Worker's Compensation Court

Back to Digital Index

REGELIN CASTILLO
Plaintiff

vs

ADVENTIST HEALTH WHITE MEMORIAL
Defendant

Case Number: **ADJ14349578**

Worker's Compensation Subpoena Duces Tecum

Claim Number: **18025499/30217364863-0001**

RECORDS PERTAINING TO:
REGELIN CASTILLO

RECORDS FROM:
USAA CASUALTY INSURANCE COMPANY

ATTN: CUSTODIAN OF RECORDS
2710 GATEWAY OAKS DR. #150N
SACRAMENTO, CA 95833

☒ **CLIENT ORDERING RECORDS:**
ALBERT & MACKENZIE
ATTN: MICHELLE PARTINGTON, ESQ
28216 DOROTHY DRIVE #200
AGOURA HILLS, CA 91301

☐ **OPPOSING PARTY:**
WORKERS DEFENDERS
ATTN:
751 S. WEIR CANYON RD #157-445
ANAHEIM, CA 92808

STATEWIDE RECORD SERVICES, INC.
P.O. BOX 15617
SACRAMENTO, CA 95852-0617
(916) 344-0446 FAX (916) 344-0104

Order#: 54445-03/STCVR

STATEWIDE RECORD SERVICES, INC.

PHOTOCOPIED RECORDS - COMPLETED REPORT

ALBERT & MACKENZIE
MICHELLE PARTINGTON, ESQ
28216 DOROTHY DRIVE #200
AGOURA HILLS, CA 91301

RE: CASE NAME:	REGELIN CASTILLO vs. ADVENTIST HEALTH WHITE MEMORIAL
COURT:	Worker's Compensation Court
CASE NUMBER:	ADJ14349578
YOUR FILE #:	18025499/30217364863-0001
OUR FILE #:	54445
FACILITY:	USAA CASUALTY INSURANCE COMPANY
PATIENT NAME:	REGELIN CASTILLO

Dear Ms. Partington:

Your request to photocopy records at the above referenced location has been completed. A copy of the records has been shipped to:

☒ **MICHELLE PARTINGTON, ESQ**
ALBERT & MACKENZIE
28216 DOROTHY DRIVE #200
AGOURA HILLS, CA 91301
Date Shipped: AUG 2 0 2021

☒ **WORKERS DEFENDERS**
751 S. WEIR CANYON RD #157-445
ANAHEIM, CA 92808
Date Shipped: AUG 2 0 2021

Thank you for choosing STATEWIDE RECORD SERVICES, INC. to assist you.
If you have any questions or coments, please feel free to contact our office.

Respectfully Submitted,

Alfonso Velasco

Order#: 54445-03/CPROOF36

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

WORKERS' COMPENSATION APPEALS BOARD

REGELIN CASTILLO

Claimant/Applicant

VS.

ADVENTIST HEALTH WHITE MEMORIAL

Employer/Insurance Carrier/Defendant

CASE NO. ADJ14349578

(If application has been filed, case number must be indicated regardless of date of injury.)

SUBPOENA DUCES TECUM

(When records are mailed, identify them by using the above Case No. or attaching copy of the subpoena.)

Where no application has been filed for injuries on or after January 1, 1990 and before January 1, 1994, subpoena will be valid without a case number, but subpoena must be served on claimant and employer and/or insurance carrier.

See Instructions below.*

The People of the State of California Send Greetings to:

USAA CASUALTY INSURANCE COMPANY

WE COMMAND YOU to appear before: **STATEWIDE RECORD SERVICES, INC.**
at **P.O. BOX 15617, SACRAMENTO, CA 95852-0617 Phone:(916) 344-0446**
on **August 20, 2021** ,at **10:00 AM** ,to testify in the above-entiltled matter and to bring with you and produce the following described documents, papers, books and records:

COPY OF CLAIM FILE# 020829714003, D.O.L. 07/19/2010 INCLUDING BUT NOT LIMITED TO MOTOR VEHICLE ACCIDENT RECORDS, SETTLEMENT RECORDS, PLEADINGS, STATEMENTS, MEDICAL RECORDS, INDUSTRIAL & NON-INDUSTRIAL INJURIES, EXCLUDING ANY PRIVILEGED INFORMATION AND ATTORNEY CLIENT WORK PRODUCT, CONCERNING: REGELIN CASTILLO,DOB:7/23/1965,SSN#550-67-9707

(Do not produce X-rays unless specifically mentioned above)

For failure to attend and to produce said documents you may be deemed guilty of a contempt and liable to pay to the parties aggrieved all damages sustained thereby and forfeit one hundred dollars in addition thereto.

This subpoena is issued at the request of the person making the declaration on the reverse hereof, or on the copy which is served herewith.

Date: **August 5, 2021**

WORKERS' COMPENSATION APPEALS BOARD
OF THE STATE OF CALIFORNIA

Secretary/Assistant Secretary, Worker's Compensation Judge

***FOR INJURIES OCCURRING ON OR AFTER JANUARY 1,1990 AND BEFORE JANUARY 1, 1994:**

If no Application for Adjucation of Claim has been filed, a declaration under penalty of perjury that the Employee's Claim for Workers' Compensation Benefits (Form DWC-1) has been filed pursuant to Labor Code Section 5401 must be executed properly.

SEE REVERSE SIDE
[SUBPOENA INVALID WITHOUT DECLARATION]

You may fully comply with this subpoena by mailing the records described (or authenticated copies, Evid. Code 1561) to the person and place stated above within (10) days of the date of service of this subpoena.

This subpoena does not apply to any member of the Highway Patrol, Sheriff's Office or city Police Department unless accompanied by notice from this Board that deposit of the witness fee has been made in accordance with Gov't Code 68097.2 et seq.

DECLARATION FOR SUBPOENA DUCES TECUM

Case No. ADJ14349578

STATE OF CALIFORNIA, County of ORANGE

The undersigned states:

That **STATEWIDE RECORD SERVICES, INC.** is (one of) **ALBERT & MACKENZIE** representative(s) for the Defendant in the action captioned on the reverse hereof.

That **USAA CASUALTY INSURANCE COMPANY**

has in his/her possession or under his/her control the documents described on the reverse hereof. That said documents are material to the issues involved in the case for the following reasons:

The records sought are relevant to the claim/case and may lead to discoverable evidence.
These records may contain information that will help in the resolution of this claim/case.

Declaration for Injuries on or After January 1, 1990 and before January 1,1994.

o That an Employee's Claim for Workers' Compensation Benefits (DWC FORM 1) has been filed in accordance with Labor Code Section 5401 by the alleged injured worker whose records are sought, or if the worker is deceased, by the dependent(s) of the decedent, and that a true copy of the form filed is attached hereto. (Check box if applicable and part of declaration below. See instructions on front of subpoena.)

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

August 5, 2021 at AGOURA HILLS ,California.

/S/ MICHELLE PARTINGTON, ESQ	ALBERT & MACKENZIE 28216 DOROTHY DRIVE #200 AGOURA HILLS, CA 91301	(818) 575-9876
Signature	Address	Telephone

DECLARATION OF SERVICE

STATE OF CALIFORNIA, County of Sacramento

I, the undersigned, state that: I served the foregoing subpoena by showing the original and delivering a true copy thereof, together with a copy of the declaration in support thereof, to each of the following named persons, personally, at the date and place set forth opposite each name.

Name of person served	Date of service	Place
Koy S.	8-6-21	2710 Gateway Oaks #150N Sacramento, CA 95833

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

Executed on 8-6-21 at Sacramento, California.

V. Lemus

Signature

DIA WCAB 32 (Page 2)(Rev 06/18)

Order#: 54445-03/CPROOF34

PROOF OF SERVICE BY MAIL CCP 1013A

Case No. ADJ14349578

Case Name: REGELIN CASTILLO
vs.
ADVENTIST HEALTH WHITE MEMORIAL

I am a resident of the State of California, County of Sacramento. I am over the age of eighteen years and not a party to the entitled action; my business address is P.O. BOX 15617, SACRAMENTO, CA 95852-0617.

On August 5, 2021 I served this Notice of Taking Deposition (if applicable)/ Notice to Consumer (if applicable) along with the Subpoena and Affidavit in Support of Issuance (if applicable) on the attorneys for all appearing parties in said action, by placing a true copy thereof enclosed in a sealed envelope; with postage thereon fully prepaid, in the United States mail at SACRAMENTO, CA, addresses as follows:

WORKERS DEFENDERS
751 S. WEIR CANYON RD #157-445
ANAHEIM, CA 92808

I declare under penalty of purjury that the forgoing is true and correct. Executed on August 5, 2021, at SACRAMENTO, CA.

Sincerely,

JESSE BONILLA

Order#: 54445-03/CPROOF23

ATTORNEY OR PARTY WITHOUT ATTORNEY (Name, state bar number, and address):
ALBERT & MACKENZIE
MICHELLE PARTINGTON, ESQ, SBN 273448
28216 DOROTHY DRIVE #200
AGOURA HILLS, CA 91301
TELEPHONE NO.: **(818) 575-9876** FAX NO.: **(818) 575-9006**
E-MAIL ADDRESS:
ATTORNEY FOR (Name): **Defendant**

FOR COURT USE ONLY

SUPERIOR COURT OF CALIFORNIA, COUNTY OF ORANGE
STREET ADDRESS: **1065 N. PacifiCenter Dr., Suite #170**
MAILING ADDRESS:
CITY AND ZIP CODE: **Anaheim 92806**
BRANCH NAME: **Anaheim**

PLAINTIFF/PETITIONER: REGELIN CASTILLO

DEFENDANT/RESPONDENT: ADVENTIST HEALTH WHITE MEMORIAL

CASE NUMBER:
ADJ14349578

NOTICE TO CONSUMER OR EMPLOYEE AND OBJECTION
(Code Civ. Proc.,§§ 1985.3, 1985.6)

NOTICE TO CONSUMER OR EMPLOYEE

TO (name): **REGELIN CASTILLO AND/OR ATTORNEY OF RECORD**

1. PLEASE TAKE NOTICE THAT **REQUESTING PARTY** (name): **ALBERT & MACKENZIE**
   SEEKS YOUR RECORDS FOR EXAMINATION by the parties to this action on (specify date): **August 20, 2021**
   The records are described in the subpoena directed to **witness** (specify name and address of person or entity from whom records are sought):
   USAA CASUALTY INSURANCE COMPANY 2710 GATEWAY OAKS DR. #150N, SACRAMENTO, CA 95833
   A copy of the subpoena is attached.

2. IF YOU OBJECT to the production of these records, YOU MUST DO ONE OF THE FOLLOWING BEFORE THE DATE SPECIFIED IN ITEM a. OR b. BELOW:
   a. If you are a party to the above-entiltled action, you must file a motion pursuant to Code of Civil Procedure section 1987.1 to quash or modify the subpoena and give notice of that motion to the **witness** and the **deposition officer** named in the subpoena at least five days before the date set for the production of the records.
   b. If you are not a party to this action, you must serve on the **requesting party** and on the **witness,** before the date set for production of the records, a written objection that states the specific grounds on which production of such records should be prohibited. You may use the form below to object and state the grounds for your objection. You must complete the Proof of Service on the reverse side indicating whether you personally served or mailed the objection. The objection should **not** be filed with the court. **WARNING:** IF YOUR OBJECTION IS NOT RECEIVED BEFORE THE DATE SPECIFIED IN ITEM 1, YOUR RECORDS MAY BE PRODUCED AND MAY BE AVAILABLE TO ALL PARTIES.

3. YOU OR YOUR ATTORNEY MAY CONTACT THE UNDERSIGNED to determine whether an agreement can be reached in writing to cancel or limit the scope of the subpoena. If no such agreement is reached, and if you are not otherwise represented by an attorney in this action, YOU SHOULD CONSULT AN ATTORNEY TO ADVISE YOU OF YOUR RIGHTS OF PRIVACY.

Date: **August 5, 2021**
MICHELLE PARTINGTON, ESQ
(TYPE OR PRINT NAME)

▶ **/S/ MICHELLE PARTINGTON, ESQ**
(SIGNATURE OF ☒ REQUESTING PARTY ☐ ATTORNEY

OBJECTION BY NON-PARTY TO PRODUCTION OF RECORDS

1. ☐ I object to the production of all of my records specified in the subpoena.
2. ☐ I object only to the production of the following specified records:

3. The specific grounds for my objection are as follows:

Date:

▶
(TYPE OR PRINT NAME) (SIGNATURE)

(See next page for proof of service)

Form Adopted for Mandatory Use
Judicial Council of California
SUBP-025 [Rev. January 1, 2008]

NOTICE TO CONSUMER OR EMPLOYEE AND OBJECTION

Code of Civil Procedure,
§§1985.3, 1985.6,
2020.010-2020.510
www.TristarSoftware.com
Order#: 54445-03/CPROOF15

PLAINTIFF/PETITIONER: REGELIN CASTILLO DEFENDANT/RESPONDENT: ADVENTIST HEALTH WHITE MEMORIAL	CASE NUMBER: ADJ14349578

PROOF OF SERVICE OF NOTICE TO CONSUMER OR EMPLOYEE AND OBJECTION

(Code Civ. Proc.,§§ 1985.3, 1985.6)

☐ **Personal Service** ☑ **Mail**

1. At the time of service I was at least 18 years of age and **not a party to this legal action.**
2. I served a copy of the *Notice to Consumer or Employee and Objection* as follows *(check either a or b):*
   a. ☐ **Personal service.** I personally delivered the *Notice to Consumer or Employee and Objection* as follows:
      (1) Name of person served:
      (2) Address:
      (3) Date served:
      (4) Time served:
   b. ☑ **Mail.** I deposited the *Notice to Consumer or Employee and Objection* in the United States mail, in a sealed envelope with postage fully prepaid. The envelope was addressed as follows:
      (1) Name of person served: **WORKERS DEFENDERS**
      (2) Address: **751 S. WEIR CANYON RD #157-445, ANAHEIM, CA 92808**
      (3) Date of mailing: **8/5/2021**
      (4) Place of mailing: **SACRAMENTO, CA**
      (5) I am a resident of or employed in the county where the *Notice to Consumer or Employee and Objection* was mailed.
   c. My residence or business address is *(specify):* **P.O. BOX 15617, SACRAMENTO, CA 95852-0617**
   d. My phone number is *(specify):* **(916) 344-0446**

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

Date: 8/5/2021

JESSE BONILLA
(TYPE OR PRINT NAME OF PERSON WHO SERVED)

▶ _____
(SIGNATURE OF PERSON WHO SERVED)

PROOF OF SERVICE OF OBJECTION TO PRODUCTION OF RECORDS

(Code of Civ. Proc.,§§ 1985.3, 1985.6)

☐ **Personal Service** ☐ **Mail**

1. At the time of service I was at least 18 years of age and **not a party to this legal action.**
2. I served a copy of the *Objection to Production of Records* as follow *(complete either a or b):*
   a. ON THE REQUESTING PARTY
      (1) ☐ **Personal service.** I personally delivered the *Objection to Production of Records* as follows:
         (i) Name of person served:
         (ii) Address where served:
         (iii) Date served:
         (iv) Time served:
      (2) ☐ **Mail.** I deposited the *Objection to Production of Records* in the United States mail, in a sealed envelope with postage fully prepaid. The envelope was addressed as follows:
         (i) Name of person served:
         (ii) Address:
         (iii) Date of mailing:
         (iv) Place of mailing *(city and state:*
         (v) I am resident of or employed in the county where the *Objection to Production of Records* was mailed.
   b. ON THE WITNESS:
      (1) ☐ **Personal service.** I personally delivered the *Objection to Production of Records* as follows:
         (i) Name of person served:
         (ii) Address where served:
         (iii) Date served:
         (iv) Time served:
      (2) ☐ **Mail.** I deposited the *Objection to Production of Records* in the United States mail, in a sealed envelope with postage fully prepaid. The envelope was addressed as follows:
         (i) Name of person served:
         (ii) Address:
         (iii) Date of mailing:
         (iv) Place of mailing *(city and state):*
         (v) I am a resident of or employed in the county where the *Objection to Production of Records* was mailed.
3. My residence or business address is (specify):
4. My phone number is (specify):

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

Date:

_____
(TYPE OR PRINT NAME OF PERSON WHO SERVED)

▶ _____
(SIGNATURE OF PERSON WHO SERVED)

CLAIMFOX, INC.
905 MARCONI AVE
RONKONKOMA, NY 11779

P. 631.205.1200
F. 631.205.1211
CLAIMFOX.COM

CLAIMFOX
CONSIDER IT DONE

To Whom It May Concern,

ClaimFox, Inc. processes requests for insurance documents on behalf of United Services Automobile Association.

Respondent objects to any portion of the request for documents or information that seek attorney-client privileged communications or attorney work product. Respondent intends to withhold from production any such materials that are exempt from discovery.

Please contact ClaimFox directly with any questions.

Sincerely,

ClaimFox
631.205.1200 Ext 555
inquiry@claimfox.com

Access
General Insurance Adjusters, Inc.
P.O. Box 250087, Atlanta, Georgia 30325

589

VICKY LOMAY
USAA INSURANCE
PO BOX 659463
SAN ANTONIO TX 78265-9463

July 22, 2010

Insurance Company:	**Access General Insurance Company**
Policy Number:	ACA001419943
Claim Number:	ACI0104325
Date of Loss:	07/19/2010
Insured:	FELIX CISNEROS-GUEVARA
Claimant:	Regelan Castillo / Claim#20829714

Dear VICKY LOMAY :

Access General Insurance Adjusters, Inc. is the administrator for the referenced insurance claim. Any correspondence or inquiry related to the captioned loss should be directed to our attention.

This letter will serve to acknowledge your representation of the above metioned claim and we are currently conducting an investigation of this matter. Our investigation will include confirming coverage for our insured and determining negligence for the accident.

If you require a rental vehicle, be advised that the rental reimbursement procedure applies after coverage has been confirmed, and after negligence has been determined. The reimbursement would be based on the cost of a replacement vehicle comparable to your vehicle plus sales tax for the reasonable amount of time it takes to repair your vehicle.

However, we would only pay our share equal to the percent of negligence attributed to our insured, and then up to the insured's policy limit for all property damage. On this basis, we do not reimburse for mileage, gasoline, insurance, or extra time due to delay of parts availability and/or unforeseen body shop delays.

We will not retain the salvage to your vehicle in the event it is determined to be a total loss. It is your duty to mitigate any towing and storage charges on your vehicle. If coverage is confirmed for our insured and negligence rests with the insured, we will not be responsible for towing and/or storage charges which are excessive or unreasonable. We will also not be responsible for authorizing repairs to your vehicle, as only the owner of a vehicle can authorize the repairs.

Also, this letter is to inform you that there is a 3-year statute of limitations from the date of loss for property damage and a 2-year statute of limitations from the date of loss for bodily injury. You may be barred from pursuing your respective claims if you fail to timely and properly protect the statute of limitations.

Feel free to contact the undersigned with any questions or concerns.

Sincerely,

Alexis Bountthong

, Claims Services
telephone 866.747.6931 ext. 8618
fascimile 866.347.2110

S - ACAANLM01

AUDIT SERVICES INC.
ESTIMATE AUDIT
2123 EASTVIEW PARKWAY
CONYERS, GA 30013
(800)647-3626 FAX: (800)952-5371
WRITTEN BY: HOUGH MIKE 08/02/2010 03:22 PM

FOR: USAA - TAMPA
ADJUSTER: 00009

ESTIMATE OF RECORD

INSURED: MSGT ABEL CASTILLO
OWNER: MSGT ABEL CASTILLO
ADDRESS: 509 HILL DR
GLENDALE, CA 91206-2840
DAY: (818)653-1537
OTHER: (310)416-1532

CLAIM #02082971400000000 3001
POLICY #020829714
DATE OF LOSS: 07/19/2010 AT 12:00 AM
TYPE OF LOSS: COLLISION
POINT OF IMPACT: 6. REAR

INSPECT 471136
LOCATION: UNKNOWN
1400 E CHEVY CHASE DR
GLENDALE, CA 91206-0000

DAY: (818)242-6876
OTHER

REPAIR BISTAGE BROS BODY SHOP
FACILITY: 1400 E CHEVY CHASE DR
FAX: 8185458854
GLENDALE, CA 91206

BUSINESS: (818)242-6876
3 DAYS TO REPAIR
LICENSE # 954051210

2009 VW JETTA SE 5-2.5L-FI 4D SED GREEN INT:
VIN: 3VWRZ71K89M121906 LIC: 6JJJ007 CA PROD DATE: 12/2008 ODOMETER: 0

AIR CONDITIONING	REAR DEFOGGER	TILT WHEEL
CRUISE CONTROL	TELESCOPIC WHEEL	INTERMITTENT WIPERS
KEYLESS ENTRY	ALARM	TINTED GLASS
DUAL MIRRORS	ELECTRIC GLASS SUNROOF	TRACTION CONTROL
STABILITY CONTROL	SIGNAL INTEGRATED MIRRORS	CLEAR COAT PAINT
POWER STEERING	POWER BRAKES	POWER WINDOWS
POWER LOCKS	POWER MIRRORS	HEATED MIRRORS
POWER TRUNK/GATE RELEASE	AM RADIO	FM RADIO
STEREO	SEARCH/SEEK	CD CHANGER/STACKER
PREMIUM RADIO	AUXILIARY AUDIO CONNECTIO	SATELLITE RADIO
ANTI-LOCK BRAKES (4)	DRIVER AIR BAG	PASSENGER AIR BAG
HEAD/CURTAIN AIR BAGS	FRONT SIDE IMPACT AIR BAG	4 WHEEL DISC BRAKES
POSITRACTION	BUCKET SEATS	HEATED SEATS
AUTOMATIC TRANSMISSION	OVERDRIVE	ALUMINUM/ALLOY WHEELS

ESTIMATE OF RECORD
2009 VW JETTA SE 5-2.5L-FI 4D SED GREEN INT:

	NO.	OP.	DESCRIPTION	QTY	EXT. PRICE	LABOR	PAINT
	1		REAR BUMPER				
	2		O/H REAR BUMPER			2.2	
	3	REPL	BUMPER COVER W/O REVERSE SENSOR	1	325.00	INCL.	2.4
	4		ADD FOR CLEAR COAT				1.0
	5*	REPL	SPOILER W/O GLI	1	215.00	INCL.	0.0*
	6*	REPL	MOLDING	1	55.00	INCL.	0.0*
	7		FRONT BUMPER & GRILLE				
	8		O/H FRONT BUMPER			2.6	
	9	REPL	BUMPER COVER	1	350.00	INCL.	2.6
	10		ADD FOR CLEAR COAT				1.0
	11	REPL	SPOILER BLACK	1	154.00	INCL.	
	12	REPL	UPPER GRILLE W/O GLI FROM 12/08	1	148.00	INCL.	
	13	REPL	COVER MOLDING	1	245.00	INCL.	
	14	REPL	FRAME MOLDING	1	122.00	INCL.	
	15	REPL	LOWER GRILLE W/O GLI	1	60.50	INCL.	
	16	REPL	RT OUTER GRILLE W/O FOG LAMPS	1	42.00	INCL.	
	17*	REPL	RT LOWER MOLDING	1	68.50	INCL.	0.0*
N	18#	REPL	FLEX ADDITIVE	1	15.00		
N	19#	RPR	COLOR SAND AND BUFF			1.0	
	20#	RPR	COLOR TINT			0.5	
	21#	SUBL	HAZARDOUS WASTE REMOVAL	1	3.00 X		
			SUBTOTALS ==>		1803.00	6.3	7.0

LINE 18 : 2 BUMPER COVERS
LINE 19 : 2 MAJOR PANELS

ESTIMATE NOTES:

SPOKE TO ROBERT AT SHOP OF OWNERS CHOICE AND SECURED AN AGREED COST OF REPAIRS
PLEASE CALL (800) 647-3626 EXT 6345 FOR SUPPLEMENT NOTIFICATION PRIOR TO COMPLETING REPAIRS
PHOTOS & PARTS INVOICES ARE REQUIRED FOR SUPPLEMENTAL REPAIRS
SUPPLEMENT DOCUMENTATION MAY BE EMAILED TO SUPPLEMENTS@ASICLAIMS.COM
ESTIMATE COPY FAXED TO SHOP, ESTIMATE COPY MAILED TO VEHICLE OWNER
DOM AVAILABLE - VEHICLE NOT SUBJECT TO QRP
VEHICLE IS DRIVABLE
DR=08/02/10 DI=08/02/10 DS=08/02/10

08/02/2010 AT 03:22 PM FILE ID: 471136
102564
ESTIMATE OF RECORD
2009 VW JETTA SE 5-2.5L-FI 4D SED GREEN INT:

PARTS			1800.00
BODY LABOR	6.3 HRS	@$ 45.00/HR	283.50
PAINT LABOR	7.0 HRS	@$ 45.00/HR	315.00
PAINT SUPPLIES	7.0 HRS	@$ 35.00/HR	245.00
SUBLET/MISC.			3.00
SUBTOTAL			$ 2646.50
SALES TAX	$ 2045.00	@ 9.7500%	199.39
TOTAL COST OF REPAIRS			$ 2845.89
ADJUSTMENTS:			
DEDUCTIBLE			500.00
TOTAL ADJUSTMENTS			$ 500.00
NET COST OF REPAIRS			$ 2345.89

THIS ESTIMATE AUDIT DOES NOT REPRESENT AUTHORIZATION TO REPAIR OR AN ACCEPTANCE/DETERMINATION OF LIABILITY. THIS ESTIMATE AUDIT DOES NOT CONFIRM THAT PAYMENT WILL BE ISSUED. SIGNED AUTHORIZATION MUST BE OBTAINED BY THE REPAIR FACILITY FROM THE VEHICLE OWNER PRIOR TO STARTING REPAIR. THE VEHICLE OWNER SHOULD CONFIRM COVERAGE WITH HIS /HER CLAIM REPRESENTATIVE PRIOR TO SIGNING ANY REPAIR AUTHORIZATION. A COPY OF THIS ESTIMATE AUDIT MUST BE PRESENTED TO THE REPAIR SHOP OF YOUR CHOICE PRIOR TO THE START OF REPAIRS. ALL SUPPLEMENTS REQUIRE PRIOR APPROVAL. PLEASE CALL (800) 647-3626 FOR ANY QUESTIONS REGARDING SUPPLEMENTS ETC.

08/02/2010 AT 03:22 PM FILE ID: 471136
102564

ESTIMATE OF RECORD
2009 VW JETTA SE 5-2.5L-FI 4D SED GREEN INT:

PLEASE PRESENT A COPY OF THIS ESTIMATE TO A REPAIR FACILITY OF YOUR CHOICE
*USAA SUBSIDIARIES INCLUDE: UNITED SERVICES AUTOMOBILE ASSOCIATION(USAA), USAA CASUALTY INSURANCE COMPANY(CIC), USAA GENERAL INDEMNITY COMPANY(GIC) USAA COUNTY MUTUAL INSURANCE(CMI) AND GARRISON PROPERTY CASUALTY INSURANCE COMPANY. GARRISON PROPERTY AND CASUALTY INSURANCE COMPANY, A SUBSIDIARY OF USAA

CASUALTY INSURANCE COMPANY, IS AUTHORIZED TO USE THE USAA LOGO, A REGISTERED TRADEMARK OF UNITED SERVICES AUTOMOBILE ASSOCIATION.

