



# 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: Gema Muñoz

Telephone No: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Please briefly describe the results of your treatment.

IT has been a wonderful treatment, with mostly no pain, as I thought, and not only fast but maximum satisfactory results, with a very efficient therapist, Raisa.

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?  
Everything is right so far.

Patient Signature: [Signature]  
Date: 3/6/06



# SPECIAL MEDICAL EVALUATION

## Medical Necessity Report. Documentation Support

For Direct access to medical record [www.expertsinviens.com](http://www.expertsinviens.com)

Name: MUNOZ

GEMA

Address

Miami

FL

Control No. (P05)

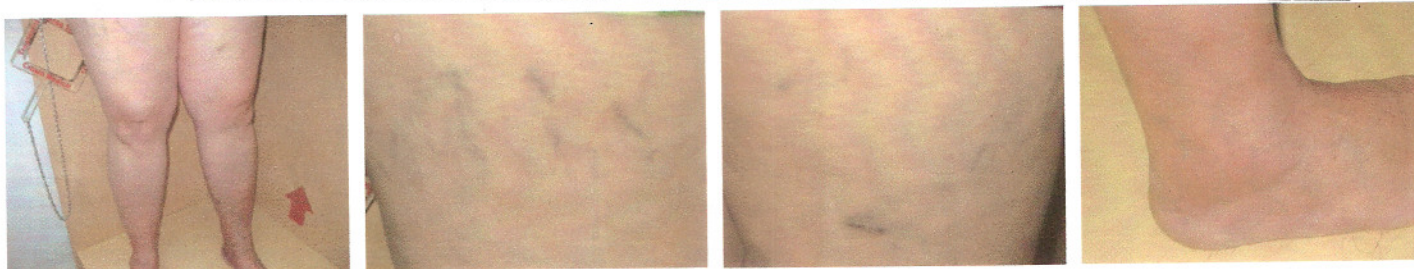
9/17/2005

SSN.

Saturday, September 17, 2005

Date.

Areas: \_\_\_\_\_



Areas: \_\_\_\_\_



Areas: \_\_\_\_\_



Treatment Options Surgery [ ]: \_\_\_\_\_

Ulcer [ ]: \_\_\_\_\_

Sclerotherapy [ ]: \_\_\_\_\_

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**MIAMI - DADE**

6785 SW 40 ST. • PH. 305-740-4444

**MIAMI LAKES - BROWARD**

8028 NW 154 ST. • PH. 305-820-5001



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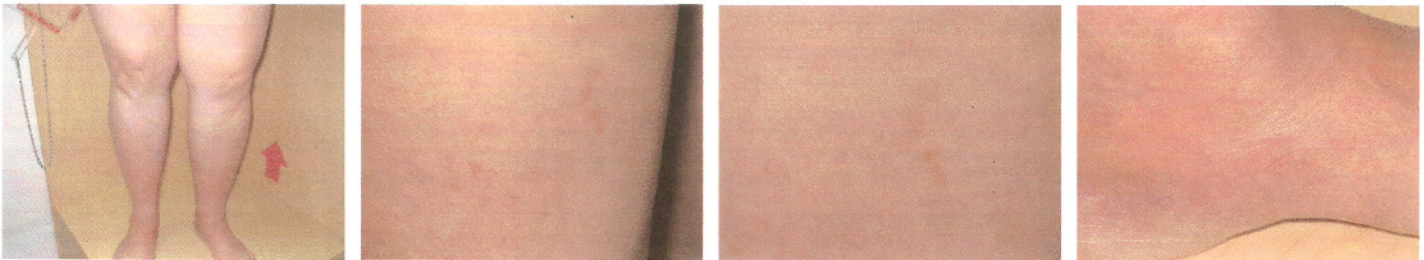
3/6/2006

SSN.

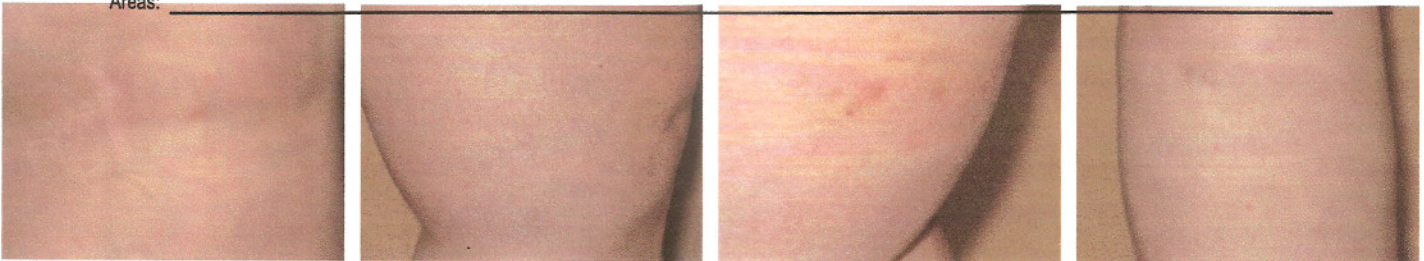
Tuesday, March 14, 2006

Date.

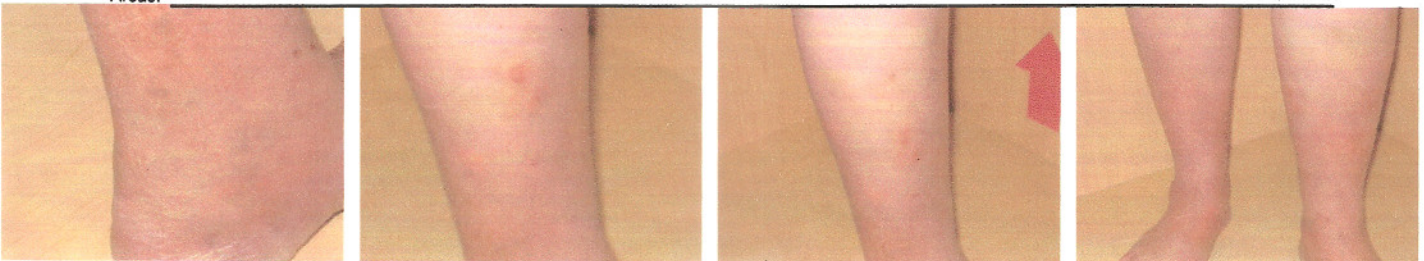
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