



FINAL TREATMENT REVIEW

Quality Control Department

Dear patient,
In an effort to improve our services and increase our patient satisfaction, as well as to evaluation the performance of our staff, we would appreciate if you could give us your candid and sincere opinion of our services.

Patient Name: Marlenis Calmell
Telephone No: (305) 441-1111 D.O.B: _____

Please briefly describe the results of your treatment.

It was an excellent treatment, I can see the results with satisfaction, now I have different legs. I appreciate your effort. Thank you (to you all)

Would you recommend the service to a friend or family member..... Yes No

Did you receive a professional and courteous treatment from start to finish... Yes No

Did everyone you came in contact with give you a detailed explanation of his or her services..... Yes No

Are there any suggestions that you would like to give us that could make our services better?

It is excellent already

Patient Signature: *[Signature]*
Date: 01/04/07

MIAMI - DADE 6785 SW 40 ST. • PH. 305-740-4444

MIAMI LAKES - BROWARD 8028 NW 154 ST. • PH. 305-820-5001



SPECIAL MEDICAL EVALUATION

Medical Necessity Report. Documentation Support

For Direct access to medical record www.expertsinviens.com

Name: CALMELL

MARLENIS

Address:

Miami

FL

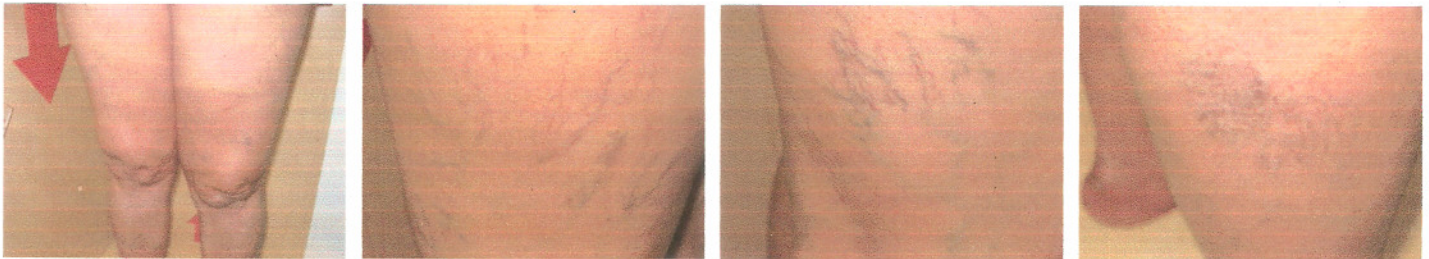
Control No.

1/10/2006

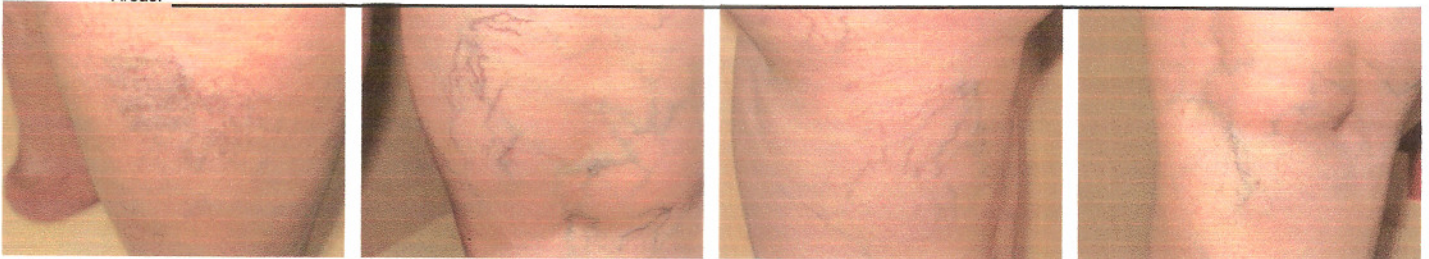
SSN.

Date. Tuesday, January 10, 2006

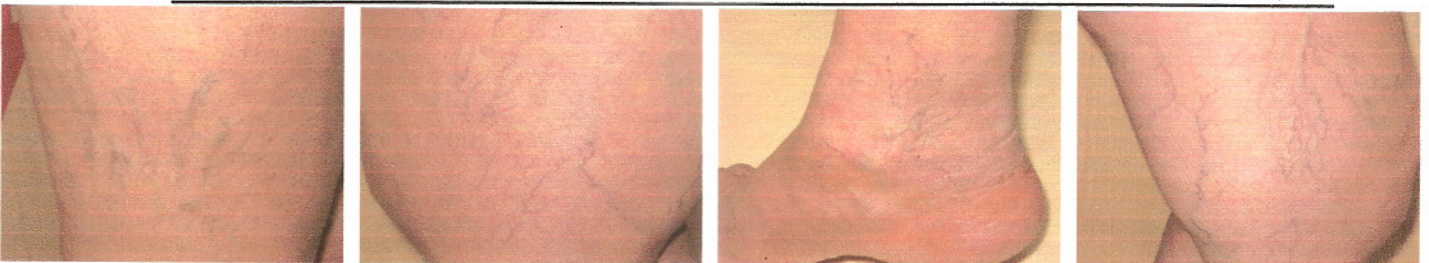
Areas: _____



Areas: _____



Areas: _____



Treatment Options Surgery []: _____

Ulcer []: _____

Sclerotherapy []: _____



SPECIAL MEDICAL EVALUATION

Medical Necessity Report. Documentation Support

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Name CALMELL
Address
Control No

MARLENIS

Miami

FL 3:

SSN.

1/4/2007

Date. Thursday, January 04, 2007

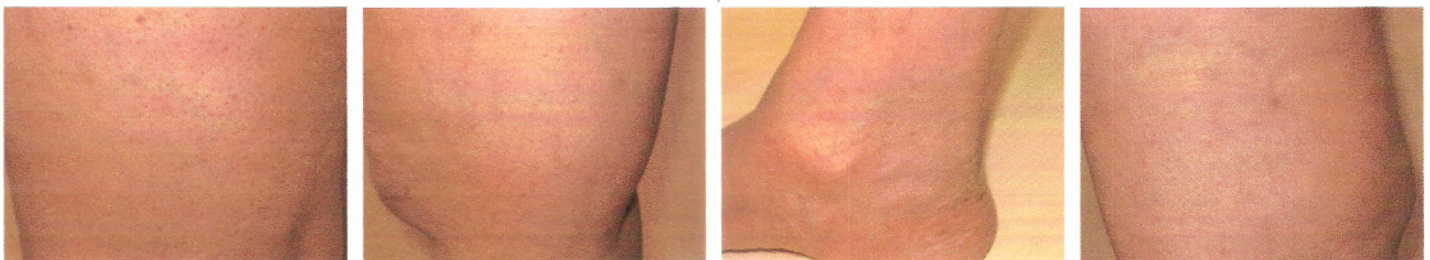
Areas: _____



Areas: _____



Areas: _____



Treatment Options Surgery : _____
Ulcer : _____
Sclerotherapy : _____