THIS IS NOT AN AUTHORIZATION TO REPAIR. FAILING TO PRESENT THIS ESTIMATE TO THE REPAIRING GARAGE BEFORE REPAIR MAY RESULT IN ADDITIONAL EXPENSES TO YOU. A USAA APPRAISER MUST AUTHORIZE ANY SUPPLEMENT TO THIS ESTIMATE. REPAIRS TO THIS VEHICLE MAY REQUIRE SPECIFIC WELDING EQUIPMENT AS RECOMMENDED BY THE MANUFACTURER.
IF ALTERNATIVE QUALITY REPLACEMENT PARTS HAVE BEEN INCLUDED IN THIS APPRAISAL, THE SOURCE FOR THESE PARTS HAS ALSO BEEN DISCLOSED. IF ALTERNATIVE QUALITY REPLACEMENT PARTS AS LISTED ON THE APPRAISAL ARE ULTIMATELY USED IN THE REPAIR OF YOUR VEHICLE, THE WARRANTY ON SUCH PARTS WILL BE EQUAL TO, OR GREATER THAN, THE PARTS BEING REPLACED, AS STATED IN USAA'S LIMITED PARTS WARRANTY. USAA WARRANTS THAT THE PARTS USED ON YOUR VEHICLE WILL BE OF LIKE KIND AND QUALITY, FUNCTION, FIT, SAFETY AND CORROSION PROTECTION AS THE PART OR PARTS THEY REPLACE. USAA IDENTIFIES CERTIFIED AND VALIDATED PARTS FOR SHEET METAL REPLACEMENT PARTS.

08/02/2010 AT 03:22 PM FILE ID: 471136
102564

ESTIMATE OF RECORD
2009 VW JETTA SE 5-2.5L-FI 4D SED GREEN INT:

FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM:

ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

THE FOLLOWING IS A LIST OF ABBREVIATIONS OR SYMBOLS THAT MAY BE USED TO DESCRIBE WORK TO BE DONE OR PARTS TO BE REPAIRED OR REPLACED: MOTOR ABBREVIATIONS/SYMBOLS: D=DISCONTINUED PART A=APPROXIMATE PRICE LABOR TYPES:

B=BODY LABOR D=DIAGNOSTIC E=ELECTRICAL F=FRAME G=GLASS M=MECHANICAL P=PAINT LABOR S=STRUCTURAL T=TAXED MISCELLANEOUS X=NON TAXED MISCELLANEOUS PATHWAYS: ADJ=ADJACENT ALGN=ALIGN A/M=AFTERMARKET BLND=BLEND CAPA=CERTIFIED AUTOMOTIVE PARTS ASSOCIATION D&R=DISCONNECT AND RECONNECT EST=ESTIMATE EXT. PRICE=UNIT PRICE MULTIPLIED BY THE QUANTITY INCL=INCLUDED MISC=MISCELLANEOUS NAGS=NATIONAL AUTO GLASS SPECIFICATIONS NON-ADJ=NON ADJACENT O/H=OVERHAUL OP=OPERATION NO=LINE NUMBER QTY=QUANTITY QUAL RECY=QUALITY RECYCLED PART QUAL REPL=QUALITY REPLACEMENT PART COMP REPL PARTS=COMPETITIVE REPLACEMENT PARTS RECOND=RECONDITION REFN=REFINISH REPL=REPLACE R&I=REMOVE AND INSTALL R&R=REMOVE AND REPLACE RPR=REPAIR RT=RIGHT SECT=SECTION SUBL=SUBLET LT=LEFT W/O=WITHOUT W/_=WITH/_ SYMBOLS: #=MANUAL LINE ENTRY *=OTHER [IE..MOTORS DATABASE INFORMATION WAS CHANGED] **=DATABASE LINE WITH AFTERMARKET N=NOTES ATTACHED TO LINE. OPT OEM=ORIGINAL EQUIPMENT MANUFACTURER PARTS EITHER OPTIONALLY SOURCED OR OTHERWISE PROVIDED WITH SOME UNIQUE PRICING OR DISCOUNT. NWCPP=NATIONWIDE CRASH PARTS PROGRAM.

ESTIMATE OF RECORD
2009 VW JETTA SE 5-2.5L-FI 4D SED GREEN INT:

ESTIMATE BASED ON MOTOR CRASH ESTIMATING GUIDE. UNLESS OTHERWISE NOTED ALL ITEMS ARE DERIVED FROM THE GUIDE ERA9278, CCC DATA DATE 07/16/2010, AND THE PARTS SELECTED ARE OEM-PARTS MANUFACTURED BY THE VEHICLES ORIGINAL EQUIPMENT MANUFACTURER. OEM PARTS ARE AVAILABLE AT OE/VEHICLE DEALERSHIPS. OPT OEM (OPTIONAL OEM) OR ALT OEM (ALTERNATIVE OEM) PARTS ARE OEM PARTS THAT MAY BE PROVIDED BY OR THROUGH ALTERNATE SOURCES OTHER THAN THE OEM VEHICLE DEALERSHIPS. OPT OEM OR ALT OEM PARTS MAY REFLECT SOME SPECIFIC, SPECIAL, OR UNIQUE PRICING OR DISCOUNT. OPT OEM OR ALT OEM PARTS MAY INCLUDE "BLEMISHED" PARTS PROVIDED BY OEM'S THROUGH OEM VEHICLE DEALERSHIPS. ASTERISK (*) OR DOUBLE ASTERISK (**) INDICATES THAT THE PARTS AND/OR LABOR INFORMATION PROVIDED BY MOTOR MAY HAVE BEEN MODIFIED OR MAY HAVE COME FROM AN ALTERNATE DATA SOURCE. TILDE SIGN (~) ITEMS INDICATE MOTOR NOT-INCLUDED LABOR OPERATIONS. NON-ORIGINAL EQUIPMENT MANUFACTURER AFTERMARKET PARTS ARE DESCRIBED AS AM, QUAL REPL PARTS OR COMP REPL PARTS WHICH STANDS FOR COMPETITIVE REPLACEMENT PARTS. USED PARTS ARE DESCRIBED AS LKQ, QUAL RECY

PARTS, RCY, OR USED. RECONDITIONED PARTS ARE DESCRIBED AS RECOND. RECORED PARTS ARE DESCRIBED AS RECORE. NAGS PART NUMBERS AND BENCHMARK PRICES ARE PROVIDED BY NATIONAL AUTO GLASS SPECIFICATIONS. LABOR OPERATION TIMES LISTED ON THE LINE WITH THE NAGS INFORMATION ARE MOTOR SUGGESTED LABOR OPERATION TIMES. NAGS LABOR OPERATION TIMES ARE NOT INCLUDED. POUND SIGN (#) ITEMS INDICATE MANUAL ENTRIES. SOME 2010 VEHICLES CONTAIN MINOR CHANGES FROM THE PREVIOUS YEAR. FOR THOSE VEHICLES, PRIOR TO RECEIVING UPDATED DATA FROM THE VEHICLE MANUFACTURER, LABOR AND PARTS DATA FROM THE PREVIOUS YEAR MAY BE USED. THE PATHWAYS ESTIMATOR HAS A COMPLETE LIST OF APPLICABLE VEHICLES. PARTS NUMBERS AND PRICES SHOULD BE CONFIRMED WITH THE LOCAL DEALERSHIP.

CCC PATHWAYS - A PRODUCT OF CCC INFORMATION SERVICES INC.

08/02/2010 AT 03:22 PM FILE ID: 471136
102564

ESTIMATE OF RECORD
2009 VW JETTA SE 5-2.5L-FI 4D SED GREEN INT:

ALTERNATE PARTS USAGE

AFTERMARKET PARTS

AFTERMARKET SELECTION METHOD: MANUALLY LIST

NO. OF TIMES USER WAS NOTIFIED THAT AN AFTERMARKET PART WAS AVAILABLE: 0

NO. OF AFTERMARKET PARTS THAT APPEAR IN THE FINAL ESTIMATE: 0

OPTIONAL OEM PARTS

OPTIONAL OEM SELECTION METHOD: MANUALLY LIST

NO. OF TIMES USER WAS NOTIFIED THAT AN OPTIONAL OEM PART WAS AVAILABLE: 0

NO. OF OPTIONAL OEM PARTS THAT APPEAR IN THE FINAL ESTIMATE: 0

RECONDITIONED PARTS

RECONDITIONED SELECTION METHOD: MANUALLY LIST

NO. OF TIMES USER WAS NOTIFIED THAT A RECONDITIONED PART WAS AVAILABLE: 3

NO. OF RECONDITIONED PARTS THAT APPEAR IN THE FINAL ESTIMATE: 0

RECYCLED PARTS

NO. OF TIMES USER WAS NOTIFIED THAT A RECYCLED PART WAS AVAILABLE: 2

NO. OF RECYCLED PARTS THAT APPEAR IN THE FINAL ESTIMATE: 0

LAW OFFICES
RANDOLPH & ASSOCIATES
1717 FOURTH STREET
THIRD FLOOR
SANTA MONICA, CALIFORNIA 90401-3319

TELEPHONE
(310) 395-7900
(800) 953-4500

FACSIMILE
(310) 395-1833
randolphassociates.com

August 4, 2010

USAA
PO Box 659463
San Antonio, TX 72865

Re: Our Client/Your Insured : Regelin P. Castillo
Your Claim No : 20829741
Date of Loss : 7/19/2010

Dear Vivian:

This letter is to advise you that this office represents Regelin P. Castillo with regard to personal injuries and other damages which she sustained as a result of the above-captioned incident. It is our understanding that you insured Regelin P. Castillo as of the date of loss.

Please do not contact our client, and forward all correspondence and other communication pertaining to this matter to the undersigned.

Also, please send us a letter which contains the following information:

(a) Name(s), address(es), and telephone number(s) of your insured(s);
(b) Names, addresses, and telephone numbers of any other interested parties;
(c) **TYPE OF INSURANCE COVERAGE AND POLICY LIMITS;**
(d) Accident reports; photos of your insured's vehicle;
(e) The names, addresses, and telephone numbers of any witness(es);
(f) If applicable, excess insurance coverage and the medical payment benefits for this occurrence.

Please send us a copy of all statements which you have obtained from our client(s). Additionally, if you have obtained any authorizations from our client(s) to inspect or copy any records, including medical, employment, etc., or to discuss her condition with her doctors, ALL AUTHORIZATIONS ARE HEREBY EXPRESSLY REVOKED.

We have an attorney fee and cost lien against any monies paid on this claim, including settlements and/or judgments. As such, we request that our name and address as an additional payee to any monies paid on this claim.

If there is any further information that you need to commence the claims process, please advise this office.

Thank you for your cooperation in this matter.

Very truly yours,
Randolph & Associates

Saul Ochoa
Legal Assistant to Donald C. Randolph

DCR:so

9800 Fredericksburg Road
San Antonio, Texas 78288

JOHN PETERSEN
1717 FOURTH ST
THIRD FLOOR
SANTA MONICA CA 90401-3319

August 4, 2010

Reference: Acknowledgement Of Representation

Saul Ochoa,

We received your letter of representation dated August 4, 2010 regarding this claim:

Your client: Regelin Castillo
USAA policyholder: Abel Castillo
Claim number: 20829714-7104-3-8509
Date of loss: July 19, 2010
Loss location: Glendale, California

Information you requested:
*Name for our insured: Regelin Castillo
*Address for our insured: 509 HILL DR GLENDALE, CA, 91206-2840
*Phone numbers for our insured: 818-653-1521
*Types of insurance coverage and policy limits: Collision $500 deductible Rental Reimbursement $30/day, $900 maximun, Medical Payments $10,000 per person Uninsured Motorists Property Damage/Waiver of Collision Deductible $500 limit per accident, Uninsured Motorists Bodily Injury $30,000 per person, $60,000 per accident
*We do not have any client statements or any pictures of their vehicle
*To our knowledge there were no witnesse

Include the reference number 20829714-7104-3-8509 on all correspondence and mail it to:
Auto Injury Solutions
Attn: USAA Medical Mail Dept.
P.O. Box 5000
Daphne, AL 36526
Fax: 1-888-272-1255

If you have questions, please call me at **800-531-8722, ext. 3-1290**.

Sincerely,

Vivian R Worley
Injury Unit
United Services Automobile Association

9800 Fredericksburg Road
San Antonio, Texas 78288

JOHN PETERSEN
1717 FOURTH ST
THIRD FLOOR
SANTA MONICA CA 90401-3319

August 5, 2010

Reference: Acknowledgement Of Representation

Dear Mr. Petersen,

We received your letter of representation dated August 4, 2010 regarding this claim:

Your client:	Regelin Castillo
USAA policyholder:	Abel Castillo
Claim number:	20829714-7104-3-7458
Date of loss:	July 19, 2010
Loss location:	Glendale, California

We also need to receive these forms, completed and signed:

- Application for MP Benefits
- Authorization for Disclosure of Medical Information to USAA

Include the reference number 20829714-7104-3-7458 on all correspondence and mail it to:

Auto Injury Solutions
Attn: USAA Medical Mail Dept.
P.O. Box 5000
Daphne, AL 36526
Fax: 1-888-272-1255

If you have questions, please call **1-800-531-8722 x74047.**

Sincerely,

Josh Ramirez
Central Region
United Services Automobile Association

Enc: Imp. Notice, MP Application, Medical Authori

20829714 - 3 - CA - 07/19/10 - 7458 - 70 - P157

United Services
Automobile Association

Member Name	USAA Number	L/R Number	Date of Loss
Abel Castillo	**20829714**	**3**	**07-19-2010**

IMPORTANT NOTICE!

The language of the USAA auto policy and applicable state statutes determine the benefits available to you under your medical coverage. If you have questions, please refer to the auto policy for details of your medical coverage. To request a copy of the auto policy, please contact your claim representative.

The continuing increase in the cost of health care has a direct impact on the premiums paid by USAA's insureds. USAA receives more than 600,000 health care bills each year. While the majority of these bills are proper and appropriate, some contain billing errors or excessive charges. Many other bills are duplicates. Regrettably, some bills are simply fraudulent. In order to ensure that USAA pays only those medical bills that are appropriate, USAA utilizes an independent third party contractor, Auto Injury Solutions, to provide a medical bill auditing tool to assist USAA in reviewing health care providers services and charges to ensure billing accuracy, to avoid duplication of payment, to identify treatment that is reasonable, necessary and appropriate for accident related injuries and to evaluate the reimbursement amount. USAA uses this analysis in determining whether the services rendered and fees charged are covered by the provisions of the policy and applicable state laws.

USAA remains committed to providing the best possible service at the most affordable price. Please be advised that your health care provider may provide services not covered by the auto policy or charge more for services than the amount covered by the policy. Some providers will expect you to pay the balance of the bill not paid by USAA. We suggest you discuss with your health care providers their payment expectations for non-reimbursable services or costs.

Please have your health care providers send their invoices for your care directly to USAA either electronically or by regular mail. It is important that the USAA claim number, date of accident, your name, your address, your date of birth, the physical address where the treatment occurred, the provider's Tax ID number, and ICD-9-CM codes and CPT codes for each date of service appear on each medical bill we receive. Therefore, please provide each of your health care providers with this information and request that your providers submit, with each invoice, the above information and their treatment and/or office notes for each date of service.

Should you receive any invoices from your health care providers, please forward them to USAA with the above information.

APPLICATION FOR MEDICAL PAYMENTS BENEFITS

United Services Automobile Association

Member Name	USAA Number	L/R Number	Date of Loss
Abel Castillo	**20829714**	**3**	**07-19-2010**

PATIENT NAME	DATE OF BIRTH	
Regelin Castillo		
ADDRESS (NO., STREET, CITY OR TOWN, STATE, AND ZIP CODE)	HOME PHONE ( )	BUSINESS PHONE ( )
DATE AND TIME OF ACCIDENT	PLACE OF ACCIDENT (STREET, CITY OR TOWN, AND STATE)	

BRIEF DESCRIPTION OF ACCIDENT AND AUTOMOBILE YOU OCCUPIED OR WERE STRUCK BY

AT TIME OF ACCIDENT:

WERE YOU AN OCCUPANT OF OUR MEMBER'S CAR? ☐ YES ☐ NO

WERE YOU RIDING IN A SEAT PROTECTED BY AN AIRBAG? ☐ YES ☐ NO

WERE YOU A PEDESTRIAN STRUCK BY OUR MEMBER'S CAR? ☐ YES ☐ NO

WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? ☐ YES ☐ NO

WAS YOUR SEATBELT/CHILD RESTRAINT IN USE? ☐ YES ☐ NO

DOES YOUR HOUSEHOLD HAVE ANY OTHER AUTO INSURANCE POLICIES? ☐ YES ☐ NO

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR MEDICAL OR DISABILITY BENEFITS UNDER

(1) ANY WORKERS' COMPENSATION? ☐ YES ☐ NO AMT OF BENEFIT $ _____

(2) ANY OTHER BENEFIT OR INSURANCE PLAN? ☐ YES ☐ NO (NAME) _____ $ _____

(3) GOVERNMENT MEDICAL INSURANCE? ☐ YES ☐ NO (NAME) _____ $ _____

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR? ☐ YES ☐ NO

DATE OF 1ST TREATMENT

DOCTOR'S NAME AND ADDRESS

IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN ☐ INPATIENT ☐ OUTPATIENT

HOSPITAL'S NAME AND ADDRESS

HAVE YOU PREVIOUSLY BEEN TREATED BY THE ABOVE LISTED DOCTORS OR HOSPITALS? ☐ YES ☐ NO
IF YES, PLEASE PROVIDE DATE(S) OF TREATMENT AND NATURE OF CONDITION TREATED ON REVERSE SIDE.

HAVE YOU EVER BEEN TREATED FOR THIS TYPE OF INJURY OR CONDITION PRIOR TO THIS ACCIDENT? ☐ YES ☐ NO
IF YES, PLEASE PROVIDE DATE(S) AND DOCTORS AND/OR HOSPITALS WHERE TREATMENT WAS OBTAINED ON REVERSE SIDE.

HAD YOU RECOVERED FROM THIS CONDITION AT THE TIME OF THE ACCIDENT? ☐ YES ☐ NO

AMOUNT OF MEDICAL BILLS TO DATE $ _____ WILL YOU HAVE MORE MEDICAL BILLS? ☐ YES ☐ NO

AS A RESULT OF YOUR INJURY, WILL YOU HAVE ANY OTHER EXPENSES, INCLUDING TRANSPORTATION EXPENSES? ☐ YES ☐ NO
IF YES, PLEASE EXPLAIN ON REVERSE.

CALIFORNIA Statutes, Section 1871.2(a) states: "For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

"WHERE PERMITTED BY LAW, I UNDERSTAND AND AGREE THAT THE TOTAL AMOUNT OF PAYMENTS UNDER THE MEDICAL PAYMENTS COVERAGE AND EXTENDED MEDICAL, DEATH AND DISABILITY BENEFITS TO ME OR TO MY PERSONAL REPRESENTATIVE SHALL BE APPLIED TO THE SETTLEMENT OF ANY CLAIMS OR THE SATISFACTION OF ANY JUDGMENT FOR DAMAGES IN MY FAVOR AGAINST ANY PERSON INSURED UNDER THE LIABILITY COVERAGE OF THE POLICY, OR TO THE SETTLEMENT OR SATISFACTION OF ANY AWARD OR JUDGMENT IN MY FAVOR UNDER THE UNINSURED/UNDERINSURED PART OF THE POLICY."

SIGNATURE _____ DATE _____

IMPORTANT:
1. COMPLETE AND SIGN THIS APPLICATION.
2. SIGN AND RETURN PROMPTLY ANY ATTACHED AUTHORIZATION(S).
3. SEND ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION TO USAA

United Services Automobile Association

USAA Number	Member Name	L/R Number	Date of Loss
20829714	Abel Castillo		07-19-2010

We are not HIPAA covered entities. Your disclosure of information to us is not subject to the Minimum Necessary standard.

Patient: Regelin Castillo

I HEREBY GRANT PERMISSION TO, AND AUTHORIZE THE USE OR DISCLOSURE OF, THE ABOVE NAMED INDIVIDUAL'S RECORDS.

I authorize the following persons and organizations (a) any licensed physician, surgeon, or dentist; (b) any psychiatrist or psychologist; (c) any other medical practitioner or nurse; (d) any hospital, clinic, health care facility or rehabilitation/convalescent/custodial facility; (e) ambulance owner; (f) any insurance company (the "Provider") to provide information (as defined below) to USAA and/or their retrieval service ABI/VIP.

I, the Undersigned, as the patient, or in my capacity as personal representative of the patient, Regelin Castillo , understand the information obtained by this Authorization will be used by USAA and its authorized representatives, performing business or legal services, its affiliated insurance companies, and its authorized representatives, performing business or legal services for the purpose of verification, evaluation, and negotiation of any claim for benefits or services, arising from the above-identified date of loss, and any other pertinent claim handling or legal uses in connection to such claims, or as USAA otherwise determines is necessary to underwrite insurance.

For purposes of this Authorization, "Information" means all records or knowledge concerning the patient's health, any injuries, medical history, mental and physical conditions, before and after the date of this Authorization, regardless of the time of occurrence. The term "records" includes, but is not limited to, written or graphic documentation, including notes,

billing records or statements, sound recordings, computer records of health care services, and diagnostic documentation, such as x-rays, lab test results, and other test results such as blood alcohol level and drug use. In addition to medical records developed by the Provider described above, this Authorization also includes any medical records received by the Provider from other providers.

This Authorization shall be in force and effect until all claims arising from the above-identified date of loss are concluded, at which time this Authorization to disclose this information expires.

I also understand and agree to the following:

- **Although this Authorization is voluntary, USAA reserves the right to discontinue processing any claim if I refuse to grant this Authorization, and such refusal may be in breach of a policy condition if USAA reasonably needs this Authorization to adequately investigate any claim.**
- **That the information released pursuant to this Authorization may be redisclosed by USAA and may no longer be protected by federal privacy regulations.**
- **That I may receive a copy of this Authorization, and I have the right to revoke this Authorization, in writing, at any time. I may request a copy or revoke the Authorization by sending such written request to**

  Josh Ramirez at

  9800 Fredericksburg Road, San Antonio,TX 78288.
- **That a revocation is not effective: (i) until receipt by USAA, and (ii) to the extent that USAA has relied on the use or disclosure of the information.**
- **That: (1) this Authorization overrides any existing agreement to restrict information pursuant to 45 CFR 164.502(b)(2)(ii), (2) a copy of this Authorization is as valid as an original, and (3) I have read and understand this Authorization.**

CALIFORNIA Statutes, Section 1871.2(a) states: ''For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.''

THIS IS NOT A RELEASE OF CLAIM FOR DAMAGES.

Signature of Patient or Personal Representative **Date**

Patient's Date of Birth / Social Security Number

Description of Personal Representative's Authority

(Reminder: Please return this entire form, including the signature page.)

08/10/2010 AT 07:45 AM FILE ID: 471136
102564

AUDIT SERVICES INC.
ESTIMATE AUDIT
2123 EASTVIEW PARKWAY
CONYERS, GA 30013
(800)647-3626 FAX: (800)952-5371
WRITTEN BY: HOUGH MIKE 08/10/2010 07:45 AM

FOR: USAA - TAMPA
ADJUSTER: 00009

SUPPLEMENT OF RECORD 1 WITH SUMMARY

INSURED: MSGT ABEL CASTILLO
OWNER: MSGT ABEL CASTILLO
ADDRESS: 509 HILL DR
GLENDALE, CA 91206-2840
DAY: (818)653-1537
OTHER: (310)416-1532

CLAIM #020829714000000003001
POLICY #020829714
DATE OF LOSS: 07/19/2010 AT 12:00 AM
TYPE OF LOSS: COLLISION
POINT OF IMPACT: 6. REAR

INSPECT 471136
LOCATION: UNKNOWN
1400 E CHEVY CHASE DR
GLENDALE, CA 91206-0000

DAY: (818)242-6876
OTHER

REPAIR BISTAGE BROS BODY SHOP
FACILITY: 1400 E CHEVY CHASE DR
FAX: 8185458854
GLENDALE, CA 91206

BUSINESS: (818)242-6876
3 DAYS TO REPAIR
LICENSE # 954051210

2009 VW JETTA SE 5-2.5L-FI 4D SED GREEN INT:
VIN: 3VWRZ71K89M121906 LIC: 6JJJ007 CA PROD DATE: 12/2008 ODOMETER: 0

AIR CONDITIONING	REAR DEFOGGER	TILT WHEEL
CRUISE CONTROL	TELESCOPIC WHEEL	INTERMITTENT WIPERS
KEYLESS ENTRY	ALARM	TINTED GLASS
DUAL MIRRORS	ELECTRIC GLASS SUNROOF	TRACTION CONTROL
STABILITY CONTROL	SIGNAL INTEGRATED MIRRORS	CLEAR COAT PAINT
POWER STEERING	POWER BRAKES	POWER WINDOWS
POWER LOCKS	POWER MIRRORS	HEATED MIRRORS
POWER TRUNK/GATE RELEASE	AM RADIO	FM RADIO
STEREO	SEARCH/SEEK	CD CHANGER/STACKER
PREMIUM RADIO	AUXILIARY AUDIO CONNECTIO	SATELLITE RADIO
ANTI-LOCK BRAKES (4)	DRIVER AIR BAG	PASSENGER AIR BAG
HEAD/CURTAIN AIR BAGS	FRONT SIDE IMPACT AIR BAG	4 WHEEL DISC BRAKES
POSITRACTION	BUCKET SEATS	HEATED SEATS
AUTOMATIC TRANSMISSION	OVERDRIVE	ALUMINUM/ALLOY WHEELS

SUPPLEMENT OF RECORD 1 WITH SUMMARY
2009 VW JETTA SE 5-2.5L-FI 4D SED GREEN INT:

	NO.	OP.	DESCRIPTION	QTY	EXT. PRICE		LABOR	PAINT
	1		REAR BUMPER					
	2		O/H REAR BUMPER				2.2	
	3	REPL	BUMPER COVER W/O REVERSE SENSOR	1	325.00		INCL.	2.4
	4		ADD FOR CLEAR COAT					1.0
	5*	REPL	SPOILER W/O GLI	1	215.00		INCL.	0.0*
	6*	REPL	MOLDING	1	55.00		INCL.	0.0*
	7	S01 REPL	ABSORBER	1	68.50		INCL.	
	8	S01 REPL	IMPACT BAR	1	180.00		INCL.	
	9	S01 REPL	TOW EYE CAP W/O GLI	1	16.50		INCL.	0.2
	10	S01	ADD FOR CLEAR COAT					0.1
	11		FRONT BUMPER & GRILLE					
	12		O/H FRONT BUMPER				2.6	
	13	REPL	BUMPER COVER	1	350.00		INCL.	2.6
	14		ADD FOR CLEAR COAT					1.0
	15	REPL	SPOILER BLACK	1	154.00		INCL.	
	16	REPL	UPPER GRILLE W/O GLI FROM 12/08	1	148.00		INCL.	
	17	REPL	COVER MOLDING	1	245.00		INCL.	
	18	REPL	FRAME MOLDING	1	122.00		INCL.	
	19	REPL	LOWER GRILLE W/O GLI	1	60.50		INCL.	
	20	REPL	RT OUTER GRILLE W/O FOG LAMPS	1	42.00		INCL.	
	21*	REPL	RT LOWER MOLDING	1	68.50		INCL.	0.0*
N	22#	REPL	FLEX ADDITIVE	1	15.00			
N	23#	RPR	COLOR SAND AND BUFF				1.0	
	24#	RPR	COLOR TINT				0.5	
	25#	SUBL	HAZARDOUS WASTE REMOVAL	1	3.00	X		
			SUBTOTALS ==>		2068.00		6.3	7.3

LINE 22 : 2 BUMPER COVERS
LINE 23 : 2 MAJOR PANELS

08/10/2010 AT 07:45 AM FILE ID: 471136
102564

SUPPLEMENT OF RECORD 1 WITH SUMMARY
2009 VW JETTA SE 5-2.5L-FI 4D SED GREEN INT:

ESTIMATE NOTES:

SPOKE TO ROBERT AT SHOP OF OWNERS CHOICE AND SECURED AN AGREED COST OF REPAIRS
PLEASE CALL (800) 647-3626 EXT 6345 FOR SUPPLEMENT NOTIFICATION PRIOR TO COMPLETING REPAIRS
PHOTOS & PARTS INVOICES ARE REQUIRED FOR SUPPLEMENTAL REPAIRS
SUPPLEMENT DOCUMENTATION MAY BE EMAILED TO SUPPLEMENTS@ASICLAIMS.COM
ESTIMATE COPY FAXED TO SHOP, ESTIMATE COPY MAILED TO VEHICLE OWNER
DOM AVAILABLE - VEHICLE NOT SUBJECT TO QRP
VEHICLE IS DRIVABLE
DR=08/02/10 DI=08/02/10 DS=08/02/10

THE ATTACHED SUPPLEMENTAL REVIEW HAS BEEN PREPARED UTILIZING A SUPPLEMENT WRITTEN BY THE BODY SHOP OF THE VEHICLE OWNERS CHOICE. THE SUPPLEMENT APPEARS TO BE CONSISTENT WITH THE ORIGINAL DAMAGES REPORTED. PHOTOS & INVOICES HAVE BEEN SUPPLIED BY THE REPAIRER AND ARE ON FILE AT ASI. THIS SUPPLEMENT DOES NOT CONTAIN ANY ITEMS REMOVED OR MODIFIED DURING THE ORIGINAL ESTIMATE REVIEW.

