUABLE | : : |

I understand my belongings are my responsibility and I have been advised to send any items of value home. I release CHS from any liability for the loss, damage to, or theft of any of my belongings. Safes or lockers are available at the hospital facilities and may be used to store valuables.

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I understand I am responsible for the notification to my insurance company to obtain authorization before service is rendered. I further understand that if I do not pre-certify I may incur a reduction or loss of paid benefits to the hospital for which I will be liable.

ASSIGNMENT OF BENEFITS/ AGREEMENT FOR PAYMENT

I hereby authorize payment to be made directly to CHS and to the Independent professional(s) for all insurance benefits otherwise payable to me. I understand I am financially responsible to CHS and independent professionals for all charges incurred. Patient "out-of-pocket" amounts will be requested prior to or upon discharge. In the event of default or non-payment, CHS shall be entitled to the right of recovery of all collection expenses, attorney's fees for the purpose of securing payment. It is further agreed that any other account owed CHS by the guarantor/responsible party, or any open account for his/her dependent family.

| attorney's fees for the purpose of securing payment. It is further agreed that any credit balance may be applied on any other account owed CHS by the guarantor/responsible party, or any open account for his/her dependent family. |
|--|
| PATIENT INFORMATION OFFERED |
| Patient Rights/Responsibilities Yes Declined If No, Explain: Advance Directive Information Yes Declined If No, Explain: Notice of Privacy Practices. Yes Declined If No, Explain: Patient Billing Information Yes Declined If No, Explain: |
| PATIENT CERTIFICATION |
| By signing this General Consent and Acknowledgement Form, I acknowledge I have read and understand the information contained in this form and accept its terms. I also acknowledge I have received a copy of this form for my records. |
| INPATIENTS ONLY: |
| TRICARE (Military) Insurance PATIENTSYes, I have received TRICARE "Important Message" |
| Patient/ Authorized Person Relationship Witness |
| I,, have interpreted/translated the above form to the patient. The patient has informed me he/she fully understands and agrees to the terms set out in this consent form. |
| Interpreter/Translator (Please Print Name) Language Interpretation/Translation Provider (Company name or Relationship to Patient) |

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GENERAL CONSENT AND ARMIQUEDGMENT
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