PARTS			2065.00
BODY LABOR	6.3 HRS	@$ 45.00/HR	283.50
PAINT LABOR	7.3 HRS	@$ 45.00/HR	328.50
PAINT SUPPLIES	7.3 HRS	@$ 35.00/HR	255.50
SUBLET/MISC.			3.00
SUBTOTAL			$ 2935.50
SALES TAX	$ 2320.50	@ 9.7500%	226.25
TOTAL COST OF REPAIRS			$ 3161.75
ADJUSTMENTS:			
DEDUCTIBLE			500.00
TOTAL ADJUSTMENTS			$ 500.00
NET COST OF REPAIRS			$ 2661.75

08/10/2010 AT 07:45 AM FILE ID: 471136
102564

SUPPLEMENT OF RECORD 1 WITH SUMMARY
2009 VW JETTA SE 5-2.5L-FI 4D SED GREEN INT:

THIS ESTIMATE AUDIT DOES NOT REPRESENT AUTHORIZATION TO REPAIR OR AN ACCEPTANCE/DETERMINATION OF LIABILITY. THIS ESTIMATE AUDIT DOES NOT CONFIRM THAT PAYMENT WILL BE ISSUED. SIGNED AUTHORIZATION MUST BE OBTAINED BY THE REPAIR FACILITY FROM THE VEHICLE OWNER PRIOR TO STARTING REPAIR. THE VEHICLE OWNER SHOULD CONFIRM COVERAGE WITH HIS /HER CLAIM REPRESENTATIVE PRIOR TO

SIGNING ANY REPAIR AUTHORIZATION. A COPY OF THIS ESTIMATE AUDIT MUST BE PRESENTED TO THE REPAIR SHOP OF YOUR CHOICE PRIOR TO THE START OF REPAIRS. ALL SUPPLEMENTS REQUIRE PRIOR APPROVAL. PLEASE CALL (800) 647-3626 FOR ANY QUESTIONS REGARDING SUPPLEMENTS ETC.

PLEASE PRESENT A COPY OF THIS ESTIMATE TO A REPAIR FACILITY OF YOUR CHOICE *USAA SUBSIDIARIES INCLUDE: UNITED SERVICES AUTOMOBILE ASSOCIATION(USAA), USAA CASUALTY INSURANCE COMPANY(CIC), USAA GENERAL INDEMNITY COMPANY(GIC) USAA COUNTY MUTUAL INSURANCE(CMI) AND GARRISON PROPERTY CASUALTY INSURANCE COMPANY. GARRISON PROPERTY AND CASUALTY INSURANCE COMPANY, A SUBSIDIARY OF USAA CASUALTY INSURANCE COMPANY, IS AUTHORIZED TO USE THE USAA LOGO, A REGISTERED TRADEMARK OF UNITED SERVICES AUTOMOBILE ASSOCIATION.

THIS IS NOT AN AUTHORIZATION TO REPAIR. FAILING TO PRESENT THIS ESTIMATE TO THE REPAIRING GARAGE BEFORE REPAIR MAY RESULT IN ADDITIONAL EXPENSES TO YOU. A USAA APPRAISER MUST AUTHORIZE ANY SUPPLEMENT TO THIS ESTIMATE. REPAIRS TO THIS VEHICLE MAY REQUIRE SPECIFIC WELDING EQUIPMENT AS RECOMMENDED BY THE MANUFACTURER.
IF ALTERNATIVE QUALITY REPLACEMENT PARTS HAVE BEEN INCLUDED IN THIS APPRAISAL, THE SOURCE FOR THESE PARTS HAS ALSO BEEN DISCLOSED. IF ALTERNATIVE QUALITY REPLACEMENT PARTS AS LISTED ON THE APPRAISAL ARE ULTIMATELY USED IN THE REPAIR OF YOUR VEHICLE, THE WARRANTY ON SUCH PARTS WILL BE EQUAL TO, OR GREATER THAN, THE PARTS BEING REPLACED, AS STATED IN USAA'S LIMITED PARTS WARRANTY. USAA WARRANTS THAT THE PARTS USED ON YOUR VEHICLE WILL BE OF LIKE KIND AND QUALITY, FUNCTION, FIT, SAFETY AND CORROSION PROTECTION AS THE PART OR PARTS THEY REPLACE. USAA IDENTIFIES CERTIFIED AND VALIDATED PARTS FOR SHEET METAL REPLACEMENT PARTS.

08/10/2010 AT 07:45 AM FILE ID: 471136
102564

SUPPLEMENT OF RECORD 1 WITH SUMMARY
2009 VW JETTA SE 5-2.5L-FI 4D SED GREEN INT:

FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM:

ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

THE FOLLOWING IS A LIST OF ABBREVIATIONS OR SYMBOLS THAT MAY BE USED TO DESCRIBE WORK TO BE DONE OR PARTS TO BE REPAIRED OR REPLACED: MOTOR ABBREVIATIONS/SYMBOLS: D=DISCONTINUED PART A=APPROXIMATE PRICE LABOR TYPES:

B=BODY LABOR D=DIAGNOSTIC E=ELECTRICAL F=FRAME G=GLASS M=MECHANICAL P=PAINT LABOR S=STRUCTURAL T=TAXED MISCELLANEOUS X=NON TAXED MISCELLANEOUS PATHWAYS: ADJ=ADJACENT ALGN=ALIGN A/M=AFTERMARKET BLND=BLEND CAPA=CERTIFIED AUTOMOTIVE PARTS ASSOCIATION D&R=DISCONNECT AND RECONNECT EST=ESTIMATE EXT. PRICE=UNIT PRICE MULTIPLIED BY THE QUANTITY INCL=INCLUDED MISC=MISCELLANEOUS NAGS=NATIONAL AUTO GLASS SPECIFICATIONS NON-ADJ=NON ADJACENT O/H=OVERHAUL OP=OPERATION NO=LINE NUMBER QTY=QUANTITY QUAL RECY=QUALITY RECYCLED PART QUAL REPL=QUALITY REPLACEMENT PART COMP REPL PARTS=COMPETITIVE REPLACEMENT PARTS RECOND=RECONDITION REFN=REFINISH REPL=REPLACE R&I=REMOVE AND INSTALL R&R=REMOVE AND REPLACE RPR=REPAIR RT=RIGHT SECT=SECTION SUBL=SUBLET LT=LEFT W/O=WITHOUT W/_=WITH/_ SYMBOLS: #=MANUAL LINE ENTRY *=OTHER [IE..MOTORS DATABASE INFORMATION WAS CHANGED] **=DATABASE LINE WITH AFTERMARKET N=NOTES ATTACHED TO LINE. OPT OEM=ORIGINAL EQUIPMENT MANUFACTURER PARTS EITHER OPTIONALLY SOURCED OR OTHERWISE PROVIDED WITH SOME UNIQUE PRICING OR DISCOUNT. NWCPP=NATIONWIDE CRASH PARTS PROGRAM.

SUPPLEMENT OF RECORD 1 WITH SUMMARY
2009 VW JETTA SE 5-2.5L-FI 4D SED GREEN INT:

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PARTS, RCY, OR USED. RECONDITIONED PARTS ARE DESCRIBED AS RECOND. RECORED PARTS ARE DESCRIBED AS RECORE. NAGS PART NUMBERS AND BENCHMARK PRICES ARE PROVIDED BY NATIONAL AUTO GLASS SPECIFICATIONS. LABOR OPERATION TIMES LISTED ON THE LINE WITH THE NAGS INFORMATION ARE MOTOR SUGGESTED LABOR OPERATION TIMES. NAGS LABOR OPERATION TIMES ARE NOT INCLUDED. POUND SIGN (#) ITEMS INDICATE MANUAL ENTRIES. SOME 2010 VEHICLES CONTAIN MINOR CHANGES FROM THE PREVIOUS YEAR. FOR THOSE VEHICLES, PRIOR TO RECEIVING UPDATED DATA FROM THE VEHICLE MANUFACTURER, LABOR AND PARTS DATA FROM THE PREVIOUS YEAR MAY BE USED. THE PATHWAYS ESTIMATOR HAS A COMPLETE LIST OF APPLICABLE VEHICLES. PARTS NUMBERS AND PRICES SHOULD BE CONFIRMED WITH THE LOCAL DEALERSHIP.

CCC PATHWAYS - A PRODUCT OF CCC INFORMATION SERVICES INC.

SUPPLEMENT OF RECORD 1 WITH SUMMARY
2009 VW JETTA SE 5-2.5L-FI 4D SED GREEN INT:

NO.	OP.	DESCRIPTION	QTY	EXT. PRICE	LABOR	PAINT
		------- ADDED ITEMS -------				
7	S01	REPL ABSORBER	1	68.50	INCL.	
8	S01	REPL IMPACT BAR	1	180.00	INCL.	
9	S01	REPL TOW EYE CAP W/O GLI	1	16.50	INCL.	0.2
10	S01	ADD FOR CLEAR COAT				0.1
		SUBTOTALS ==>		265.00	0.0	0.3

ESTIMATE NOTES:

SPOKE TO ROBERT AT SHOP OF OWNERS CHOICE AND SECURED AN AGREED COST OF REPAIRS
PLEASE CALL (800) 647-3626 EXT 6345 FOR SUPPLEMENT NOTIFICATION PRIOR TO COMPLETING REPAIRS
PHOTOS & PARTS INVOICES ARE REQUIRED FOR SUPPLEMENTAL REPAIRS

SUPPLEMENT DOCUMENTATION MAY BE EMAILED TO SUPPLEMENTS@ASICLAIMS.COM
ESTIMATE COPY FAXED TO SHOP, ESTIMATE COPY MAILED TO VEHICLE OWNER
DOM AVAILABLE - VEHICLE NOT SUBJECT TO QRP
VEHICLE IS DRIVABLE
DR=08/02/10 DI=08/02/10 DS=08/02/10

THE ATTACHED SUPPLEMENTAL REVIEW HAS BEEN PREPARED UTILIZING A SUPPLEMENT WRITTEN BY THE BODY SHOP OF THE VEHICLE OWNERS CHOICE. THE SUPPLEMENT APPEARS TO BE CONSISTENT WITH THE ORIGINAL DAMAGES REPORTED. PHOTOS & INVOICES HAVE BEEN SUPPLIED BY THE REPAIRER AND ARE ON FILE AT ASI. THIS SUPPLEMENT DOES NOT CONTAIN ANY ITEMS REMOVED OR MODIFIED DURING THE ORIGINAL ESTIMATE REVIEW.

PARTS			265.00
PAINT LABOR	0.3 HRS	@$ 45.00/HR	13.50
PAINT SUPPLIES	0.3 HRS	@$ 35.00/HR	10.50
SUBTOTAL			$ 289.00
SALES TAX	$ 275.50	@ 9.7500%	26.86
TOTAL SUPPLEMENT AMOUNT			$ 315.86
NET COST OF SUPPLEMENT			$ 315.86

08/10/2010 AT 07:45 AM FILE ID: 471136
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SUPPLEMENT OF RECORD 1 WITH SUMMARY
2009 VW JETTA SE 5-2.5L-FI 4D SED GREEN INT:

ESTIMATE	2845.89	HOUGH MIKE	
SUPPLEMENT S01	315.86	HOUGH MIKE	
		TOTAL ADJUSTMENTS	$ 500.00
WORKFILE TOTAL	$ 3161.75	NET COST OF REPAIRS	$ 2661.75

THIS ESTIMATE AUDIT DOES NOT REPRESENT AUTHORIZATION TO REPAIR OR AN ACCEPTANCE/DETERMINATION OF LIABILITY. THIS ESTIMATE AUDIT DOES NOT CONFIRM THAT PAYMENT WILL BE ISSUED. SIGNED AUTHORIZATION MUST BE OBTAINED BY THE REPAIR FACILITY FROM THE VEHICLE OWNER PRIOR TO STARTING REPAIR. THE VEHICLE OWNER SHOULD CONFIRM COVERAGE WITH HIS /HER CLAIM REPRESENTATIVE PRIOR TO SIGNING ANY REPAIR AUTHORIZATION. A COPY OF THIS ESTIMATE AUDIT MUST BE PRESENTED TO THE REPAIR SHOP OF YOUR CHOICE PRIOR TO THE START OF REPAIRS. ALL SUPPLEMENTS REQUIRE PRIOR APPROVAL. PLEASE CALL (800) 647-3626 FOR ANY QUESTIONS REGARDING SUPPLEMENTS ETC.

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08/10/2010 AT 07:45 AM FILE ID: 471136
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SUPPLEMENT OF RECORD 1 WITH SUMMARY
2009 VW JETTA SE 5-2.5L-FI 4D SED GREEN INT:

ALTERNATE PARTS USAGE

AFTERMARKET PARTS

AFTERMARKET SELECTION METHOD: MANUALLY LIST

NO. OF TIMES USER WAS NOTIFIED THAT AN AFTERMARKET PART WAS AVAILABLE: 0

NO. OF AFTERMARKET PARTS THAT APPEAR IN THE FINAL ESTIMATE: 0

OPTIONAL OEM PARTS

OPTIONAL OEM SELECTION METHOD: MANUALLY LIST

NO. OF TIMES USER WAS NOTIFIED THAT AN OPTIONAL OEM PART WAS AVAILABLE: 0

NO. OF OPTIONAL OEM PARTS THAT APPEAR IN THE FINAL ESTIMATE: 0

RECONDITIONED PARTS

RECONDITIONED SELECTION METHOD: MANUALLY LIST

NO. OF TIMES USER WAS NOTIFIED THAT A RECONDITIONED PART WAS AVAILABLE: 3

NO. OF RECONDITIONED PARTS THAT APPEAR IN THE FINAL ESTIMATE: 0

RECYCLED PARTS

NO. OF TIMES USER WAS NOTIFIED THAT A RECYCLED PART WAS AVAILABLE: 2

NO. OF RECYCLED PARTS THAT APPEAR IN THE FINAL ESTIMATE: 0

9800 Fredericksburg Road
San Antonio, Texas 78288

JOHN PETERSEN
1717 FOURTH ST
THIRD FLOOR
SANTA MONICA CA 90401-3319

August 17, 2010

Reference: Claim Handling

Dear Sir,

I will be handling the below referenced Uninsured Motorist claim you presented to USAA on behalf of your client. We're still investigating the claim and will contact you to make arrangements for a recorded interview with your client.

Your client:	Regelin Castillo
Policyholder:	Abel Castillo
Claim #:	20829714-7104-3-8523
Date of loss:	July 19, 2010
Loss location:	Glendale, California

Please provide all documentation concerning this case as it becomes available, including your client's medical condition and treatment status. The information you provide will assist us with our investigation and enable us to maintain a current evaluation of your client's claim.

Please include the claim number referenced above on all correspondence and send to my attention by either:

Mail: Auto Injury Solutions
Attn: USAA Medical Mail Dept.
P.O. Box 5000
Daphne, AL 36526

Fax: 1-888-272-1255

You can call me at **800-531-8722, ext. 31455.** I look forward to working with you to resolve the claim.

Sincerely,

Cindy L Gillis, SCLA
Injury Unit
United Services Automobile Association

20829714 - 3 - CA - 07/19/10 - 8523 - 18 - P390 - DM04664

United Services
Automobile Association

Member Name	USAA Number	L/R Number	Date of Loss
Abel Castillo	**20829714**	**3**	**07-19-2010**

IMPORTANT NOTICE!

The language of the USAA auto policy and applicable state statutes determine the benefits available to you under your medical coverage. If you have questions, please refer to the auto policy for details of your medical coverage. To request a copy of the auto policy, please contact your claim representative.

The continuing increase in the cost of health care has a direct impact on the premiums paid by USAA's insureds. USAA receives more than 600,000 health care bills each year. While the majority of these bills are proper and appropriate, some contain billing errors or excessive charges. Many other bills are duplicates. Regrettably, some bills are simply fraudulent. In order to ensure that USAA pays only those medical bills that are appropriate, USAA utilizes an independent third party contractor, Auto Injury Solutions, to provide a medical bill auditing tool to assist USAA in reviewing health care providers services and charges to ensure billing accuracy, to avoid duplication of payment, to identify treatment that is reasonable, necessary and appropriate for accident related injuries and to evaluate the reimbursement amount. USAA uses this analysis in determining whether the services rendered and fees charged are covered by the provisions of the policy and applicable state laws.

USAA remains committed to providing the best possible service at the most affordable price. Please be advised that your health care provider may provide services not covered by the auto policy or charge more for services than the amount covered by the policy. Some providers will expect you to pay the balance of the bill not paid by USAA. We suggest you discuss with your health care providers their payment expectations for non-reimbursable services or costs.

Please have your health care providers send their invoices for your care directly to USAA either electronically or by regular mail. It is important that the USAA claim number, date of accident, your name, your address, your date of birth, the physical address where the treatment occurred, the provider's Tax ID number, and ICD-9-CM codes and CPT codes for each date of service appear on each medical bill we receive. Therefore, please provide each of your health care providers with this information and request that your providers submit, with each invoice, the above information and their treatment and/or office notes for each date of service.

Should you receive any invoices from your health care providers, please forward them to USAA with the above information.

9800 Fredericksburg Road
San Antonio, Texas 78288

GINA LEAGO
1717 FOURTH ST
THIRD FLOOR
SANTA MONICA CA 90401-3319

September 16, 2010

Reference: Additional Information Needed

Dear Ms Leago,

We are writing regarding the following claim:

Your client:	REGELIN CASTILLO
Policyholder:	Abel Castillo
Claim #:	20829714-7104-3-8523
Date of loss:	July 19, 2010
Loss location:	Glendale, California

Please provide the following information needed to evaluate and complete the claim:

- Please let me know when a interview can be arranged for our insured/your client. Also, I need clarification of her injury so that we can properly reserve our file.

If you have questions, please call me at 800-531-8722, ext. 3-1455.

Sincerely,

Cindy L Gillis, SCLA
Injury Unit
United Services Automobile Association

9800 Fredericksburg Road
San Antonio, Texas 78288

GINA LEAGO
1717 FOURTH ST
THIRD FLOOR
SANTA MONICA CA 90401-3319

October 15, 2010

Reference: Additional Information Needed

Dear sir,

We are writing regarding the following claim:

Your client:	REGELIN CASTILLO
Policyholder:	Abel Castillo
Claim #:	20829714-7104-3-8523
Date of loss:	July 19, 2010
Loss location:	Glendale, California

Please provide the following information needed to evaluate and complete the claim:

- We have been requesting a statement from your client/our insured for months. As you know, per the policy, our insured/representative is to cooperate with our investigation. I also need an injury status so that I can properly reserve our file. Your anticipated cooperation is greatly appreciated.

If you have questions, please call me at 800-531-8722, ext. 3-1455.

Sincerely,

Cindy L Gillis, SCLA
Injury Unit
United Services Automobile Association

LAW OFFICES OF
JACOB EMRANI
PROFESSIONAL CORPORATION
1516 South Broadway, Los Angeles, CA 90015
Tel. (213) 748-7734; Fax: (213) 748-8879

October 27, 2010

Via Facsimile & U.S. Mail
(800) 531-8669

USAA
Attn: Cindy Gillis, Claims Rep.
PO Box. 659463
San Antonio, TX 78265

Re:	Our Client	Regelin Castillo
	Your Insured	Abel Castillo
	Claim No.	020829714U7104-3
	Date of Accident	7/19/10

Dear Ms. Gillis:

This office has been retained as attorneys on behalf of the above-referenced client who sustained injuries resulting from an accident on the above date. We ask that all further communications be directed to our attention and no contact be made directly with our client.

Pursuant to Boicourt v. Amex Assurance Co. (2007) 78 Cal.App.4th 1390, please advise our office in writing of your insured's automobile coverage and policy limits. We hereby formally demand that you immediately furnish us with any and all information secured from our client or with authorization or permission granted by our clients, including but not limited to, statements, photographs, medical reports, bills and property damage estimates.

All authorizations previously obtained from our client are hereby REVOKED. From this date forward, you may not contact any of our client's medical providers or their agents or assigns, or any other person with confidential client information, to obtain from them any medical records, billing statements, or any other confidential information, or communicate with them in any way.

As soon as all specials have been received, we shall forward them to you. If you require any further information, please do not hesitate to contact our office.

Very truly yours,

JACOB EMRANI, ESQ.

LAW OFFICES OF
JACOB EMRANI
PROFESSIONAL CORPORATION

1516 South Broadway, Los Angeles, CA 90015
Tel: (213) 748-7734 • Fax: (213) 748-8879

DESIGNEE AUTHORIZATION

TO: USAA

CLAIM NO.: 02082-9714U 7104-3

DATE OF LOSS: 7/19/10

Pursuant to Section 2695.2(c) of the California Code of Regulations, Title 10 chapter 5; I authorize **THE LAW OFFICES OF JACOB EMRANI** my attorneys, to handle my personal injury claim under the above captioned loss.

This authorization shall be valid for 2 (two) years from the date below unless renewed or revoked by the undersigned. Any and all prior authorizations are hereby revoked by the undersigned as of the date of this authorization.

Signature

Regelin P. Castillo
Printed Name

27003 Mountain Wellwalk
Address

Santa Clarita CA 91387

Date

8186531521
Telephone

9800 Fredericksburg Road
San Antonio, Texas 78288

JACOB EMRANI
1516 SOUTH BROADWAY
LOS ANGELES CA 90015

October 28, 2010

Reference: Acknowledgement Of Representation

Dear Sir,

We received your letter of representation dated October 27, 2010 regarding this claim:

Your client: REGELIN CASTILLO
USAA policyholder: Abel Castillo
Claim number: 20829714-7104-3-8523
Date of loss: July 19, 2010
Loss location: Glendale, California

Please be advised that our insured's auto policy has Uninsured Motorist Coverage $30,000 per person/$60,000 per person. Also, there is Medical Payments coverage of $10,000 per person.

I am handling the investigation and uninsured motorist portion of the claim and Kevin Fontana is handling the medical payments portion of the loss. He can be contacted at 800-531-8722 x61455.

To assist us with our evaluation of your client's claim, please provide documentation about the case as it becomes available.

Include the reference number 20829714-7104-3-8523 on all correspondence and mail it to:
Auto Injury Solutions
Attn: USAA Medical Mail Dept.
P.O. Box 5000
Daphne, AL 36526
Fax: 1-888-272-1255

If you have questions, please call me at **800-531-8722, ext. 3-1455**.

Sincerely,

Cindy L Gillis, SCLA
Injury Unit
United Services Automobile Association

20829714 - 3 - CA - 07/19/10 - 8523 - 18 - P157

United Services
Automobile Association

Member Name	USAA Number	L/R Number	Date of Loss
Abel Castillo	**20829714**	**3**	**07-19-2010**

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The continuing increase in the cost of health care has a direct impact on the premiums paid by USAA's insureds. USAA receives more than 600,000 health care bills each year. While the majority of these bills are proper and appropriate, some contain billing errors or excessive charges. Many other bills are duplicates. Regrettably, some bills are simply fraudulent. In order to ensure that USAA pays only those medical bills that are appropriate, USAA utilizes an independent third party contractor, Auto Injury Solutions, to provide a medical bill auditing tool to assist USAA in reviewing health care providers services and charges to ensure billing accuracy, to avoid duplication of payment, to identify treatment that is reasonable, necessary and appropriate for accident related injuries and to evaluate the reimbursement amount. USAA uses this analysis in determining whether the services rendered and fees charged are covered by the provisions of the policy and applicable state laws.

USAA remains committed to providing the best possible service at the most affordable price. Please be advised that your health care provider may provide services not covered by the auto policy or charge more for services than the amount covered by the policy. Some providers will expect you to pay the balance of the bill not paid by USAA. We suggest you discuss with your health care providers their payment expectations for non-reimbursable services or costs.

Please have your health care providers send their invoices for your care directly to USAA either electronically or by regular mail. It is important that the USAA claim number, date of accident, your name, your address, your date of birth, the physical address where the treatment occurred, the provider's Tax ID number, and ICD-9-CM codes and CPT codes for each date of service appear on each medical bill we receive. Therefore, please provide each of your health care providers with this information and request that your providers submit, with each invoice, the above information and their treatment and/or office notes for each date of service.

Should you receive any invoices from your health care providers, please forward them to USAA with the above information.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION TO USAA

United Services Automobile Association

USAA Number	Member Name	L/R Number	Date of Loss
20829714	Abel Castillo		07-19-2010

We are not HIPAA covered entities. Your disclosure of information to us is not subject to the Minimum Necessary standard.

Patient: REGELIN CASTILLO

I HEREBY GRANT PERMISSION TO, AND AUTHORIZE THE USE OR DISCLOSURE OF, THE ABOVE NAMED INDIVIDUAL'S RECORDS.

I authorize the following persons and organizations (a) any licensed physician, surgeon, or dentist; (b) any psychiatrist or psychologist; (c) any other medical practitioner or nurse; (d) any hospital, clinic, health care facility or rehabilitation/convalescent/custodial facility; (e) ambulance owner; (f) any insurance company (the "Provider") to provide information (as defined below) to USAA and/or their retrieval service ABI/VIP.

I, the Undersigned, as the patient, or in my capacity as personal representative of the patient, REGELIN CASTILLO , understand the information obtained by this Authorization will be used by USAA and its authorized representatives, performing business or legal services, its affiliated insurance companies, and its authorized representatives, performing business or legal services for the purpose of verification, evaluation, and negotiation of any claim for benefits or services, arising from the above-identified date of loss, and any other pertinent claim handling or legal uses in connection to such claims, or as USAA otherwise determines is necessary to underwrite insurance.

For purposes of this Authorization, "Information" means all records or knowledge concerning the patient's health, any injuries, medical history, mental and physical conditions, before and after the date of this Authorization, regardless of the time of occurrence. The term "records" includes, but is not limited to, written or graphic documentation, including notes,

billing records or statements, sound recordings, computer records of health care services, and diagnostic documentation, such as x-rays, lab test results, and other test results such as blood alcohol level and drug use. In addition to medical records developed by the Provider described above, this Authorization also includes any medical records received by the Provider from other providers.

This Authorization shall be in force and effect until all claims arising from the above-identified date of loss are concluded, at which time this Authorization to disclose this information expires.

I also understand and agree to the following:

- **Although this Authorization is voluntary, USAA reserves the right to discontinue processing any claim if I refuse to grant this Authorization, and such refusal may be in breach of a policy condition if USAA reasonably needs this Authorization to adequately investigate any claim.**
- **That the information released pursuant to this Authorization may be redisclosed by USAA and may no longer be protected by federal privacy regulations.**
- **That I may receive a copy of this Authorization, and I have the right to revoke this Authorization, in writing, at any time. I may request a copy or revoke the Authorization by sending such written request to**

  Cindy L Gillis, SCLA at

  P.O. Box 659463, San Antonio, TX 78265.
- **That a revocation is not effective: (i) until receipt by USAA, and (ii) to the extent that USAA has relied on the use or disclosure of the information.**
- **That: (1) this Authorization overrides any existing agreement to restrict information pursuant to 45 CFR 164.502(b)(2)(ii), (2) a copy of this Authorization is as valid as an original, and (3) I have read and understand this Authorization.**

CALIFORNIA Statutes, Section 1871.2(a) states: ''For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.''

THIS IS NOT A RELEASE OF CLAIM FOR DAMAGES.

Signature of Patient or Personal Representative **Date**

Patient's Date of Birth / Social Security Number

Description of Personal Representative's Authority

(Reminder: Please return this entire form, including the signature page.)

USAA®

United Services
Automobile Association

LIST OF PROVIDERS/EMPLOYERS

Member Name	USAA Number	L/R Number	Date of Loss
Abel Castillo	**20829714**	**3**	**07-19-2010**

INJURED PERSON: **REGELIN CASTILLO**

PLEASE LIST BELOW THE NAMES AND ADDRESSES OF ANY TREATING PROVIDERS /EMPLOYERS:

NAME OF PROVIDER : _____

ADDRESS : _____

CITY, STATE, ZIP : _____

PHONE NUMBER : _____

FAX NUMBER : _____

DESCRIBE TYPE OF TREATMENT BEING PROVIDED: _____

_____

_____

NAME OF PROVIDER : _____

ADDRESS : _____

CITY, STATE, ZIP : _____

PHONE NUMBER : _____

FAX NUMBER : _____

DESCRIBE TYPE OF TREATMENT BEING PROVIDED: _____

_____

_____

NAME OF EMPLOYER: _____

ADDRESS : _____

CITY, STATE, ZIP : _____

PHONE NUMBER : _____

FAX NUMBER : _____

GIVE OCCUPATION AND DATES OF EMPLOYMENT _____

_____

_____

***USE BACK OF FORM FOR ANY ADDITIONAL INFORMATION.**

PLEASE RETURN THIS FORM WITH YOUR SIGNED MEDICAL AND/OR WAGE AUTHORIZATION OR PERSONAL INJURY PROTECTION APPLICATION FORMS.

LAW OFFICES
RANDOLPH & ASSOCIATES
1717 FOURTH STREET
THIRD FLOOR
SANTA MONICA, CALIFORNIA 90401-3319

TELEPHONE
(310) 395-7900
(800) 953-4500

FACSIMILE
(310) 395-1833

November 2, 2010

Cindy L. Gillis, SCLA
USAA
9800 Fredericksburg Road
San Antonio, Texas 78288

Re:	**Our Client**	**: Regelin Castillo**
	Your Insured	**: Abel Castillo**
	Your Claim Number	**: 20829714-7104-3-8523**
	Date of Loss	**: July 19, 2010**

Dear Mrs. Gillis:

This will serve to inform you that this office no longer represents Ms. Regelin Castillo with respect to their auto accident.

There will also be no lien asserted to this case from our office.

Very truly yours,
Randolph & Associates

Gina A. Leago

Gina Leago, Esq.

GL: dl

9800 Fredericksburg Road
San Antonio, Texas 78288

JACOB EMRANI
1516 SOUTH BROADWAY
LOS ANGELES CA 90015

November 8, 2010

Reference: Additional Information Needed

Dear Sir,

We are writing regarding the following claim:

Your client:	REGELIN CASTILLO
Policyholder:	Abel Castillo
Claim #:	20829714-7104-3-8523
Date of loss:	July 19, 2010
Loss location:	Glendale, California

Please provide the following information needed to evaluate and complete the claim:

- Please call me with your client's injury status as well as our request for an interview.

If you have questions, please call me at 800-531-8722, ext. 3-1455.

Sincerely,

Cindy L Gillis, SCLA
Injury Unit
United Services Automobile Association

Enc: 00792 Env

9800 Fredericksburg Road
San Antonio, Texas 78288

JACOB EMRANI
1516 SOUTH BROADWAY
LOS ANGELES CA 90015

November 22, 2010

Reference: Additional Information Needed

MR. EMRANI,

We are writing regarding the following claim:

Your client:	REGELIN CASTILLO
Policyholder:	Abel Castillo
Claim #:	20829714-7104-3-6839
Date of loss:	July 19, 2010
Loss location:	Glendale, California

The claim is unresolved because I am in need of any unpaid medical bills and medical records.

If you have questions, please call me at 1-800-531-8722, ext. 6-1455.

Sincerely,

Kevin Fontana

Kevin L Fontana
1st Party Center of Excellence
United Services Automobile Association

Enc: 00792 Env

9800 Fredericksburg Road
San Antonio, Texas 78288

JACOB EMRANI
1516 SOUTH BROADWAY
LOS ANGELES CA 90015

December 16, 2010

Reference: Additional Information Needed

Dear Sir,

We are writing regarding the following claim:

Your client:	REGELIN CASTILLO
Policyholder:	Abel Castillo
Claim #:	20829714-7104-3-8523
Date of loss:	July 19, 2010
Loss location:	Glendale, California

Please provide the following information needed to evaluate and complete the claim:

- Please call me with our insured/your client's injury status as well as our request for a recorded statement that can be done by conference call at your office.

If you have questions, please call me at 800-531-8722, ext. 3-1455.

Sincerely,

Cindy L Gillis, SCLA
Injury Unit
United Services Automobile Association

9800 Fredericksburg Road
San Antonio, Texas 78288

ACCESS GENERAL INS
PO BOX 105143
ATLANTA GA 30348

December 23, 2010

Policyholder: Abel Castillo
Reference Number: 20829714-7104-3-4262
Date Of Loss: July 19, 2010
Loss Location: Glendale, California
Your Policyholder: Glenda and Felix Cisneros
Your Reference Number: AXI0104325

Med Pay Claimant: Regelin Castillo

Med Pay Total: $4,243.50

Dear Mr. Bounthong:

According to the terms of our policy, we have a reimbursement agreement with the Medical Payments claimant on this file. We understand that you are handling the liability claim made by this person. Upon your settlement, we will have a right to reimbursement from the liability claim recovery.

Please advise us of the status of this claim by returning a copy of this letter.

If you have already settled, please indicate below and state the date of the settlement. If the case is still pending, please suggest a diary date for our follow-up.

A return address envelope is enclosed for your convenience in replying. If you have questions, please call me.

Sincerely,

Catherine F. Cole

Catherine F Cole
Litigation Manager
Claims Litigation Operations
P.O. Box 33490
San Antonio, TX 78265
Phone: 1-800-531-8722, Ext.64409
Fax Phone: 877-845-5647

20829714 - 3 - CA - 07/19/10 - 4262 - 85 - A287 - DM01771

_____ CASE SETTLED ON _____

_____ CASE NOT SETTLED. SUGGESTED DIARY _____

COMMENTS: _____

_____

_____

Date: _____ SIGNATURE: _____

Access
General Insurance Adjusters, Inc.
P.O. Box 105143 Atlanta, GA 30348-5143

October 29, 2010

Law offices of Jacob Ermani
1516 South Broadway
Los Angeles, CA 90015

Insurance Company:	**Access General Insurance Company**
Policy Number:	**ACA001419943**
Claim Number:	**ACI0104325**
Date of Loss:	**07/19/2010**
Insured:	**Felix Cisneros-Guevara**
Your Client(s):	**Reglan Castillo**

Dear Sir or Madam:

Access General Insurance Adjusters, Inc. is the administrator for the referenced insurance claim. Any correspondence or inquiry related to the captioned loss should be directed to our attention.

We have completed our coverage investigation and based upon information we have developed, at this time, we must respectfully decline coverage under policy number ACA001419943 for any claim(s) or other action(s) brought by your client as a result of the above-referenced matter because:

Glenda Cisneros was not an identified listed insured driver on the Access General Insurance policy purchased by Felix Cisneros-Guevara despite the fact they were a resident of the insured's household on the date the policy was purchased and on the date of the accident. Therefore, we have determined that Glenda Cisneros did not qualify as an insured pursuant to all of the terms and provisions of this Access General Insurance Policy.

NOTICE: If you feel that all or part of this claim has been wrongfully denied or rejected, you may have the matter reviewed by the Consumer Communications Bureau of the California Department of Insurance, 300 South Spring Street, South Tower, Los Angeles, California 90013, telephone number (800) 927-4357 or (213) 897-8921.

Sincerely,

Brooke Ernst
Claim Representative
866.747.6931 ext. 6697
866.347.2110 facsimile

cc: Felix Cisneros-Guevara

9800 Fredericksburg Road
San Antonio, Texas 78288

USAA®

ACCESS GENERAL INS
PO BOX 105143
ATLANTA GA 30348

December 23, 2010

Policyholder: Abel Castillo
Reference Number: 20829714-7104-3-4262
Date Of Loss: July 19, 2010
Loss Location: Glendale, California
Your Policyholder: Glenda and Felix Cisneros
Your Reference Number: AX10104325

Med Pay Claimant: Regelin Castillo

Med Pay Total: $4,243.50

Dear Mr. Bounthong:

According to the terms of our policy, we have a reimbursement agreement with the Medical Payments claimant on this file. We understand that you are handling the liability claim made by this person. Upon your settlement, we will have a right to reimbursement from the liability claim recovery.

Please advise us of the status of this claim by returning a copy of this letter.

If you have already settled, please indicate below and state the date of the settlement. If the case is still pending, please suggest a diary date for our follow-up.

A return address envelope is enclosed for your convenience in replying. If you have questions, please call me.

Sincerely,

Catherine F. Cole

Catherine F Cole
Litigation Manager
Claims Litigation Operations
P.O. Box 33490
San Antonio, TX 78265
Phone: 1-800-531-8722, Ext.64409
Fax Phone: 877-845-5647

20829714 - 3 - CA - 07/19/10 - 4262 - 85 - A287 - DM01771

_____ CASE SETTLED ON _____

_____ CASE NOT SETTLED. SUGGESTED DIARY _____

COMMENTS: _____

_____

_____

Date: _____ SIGNATURE: _____

9800 Fredericksburg Road
San Antonio, Texas 78288

JACOB EMRANI
1516 SOUTH BROADWAY
LOS ANGELES CA 90015

January 11, 2011

Reference: REGELIN CASTILLO

Dear Sir,

I am writing regarding the claim referenced below.

Please call me to arrange for an interview with our insured/your client Regelin Castillo. As you know, per our policy and you being our insured's representative, is supposed help in the investigation of this claim. To that end, I would appreciate your cooperation.

I look forward to hearing from you.

Policyholder:	Abel Castillo
Reference #:	20829714-7104-3-8523
Date of loss:	July 19, 2010
Loss location:	Glendale, California

You may submit correspondence or questions to me. My contact information is:

Address:	Auto Injury Solutions Attn: USAA Medical Mail Dept. P.O. Box 5000 Daphne, AL 36526
Fax:	1-888-272-1255
Phone:	800-531-8722, ext. 3-1455

Sincerely,

Cindy L Gillis, SCLA
Injury Unit
United Services Automobile Association

20829714 - 3 - CA - 07/19/10 - 8523 - 18 - A200 - DM01771

9800 Fredericksburg Road
San Antonio, Texas 78288

GLENDALE ADV MEDICAL CENTER
DEPT 2006
LOS ANGELES CA 90008

January 22, 2011

Reference: Request for Medical Records/Itemized Billing

Dear Gentleperson,

Please provide for the patient below the information requested in the attached Request for Medical Records and Itemized Billing.

Insured:	Abel Castillo
Claim #:	20829714-7104-3-6839
Date of loss:	July 19, 2010
Loss location:	Glendale, California
Patient:	Regelin Castillo

We've included a medical authorization form signed by your patient.

Thank you for your assistance. If you have questions, please call me at 1-800-531-8722, ext. 6-1754.

Sincerely,

Seth Greenberg

SETH GREENBERG
1st Party Center of Excellence
United Services Automobile Association

Enc: Req for Med Rec, Medical Auth.

Request for Medical Records and Itemized Billing

Information requested

All records resulting from treatment of the insured referenced above, including, but not limited to, office charts, daily progress records/notes, intake evaluations or forms, ambulance/paramedic records, hospital & admitting records, physical examination sheets, physicians' orders and notes, history sheets, nurses' notes, operative reports, anesthesiology records, medication sheets, pathology reports, prescriptions and prescription records, correspondence, dental records and study models/molds, counseling records, x-ray and other diagnostic test reports, itemized billings including computer records, and computer records of any kind for services rendered in relation to any examination, medical treatment or hospitalization.

Mail records or invoices to: Auto Injury Solutions
Attn: USAA Medical Mail Dept.
P.O. Box 5000
Daphne, AL 36526

Fax records to: 1-888-272-1255

Submitting invoices for Payment

Electronic Billing

Submit Bills to Emdeon Business Services 1-800-845-6592.
Note: For electronic billing, enter the claim number (pre-filled below) in the prior authorization data field: for medical services use Record Type EO, Field 30; for hospital service use Record Type 40, Field 5, 6 and 7.

If you are currently not sending your charges electronically, you may want to call the information number listed above to learn the benefits of using this type service.

Submit all documents which cannot be submitted electronically to the address set forth above.

Whether submitting charges electronically or by mail to the address below, please ensure each medical bill submitted includes the following information or it may be returned to you:

- The USAA claim number referenced above;
- The date of the accident;
- Your name and address;
- Your date of birth;
- The name of the provider;
- The physical address where the treatment occurred;
- The provider's Tax ID number; and
- ICD-9 codes and CPT codes for each date of service.

Additionally, please provide the treatment and/or office notes for each date of service. These can be included with the invoice if sent via mail or mailed separately if the invoice is sent electronically.

All correspondence to USAA relating to this claim, including bills, medical records or other documents or information, must include the following information or it may be returned to you:

- The USAA claim number referenced above;
- The date of the accident;
- The patient's name;
- The patient's address; and
- The patient's date of birth.

9800 Fredericksburg Road
San Antonio, Texas 78288

JACOB EMRANI
1516 SOUTH BROADWAY
LOS ANGELES CA 90015

March 8, 2011

Reference: Additional Information Needed

Dear Sir/jasmine,

We are writing regarding the following claim:

Your client:	REGELIN CASTILLO
Policyholder:	Abel Castillo
Claim #:	20829714-7104-3-8523
Date of loss:	July 19, 2010
Loss location:	Glendale, California

Please provide the following information needed to evaluate and complete the claim:

- Please call me with your client's injury status. We need an update of her condition-recovery. Have the injuries resolved?

If you have questions, please call me at 1-800-531-8722, ext. 3-1455.

Sincerely,

Cindy L Gillis, SCLA
USAA Southwest Regional Office
United Services Automobile Association

Enc: 00792 Env

9800 Fredericksburg Road
San Antonio, Texas 78288

JACOB EMRANI
1516 SOUTH BROADWAY
LOS ANGELES CA 90015

April 7, 2011

Reference: Additional Information Needed

Dear Sir,

We are writing regarding the following claim:

Your client:	REGELIN CASTILLO
Policyholder:	Abel Castillo
Claim #:	20829714-7104-3-8523
Date of loss:	July 19, 2010
Loss location:	Glendale, California

Please provide the following information needed to evaluate and complete the claim:

- Please call me with our insured/your client's injury status. I have not received an update in months. Do you still represent our insured? If not, I will call her directly.

If you have questions, please call me at 1-800-531-8722, ext. 3-1455.

Sincerely,

Cindy L Gillis, SCLA
USAA Southwest Regional Office
United Services Automobile Association

Enc: 00792 Env

9800 Fredericksburg Road
San Antonio, Texas 78288

JACOB EMRANI
1516 SOUTH BROADWAY
LOS ANGELES CA 90015

May 4, 2011

Reference: Additional Information Needed

Dear Sir,

We are writing regarding the following claim:

Your client:	REGELIN CASTILLO
Policyholder:	Abel Castillo
Claim #:	20829714-7104-3-8523
Date of loss:	July 19, 2010
Loss location:	Glendale, California

Please provide the following information needed to evaluate and complete the claim:

- We have not heard from your office in months. Please call me with our insured/your client's injury status. Your cooperation would be greatly appreciated.

If you have questions, please call me at 1-800-531-8722, ext. 3-1455.

Sincerely,

Cindy L Gillis, SCLA
USAA Southwest Regional Office
United Services Automobile Association

9800 Fredericksburg Road
San Antonio, Texas 78288

JACOB EMRANI
1516 SOUTH BROADWAY
LOS ANGELES CA 90015

May 5, 2011

Reference: REGELIN CASTILLO

Dear Sir,

This letter is to acknowledge receipt of your demand for our insured/your client Regelin Castillo.

I will be evaluating the demand and will contact you to discuss resolution.

Please note, however, that our insured's uninsured motorist policy limits are $30,000 per person/$60,000 per accident.

If you have any questions, please call me.

Policyholder:	Abel Castillo
Reference #:	20829714-7104-3-8523
Date of loss:	July 19, 2010
Loss location:	Glendale, California

You may submit correspondence or questions to me. My contact information is:

Address:	Auto Injury Solutions Attn: USAA Medical Mail Dept. P.O. Box 5000 Daphne, AL 36526
Fax:	1-888-272-1255
Phone:	1-800-531-8722, ext. 3-1455

Sincerely,

Cindy L Gillis, SCLA
USAA Southwest Regional Office
United Services Automobile Association

20829714 - 3 - CA - 07/19/10 - 8523 - 18 - A200 - DM01771

LAW OFFICES OF
JACOB EMRANI
PROFESSIONAL CORPORATION
1516 South Broadway, Los Angeles, CA 90015
Tel: (213) 748-7734 • Fax: (213) 748-8879

April 27, 2011

USAA Insurance
9500 Fredericksburg Road
San Antonio, TX 78288

Attention: Ms. Cindy Gillis

Re:

Our Client:	Regelin Castillo
Your Insured:	Abel Castillo
Claim No.:	20829714-7104-3-8523
Date of Accident:	07/19/2010

Settlement Offer – Subject to Evidence Code § 1152

Dear Ms. Gillis:

This letter and its contents are made expressly subject to California Evidence Code § 1152 and do not constitute, nor should be construed as, an admission of any fact or contention. Now that treatment is completed, this office would like to discuss settlement of this action. Toward this resolution, the following is provided:

A. ***MEDICAL DIAGNOSES***:

DIAGNOSES: Neck pain; upper back pain; mid back pain; bilateral shoulder pain; cervical spine sprain/strain; lumbar spine sprain/strain; neck sprain/strain; bilateral shoulder sprain/strain;

B. ***MEDICAL BILLS:***

Medical Provider	Total Charges
Glendale Adventist	$ 9,406.00
T o t a l	**$ 9,406.00**

C. ***FUTURE MEDICALS***

Ms. Castillo has been advised that if they she has any flare-ups or exacerbations to the injuries sustained in this accident she should seek further medical treatment immediately.

D. ***GENERAL DAMAGES***:

As reflected in the treating physicians' report, our client continues to suffer significant pain, suffering disability, which has adversely impacted upon all areas of his life. Although general damages are frequently difficult to quantify, based upon the specials itemized above, we believe that pain and suffering awards in the amount of **$75,000.00** is clearly attainable at time of trial.

SETTLEMENT DEMAND

In addition to our client's past and future medical expenses and pain and suffering, certain intangible factors come into play in formulating our client's demand for settlement. The cost-effectiveness of any additional outlays for defense, including legal fees is highly suspect. Taking all matters into consideration, our client would be willing to entertain a settlement in the amount of **$70,000.00** in full and final satisfaction of her claim.

Time is of the essence, thus the offer will expire thirty (30) days from date of this letter. I trust that you and your client will agree that this figure is very reasonable given the facts and laws articulated in this letter. Please note, that if settlement is not effected, we have been authorized by our client to file a lawsuit and litigate this matter to trial. At trial, we will seek damages in excess of the amounts demanded herein.

Please note that whatever offers you make including you meeting our demand, will have to be reviewed by our client(s) and our client(s) will have the option to either accept or deny your offer.

Your assistance and cooperation in this matter is greatly appreciated. I look forward to your response. If you have any questions please feel free to contact my office.

Very truly yours,

JACOB EMRANI, ESQ.

1 GLENDALE ADV MED CENTER 1509 WILSON TERRACE GLENDALE CA 91206 8184098200 8185465684	2 GLENDALE ADV MED CENTER DEPT NO 2006 LOS ANGELES CA 90084

3a PAT. CNTL # 144402724-4998
b. MED. REC. # 562996
4 TYPE OF BILL 0131
5 FED. TAX NO. 0000 951816017
6 STATEMENT COVERS PERIOD FROM 081110 THROUGH 083110
7 00

8 PATIENT NAME b CASTILLO REGELIN P
9 PATIENT ADDRESS a 27003 MOUNTIAN WILLOW LN b SANTA CLARITA c CA d 913870000

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	29 ACDT STATE
07231965	F	081110	17	3	1		01	CA

31 OCCURRENCE CODE / DATE: a 01 071910

38
USSA
PO BOX 5000
ATTN MEDICAL CLAIMS
DAPHNE AL 36526

	42 REV CD.	43 DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0420	ELECTRIC STIMULATION THE	97014	082410	1	7500		
2	0420	ELECTRIC STIMULATION THE	97014	082610	1	7500		
3	0420	ELECTRIC STIMULATION THE	97014	083110	1	7500		
4	0420	THERAPEUTIC EXERCISES	97110	081110	2	18200		
5	0420	THERAPEUTIC EXERCISES	97110	081910	2	18200		
6	0420	THERAPEUTIC EXERCISES	97110	082610	2	18200		
7	0420	THERAPEUTIC EXERCISES	97110	083110	2	18200		
8	0420	NEUROMUSCULAR REEDUCATIO	97112	081110	1	9100		
9	0420	NEUROMUSCULAR REEDUCATIO	97112	082410	2	18200		
10	0420	MANUAL THERAPY	97140	081110	2	18200		
11	0420	MANUAL THERAPY	97140	081910	2	18200		
12	0420	MANUAL THERAPY	97140	082410	2	18200		
13	0420	MANUAL THERAPY	97140	082610	2	18200		
14	0420	MANUAL THERAPY	97140	083110	2	18200		
15	0424	PT EVALUATION	97001	081110	1	45100		
23	0001	PAGE 1 OF 1	CREATION DATE	092010	TOTALS	258700	000	

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
A	USSA	999990000	Y	Y	000	258700
B	BLUE SHIELD EXCL CARE WMM	91036NOCD	Y	Y	000	000

56 NPI 1831188275
57 OTHER PRV ID 050239

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	CASTILLO REGELIN P	18	20829714		20829714
B	CASTILLO REGELIN P	18	16520C391	WMMC	024

63 TREATMENT AUTHORIZATION CODES
A NONENEEDED
B NONENEEDED

64 DOCUMENT CONTROL NUMBER

65 EMPLOYER NAME
A WHITE MEMORIAL MEDICAL C
B WHITE MEMORIAL MEDICAL C

66 DX V571 72310 7245

69 ADMIT DX V571
72 ECI 000

76 ATTENDING NPI 1265517114 QUAL 0B G61050
LAST LAU FIRST SUSIE H

77 OPERATING NPI QUAL
LAST FIRST

78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

80 REMARKS

81 CC a B3 282N00000X

UB-04-CMS-1450

0901119c87d95cc7

1 GLENDALE ADV MED CENTER 1509 WILSON TERRACE GLENDALE CA 91206 8184098200 8185465684	2 GLENDALE ADV MED CENTER DEPT NO 2006 LOS ANGELES CA 90084	3a PAT CNTL # 144408317-4998 b MED REC # 562996 4 TYPE OF BILL 0131 5 FED TAX NO. 951816017 6 STATEMENT COVERS PERIOD FROM 090110 THRU 093010 7 00 ATT	

8 PATIENT NAME: a CASTILLO REGELIN P

9 PATIENT ADDRESS: a 27003 MOUNTIAN WILLOW LN; b SANTA CLARITA; c CA; d 913870000

10 BIRTHDATE	11 SEX	12 DATE	13 HR	14 TYP	15 SRC	16 DHR	17 STAT
07231965	F	090110	00	3	1		01

18 CONDITION CODES

19 ACDT STATE: CA

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	SPAN FROM	THROUGH	36 OCCURRENCE CODE	SPAN FROM	THROUGH	37
a 01	071910													
b														

38
BLUE SHIELD-EXCL CARE-WMM
PO BOX 272540

CHICO CA 95927-2540

39 VALUE CODE	AMOUNT	40 VALUE CODES	AMOUNT	41 VALUE CODES	AMOUNT
a					
b					
c					
d					

	42 REV CD.	43 DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0420	ELECTRIC STIMULATION THE	97014	090210	1	7500		
2	0420	ELECTRIC STIMULATION THE	97014	090710	1	7500		
3	0420	ELECTRIC STIMULATION THE	97014	091310	1	7500		
4	0420	ELECTRIC STIMULATION THE	97014	091610	1	7500		
5	0420	ELECTRIC STIMULATION THE	97014	092010	1	7500		
6	0420	ELECTRIC STIMULATION THE	97014	092710	1	7500		
7	0420	THERAPEUTIC EXERCISES	97110	090210	2	18200		
8	0420	THERAPEUTIC EXERCISES	97110	090710	2	18200		
9	0420	THERAPEUTIC EXERCISES	97110	091310	2	18200		
10	0420	NEUROMUSCULAR REEDUCATIO	97112	091610	2	18200		
11	0420	NEUROMUSCULAR REEDUCATIO	97112	092010	2	18200		
12	0420	NEUROMUSCULAR REEDUCATIO	97112	092710	2	18200		
13	0420	NEUROMUSCULAR REEDUCATIO	97112	093010	2	18200		
14	0420	MANUAL THERAPY	97140	090210	2	18200		
15	0420	MANUAL THERAPY	97140	090710	2	18200		
16	0420	MANUAL THERAPY	97140	091310	2	18200		
17	0420	MANUAL THERAPY	97140	091610	2	18200		
18	0420	MANUAL THERAPY	97140	092010	2	18200		
19	0420	MANUAL THERAPY	97140	092710	2	18200		
20	0420	MANUAL THERAPY	97140	093010	2	18200		
21								
22								
23	0001	PAGE 1 OF 1	CREATION DATE	122810	TOTALS →	299800	000	

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL IND	53 ASG BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56 NPI	1831198275
A	USSA	999990000	Y	Y	81005	218795	57 OTHER PRV ID	050239
B	BLUE SHIELD-EXCL CARE-WMM	94086N065	Y		0005	000		
C								

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO
A	CASTILLO REGELIN P	18	20829714		20829714
B	CASTILLO REGELIN P	18	86520C891	WMMC	022
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A	NONENEEDED		
B	NONENEEDED		WHITE MEMORIAL MEDICAL C
C			WHITE MEMORIAL MEDICAL C

66 DX	V5717	72311	72451	C	C	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	V571	70 PATIENT REASON DX	a	b	c	71 PPS CODE	000	e	f	g	72	

74 PRINCIPAL PROCEDURE CODE	DATE	b OTHER PROCEDURE CODE	DATE	c OTHER PROCEDURE CODE	DATE	75
d OTHER PROCEDURE CODE	DATE	e OTHER PROCEDURE CODE	DATE	f OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 1265517114	QUAL OB	G61050
LAST LAU	FIRST SUSIE H		
77 OPERATING	NPI	QUAL	
LAST	FIRST		
78 OTHER	NPI	QUAL	
LAST	FIRST		
79 OTHER	NPI	QUAL	
LAST	FIRST		

80 REMARKS

81 CC a B3 282N00000X; b; c

UB-04-CMS-1450

1 GLENDALE ADV MED CENTER 1509 WILSON TERRACE GLENDALE CA 91206 8184098200 8185465684	2 GLENDALE ADV MED CENTER DEPT NO 2006 LOS ANGELES CA 90084	3a PAT CNTRL 144423332-5814 b MED REC# 562996 4 TYPE OF BILL 0131 5 FED TAX NO. 0000 951816017 6 STATEMENT COVERS PERIOD FROM 100110 THRU 103110 7 00 ATT					
8 PATIENT NAME a b CASTILLO REGELIN P	9 PATIENT ADDRESS a 27003 MOUNTIAN WILLOW LN b SANTA CLARITA c CA d 913870000 e						
10 BIRTHDATE 07231965	11 SEX F	12 ADMISSION DATE 100110	HR 00	14 TYPE 3	15 SRC 1	16 DHR	17 STAT 01
18 CONDITION CODES							
19 ICD-9-CM PRINCIPAL DIAGNOSIS CODE							
20							
21 ICD-9-CM OTHER DIAGNOSIS CODES							
22							
23 PRIOR AUTHORIZATION NUMBER							
24 REVENUE CODE	25 HCPCS/RATE/HIPPS CODE	26 SERVICE DATE	27 SERVICE UNITS	28 TOTAL CHARGES	29 NON-COVERED CHARGES	30	
0420	97014	100710	1	7500			
0420	97010	102110	1	7500			
0420	97032	101410	1	7500			
0420	97112	100710	2	18200			
0420	97112	101410	2	18200			
0420	97112	102110	2	18200			
0420	97140	100710	2	18200			
0420	97140	101410	2	18200			
0420	97140	102110	2	18200			
0001	PAGE 1 OF 1	CREATION DATE 020911		TOTALS 131700	000		

31 OCCURRENCE CODE/DATE: a 01 071910

32 OCCURRENCE CODE/DATE: b

33 OCCURRENCE CODE/DATE: c

34 OCCURRENCE CODE/DATE: d

35 OCCURRENCE SPAN CODE/FROM/THROUGH:

36 OCCURRENCE SPAN CODE/FROM/THROUGH:

37:

38
BLUE SHIELD-EXCL CARE-WMM
PO BOX 272540

CHICO CA 95927-2540

39 VALUE CODES CODE/AMOUNT: a b c d

40 VALUE CODES CODE/AMOUNT:

41 VALUE CODES CODE/AMOUNT:

42 REVENUE CODE / 43 DESCRIPTION / 44 HCPCS/RATE/HIPPS CODE / 45 SERVICE DATE / 46 SERVICE UNITS / 47 TOTAL CHARGES / 48 NON-COVERED CHARGES / 49

1	0420	ELECTRIC STIMULATION THE	97014	100710	1	7500		
2	0420	ELECTRIC STIMULATION THE	97010	102110	1	7500		
3	0420	ELECTRICAL STIMULATION	97032	101410	1	7500		
4	0420	NEUROMUSCULAR REEDUCATIO	97112	100710	2	18200		
5	0420	NEUROMUSCULAR REEDUCATIO	97112	101410	2	18200		
6	0420	NEUROMUSCULAR REEDUCATIO	97112	102110	2	18200		
7	0420	MANUAL THERAPY	97140	100710	2	18200		
8	0420	MANUAL THERAPY	97140	101410	2	18200		
9	0420	MANUAL THERAPY	97140	102110	2	18200		
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	0001	PAGE 1 OF 1	CREATION DATE 020911	TOTALS		131700	000	

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56 NPI	1831188275
A	USSA	999990000	Y	Y	000	131700	57 OTHER PRV ID	050239
B	BLUE SHIELD-EXCL CARE-WMM	94036NOOO	Y	Y	000	000		
C								

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	CASTILLO REGELIN P	18	20829714		20829714
B	CASTILLO REGELIN P	18	166700391		000
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A	NONENEEDED		WHITE MEMORIAL MEDICAL C
B	NONENEEDED		WHITE MEMORIAL MEDICAL C
C			

66 DX: V5747 | 7231 | 7245 | C | D | E | F | G | H | 68

I | J | K | L | M | N | O | P | Q

67 ADMIT DX: V571 | 69 PATIENT REASON DX: a | b | c | 71 PPS CODE: 000 | 72 ECI: a | b | c | 73

74 PRINCIPAL PROCEDURE CODE/DATE | 74a OTHER PROCEDURE CODE/DATE | 74b OTHER PROCEDURE CODE/DATE | 75

74c OTHER PROCEDURE CODE/DATE | 74d OTHER PROCEDURE CODE/DATE | 74e OTHER PROCEDURE CODE/DATE

76 ATTENDING NPI 1265517114 QUAL 0B G61050
LAST LAU FIRST SUSIE H

77 OPERATING NPI QUAL
LAST FIRST

78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

80 REMARKS

81 CC a B3 282N00000X
b
c
d

UB-04-CMS-1450

AIS2 : 05 04 2011 08:43 532

1 GLENDALE ADV MED CENTER 1509 WILSON TERRACE GLENDALE CA 91206 8184098200 8185465684	2 GLENDALE ADV MED CENTER DEPT NO 2006 LOS ANGELES CA 90084

3a PAT CNTL # 144438884-4998 — 4 TYPE OF BILL 0131
b MED REC # 562996
5 FED TAX NO. 0000 951816017 — 6 STATEMENT COVERS PERIOD FROM 110110 THRU 113010 — 7 00

8 PATIENT NAME b CASTILLO REGELIN P
9 PATIENT ADDRESS a 27003 MOUNTIAN WILLOW LN b SANTA CLARITA c CA d 913870000

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	29 ACDT STATE
07231965	F	110110	00	3	1		01	CA

31 OCCURRENCE CODE	DATE
01	071910

38
USSA
PO BOX 5000
ATTN MEDICAL CLAIMS
DAPHNE AL 36526

	42 REV CD.	43 DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0420	ELECTRIC STIMULATION THE	97014	111010	1	7500		
2	0420	THERAPEUTIC EXERCISES	97110	111010	2	18200		
3	0420	NEUROMUSCULAR REEDUCATIO	97112	111610	2	18200		
4	0420	NEUROMUSCULAR REEDUCATIO	97112	112910	2	18200		
5	0420	MANUAL THERAPY	97140	111010	2	18200		
6	0420	MANUAL THERAPY	97140	111610	2	18200		
7	0420	MANUAL THERAPY	97140	112910	2	18200		
23	0001	PAGE 1 OF 1	CREATION DATE	121310	TOTALS	116700	000	

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
A	USSA	999990000	Y	Y	000	116700
B	BLUE SHIELD-EXCL CARE-WMM	94036NOCD	Y	Y	000	000

56 NPI 1831188275
57 OTHER PRV ID A 050239

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	CASTILLO REGELIN P	18	20829714		20829714
B	CASTILLO REGELIN P	18	16520C381	WMMC	024

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A	NONENEEDED		WHITE MEMORIAL MEDICAL C
B	NONENEEDED		WHITE MEMORIAL MEDICAL C

66 DX V5717 7231 7245

69 ADMIT DX V571 — 71 PPS CODE 000

76 ATTENDING NPI 1265517114 QUAL 0B G61050
LAST LAU FIRST SUSIE H
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
81CC a B3 282N00000X

UB-04-CMS-1450

63

1 GLENDALE ADV MED CENTER 1509 WILSON TERRACE GLENDALE CA 91206 8184098200 8185465684	2 GLENDALE ADV MED CENTER DEPT NO 2006 LOS ANGELES CA 90084	3a PAT CNTL # 144454519-4998 b MED REC # 562996 4 TYPE OF BILL 0131 5 FED TAX NO. 0000 951816017 6 STATEMENT COVERS PERIOD FROM 120110 THROUGH 123110 7 00

8 PATIENT NAME: b CASTILLO REGELIN P
9 PATIENT ADDRESS: a 27003 MOUNTIAN WILLOW LN; b SANTA CLARITA; c CA; d 913870000

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE
07231965	F	120110	00	3	1		01		CA

31 OCCURRENCE CODE	DATE
01	071910

38
USSA
PO BOX 5000
ATTN MEDICAL CLAIMS
DAPHNE AL 36526

42 REV CD.	43 DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0420	ELECTRIC STIMULATION THE	97014	120810	1	7500	
0420	ELECTRIC STIMULATION THE	97014	121410	1	7500	
0420	NEUROMUSCULAR REEDUCATIO	97112	120810	2	18200	
0420	NEUROMUSCULAR REEDUCATIO	97112	121410	2	18200	
0420	MANUAL THERAPY	97140	120810	2	18200	
0420	MANUAL THERAPY	97140	121410	2	18200	
0001	PAGE 1 OF 1	CREATION DATE	011011	TOTALS	87800	000

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 1831188275
A USSA	999990000	Y	Y	000	87800	57 050239
B BLUE SHIELD EXCL CARE WMM	91036NOCD	Y	Y	000	000	OTHER PRV ID

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A CASTILLO REGELIN P	18	20829714		20829714
B CASTILLO REGELIN P	18	16520C391	WMMC	024

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A NONENEEDED		
B NONENEEDED		WHITE MEMORIAL MEDICAL C
C		WHITE MEMORIAL MEDICAL C

66 DX: V5717 7231 72453
69 ADMIT DX: V571 70 PATIENT REASON DX — 72 ECI 000

74 PRINCIPAL PROCEDURE CODE DATE; a OTHER PROCEDURE CODE DATE; b OTHER PROCEDURE CODE DATE; 75
c OTHER PROCEDURE CODE DATE; d OTHER PROCEDURE CODE DATE; e OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 1265517114 QUAL 0B G61050
LAST LAU FIRST SUSIE H
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
81CC a B3 282N00000X
b
c
d

UB-04-CMS-1450

1 GLENDALE ADV MED CENTER 1509 WILSON TERRACE GLENDALE CA 91206 8184098200 8185465684	2 GLENDALE ADV MED CENTER DEPT NO 2006 LOS ANGELES CA 90084	3a PAT. CNTL # 144470309-4998 b MED. REC. # 562996 5 FED TAX NO. 0000	4 TYPE OF BILL 0131 6 STATEMENT COVERS PERIOD FROM 010111 THRU 013111	7 00	

8 PATIENT NAME	9 PATIENT ADDRESS				
b CASTILLO REGELIN P	b 27003 MOUNTIAN WILLOW LN				
	c SANTA CLARITA		d CA	e 913870000	

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	HR	14 TYPE	15 SRC	16 DHR	17 STAT	18-28 CONDITION CODES	29 ACCT STATE	30
07231965	F	010111	00	3	1		01		CA	

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	FROM	THROUGH	36 OCCURRENCE CODE	FROM	THROUGH	37
a	01	071910													
b															

38
USSA
PO BOX 5000
ATTN MEDICAL CLAIMS
DAPHNE AL 36526

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

	42 REV CD.	43 DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0420	ELECTRIC STIMULATION THE	97014	011211	1	7900		
2	0420	THERAPEUTIC EXERCISES	97110	011211	2	9000		
3	0420	MANUAL THERAPY	97140	011211	2	19000		
4								
5								
6								
7								
8								
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11								
12								
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14								
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16								
17								
18								
19								
20								
21								
22								
23	0001	PAGE 1 OF 1	CREATION DATE	022211	TOTALS	45900	000	

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL IND	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57
A	USSA	999990000	Y	Y	000	45900	1831188275	OTHER PRV ID 050239
B	BLUE SHIELD EXC/ CARE-WMM	94084NOCC	Y	Y	000	000		
C								

	58 INSURED'S NAME	PAT REL	59 INSURED'S UNIQUE ID	60 GROUP NAME	61 INSURANCE GROUP NO.
A	CASTILLO REGELIN P	18	20829714		20829714
B	CASTILLO REGELIN P	18	165Z0C391	WMMC	02
C					

	62 TREATMENT AUTHORIZATION CODES	63 DOCUMENT CONTROL NUMBER	64 EMPLOYER NAME
A	NONENEEDED		WHITE MEMORIAL MEDICAL C
B	NONENEEDED		WHITE MEMORIAL MEDICAL C
C			

	65 IDC		A	B	C	D	E	F	G	H	I
		V5767	7231	7245							
		J	K	L	M	N	O	P	Q		

67 ADMIT DX	68	69 PATIENT REASON DX	a	b	c	70 PPS CODE	000	a	b	c	71
V571											

72 ECI	73

74 PRINCIPAL PROCEDURE CODE	DATE	b OTHER PROCEDURE CODE	DATE	c OTHER PROCEDURE CODE	DATE	75
d OTHER PROCEDURE CODE	DATE	e OTHER PROCEDURE CODE	DATE	f OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 1265517114	QUAL 0B	G61050
LAST LAU		FIRST SUSIE H	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81 CC	
	a	B3 282N00000X
	b	
	c	
	d	

UB-04-CMS-1450

Authorization / Registration Documents

Result Type:	Conditions of Registration	**Result Status:**	Auth (Verified)
Event Date:	01/31/2011 23:59:00 PST	**Reviewed By:**	
Performed By:	Scanned, Document	**Signed By:**	
Transcribed Date/Time:		**Signed Date/Time:**	

Adventist Health

GLENDALE ADVENTIST MEDICAL CENTER
1509 WILSON TERRACE, GLENDALE, CA 91206-4007, (818) 409-8000

144402724

CONDITIONS OF REGISTRATION

1. **Medical Treatment and Surgical Consent:** I consent to the procedures that may be performed during this hospitalization or while I am an outpatient. These may include, but are not limited to, emergency treatment or services, laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, anesthesia, or hospital services provided to me under the general and surgical instructions of my physician or surgeon. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury, or even death. I acknowledge that no guarantees have been made to me as to the result of examination or treatment in this hospital.

2. **Nursing Care:** Nurses are hospital employees and they provide general nursing care and care ordered by the physician(s). If I want private duty nursing care, I (or my legal representative) agree to make such arrangements.

3. **Legal Relationship Between Hospital and Physician:** Physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, cardiologist and surgeon, are NOT employees of the hospital and have been granted the privilege of using the hospital for the care and treatment of their patients. Physicians may bill separately for their services. I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible to carry out his/her instructions. My physician or surgeon is responsible for obtaining my informed consent, when required, for specific medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered to me under his/her general or special instructions.

Patient Initials: [signature]

4. **Photography:** I consent to the taking of photographs, videotapes, digital or other images, and surveillance monitoring for purposes of my diagnosis, treatment, or for the hospital's operations, including peer review, education or training programs conducted by the hospital. My consent will be requested for non-treatment photography such as marketing or external purposes.

5. **Maternity Consent for Newborns:** If I deliver an infant(s) while a patient of this hospital, I agree that these same Conditions of Registration shall apply to the newborn infant(s).

6. **Release of Information:** I have received a copy of the Notice of Privacy Practices (NPP), which describes when the hospital may use or disclose my information for treatment, payment and health care operations. The NPP is incorporated into these Conditions of Registration and Financial Agreement by this reference. This notice is only provided the first time I receive services from the Hospital and is otherwise available upon request.

7. **Personal Valuables:** As a patient, I am encouraged to leave personal items at home. While the hospital maintains a safe for small personal items of unusual value, it is not responsible for these items. Hospital liability for any personal property deposited with the hospital for safekeeping is limited to $500.

8. **Teaching Program:** If the hospital conducts teaching programs, students will be allowed to participate in my care, unless I (or my legal representative) notify the hospital to the contrary in writing.

I have read the above, received a copy, and am the patient OR I am the patient's legal representative OR I have been authorized by the patient to sign on his/her behalf.

Date: 8/11/10 Time: 5PM Signature: [signature]

If signed by other than patient, indicate relationship: _____

Witness: PM 9958

Interpreter Signature: _____ Language: _____

Interpreter Name: _____ Telephone Number: (____) _____ - _____
(PRINTED)

Admit Date	Admit Time	Patient Name	Medical Record #	Patient's Account #
8/11/2010	17:00	CASTILLO, REGELIN P	56-29-96	144402724

CDAI_CA 03/10 California Version

562996-144402724

Adventist Health GLENDALE ADVENTIST MEDICAL CENTER
1509 WILSON TERRACE, GLENDALE, CA 91206-4007, (818) 409-8000

144402724

CONDITIONS OF REGISTRATION

9. **Financial Agreement:** I accept financial responsibility for all services during this episode of care. I understand that I can expect to receive separate bills from physicians and specialty services.

Patient Initials:

I agree to promptly pay all hospital bills, in accordance with the regular rates and terms of the hospital. Should the account be referred to an attorney or agency for collection, I will pay actual attorney's fees and collection expenses. All delinquent accounts are subject to interest at the legal rate.

In the event my account becomes delinquent and is assigned to a collection agency, I authorize the hospital, and or their agent, to obtain a credit report from national credit bureaus.

10. **Assignment of Insurance Benefits:** I assign and authorize direct payment to the hospital of all insurance and plan benefits that are payable for this episode of care. With this authorization, all parties agree that the insurance company's payment to the hospital shall satisfy the insurance company's obligations related to this episode of care. I further understand that I am financially responsible for charges not paid according to this assignment.

11. **Medicare Assignment:** I certify that the information given by me in applying for payment from any third party payer including payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf, and I authorize the Social Security Administration Office of the Department of Health and Human Services to release information regarding my eligibility for coverage under Medicare Part A and Medicare Part B, including but not limited to the effective date of such coverage. I also authorize the hospital and my physician(s) to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim(s).

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the financial Agreement and Assignment of Insurance Benefits.

Date: 8/11/10 Time: 5pM Signature: [signature]

If signed by other than patient, Indicate relationship: _____

Witness: FM 9958

Interpreter Signature: _____ Language: _____

Interpreter Name: _____ Telephone Number: (____) _____ - _____
(PRINTED)

Admit Date	Admit Time	Patient Name	Medical Record #	Patient's Account #
8/11/2010	17:00	CASTILLO, REGELIN P	56-29-96	144402724

COA2_CA 03/10 Cerner Version

562996-144402724

Adventist Health

GLENDALE ADVENTIST MEDICAL CENTER
1509 WILSON TERRACE, GLENDALE, CA 91206-4007, (818) 409-8000

144402724

Admit Date/Time: 8/11/2010 17:00
Discharge Date/Time:

8/9/10 11:21

REGISTRATION RECORD

JL

Patient Name and Address	Phone	Account Number	Medical Record No.
CASTILLO, REGELIN P 27003 MOUNTIAN WILLOW LN SANTA CLARITA CA 91387-	818 553-1521	144402724	56-29-96
	Other Phone #:	P/C: 4998	Service: RHB / Type: S
	Social Security Number: xxx-xx- 9707	Mode of Arrival:	Room: -
Birth Date: 7/23/1965 / Age: 045Y / Sex: F / Marital Status: M / Religion: SEV	Drivers License No.: NONE AVAIL	Language Preference: English	Accom.
Birth Place: PHILIPPINES	Previous/Maiden Name: PIMENTEL	Spouse: CASTILLO, ABEL	

GUARANTOR

Name	Occupation	Relation	Birth Date	Phone
CASTILLO, REGELIN P	MED STAFF COORD	SELF	7/23/1965	818 553-1521

Address: 27003 MOUNTIAN WILLOW LN SANTA CLARITA CA 91387 — Social Security Number: xxx-xx- 9707

Guarantor Employer Name and Address: WHITE MEMORIAL MEDICAL CENTER 1720 BROOKLYN AVE LOS ANGELES, CA 90033 323 260-5785

Relative/Friend	Address	
CASTILLO, ABEL	27003 MOUNTIAN WILLOW LA SANTA CLARITA, CA 91387	Relation: HUSBAND / Phone: 818 553-1521
Relative/Friend: NONE, NONE	Address: UNKNOWN UNKNOWN, XX XXXXX	Relation: OTHER / Phone:

Doctor Information		Dr. Phone #s
ATT	LAU, SUSIE H	(323) 262-4176
ADM	LAU, SUSIE H	(323) 262-4176
REF		(000)
FAM	CHAN, SHIRLEY	(818) 243-8431

Initial Diagnosis Impression/Statement of Illness/Injury: NECK AND BACK PAIN

ACCIDENT INFORMATION	Date: 7/19/2010	Type: 1	Service related to accident: YES
Location: CA	Description: MVA		

Patient Employer: WHITE MEMORIAL MEDICAL CENTER, 1720 BROOKLYN AVE, LOS ANGELES, CA 90033
Phone: 323 260-5785
Occupation: MED STAFF COORD
Retirement Date: / /
LMP

CARRIER 1

USAA
PO BOX 5000
ATTN MEDICAL CLAIMS
DAPHNE, AL 36526

Phone:
Subscriber Name: CASTILLO, REGELI
Relation: SELF
Subscriber Birth Date: 7/23/65
Subscriber ID (Cert, SSN, or HIC number): 20829714
Group Name:
Group Number: 20829714
Pre-authorization #: NONENEEDED

CARRIER 2

BLUE SHIELD-EXCL CARE-WMMC AH
PO BOX 272540
CHICO, CA 959272540

Phone: (800) 343-1691
Subscriber Name: CASTILLO, REGELI
Relation: SELF
Subscriber Birth Date: 7/23/65
Subscriber ID (Cert, SSN, or HIC number): 16520C391
Group Name: WMMC
Group Number: 024
Pre-authorization #: NONENEEDED

CAR 3

Carrier 3 Name / Subscriber / Relation / Policy # / Group #: SELF PAY - BAL AFTER INS. CASTILLO, REGELI SELF 550679707
Phone:

Remarks: PHYSICAL TEHRAPY EVAL AND TREATMENT

Transferring Facility:
Patient Initials:

Source	Route	Requested By
1	3	LUNSFOMB

Regstr 03/10

562996-144402724

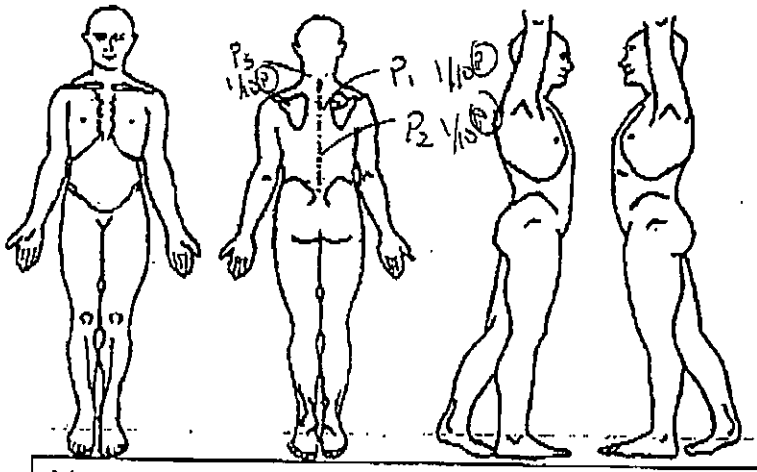
Rehab Therapies

Result Type:	Rehab Notes	**Result Status:**	Transcribed
Event Date:	01/31/2011 23:59:00 PST	**Reviewed By:**	
Performed By:	Scanned, Document	**Signed By:**	
Transcribed Date/Time:		**Signed Date/Time:**	

PHYSICAL THERAPY *SPINE EVALUATION*

Evaluation Date 8/11/10 Onset Date(DOI/DOS) 7/10 Insurance ☐HMO ☐PPO ☐Mcal ☐Mcare ☐Self ☐WC.
Diagnosis C/S (P) & L/S (P)
Precautions None Screen for Abuse ☐ No ☑ Yes Allergies (Iontо) ☑ No ☐ Yes
Assessment Learning Needs/Style Preference/Barriers ☐ Yes _____ Fall Risk ☑ No ☐ Yes
Description of Injury Pt was involved in a rear ended car accident on 7/14/2010. (~5mph std) Fortunately, the pt was alone at the accident during the impact. No ecchymosis Sorky movement noted during the impact. The pt stated to notice (P) L/S stiffness in her C/S & L/S 1 wk Post accident. No nause or vomiting Post Incident ONLY | episode of headache thus far.
Occupation/Recreation Hospital Admissitic
Patient's Goals ↓ sx, fitness
PMH ☐High BP ☐Diabetes ☐Cancer ☐Pacemaker ☐Cardiopulmonary ☐Asthma _____

Medications Muscle relaxant, Ibuprofen
☐XRay ☐MRI ☐CT ☐NCV ☐EMG ☐ENG (-) fx of the C/S.



Pain = XXX | P_1 = 1° Sx | Radiate = ↑↓ | NR = not related
No Sx = √ | P_2 = 2° Sx | Numb = //// | Θ = TTP

Other Symptoms
☐ Cough/Sneeze ☐ Dizziness
☐ Bowel/Bladder ☑ Headaches | episodic
☐ Chest Pain ☐ Ataxia
☐ Night Sweats ☐ Recent Weight Gain/Loss

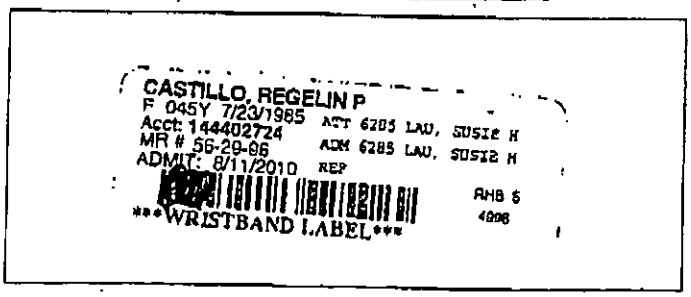
Nature of Symptoms
☐ Constant ☐ Intermittent
☐ Sharp ☑ Dull
☑ Achy ☐ Burning
☐ At rest ☑ w/Movement
☐ Throbbing ☐ Pop/Twinge/Clicking
☐ Sleep Disturbance ___ x Night

Patient Complaint of Pain: ☐ No ☐ Yes
Pattern of Symptoms
AM ___ Mid Day ___ End Day ___ PM ___
Other _____

Rating of Symptoms
Pain Rating: 0-10 (0 = no pain)
P_1: Best ___ Worst ___ Currently 1/10
P_2: Best ___ Worst ___ Currently 1/10

Signature [signature] SPT/ Jimmy Lin PT Date 8/11/10 Time 17:00

Glendale Adventist Medical Center
Spine Evaluation
Physical Therapy
Therapy & Wellness Center
Form # 104.086 Revised 08-2010 Page 1 of 6



Aggravating Factors	Easing Factors
☑ Sit · 45 mins (Stiffness)	Sit
☐ Sit ↔ Stand ☐	Supine
☐ Stand	Sidelying
☐ Squat/Kneel	Prone
☐ Bend	Walk
☐ Turn/Twist	Hot/Cold
☐ Walk	Meds
☐ Run	Stretching
☐ ↑↓ Stairs	Assistive Device: _____
☐ ADLs	
☑ Drive 45 mins (Stiffness)	
☐ Prone	

OBSERVATION

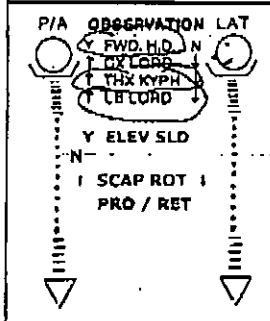
PELVIC GIRDLE

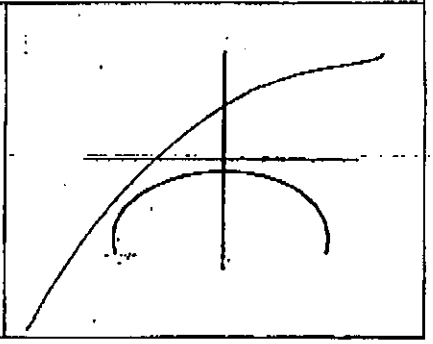
↑↓	R	L
ASIS	NT	
PSIS		

Test	Result	R	L
March	+ -		
Sidebend	+ -	NT	
Flare	+ -		
Rotation	A P		
Compression	+ -		
Distraction	+ -		
SLR – active	+ -		
Leg Length	+ -		

SEGMENTAL MOBILITY

Segment	Grades: (N) Normal (Hyper) Hypermobile (Hypo) Hypomobile		
(L) C7	N	Hyper	(Hypo)
T2-T4 eff	N	Hyper	(Hypo)
	N	Hyper	Hypo





Signature [signature] Jimmy Lin PT Date 8/11/10 Time 17:00

MUSCLE AND JOINT TESTING

STRENGTH	R	L
C4 Shrug	/5	/5
C5 Biceps	/5	/5
C6 Wrist Extensors	/5	/5
C7 Wrist Flex/Triceps	/5	/5
C8 Finger Flexors	/5	/5
T1 Finger Ab/Ad	NT /5	/5
L1-2 Psoas	NT /5	/5
L3 Quads	/5	/5
L4 Tibialis Anterior	/5	/5
L5 EHL	/5	/5
S1 FHL/Gastroc	To be assess /5	/5
S2 Hamstrings		/5
Gluteus Medius	/5	/5
Gluteus Maximus	/5	/5
Grip R (Position:)		
Grip L (Position:)		

AROM	C/S	L/S
Flexion	WFL	limited
Extension	WFL	WFL
R Sidebending	WFL	limited
L Sidebending	WFL	limited
R Rotation	WFL	WFL
L Rotation	WFL	WFL
Quadrant	During L/S Sidebat pt tends to	
Shoulder	Mve more than T/S	

Astute: excessive L/S lordosis
Forward head posture & (B) protracted scapulae

NT TESTING	R	L
Median		
Ulnar		
Radial		
SLR	NT	
PKF		
Sciatic		
Tibial		
Peroneal		
Sural		
Saphenous		

SPECIAL TESTS	R	L
Thomas (Short)	To be assess	
Thomas (Long)		
VAT		
Sharp-Purser		
Alar Ligament		
Spurlings		
Slump Test		

Signature [signature] Jimmy Lin PT Date 8/11/10 Time 17:00

MUSCLE AND JOINT TESTING

REFLEXES	R	L
Levator Scap C4		
Biceps C5		
Brachioradialis C6	NT	
Triceps C7		
Finger Flexors C8		
Knee L4		
Hamstrings L5		
Ankle S1		
Babinski		
Hoffman's		

SENSATION	R	L
Light touch	NT	
Sharp/Dull		
Vibration (Hz:)		

GAIT: NT

PHYSICAL THERAPY IMPAIRMENTS

Swelling _____ ☐ Poor biomechanics _____ ☑ Hypomobility T/S & L/S
Weakness _____ ☐ Neural restrictions _____ ☑ Hypermobility L/S ext
↓ Flexibility _____ ☑ Myofascial restrictions hypertonicity ut erector spinae (B) T/S/L/S
Poor motor control/propriception/balance _____
Other impairments _____

Assessment: Pt is a 45 YO female c medical diagnosis of C/S(P) & L/S(P). Pt was involved in a rear-ended automobile accident on 7/2010 resulting her having discomfort at her neck & mid/lower back. Pt currently complains of stiffness in her c/s/upper back & mid back/lower back. Pt exhibits mobility deficits C4/5 sidebent c V. (L) C7 downglide, mid/upper T/S ext restriction) and coordination deficits resulting her having discomfort c driving & sitting greater than 45 mins. Pt presents good physpris c PT intervention at this time.

Signature [signature] SPT/Jimmy Lin PT Date 8/11/10 Time 17:00

Glendale Adventist Medical Center
Spine Evaluation
Physical Therapy
Therapy & Wellness Center
Form # 104.088 Revised 08-2010 Page 4 of 5

CASTILLO, REGELIN P
F 045Y 7/23/1965 ATT 6285 LAU, SUSIE H
Acct: 144402724 ADM 6285 LAU, SUSIE H
MR # 56-29-96
ADMIT: 8/11/2010 REF
RHB S
4806
GLENDALE ADVENTIST MEDICAL CEN

PHYSICAL THERAPY
PLAN OF CARE

TREATMENT GOALS
- ☑ Improve Biomechanics
- ☑ Improve Joint Mobility
- ☑ Improve Joint Stability
- ☑ Improve Posture
- ☑ Improve Motor Control
- ☐ Increase Strength
- ☑ Increase Flexibility
- ☐ Decrease Pain
- ☐ Decrease Guarding
- ☐ Decrease Neural Symptoms
- ☑ Independent HEP

DIAGNOSIS: C/S(P) & L/S(P)

FUNCTIONAL / MEASUREABLE GOALS
1. Independent & HEP and demonstrate proper body mechanic & posture.
2. ↑ ext mobility at upper T/S that she will be able
3. to drive at least 1hr w/o any difficulty.
4. ↑ L/S Sidebent mobility that she will be able to reach behind
5. her w/o any difficulty.

Estimated Treatments Required to Meet Goals:
2X for 6wks weeks followed by
_____ for _____ weeks

TREATMENT PLAN
- ☑ Therapeutic Exercises
- ☑ Therapeutic (Functional) Activities
- ☑ Neuromuscular Reeducation
- ☑ Manual Therapy
- ☐ Aquatic Therapy
- ☑ Self Care Management Training
- ☐ Orthotic Management/Training
- ☐ Prosthetic Training
- ☐ Physical Performance Test
- ☐ Iontophoresis – Dosage _____
- ☐ Electrical Stimulation
- ☐ Ultrasound
- ☐ Whirlpool
- ☐ Mechanical Traction
- ☐ Vasopneumatic Device
- ☐ _____

Signature [signature] Jimmy Lin PT Date 8/11/10 Time 17:00

Glendale Adventist Medical Center
Spine Evaluation
Physical Therapy
Therapy & Wellness Center
Form # 104.086 Revised 08-2010 Page 5 of 5

CASTILLO, REGELIN P
F 045Y 7/23/1965 ATT 6285 LAU, SUSIE H
Acct: 144402724 ADM 6285 LAU, SUSIE H
MR # 56-29-96
ADMIT: 8/11/2010 REF
GLENDALE ADVENTIST MEDICAL CEN

PATIENT QUESTIONNAIRE

BIRTHDATE: 072365 AGE: 45 HEIGHT: 5'2" WEIGHT: 154

MEDICAL HISTORY

☐ ANEMIA	☐ TUBERCULOSIS	☐ THYROID PROBLEMS
☐ POLIO	☐ HIGH BLOOD PRESSURE	☐ SHORTNESS OF BREATH
☐ CANCER	☐ HYPOGLYCEMIA	☐ PROLONGED BLEEDER
☐ GOUT	☐ EMPHYSEMA	☐ NERVOUS DISORDER
☐ DIABETES	☐ ARTHRITIS	☐ INFECTIOUS DISEASE
☐ PHLEBITIS	☐ FREQUENT ILLNESS	☐ LIVER DISEASE
☐ HERNIA	☐ FREQUENT ILLNESS	☐ LIVER DISEASE
☐ DIZZINESS	☐ HEADACHES	☐ VISUAL DISTURBANCE
☐ OSTEOPOROSIS	☐ CIRCULATION PROBLEMS	☐ HIGH BLOOD PRESSURE
☐ OTHER _____		☐ HIGH CHOLESTEROL

List all hospitalizations for any medical illness or surgery. Please indicate reason and date:

List all medical tests you have had within the past few years:
Birth control pills, Ibuprofen (advil), zyrtec, muscle relaxant (as needed)

Are you currently or have you been treated for a heart or lung condition? If yes, explain:
NO

Please list any medications you are taking: (currently)
Birth control pills, Ibuprofen (advil), Zyrtec, muscle relaxant (as needed)

Please list any medications you are allergic to:
Sulfa

Do you have adverse reaction to heat or cold?	YES ☐	NO ☑
Do you have a cardiac pacemaker?	YES ☐	NO ☑
Do you have metal implants (plates, screws, IUD)?	YES ☐	NO ☑
Explain: _____		
Do you have any skin areas which are sensitive or lack sensation?	YES ☐	NO ☑
Where: _____		

Have you had a recent infection or dental surgery? YES ☐ NO ☑
When: _____ Where: _____
Are you pregnant? YES ☐ NO ☑
How many months? _____
Are you currently working? YES ☑ NO ☐

What is your occupation? coordinator/ administrature

What tasks do you do in your job? (sitting, lifting, etc)
sitting, typing, transcription of meeting minutes (during/after mtg)

Briefly describe your physical activity level, include job description and leisure activities?
jogging/ cardio exercise, muscle strengthening with theraband/free weights

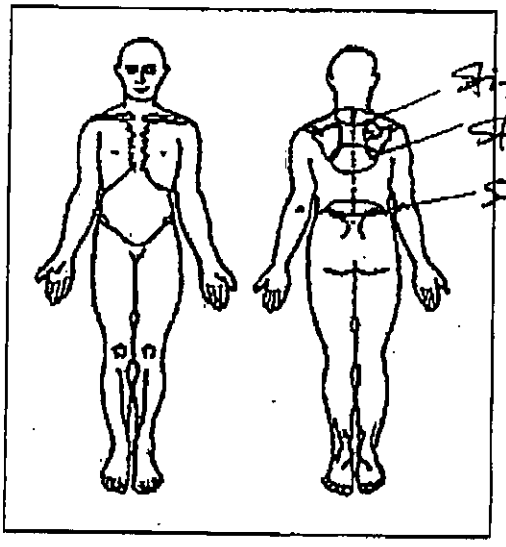
What is the nature of your visit? MVA
car accident → auto was rear-ended and at same time I rear-ended another car

If you have pain and/or discomfort, please complete the following:
Please indicate the area(s) of pain/discomfort on the drawing → → ↓
Most painful = ▓ Least painful = ‖ Numbness or Tingling = ▒ ↓

Since this problem started, what activities cause you pain and/or difficulty? _____

What makes you feel better? _____
stretching
massage

What makes you feel worse? _____



Glendale Adventist Medical Center
Patient Questionnaire
Therapy & Wellness Center
Form # 104.078 Revised05/2010
Page 2 of 2

CASTILLO, REGELIN P
F 04SY 7/23/1965 ATT 6285 LAU, SUSIE H
Acct: 144402724 ADM 6285 LAU, SUSIE H
MR # 56-29-96
ADMIT: 8/11/2010 REF
RHB 6
4008
GLENDALE ADVENTIST MEDICAL CEN

PHYSICAL THERAPY TREATMENT RECORD

Diagnosis: C/S Stiffness Onset Date: _____ Precautions: _____ Expiration Date: _____

Date 20	8/11/10	8/19/10	8/24	8/26/10	8/31	9/2	9/7	9/13	9/16	9/20	9/27
Time	5:00		6:00	6:00	6:00	6:00	6:00	6:00	6:00	6:10	6:20
Number of Treatments	1										
Therapeutic Exercises	30	30	30	30	30	30	30	30	30	30	
Manual Therapy	30	30	30	30	30	30	30	30	30	30	
Neuromuscular Re-Education	15		30						30	30	30
Functional Activities									30	30	30
Self Care/Management/Training											
Others			15	15	15	15	15	15	15	15	
Total Treatment Time	60'	60'	75	60'	75	75	75	75	75	75	
STM to (B) T/L Prone	10'	10'	10'		✓						
(B) UT 9 level Stretch	3X30"	3X30"	5'	5'	pt						
Advanced blocking ex	2X10										
glide 5 T/S PA mob	✓	✓		✓				✓ 5			
~~ES Side Lying~~ upper arm	✓										
C/S UE glides		✓	✓								
UBE wall Angle		3/3							2X10	2X10	2X10
Supine isometrics		3X10									
Wall angel		3X10									
Prone x's T/T		3X10			10X	X10	10X			3X10	3X10
(B) UT/Mid Stretch		3X30"									
Serving trays		L1 3X10		2X10					OH L2 3X12		
True stretch		B2 3X30"	5' pace		3'		3' B2	1'			
Rowing				2X10			3X10			3X10	3X10
Foam roll					3'				5'	7'	7'
Corner stretch						3X30"			Pec 3X30"		
Prone press ups						X3 ✓					
Subocc. Rectus Cap. Obliquus Cap.			15'	15'							
HP → c/s L/s		15' ✓		15'		X15" ✓	15'	15'	15'	15'	
Impairments	PT										L2 2X10
Signature/Co-Signature	Jimmy Lin PT	Jimmy Lin PT	Jimmy Lin PT	Jimmy Lin PT	Jimmy Lin PT	Jimmy Lin PT	Jimmy Lin PT	Jimmy Lin PT	Jimmy Lin PT	Jimmy Lin PT	Jimmy Lin PT

Glendale Adventist Medical Center
Treatment Record
Physical Therapy
Therapy & Wellness Center
Form #104.074 Revised 08-2010 Page 1 of 1

CASTILLO, REGELIN P
F 045Y 7/23/1985 ATT 6285 LAU, SUSIE H
Acct: 144402724 ATN 6285 LAU, SUSIE H
MR # 56-29-96
ADMIT: 8/11/2010 REF
RHB S 4078
WRISTBAND LABEL

PHYSICAL THERAPY TREATMENT RECORD

Diagnosis: _____ Onset Date: _____ Precautions: _____ Expiration Date: _____

Date 20	9/30	10/4	10/4	10/31	11/10	11/16	11/19	12/8	12/15	12/	1/12
Time											
Number of Treatments											
Therapeutic Exercises					30						30
Manual Therapy	30	30	30	30	30	30	30	30	30		30
Neuromuscular Re-Education	30	30	30	30		30	30	30	30		
Functional Activities											
Self Care/Management Training											
Others	15	15	15	15	15			15	15		15
Total Treatment Time	75	75	75	75	75	60	60	75	75		75
Manual P.T. See Eval											
Manual											
Ys · Ts or Backstrong	15 3x30" m	30 3x30"	5x30" 45°	✓				5x30" 45°	✓	2x5 c HR 3x10	✓
Rows	3x10	3x10	4x 10'	✓			✓			Hi 3x10	✓
Body blade perturbations						3'		3'			
Wall Angels	2# 2x10	2# 2x10	2# 3x 10	✓			✓			2# 3x10	✓
LAT stretch	4x20"			—	✓		✓				
Pec str. c STM	3x30"			✓	✓		✓				
Manual Strong c body blade perturbations						3x30"		4x30"	✓		
Planks: c Horizontal Abd c TB.			3x10"	—				3x10"		✓	✓
Trunk Rot Stretch Tom Sit c SB					✓		✓	✓		✓	✓
Heat c TC			15' hot	✓		10'					
Signature/Co-Signature	Jimmy Lin PT	Jimmy Lin PT	Jimmy Lin PT	Jimmy Lin PT	Jimmy Lin PT	Jimmy Lin PT	Jimmy Lin PT	Jimmy Lin PT	Jimmy Lin PT	Jimmy Lin PT	Jimmy Lin

Glendale Adventist Medical Center
Treatment Record
Physical Therapy
Therapy & Wellness Center
Form #104.074 Revised 08-2010 Page 1 of 1

CASTILLO, REGELIN P
F 045Y 7/23/1985 ATT 6265 LAU, SUITE H
Acct: 144402724 ADM: 6265 LAU, SUITE H
MR # 56-23-86 REP
ADMIT: 8/11/2010 RHB S
4906
GLENDALE ADVENTIST MEDICAL CEN

Date: 8/31 Time 18:00 S: [illegible] O: ☐ Treatment per grid ☐ STM /JM [illegible] ☐ Stretching [illegible] ☐ HEP [illegible] A: [illegible] P: ☐ Continue POC ☐ Additional POC Signature [signature] Jimmy Lin PT Co-Signature	Date: 9/2 Time 6:00 S: [illegible] O: ☐ Treatment per grid [illegible] ☐ STM /JM [illegible] ☐ Stretching [illegible] ☐ HEP [illegible] A: [illegible] P: ☐ Continue POC ☐ Additional POC Signature [signature] Co-Signature
Date: 9/7 Time 18:00 S: [illegible] O: ☐ Treatment per grid ☐ STM /JM [illegible] ☐ Stretching [illegible] ☐ HEP [illegible] A: [illegible] P: ☐ Continue POC ☐ Additional POC Signature [signature] Co-Signature	Date: 9-13-2010 Time 18:00 S: [illegible] O: ☐ Treatment per grid ☐ STM /JM [illegible] ☐ Stretching [illegible] ☐ HEP [illegible] A: [illegible] P: ☐ Continue POC ☐ Additional POC Signature [signature] Co-Signature

Glendale Adventist Medical Center
Daily Notes
Physical Therapy
Therapy & Wellness Center
Form #104.104 Revised 08-2010
Page 1 of 1

3 8 6

CASTILLO, REGELIN P
F 045Y 7/23/1965 ATT 6285 LAU, SUSIE H
Acct 144402724 ADM 6285 LAU, SUSIE H
MR # 58-29-96 REF
ADMIT: 8/11/2010
RHB S 4098
GLENDALE ADVENTIST MEDICAL CEN

0901119c87d95cc7

Date: 1/12/2011 Time 6:00
S: pt continues [illegible] [illegible] [illegible] [illegible] general [illegible] [illegible] [illegible] [illegible] good [illegible] [illegible] [illegible]
O: ☐ Treatment per grid [illegible]
☐ STM /JM C/S V:30° /165°
☐ Stretching [illegible] L:07 R:72
☐ HEP SB L:95 R:42
Ⓡ Shoulder V:105 ABD 155
A: IR: 60 ER: >70
pt [illegible] normal [illegible] [illegible] slight [illegible] weakness [illegible] [illegible] HA [illegible] general [illegible] [illegible]
P: ☐ Continue POC ☐ Additional POC
D/c [illegible] HEP.
Signature [illegible]
Co-Signature [illegible] Jimmy Un PT

Date: ____ Time ____
S:
O: ☐ Treatment per grid
☐ STM /JM
☐ Stretching
☐ HEP
A:
P: ☐ Continue POC ☐ Additional POC
Signature
Co-Signature

Date: ____ Time ____
S:
O: ☐ Treatment per grid
☐ STM /JM
☐ Stretching
☐ HEP
A:
P: ☐ Continue POC ☐ Additional POC
Signature
Co-Signature

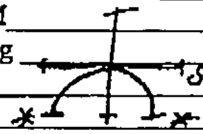
Date: ____ Time ____
S:
O: ☐ Treatment per grid
☐ STM /JM
☐ Stretching
☐ HEP
A:
P: ☐ Continue POC ☐ Additional POC
Signature
Co-Signature

Glendale Adventist Medical Center
Daily Notes
Physical Therapy
Therapy & Wellness Center
Form #104.104 Revised 08-2010
Page 1 of 1

* 3 6 6 *

CASTILLO, REGELIN P
F 045Y 7/23/1965 ATT 6285 LAU, SUSIE H
Acct 144402724 ADM 6285 LAU, SUSIE H
MR # 56-29-86 REF RH9 S
ADMIT: 8/11/2010 4898
GLENDALE ADVENTIST MEDICAL CEN

0901119c87d95cc7

Date: 8/11/10 Time S: See Initial Eval O: ☐ Treatment per grid ☐ STM/JM Grade 5 T/S PA mob ☐ Stretching STM to T/L paraspinal ☐ HEP (B) UT / levator stretching MWM (L) C/S (L) rot A: See Initial Eval P: ☐ Continue POC ☐ Additional POC T/S & C/S mobilization Signature [signature] S.PT / JL Jimmy Lin PT Co-Signature	Date: 8/19/10 Time 18:00 S: No headaches, Pt went back to boot camp, started well. Overall tightness 1-3/10 over UT & Mid-back O: ☐ Treatment per grid ☐ STM/JM - (B) UT / levator stretching ☐ Stretching - STM over C/S paraspinal ☐ HEP - Sub-occipital release - Grade 5 C/S (L) C7 up glide A: - Grade 5 mob to T/S T3-T7 Pt continues to demonstrate mobility deficit C/S rot (R)>(L) 2° to tight UT/levator. Pt will continue to benefit from the stretching. P: ☐ Continue POC ☐ Additional POC Signature [signature] S.PT Jimmy Lin PT Co-Signature
Date: 8/24/2010 Time 18:00 S: felt ↑ stiffness over past weekend since last treatment. O: ☐ Treatment per grid (B) HA repro c STM. ☐ STM/JM ☐ Stretching ☐ HEP subocc. (L)>R  A: ↓ pn @ C3-4 p̄ (L) closing/opening ∴ ↓ HA p̄ capital ✓/STM. P: ☐ Continue POC ☐ Additional POC Signature [signature] Co-Signature [signature]	Date: 8/26/10 Time 18:00 S: No more headache. Minor soreness noted (L) upper T/S. O: ☐ Treatment per grid ☐ STM/JM - Tenderness in (B) ... (L) sub-occipital ☐ Stretching - (B) UT, ... (L) upper T/S ☐ HEP - Sub-occipital release - (B) UT / levator Stretch A: - PA grade IV mob to upper T/S Pt demonstrates upper C/S - syndrome ... tight UT sub-occipital, weakness on mid/lower trap & deep neck flexors. ... has difficulty c̄ ... P: ☐ Continue POC ☐ Additional POC Signature [signature] S.PT Jimmy Lin PT Co-Signature

Glendale Adventist Medical Center
Daily Notes
Physical Therapy
Therapy & Wellness Center
Form #104.104 Revised 08-2010
Page 1 of 1

* 3 6 6 *

CASTILLO, REGELIN P
F 045Y 7/23/1965 ATT 6285 LAU, SUSIE H
Acct: 144402724 ADM 6285 LAU, SUSIE H
MR # 56-29-98
ADMIT: 8/11/2010 REF
RHB S
4098
GLENDALE ADVENTIST MEDICAL CEN

0901119c87d95cc7

Date: 11/16 Time 6:00
S: [illegible]
O: ☐ Treatment per grid [illegible]
☐ STM /JM
☐ Stretching [illegible]
☒ HEP [illegible]
A: [illegible]
P: ☐ Continue POC ☐ Additional POC
[illegible]
Signature Jimmy Lin PT
Co-Signature

Date: 11/29/201 Time 6:00
S: [illegible]
O: ☐ Treatment per grid
☐ STM /JM
☐ Stretching [illegible]
☒ HEP [illegible]
A: [illegible]
P: ☐ Continue POC ☐ Additional POC
Signature Jimmy Lin PT
Co-Signature

Date: 12/8 Time 6:00
S: [illegible]
O: ☒ Treatment per grid
☐ STM /JM
☐ Stretching
☐ HEP √ / abd / [illegible] √/SB
A: [illegible] WNL
P: ☐ Continue POC ☐ Additional POC
Signature Jimmy Lin PT
Co-Signature

Date: 12/15 Time 6:00
S: [illegible]
O: ☒ Treatment per grid
☐ STM /JM
☐ Stretching [illegible]
☐ HEP [illegible]
A: [illegible]
P: ☐ Continue POC ☐ Additional POC
[illegible]
Signature
Co-Signature

Glendale Adventist Medical Center
Daily Notes
Physical Therapy
Therapy & Wellness Center
Form #104.104 Revised 08-2010
Page 1 of 1

* 3 6 6 *

CASTILLO, REGELIN P
F 045Y 7/23/1965 ATT 6285 LAU, SUSIE H
Acct: 144402724 ADM 6285 LAU, SUSIE H
MR # 56-29-96 REF
ADMIT: 8/11/2010
RHB 6 4038
GLENDALE ADVENTIST MEDICAL CEN

Date: 10-7-2010 Time 6:00
S: [illegible]
O: ☐ Treatment per grid
☐ STM/JM [illegible]
☐ Stretching [illegible]
☐ HEP [illegible] ULTT median N. [illegible]
A: [illegible]
P: ☐ Continue POC ☐ Additional POC
Signature [signature]
Co-Signature

Date: 10-14-2010 Time 8:00
S: Pt reports slight [illegible] of HA, [illegible]
O: ☐ Treatment per grid
☐ STM/JM [illegible] median nerve
☐ Stretching distribution
☐ HEP [illegible] reproduction [illegible]
A: [illegible] ULTT to ~15° elbow [illegible]
P: ☐ Continue POC ☐ Additional POC
Signature [signature]
Co-Signature

Date: 10-21-2010 Time 6:00
S: [illegible] reports onset N/T during weekend but (-) HA
O: ☐ Treatment per grid
☐ STM/JM [illegible] reproduction [illegible]
☐ Stretching [illegible] pec minor palp.
☐ HEP [illegible] Sx [illegible] STM [illegible] stretch
A: [illegible] ULTT median nerve [illegible] elbow ~30° / ~70° [illegible] STM
P: ☐ Continue POC ☐ Additional POC
Signature
Co-Signature [signature]

Date: 11-12-2010 Time 6:00
S: [illegible] lateral neck [illegible] and [illegible] days currently
O: ☐ Treatment per grid 7/10
☐ STM/JM
☐ Stretching 5/10 [illegible]
☐ HEP [illegible]
A: Pt [illegible] postural [illegible] dysfunction [illegible] coordination deficits of [illegible]
P: ☐ Continue POC ☐ Additional POC
Signature [signature]
Co-Signature

Glendale Adventist Medical Center
Daily Notes
Physical Therapy
Therapy & Wellness Center
Form #104.104 Revised 08-2010
Page 1 of 1

* 3 6 6 *

CASTILLO, REGELIN P
F 045Y 7/23/1965 ATT 6285 LAU, SUSIE H
Acct: 144402724 ADM 6285 LAU, SUSIE H
MR # 56-29-96
ADMIT: 8/11/2010 REF
RHB 6
4998

0901119c87d95cc7

Date: 9.30.2010 Time 6:00
S: no pain c neck [illegible]

O: ☐ Treatment per grid
☐ STM /JM
☐ Stretching [illegible]
☐ HEP [illegible]

A:
pt ready for D/C
[illegible] c HEP

P: ☐ Continue POC ☐ Additional POC

Signature [illegible]
Co-Signature

Date: Time
S:

O: ☐ Treatment per grid
☐ STM /JM
☐ Stretching
☐ HEP

A:

P: ☐ Continue POC ☐ Additional POC

Signature
Co-Signature

Date: Time
S:

O: ☐ Treatment per grid
☐ STM /JM
☐ Stretching
☐ HEP

A:

P: ☐ Continue POC ☐ Additional POC

Signature
Co-Signature

Date: Time
S:

O: ☐ Treatment per grid
☐ STM /JM
☐ Stretching
☐ HEP

A:

P: ☐ Continue POC ☐ Additional POC

Signature
Co-Signature

Glendale Adventist Medical Center
Daily Notes
Physical Therapy
Therapy & Wellness Center
Form #104.104 Revised 08-2010
Page 1 of 1

* 3 6 6 *

CASTILLO, REGELIN P
F 045Y 7/23/1965 ATT 6265 LAU, SUSIE H
Acct: 144402724 ADM 6265 LAU, SUSIE H
MR # 56-29-96 REF
ADMIT: 8/11/2010
RHB S
4898
GLENDALE ADVENTIST MEDICAL CEN

Date: 9.16.2010 **Time** 6:00
S: pt denies reports soreness post Rx, but no HA.
O: ☐ Treatment per grid
☐ STM /JM @ pec sternal tightness
☐ Stretching
☐ HEP ✓ for pec sternal str.
A: pt c improved HA frequency & intensity. Reports improved posture
P: ☐ Continue POC ☐ Additional POC
Signature
Co-Signature

Date: 9/20/2010 **Time** 6:00
S: able some during during the weekend but no more HA
O: ☐ Treatment per grid
☐ STM /JM
☐ Stretching @ TTP ® C3-4.
☐ HEP ✓ post sternal/pec sternal stretch
A: pt with general ↓ of Sx c ↓ @ sternal pec tightness also noted.
P: ☐ Continue POC ☐ Additional POC
Signature
Co-Signature

Date: 9/27 **Time** 6:00
S: no HA; no Back pain - feeling much better.
O: ☒ Treatment per grid @ upper trap
☐ STM /JM ↓ UT @ mot vs @
☐ Stretching
☐ HEP ↓ UT @ SB vs @ UB (® stretch given)
A: pt with general ↓ of Sx overall more slight ↓ % mobility. Manip/GPM-5 helped ↓ @ restriction
P: ☐ Continue POC ☐ Additional POC
Signature
Co-Signature

Date: 9/30 **Time** 6:00
S: Pt reports no more HA or pain c deep suboccipital release @ head rotation
O: ☐ Treatment per grid
☐ STM /JM (tightness @)
☐ Stretching ↓ UT @ ® mot vs @
☐ HEP ✓ Symmetrical post
A: MET stretch.
Pt ready for D/C post @ c HEP
P: ☐ Continue POC ☐ Additional POC
Signature
Co-Signature

Glendale Adventist Medical Center
Daily Notes
Physical Therapy
Therapy & Wellness Center
Form #104.104 Revised 08-2010
Page 1 of 1

CASTILLO, REGELIN P
F 045Y 7/23/1865 ATT 6285 LAU, SUSIE H
Acct: 144402724 ADM 6285 LAU, SUSIE H
MR # 56-29-86 REF RHB S
ADMIT: 6/11/2010 4990
GLENDALE ADVENTIST MEDICAL CEN

Glendale Adventist Medical Center

Adventist Health

Physical Therapy Progress Report

PATIENT: Castillo, Regelin
DIAGNOSIS: neck and back pain
REFERRING PHYSICIAN: Susie Lau, M.D.

DATE: 11-30-2010
EVALUATION DATE: 8/11/2010

Dear Dr. Lau,
As of today, Regie has been seen for a total of 3 visits since her last progress report. She has continued to receive strength and flexibility ther-ex, neuromuscular re-education, and modalities for pain modulation post treatment. The following is a summary of her progress.

SUBJECTIVE:

- Regie now reports a cessation of HA that had previously been affecting her concentration and tolerance of ADLs/work activities. She also no longer complains of LUE radiating pain that had an onset during increases of her L c/s pain. At this time, she reports only moderate L UT pain/discomfort during the end of her work day or with increased activities.

OBJECTIVE:

- Strength limitations (MMT): middle trapezius 4/5 (vs. 4-/5 initially);
- AROM: L pectoralis M (sternal head) now WNL but slightly decreased vs. R; Elbow and shoulder ROM WNL
- Palpation: (-)TTP pectoralis minor/major, L rhomboid M/m insertions
- Observations: continued forward head posturing and protracted scapula
- Special tests: (-)upper limb tension test for median nerve entrapment

ASSESSMENT: Regie has demonstrated significant improvements in her HA, c/s and thoracic pain, and shoulder pain. Her c/s ROM and L shoulder girdle mobility has also increased significantly. At this time, her primary deficits are L scapular and c/s coordination that limits tolerance of increased LUE activities and prolonged/static posturing required by work. At this time, pt is progressing towards HEP independence and will soon be ready for discharge.

PLAN: Continue with physical therapy 2 x/wk x 2 wks

Thank you Dr. Lau for the opportunity to work with you and your patients. If you have any questions or comments, please contact me at 323.255.5409.

Sincerely,

Jimmy Lin DPT, CSCS
Doctor of Physical Therapy
Certified Strength and Conditioning Specialist

Glendale Adventist Medical Center
Physical Therapy Progress Report
Therapy & Wellness Center
2560 Colorado Blvd., Eagle Rock, CA 90041
phone 323.255.5409 fax 323.255.5732

Physical Therapy Problem List
(Completed by third visit)

Diagnosis: Please see over on page 1 of Physical Therapy Evaluation

Allergies: Please see over on page 1 of Physical Therapy Evaluation

Medications: Please see over on page 1 of Physical Therapy Evaluation

Surgical Procedures: Please see over on page 1 of Physical Therapy Evaluation

Problems: Please see over on final page of Physical Therapy Evaluation [Plan of Care]

Date	Time	Change in Problems	Signature
8/2/11	5:00		Jimmy Lin PT
8/19			Jimmy Lin PT
8/24	6:00		Jimmy Lin PT
8/26			
8/31	18:00		
9/7	6:00		
9/9	6:00		
9/14	6:00		
9/16	6:00		Jimmy Lin PT
9/20			Jimmy Lin PT
9/21			
9/30			
10/7			
10/14			
10/21			
11/10			
11/16			
11/29			
12/8			
12/15			
1/12			Jimmy Lin PT

Glendale Adventist Medical Center
Problem List
Physical Therapy
Therapy & Wellness Center
Form #104.106 Revised 08-2010
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CASTILLO, REGELIN P
F 045Y 7/23/1965 ATT 6205 LAU, SUSIE H
Acct: 144402724 ADM 6205 LAU, SUSIE H
MR # 58-29-96 REP
ADMIT: 8/11/2010 RHB S
WRISTBAND LABEL

Routine For: Regelin Castillo
Created By: Jimmy Lin, DPT, CSCS

Nov 16, 2010

CASTILLO, REGELIN P
F 045Y 7/23/1965 ATT 6285 LAU, SUSIE K
Acct: 144402724 ADM 6285 LAU, SUSIE K
MR # 56-29-96 REF
ADMIT: 8/11/2010
RHB 5
4998
GLENDALE ADVENTIST MEDICAL CEN

CERVICAL SPINE - 23 Flexibility: Upper Trapezius Stretch

Gently grasp _left_ side of head while reaching behind back with other hand. Tilt head away until a gentle stretch is felt. Hold _30_ seconds.

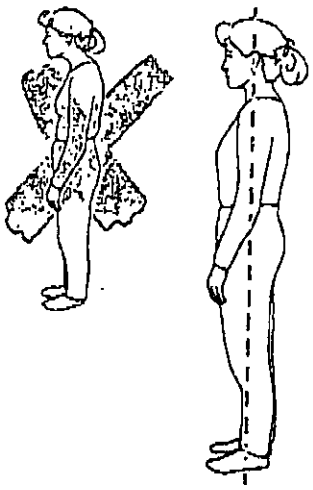
Repeat _2-3_ times per set.
Do _1_ sets per session.
Do _1_ sessions per ~~day~~.hour

0901119c87d95cc7

Routine For: Robert Williams
Created By: Jimmy Lin, DPT, CSCS

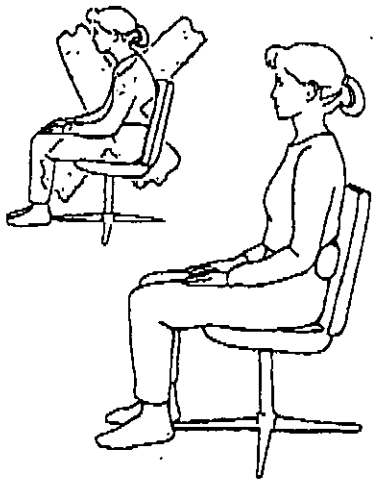
Nov 16, 2010

POSITIONING - 4
Posture - Standing



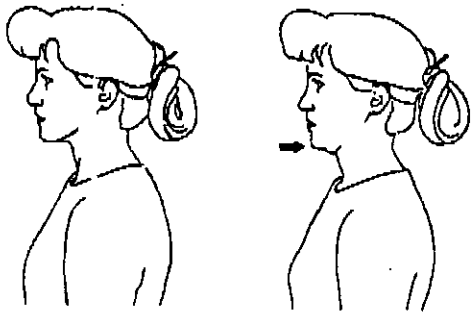
Good posture is important. Avoid slouching and forward head thrust. Maintain curve in low back and align ears over shoulders, hips over ankles.

POSITIONING - 6
Posture - Sitting



Sit upright, head facing forward. Try using a roll to support lower back. Keep shoulders relaxed, and avoid rounded back. Keep hips level with knees. Avoid crossing legs for long periods.

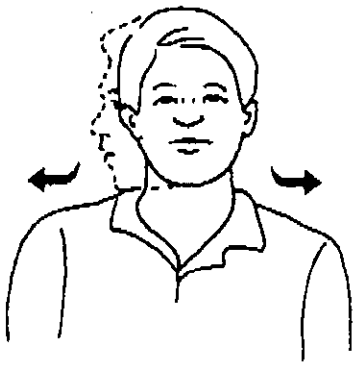
EXERCISE - 1
Stretch Break - Chin Tuck



Looking straight forward, tuck chin and hold 2-3 seconds. Relax and return to starting position.

Repeat 10 times every half hour!

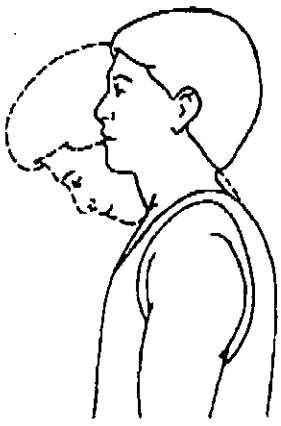
EXERCISE - 6
Stretch Break - Neck Rotation



Turn head slowly to look over left shoulder. Return to starting position. Then turn to look over right shoulder.

Repeat 10 times every 1/2 hour.

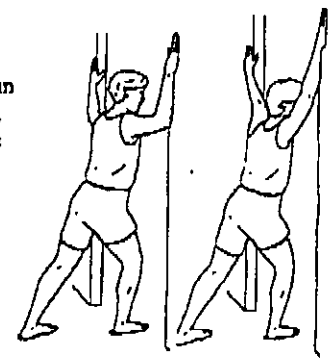
NECK - 4 Extensors



Bend head forward. Hold 20-30 seconds. Return to starting position.

Repeat 2-3 times. Do 1 sessions per hour.

CHEST - 6 Pectorals



With arms forming a T, lean forward until stretch is felt. Hold 60 seconds. Slide arms up to form a V and repeat the stretch.

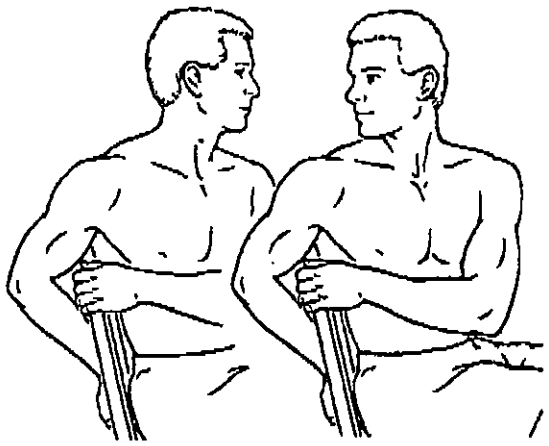
Repeat 3 times.
Do 1 sessions per hour.

Routine For: Robert Williams
Created By: Jimmy Lin, DPT, CSCS

Nov 16, 2010

SPINAL MOBILIZATION - 6 Cervico-Thoracic: Extension / Rotation (Sitting)

Reach across body with left arm and grasp back of chair. Gently look over right side shoulder. Hold 30-60 seconds. Relax.



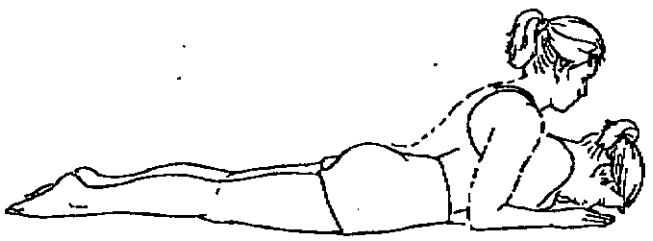
Repeat 2-3 times per set.
Do 1 sets per session.
Do 1 sessions per hour.

CASTILLO, REGELIN P
F 045Y 7/23/1965 ATT 6285 LAU, SUSIE H
Acct 144402724 ADM 6285 LAU, SUSIE H
MR # 56-29-96
ADMIT: 8/11/2010 REF
GLENDALE ADVENTIST MEDICAL CEN

Routine For: R. Castillo
Created By: Lindsay Blaauw, DPT

Aug 11, 2010

BACK - 1 On Elbows (Prone)

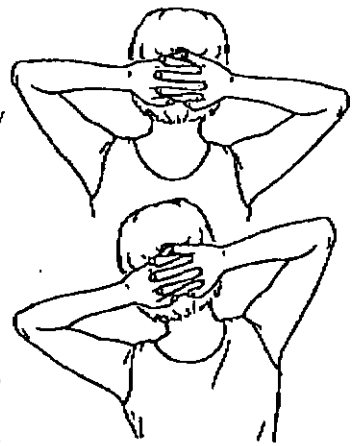


Rise up on elbows as high as possible, keeping hips on floor.
Hold 10 seconds.

Repeat 6 times per set. Do 2-3 sets per session
Do 2-3 sessions per day (as often as possible!)

SPINAL MOBILIZATION - 21 Thoracic Side-Bend (Standing)

With hands interlocked behind head, tip right elbow up, other elbow down. Do not allow body to lean.
Hold 10 seconds.
Relax.



Repeat 6 times per set.
Do 2-3 sets per session
Do 2-3 sessions per day.

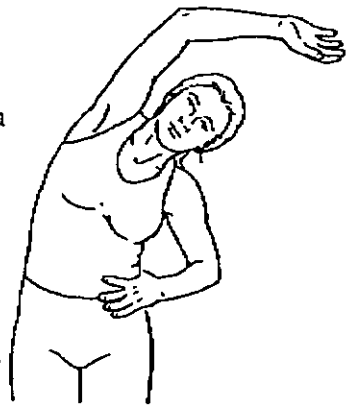
SPINAL MOBILIZATION - 10 Upper Thoracic Stretch

Sit or stand with hands clasped behind neck.
Gently bending head and shoulders back.
Hold 10 seconds.
Relax.

Repeat 6 times per set.
Do 2-3 sets per session
Do 2-3 sessions per day.

BACK - 86 Thoracolumbar Side-Bend: Single Arm (Standing)

Reach over head to other side with right then left arm until stretch is felt.
Hold 10-15 seconds.
Relax.



Repeat 4-6 times per set.
Do 1-2 sets per session
Do 2-3 sessions per day.

DEA # BL1139395 NPI # _____ CA License # G061060
Susie H. Lau, M.D.
Internal Medicine
1700 Cesar E. Chavez Avenue
Suite 3800
Los Angeles, CA 90033
323-263-4178 Fax 323-882-4129

NAME Castillo, Regelin
ADDRESS _____ DATE 7/27/10

℞ (Please Print)

Physical therapy eval + treat
Lt hip and back pain

Tramadol

☐ Label
Refill _____ Times PRN ADR
☐ DO NOT SUBSTITUTE Initials _____

27-JAN-10 _____ M.D.

CASTILLO, REGELIN P
F 045Y 7/23/1985 Atr 6285 LAU, SUSIE H
Acct: 144402724 ADM 6285 LAU, SUSIE H
MR # 56-29-96 RCF RHB S
ADMIT: 8/11/2010 4098
GLENDALE ADVENTIST MEDICAL CEN

ALL CLINICALLY PERTINENT INFORMATION HAS BEEN PRINTED ON THE PREVIOUS PAGE(S).

Glendale Adventist Medical Center
1509 Wilson Terrace
Glendale, CA 91206

Pt Name: CASTILLO, REGELIN P
MRN: 562996 Acct: 144470309
Age: 45 years Admit Date: 01/01/2011
Discharge Date: 01/31/2011
Discharge Time: 23:59:00 PST

9800 Fredericksburg Road
San Antonio, Texas 78288

JACOB EMRANI
1516 SOUTH BROADWAY
LOS ANGELES CA 90015

May 10, 2011

Reference: REGELIN CASTILLO

Dear Sir,

I am writing regarding the claim referenced below.

We reviewed your demand and as you have been advised our insured's uninsured motorist coverage is $30,000 per person/$60,000 per accident.

USAA has paid $4,243.50 through the medical payments coverage. The auto policy states that we can offset this from the value of the claim.

Today, I am offering you $7,662.50 to settle the uninsured motorist claim.

Please explain and offer this to our insured at your earliest convenience.

Policyholder:	Abel Castillo
Reference #:	20829714-7104-3-8523
Date of loss:	July 19, 2010
Loss location:	Glendale, California

You may submit correspondence or questions to me. My contact information is:

Address:	Auto Injury Solutions Attn: USAA Medical Mail Dept. P.O. Box 5000 Daphne, AL 36526
Fax:	1-888-272-1255
Phone:	1-800-531-8722, ext. 3-1455

Sincerely,

Cindy L Gillis, SCLA
USAA Southwest Regional Office
United Services Automobile Association

20829714 - 3 - CA - 07/19/10 - 8523 - 18 - A200 - DM01771

9800 Fredericksburg Road
San Antonio, Texas 78288

JACOB EMRANI
1516 SOUTH BROADWAY
LOS ANGELES CA 90015

May 11, 2011

Reference: Settlement confirmation

Dear Sir,

We received your settlement packet concerning the following claim:

Your client:	REGELIN CASTILLO
Our policyholder:	Abel Castillo
Claim #:	20829714-7104-3-8523
Date of loss:	July 19, 2010
Loss location:	Glendale, California

We decline your offer for us to pay $20,000.00. Based upon the accident and medical facts, we counter offer $8,500.00 in full and final settlement of all claims. We believe this offer represents the fair value of the claim.

You may submit correspondence to:

Auto Injury Solutions
Attn: USAA Medical Mail Dept.
P. O. Box 5000
Daphne, AL 36526
Fax: 1-888-272-1255

If you have questions, please call me at 1-800-531-8722, ext. 3-1455.

Sincerely,

Cindy L Gillis, SCLA
USAA Southwest Regional Office
United Services Automobile Association

9800 Fredericksburg Road
San Antonio, Texas 78288

JACOB EMRANI
1516 SOUTH BROADWAY
LOS ANGELES CA 90015

May 16, 2011

Reference: Claim # 20829714-7104-3-8523
Your Client: REGELIN CASTILLO

Dear Sir,

I am pleased we have reached an amicable resolution of this matter. Please have your client sign the enclosed release, have the signature witnessed, and return as soon as possible.

Upon receipt of the signed and witnessed release, we will forward our payment.

Sincerely,

Cindy L Gillis, SCLA
USAA Southwest Regional Office
United Services Automobile Association

Enc: UM Rel w/Sub

9800 Fredericksburg Road
San Antonio, Texas 78288

JACOB EMRANI
1516 SOUTH BROADWAY
LOS ANGELES CA 90015

June 20, 2011

Reference: Additional Information Needed

Dear Sir,

We are writing regarding the following claim:

Your client:	REGELIN CASTILLO
Policyholder:	Abel Castillo
Claim #:	20829714-7104-3-8523
Date of loss:	July 19, 2010
Loss location:	Glendale, California

Please provide the following information needed to evaluate and complete the claim:

- Last month we settled our insured/your client's injury claim. To date, I have not received the release. Please send/fax it to me at your earliest convenience.

If you have questions, please call me at 1-800-531-8722, ext. 3-1455.

Sincerely,

Cindy L Gillis, SCLA
USAA Southwest Regional Office
United Services Automobile Association

Enc: 00792 Env

9800 Fredericksburg Road
San Antonio, Texas 78288

REGELIN CASTILLO
509 HILL DR
GLENDALE CA 91206-2840

June 28, 2011

Reference: Settlement check notice

Dear REGELIN CASTILLO,

We issued a check on June 28, 2011, in the amount of $10,000, payable to you and your representative, JACOB EMRANI, for the claim listed below.

Policyholder:	Abel Castillo
Claim #:	20829714-71043-8523
Date of loss:	July 19, 2010
Loss location:	Glendale, California
Reason for payment:	uninsured motorist settlement

The check was mailed to:
1516 SOUTH BROADWAY
LOS ANGELES CA

If you have any questions about this notice, please contact your attorney.

Sincerely,

Cindy L Gillis, SCLA
USAA Southwest Regional Office
United Services Automobile Association

9800 Fredericksburg Road
San Antonio, Texas 78288

USAA®

01771.9DCR.JSS202306800.01.01.222

JACOB EMRANI
1516 SOUTH BROADWAY
LOS ANGELES CA 90015

June 20, 2011

Reference: Additional Information Needed

Dear Sir,

We are writing regarding the following claim:

Your client:	REGELIN CASTILLO
Policyholder:	Abel Castillo
Claim #:	20829714-7104-3-8523
Date of loss:	July 19, 2010
Loss location:	Glendale, California

Please provide the following information needed to evaluate and complete the claim:

- Last month we settled our insured/your client's injury claim. To date, I have not received the release. Please send/fax it to me at your earliest convenience.

If you have questions, please call me at 1-800-531-8722, ext. 3-1455.

Sincerely,

Cindy L Gillis, SCLA
USAA Southwest Regional Office
United Services Automobile Association

Enc: 00792 Env

USAA

United Services Automobile Association

UNINSURED MOTORIST COVERAGE RELEASE

(Bodily Injury or Death with Subrogation Provisions)

Member Name	USAA Number	UR Number	Date of Loss
Abel Castillo	20829714	3	07-19-2010

KNOW ALL MEN BY THESE PRESENTS:

that I/we REGELIN CASTILLO and ABEL CASTILLO, of the City of Los Angeles, State of California, being at least of the age of majority, for and in consideration of the sum of Ten Thousand Dollars and 00/100 ($ 10,000.00), the receipt whereof is hereby acknowledged, do release and forever discharge United Services Automobile Association (hereinafter called the COMPANY), in full and final settlement, from any and all claims that I/we may have under the Uninsured Motorist coverage of Policy No. 20829714-7104 issued in the name of Abel Castillo by the Company for damages, both known and unknown, caused by the ownership, maintenance, or use of an uninsured automobile and resulting from an accident which occurred on or about July 19, 2010 at or near Glendale, CA.

It is expressly warranted and agreed that no promise or agreement not herein expressed has been made to me/us, and in executing this release I/we am/are not relying upon any statement or representation made to me/us by anyone who has acted for the Company or on its behalf, but I/we am/are relying solely upon my/our own judgment.

I/We certify that no settlement has been made with and no release given to any person, corporation, firm or entities allegedly liable for such damages and that no such settlement will be made nor release given nor judgment obtained without the written consent of the Company and, as a further consideration of this payment, I/we agree that the aforesaid sum is repayable only in the event and to the extent of any recovery that I/we may make from any person or organization legally responsible for the damages which are the subject of this claim under the aforesaid policy.

I/We agree to take, through the representative designated by the Company, such action in my/our own name as is requested by the Company to recover damages from the owner and/or the operator of the uninsured automobile or any person or organization legally responsible for the damages because of which this payment has been made by the Company and to cooperate fully with the representative designated by the Company in presenting claim and, if necessary, to give testimony in the prosecution of an action against such party or parties and, at the request of the Company, to execute releases and any other documents that may be necessary to effectuate a final disposition of my/our claim against said party or parties. All expenses and costs incident to the taking of any action requested by the Company will be paid by the Company, and any money recovered as a result of judgment, settlement, or otherwise, whether obtained as a result of action requested by the Company or not, will be paid to the Company provided, however, any net recovery in excess of the consideration shown above, the costs and attorney's fees, shall be retained by me/us.

Continued on back

CALIFORNIA Statutes, Section 1871.2(a) states: "For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

Executed at EL SEGUNDO, CA (City/State), this 23rd (Day) day of MAY (Month), 2011 (Year)

WITNESSES:

Marianne Mackey
Signature
Farmers Chavez, Los Angeles 90033
Address

Raquel T. Arteaga
Signature
483 N. AVIATION BLVD
Address
EL SEGUNDO, CA 91206

CAUTION: READ BEFORE SIGNING

Legal Signature
REGELIN CASTILLO
Print Name

Legal Signature
ABEL CASTILLO
Print Name

RA011-1206

20629714 - CA - D - 7104 - 9 - 8523 / 18

Glendale Adventist Medical Center

Adventist Health

AIS 2 01-17-2012 17:10 2427

1ST LEVEL APPEAL
PROVIDER DISPUTE RESOLUTION

January 12, 2012

Dear Director of Claims:

We are requesting that you review the payment made to our facility regarding the patient listed below:

Re: Patient: **CASTILLO, REGELIN**
Policy: **02082-97-14**
DOS: **8/11/10-8/31/10**
Account#: **144402724**
Tax ID#: **95-1816017**

Based on the payment we received, we feel reimbursement was **UNDERPAID. PER CONVERSATION WITH KAREN AT USAA ON 12/20/11, I WAS TOLD CLAIM WAS PAID PER THREE RIVERS CONTRACT. THE THREE RIVERS CONTRACT RATE IS 85% OF BILLED CHARGES; THEREFORE THE ALLOWED AMOUNT FOR THIS CLAIM IS $2,198.95. PLEASE REPROCESS CLAIM FOR ADDITIONAL PAYMENT.**
Our records indicate we should have been paid as follows:

Total Claim Charges		**$**	**2,587.00**
Contract Amount Due		**$**	**2,198.95**
Less Amount Paid	**<**	**$**	**1,072.00** **>**
Patient Responsibility	**<**	**$**	**-** **>**
UNDERPAYMENT		**$**	**1,126.95**

We would also like to remind you of H&S code 1371.37 which states: " A health care service plan is prohibited from engaging in a demonstrable and unjust pattern, as defined by the department of reducing the amount of payment or denying complete and accurate claims."
We await your response.

Sincerely,

Shawna M.
Account Specialist
Phone: (818) 409-8200
Fax: (818) 956-7613

Glendale Adventist Medical Center
DEPT 2006
Los Angeles, CA 90084

1 GLENDALE ADV MED CENTER 1509 WILSON TERRACE GLENDALE CA 91206 8184098200 8185465684	2 GLENDALE ADV MED CENTER DEPT NO 2006 LOS ANGELES CA 90084	3a PAT CNTL # 144402724-4998 b. MED REC # 56[illegible]6	4 TYPE OF BILL 0131
		5. FED TAX NO. 0000 951816017	6 STATEMENT COVERS PERIOD FROM 081110 THRU 083110
			7 00

AI5 [illegible] -17-2012 17 :30 2428

8 PATIENT NAME	9 PATIENT ADDRESS
a	a 27003 MOUNTIAN WILLOW LN
b CASTILLO REGELIN P	b SANTA CLARITA c CA d 913870000 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
07231965	F	081110	17	3	1		01												CA	

	31 OCCURRENCE CODE	31 OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE SPAN CODE	35 FROM	35 THROUGH	36 OCCURRENCE SPAN CODE	36 FROM	36 THROUGH	37
a	01	071910													a
b															b

38	39 VALUE CODES	AMOUNT	40 VALUE CODES	AMOUNT	41 VALUE CODES	AMOUNT
USSA PO BOX 5000 ATTN MEDICAL CLAIMS DAPHNE AL 36526	a					
	b					
	c					
	d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0420	ELECTRIC STIMULATION THE	97014	082410	1	7500			1
2	0420	ELECTRIC STIMULATION THE	97014	082610	1	7500			2
3	0420	ELECTRIC STIMULATION THE	97014	083110	1	7500			3
4	0420	THERAPEUTIC EXERCISES	97110	081110	2	18200			4
5	0420	THERAPEUTIC EXERCISES	97110	081910	2	18200			5
6	0420	THERAPEUTIC EXERCISES	97110	082610	2	18200			6
7	0420	THERAPEUTIC EXERCISES	97110	083110	2	18200			7
8	0420	NEUROMUSCULAR REEDUCATIO	97112	081110	1	9100			8
9	0420	NEUROMUSCULAR REEDUCATIO	97112	082410	2	18200			9
10	0420	MANUAL THERAPY	97140	081110	2	18200			10
11	0420	MANUAL THERAPY	97140	081910	2	18200			11
12	0420	MANUAL THERAPY	97140	082410	2	18200			12
13	0420	MANUAL THERAPY	97140	082610	2	18200			13
14	0420	MANUAL THERAPY	97140	083110	2	18200			14
15	0424	PT EVALUATION	97001	081110	1	45100			15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23	0001	PAGE 1 OF 1	CREATION DATE	092010	TOTALS →	258700	000		23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO.	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1831188275	
A	USSA	999990000	Y	Y	000	258700	57	050239	A
B	BLUE SHIELD-EXCL CARE-WMM		Y	Y			OTHER PRV ID		B
C									C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	CASTILLO REGELIN P	18	20829714		20829714
B	CASTILLO REGELIN P			WMMC	
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A	NONENEEDED		WHITE MEMORIAL MEDICAL C
B			WHITE MEMORIAL MEDICAL C
C			

66 DX										68
	V571	7231	7245							

69 ADMIT DX	70 PATIENT REASON DX				71 PPS CODE	72 ECI	73
V571					000		

74 PRINCIPAL PROCEDURE CODE	DATE	a OTHER PROCEDURE CODE	DATE	b OTHER PROCEDURE CODE	DATE	75
c OTHER PROCEDURE CODE	DATE	d OTHER PROCEDURE CODE	DATE	e OTHER PROCEDURE CODE	DATE	

80 REMARKS	81 CC		
	a	B3	282N00000X
	b		
	c		
	d		

76 ATTENDING	NPI 1265517114	QUAL 0B	G61050	
LAST LAU	FIRST SUSIE	H		
77 OPERATING	NPI	QUAL		
LAST	FIRST			
78 OTHER	NPI	QUAL		
LAST	FIRST			
79 OTHER	NPI	QUAL		
LAST	FIRST			

UB-04-CMS-1450

1ST LEVEL APPEAL
PROVIDER DISPUTE RESOLUTION

January 12, 2012

Dear Director of Claims:

We are requesting that you review the payment made to our facility regarding the patient listed below:

Re: Patient: **CASTILLO, REGELIN**
Policy: **02082-97-14**
DOS: **10/1/10-10/31/10**
Account#: **144423332**
Claim#: **AM2328438 & AM2621771**
Tax ID#: **95-1816017**

Based on the payment we received, we feel reimbursement was **UNDERPAID. PER CONVERSATION WITH KAREN AT USAA ON 12/20/11, I WAS TOLD CLAIM WAS PAID PER THREE RIVERS CONTRACT. THE THREE RIVERS CONTRACT RATE IS 85% OF BILLED CHARGES; THEREFORE THE ALLOWED AMOUNT FOR THIS CLAIM IS $1,119.45. PLEASE REPROCESS CLAIM FOR ADDITIONAL PAYMENT.**
Our records indicate we should have been paid as follows:

Total Claim Charges		**$**	**1,317.00**
Contract Amount Due		**$**	**1,119.45**
Less Amount Paid	**<**	**$**	**810.05** **>**
Patient Responsibility	**<**	**$**	**-** **>**
UNDERPAYMENT		**$**	**309.40**

We would also like to remind you of H&S code 1371.37 which states: " A health care service plan is prohibited from engaging in a demonstrable and unjust pattern, as defined by the department of reducing the amount of payment or denying complete and accurate claims."
We await your response.

Sincerely,

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Account Specialist
Phone: (818) 409-8200
Fax: (818) 956-7613

Glendale Adventist Medical Center
DEPT 2006
Los Angeles, CA 90084

1	GLENDALE ADVENTIST MEDICA 1509 WILSON TERRACE GLENDALE CA 91206 ~~8184098200 8185465684~~
2	GLENDALE ADV MED CTR DEPT NO 2006 LOS ANGELES CA 90084
3a PAT CNTL #	144423332-4998
b. MED REC #	562996
4 TYPE OF BILL	0137
5. FED TAX NO.	0000 951816017
6 STATEMENT COVERS PERIOD FROM / THRU	100110 / 103110
7	00

AIS 01-17-2012 17:16 2430

8 PATIENT NAME	9 PATIENT ADDRESS
b CASTILLO REGELIN P	a 27003 MOUNTIAN WILLOW LN b SANTA CLARITA c CA d 913870000

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	29 ACDT STATE
07231965	F	100110	00	3	1		01	CA

31 OCCURRENCE CODE	DATE
a 01	071910

38
USSA
PO BOX 5000
ATTN MEDICAL CLAIMS
DAPHNE AL 36526

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0420	NEUROMUSCULAR REEDUCATIO	97112	100710	2	182 00		
2	0420	NEUROMUSCULAR REEDUCATIO	97112	101410	2	182 00		
3	0420	NEUROMUSCULAR REEDUCATIO	97112	102110	2	182 00		
4	0420	MANUAL THERAPY	97140	100710	2	182 00		
5	0420	MANUAL THERAPY	97140	101410	2	182 00		
6	0420	MANUAL THERAPY	97140	102110	2	182 00		
7	0420	ELECTRIC STIMULATION THE	97014	100710	1	75 00		
8	0420	ELECTRIC STIMULATION THE	97014	102110	1	75 00		
9	0420	ELECTRICAL STIMULATION	97032	101410	1	75 00		
23	0001	*PAGE* 1 *OF* 1	*CREATION DATE*	051011	*TOTALS*	1317 00	000	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
A USSA	999990000	Y	Y	0 00	1317 00	1831188275

57 OTHER PRV ID

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A CASTILLO REGELIN P	18	20829714		20829714

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A NONENEEDED		WHITE MEMORIAL MEDICAL C

66 DX: V571 | 7231 | 7245

69 ADMIT DX | 70 PATIENT REASON DX: V571 | 71 PPS CODE: 000 | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | a OTHER PROCEDURE CODE DATE | b OTHER PROCEDURE CODE DATE | 75
c OTHER PROCEDURE CODE DATE | d OTHER PROCEDURE CODE DATE | e OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 1265517114 QUAL 0B G61050
LAST LAU FIRST SUSIE H
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS

81CC a B3 282N00000X
b
c
d

UB-04-CMS-1450

001119c8945d284

1ST LEVEL APPEAL
PROVIDER DISPUTE RESOLUTION

January 12, 2012

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Tax ID#: **95-1816017**

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Shawna M.
Account Specialist
Phone: (818) 409-8200
Fax: (818) 956-7613

Glendale Adventist Medical Center
DEPT 2006
Los Angeles, CA 90084

1	2	3a PAT CNTL # / b. MED REC #	4 TYPE OF BILL
GLENDALE ADV MED CENTER	GLENDALE ADV MED CENTER	144402724-4998	
1509 WILSON TERRACE	DEPT NO 2006	562916	0131
GLENDALE CA 91206	LOS ANGELES CA 90084	5. FED TAX NO. 0000	6 STATEMENT COVERS PERIOD FROM / THRU; 7 00
8184098200 8185465684		951816017	081110 / 083110

AI5 01-17-2012 17:30 2

8 PATIENT NAME a
b CASTILLO REGELIN P

9 PATIENT ADDRESS a 27003 MOUNTIAN WILLOW LN
b SANTA CLARITA c CA d 913870000 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
07231965	F	081110	17	3	1		01		CA	

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a	01	071910													
b															

38
USSA
PO BOX 5000
ATTN MEDICAL CLAIMS
DAPHNE AL 36526

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0420	ELECTRIC STIMULATION THE	97014	082410	1	75 00		
2	0420	ELECTRIC STIMULATION THE	97014	082610	1	75 00		
3	0420	ELECTRIC STIMULATION THE	97014	083110	1	75 00		
4	0420	THERAPEUTIC EXERCISES	97110	081110	2	182 00		
5	0420	THERAPEUTIC EXERCISES	97110	081910	2	182 00		
6	0420	THERAPEUTIC EXERCISES	97110	082610	2	182 00		
7	0420	THERAPEUTIC EXERCISES	97110	083110	2	182 00		
8	0420	NEUROMUSCULAR REEDUCATIO	97112	081110	1	91 00		
9	0420	NEUROMUSCULAR REEDUCATIO	97112	082410	2	182 00		
10	0420	MANUAL THERAPY	97140	081110	2	182 00		
11	0420	MANUAL THERAPY	97140	081910	2	182 00		
12	0420	MANUAL THERAPY	97140	082410	2	182 00		
13	0420	MANUAL THERAPY	97140	082610	2	182 00		
14	0420	MANUAL THERAPY	97140	083110	2	182 00		
15	0424	PT EVALUATION	97001	081110	1	451 00		
16								
17								
18								
19								
20								
21								
22								
23	0001	PAGE 1 OF 1	CREATION DATE	092010	TOTALS	2587 00	0 00	

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO.	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 1831188275
A	USSA	999990000	Y	Y	0 00	2587 00	57 OTHER PRV ID 050239
B	BLUE SHIELD-EXCL CARE-WMM		Y	Y			
C							

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	CASTILLO REGELIN P	18	20829714		20829714
B	CASTILLO REGELIN P			WMMC	
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A	NONENEEDED		WHITE MEMORIAL MEDICAL C
B			WHITE MEMORIAL MEDICAL C
C			

66 DX: V571 | 7231 | 7245 — 68

69 ADMIT DX V571 | 70 PATIENT REASON DX | 71 PPS CODE 000 | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | a OTHER PROCEDURE CODE DATE | b OTHER PROCEDURE CODE DATE | 75
c OTHER PROCEDURE CODE DATE | d OTHER PROCEDURE CODE DATE | e OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 1265517114 QUAL 0B G61050
LAST LAU FIRST SUSIE H

77 OPERATING NPI QUAL
LAST FIRST

80 REMARKS

81 CC a B3 282N00000X
b
c
d

78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

UB-04-CMS-1450

901119c8945d284

1ST LEVEL APPEAL
PROVIDER DISPUTE RESOLUTION

January 12, 2012

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Shawna M.
Account Specialist
Phone: (818) 409-8200
Fax: (818) 956-7613

Glendale Adventist Medical Center
DEPT 2006
Los Angeles, CA 90084

1 GLENDALE ADVENTIST MEDICA 1509 WILSON TERRACE GLENDALE CA 91206 8184098200-8185465684	2 GLENDALE ADV MED CTR DEPT NO 2006 LOS ANGELES CA 90084	3a PAT CNTL # 144423332-4998 b. MED REC # 562996	4 TYPE OF BILL 0137
		5. FED TAX NO. 951816017	6 STATEMENT COVERS PERIOD FROM 100110 THRU 103110

AIS 03-17-2012 17:1

8 PATIENT NAME	9 PATIENT ADDRESS
a	a 27003 MOUNTIAN WILLOW LN
b CASTILLO REGELIN P	b SANTA CLARITA c CA d 913870000 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
07231965	F	100110	00	3	1		01												CA	

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a	01	071910													a
b															b

38	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
USSA PO BOX 5000 ATTN MEDICAL CLAIMS DAPHNE AL 36526	a					
	b					
	c					
	d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0420	NEUROMUSCULAR REEDUCATIO	97112	100710	2	18200		1
2	0420	NEUROMUSCULAR REEDUCATIO	97112	101410	2	18200		2
3	0420	NEUROMUSCULAR REEDUCATIO	97112	102110	2	18200		3
4	0420	MANUAL THERAPY	97140	100710	2	18200		4
5	0420	MANUAL THERAPY	97140	101410	2	18200		5
6	0420	MANUAL THERAPY	97140	102110	2	18200		6
7	0420	ELECTRIC STIMULATION THE	97014	100710	1	7500		7
8	0420	ELECTRIC STIMULATION THE	97014	102110	1	7500		8
9	0420	ELECTRICAL STIMULATION	97032	101410	1	7500		9
10								10
11								11
12								12
13								13
14								14
15								15
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21								21
22								22
23	0001	PAGE 1 OF 1		CREATION DATE 051011	TOTALS	131700	000	23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO.	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID
A	USSA	999990000	Y	Y	000	131700	1831188275	A
B								B
C								C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	CASTILLO REGELIN P	18	20829714		20829714
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A	NONENEEDED		WHITE MEMORIAL MEDICAL C
B			
C			

66 DX										67	68
	V571	7231	7245	C							
				K	L			G			

69 ADMIT DX	70 PATIENT REASON DX				71 PPS CODE	72 ECI				73
	V571	a	b	c	000					

74 PRINCIPAL PROCEDURE CODE	DATE	a OTHER PROCEDURE CODE	DATE	b OTHER PROCEDURE CODE	DATE	75
c OTHER PROCEDURE CODE	DATE	d OTHER PROCEDURE CODE	DATE	e OTHER PROCEDURE CODE	DATE	

80 REMARKS	81 CC		
	a	B3	282N00000X
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76 ATTENDING	NPI 1265517114	QUAL 0B	G61050
LAST LAU		FIRST SUSIE H	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

UB-04-CMS-1450

Adventist Health

Revenue Recovery Department
P.O. Box 619081
Roseville, CA 95661-9081

PROVIDER DISPUTE/2nd LEVEL APPEAL

URGENT REVIEW REQUIRED

June 5, 2012

USAA
ATTN: Apeals
P.O. Box 33490
San Antonio, TX 78265

Patient: CASTILLO, REGELIN	**Total Charges:**	**$ 2,587.00**
ID#: 20829714	**Contract Amount Due:**	**$ 2,198.95**
D.O.S.: 08/11/10 – 08/31/10	**Amount Paid:**	**$ 1,072.00**
Account #:144402724	**Patient Responsibility:**	**$ -**
Tax ID#: 951816017	**Underpayment:**	**$ 1,126.95**

Dear Director of Appeals:

Glendale Adventist Medical Center (GAMC) has submitted a claim and a 1st level appeal on the above referenced patient. Based on the payment we received, we feel reimbursement was reduced well below the anticipated payment. It does not appear that your company's allowance on the above claim is in compliance with our contract. Our records indicate that we should have been paid as follows, per **CONTRACT**:

The rate that is to be used in conjunction with the agreement between GAMC and TRPN will be paid at a Fifteen Percent (15%) discount from "FACILITIES" usual billed charges: Total Due GAMC = $2,198.95

Our records indicate that this claim remains un-reconciled and thus additional payment is now due. We are amicably seeking resolution to this claim. However, we would like to remind you of ***Health & Safety Code Section 1371.37*** which states: **"A health care service plan is prohibited from engaging in a demonstrable and unjust pattern, as defined by the department of reducing the amount of payment or denying complete and accurate claims."**

We remind you of ***CA Code of Regulations Title 28 1300.71(d)***: **A plan shall not improperly deny, adjust, or contest a claim. For each claim that is either denied, adjusted or contested, the plan provider shall provide an accurate and clear written explanation of the specific reasons for the action taken within the timeframes specified in Sections (g) and (h).**

We thank you in advance for your rapid response. If you have any additional questions or concerns, please feel free to contact me at (916) 781-3325.

Sincerely,

Wesley W Patton

ATS3 B6133813 18:14 4

1	2	3a PAT CNTL #	4 TYPE OF BILL
GLENDALE ADV MED CENTER 1509 WILSON TERRACE GLENDALE CA 91206 8184098200 8185465684	GLENDALE ADV MED CENTER DEPT NO 2006 LOS ANGELES CA 90084	144402721 4998 b. MED REC# 562996	0131
		5. FED TAX NO 0000 951816017	6 STATEMENT COVERS PERIOD FROM 081110 THRU 083110
			7 00

8 PATIENT NAME	9 PARENT ADDRESS
a	a 27003 MOUNTIAN WILLOW LN
b CASTILLO REGELIN P	b SANTA CLARITA c CA d 913870000 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22	23	24	25	26	27	28	29 ACCT STATE	30
07231965	F	081110	17	3	1		01												CA	

	31 OCCURRENCE CODE	31 OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE SPAN CODE	35 OCCURRENCE SPAN FROM	35 OCCURRENCE SPAN THROUGH	36 OCCURRENCE SPAN CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37	
a	01	071910														a
b																b

38	39 VALUE CODES CODE	39 VALUE CODES AMOUNT	40 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	41 VALUE CODES AMOUNT
USSA PO BOX 5000 ATTN MEDICAL CLAIMS DAPHNE AL 36526	a					
	b					
	c					
	d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0420	ELECTRIC STIMULATION THE	97014	082410	1	7500			1
2	0420	ELECTRIC STIMULATION THE	97014	082610	1	7500			2
3	0420	ELECTRIC STIMULATION THE	97014	083110	1	7500			3
4	0420	THERAPEUTIC EXERCISES	97110	081110	2	18200			4
5	0420	THERAPEUTIC EXERCISES	97110	081910	2	18200			5
6	0420	THERAPEUTIC EXERCISES	97110	082610	2	18200			6
7	0420	THERAPEUTIC EXERCISES	97110	083110	2	18200			7
8	0420	NEUROMUSCULAR REEDUCATIO	97112	081110	1	9100			8
9	0420	NEUROMUSCULAR REEDUCATIO	97112	082410	2	18200			9
10	0420	MANUAL THERAPY	97140	081110	2	18200			10
11	0420	MANUAL THERAPY	97140	081910	2	18200			11
12	0420	MANUAL THERAPY	97140	082410	2	18200			12
13	0420	MANUAL THERAPY	97140	082610	2	18200			13
14	0420	MANUAL THERAPY	97140	083110	2	18200			14
15	0424	PT EVALUATION	97001	081110	1	45100			15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23	0001	PAGE 1 OF 1	CREATION DATE	092010	TOTALS	258700	000		23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO.	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1831188275	
A	USSA	999990000	Y	Y	000	258700	57 OTHER PRV ID	050239	A
B		94036NOCD			000	000			B
C									C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
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	V571	7231	7245							

69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73
V571		000		

74 PRINCIPAL PROCEDURE CODE	DATE	a OTHER PROCEDURE CODE	DATE	b OTHER PROCEDURE CODE	DATE	75
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80 REMARKS		81 CC		
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76 ATTENDING	NPI 1265517114	QUAL 0B	G61050	
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77 OPERATING	NPI	QUAL		
LAST		FIRST		
78 OTHER	NPI	QUAL		
LAST		FIRST		
79 OTHER	NPI	QUAL		
LAST		FIRST		

UB-04-CMS-1450

2. Provided for the diagnosis or direct care and treatment of the medical condition, and
3. Within the standards of good medical practice within the organized medical community, and
4. The most appropriate supply or level of service, which can safely be provided. For Provider stays, this means that care as an inpatient is necessary due to the kind of services the Member is receiving or the severity of the Member's condition.

2.11 "Members" means subscribers or enrolled dependents covered by insurance plans of Client.

2.12 "Participating Provider" means a hospital, physician, or other health professional which has entered into an agreement with TRPN to provide health care services for previously determined rates.

2.13 "Payor" means any insurance company, third party administrator or self insured plan that is contractually obligated to indemnify or make payment on behalf of covered persons with respect to covered services, including health, workers' compensation, automobile and general liability, and that has contracted directly or indirectly with TRPN to arrange for the provisions of covered services to covered persons.

2.14 "Per Diem" means a measure of payment for a Day of Service. The Per Diem rates are shown in Attachment A to this contract (if applicable).

2.15 "Physician Services" means service provided by a physician member of an IPA, medical group, or an individually contracted physician.

III. PROVIDER SERVICES AND RESPONSIBILITIES

3.1 **"Hospital"** shall provide to Members Provider Services that are Medically Necessary when such services are ordered by a licensed physician or other licensed health professional.

3.2 Members shall be accommodated in semi-private rooms unless other accommodations are Medically Necessary. If a semi-private room is not available, then any appropriate accommodation may be used. Provider shall render Covered Services in the same manner, in accordance with the same standards, and with the same availability, as offered to other patients. Provider shall not differentiate or discriminate in the treatment of any Member because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, and health status, source of coverage or payment.

5.1 **"Hospital"** shall seek payment from TRPN's Payors only for the provision of Provider Services. The payment from TRPN's Payors for inpatient and outpatient services provided by Provider shall be in accordance with the following terms:

During the course of this agreement "Hospital" agrees to provide covered services for all eligible Members. TRPN's Payors agree to pay the Provider at the contracted rate; see Attachment A and such payment will be construed to represent payment in full which prohibits the Provider from Balance Billing the patient as described in item 2.12 when such Payor is the Primary Payor and no secondary Payor exists. It is understood, however, these payments shall be made within thirty, (30) calendar days of receipt of clean claim (defined as a claim not requiring additional information in order to process the entire claim). If payments are not timely received by **"Hospital"** from the Payor then final payment shall be based upon one hundred percent (100%) of billed charges plus any interest allowed in accordance with the laws of the in the state of California

5.2 Where a state mandated fee schedule exists for casualty and/or workers' compensation claims, **"Hospital"** agrees to accept a five percent (5%) discount below the state schedule for such claims.

5.3 Payor agreements shall require Payors to make payments within the time required pursuant to Section 5.1 herein, after receipt of Clean Claims that are accurate and ready for processing, including, but not limited to coordination of benefits determinations, and pre-certification and/or pre-authorization of specifies Covered Services.

5.4 **"Hospital"** shall bill TRPN's Payors on the UB 92 or 1500 form or successor(s). **"Hospital"** shall furnish, upon request, information reasonably required by the applicable Claims Administrator to verify and substantiate the provision of Provider Services and the charges for such services. The Claims Administrator shall maintain the confidentiality of the Member's records and other information provided in accordance with the laws of California.

5.5 TRPN's Payors agree to process and reimburse the **"Hospital"** within thirty (30) calendar days upon the receipt by the Claims Administrator of eligible complete claims that do not require additional medical records. Additional records shall be requested within ten (10) calendar days, of the initial receipt of claim and the related claims shall then be processed promptly and payment made to **"Hospital"** within ten (10) calendar days of the receipt by the Claims Administrator of the additional requested records. If the **"Hospital"** determines such claim(s) to be delinquent beyond the allowable time period above, then the final payment shall be based on one hundred percent (100%) of billed charges plus any interest allowed in accordance with the laws of the State of California.

ATTACHMENT A

The rate that is to be used in conjunction with this agreement between **Glendale Adventist Medical Center** and TRPN will be paid at a Fifteen Percent (15%) discount from **"Facilities"** usual billed charges for all covered Inpatient, Outpatient and Emergency Room services.

For workers compensation claims, **"Hospital"** agrees to accept a five percent (5%) discount below the state schedule for such claims.