



FINAL TREATMENT REIVIEW

Quality Control Department

Dear Patient

In an effort to improve our services and advance every day more our patient satisfaction, as well as to evaluate the performance of our staff we would appreciate if you could give us your candid and sincere option of the services

Patient Name: Saily Ruel
Telephone : _____, DOB: _____ Nationality : _____

Please briefly Describe the results of your treatment

Los resultados son buenos, ya que yo nunca pense que el tratamiento iba haer tan bueno como los resultados que he tenido. No lo esperaba.

*Lo recomiendo.

Gracias Saily.

Would you recommend the services to a friend or family Yes No

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

Did every one that you came in contact with gave you detail explanation of there services Yes No

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

Signature : Saily Ruel

Date : 6/11/04



SPECIAL MEDICAL EVALUATION

Medical Necessity Report. Documentation Support

For Direct access to medical record WWW.expertsinviens.com

RIVERO

SAILY

Name

Address.

Miami

FL

33125

Control No.

3/1/03

SSN.

Saturday, March 01, 2003

Date.

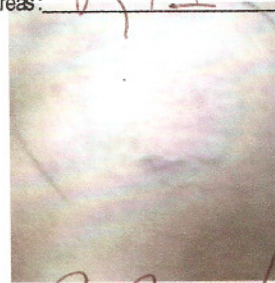
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R3E. R4E. R5E. R5A.



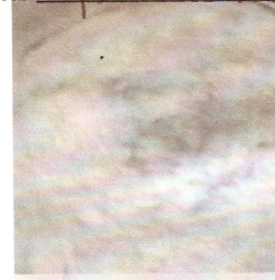
Areas:

R4I. R4P. R3P. R4P.



Areas:

R5P. R5A. R3I. R3E.



Treatment Options Surgery

Ulcer

Sclerotherapy

Treatment Negative





SPECIAL MEDICAL EVALUATION

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Name: RIVERO

SAILY

Address: _____

Miami

FL 33125

Control #: _____

SSN. _____

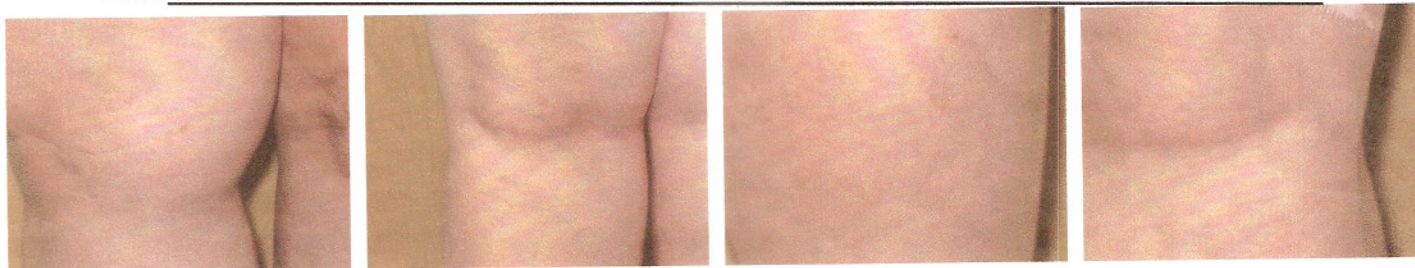
6/11/2004

Date. Friday, June 11, 2004

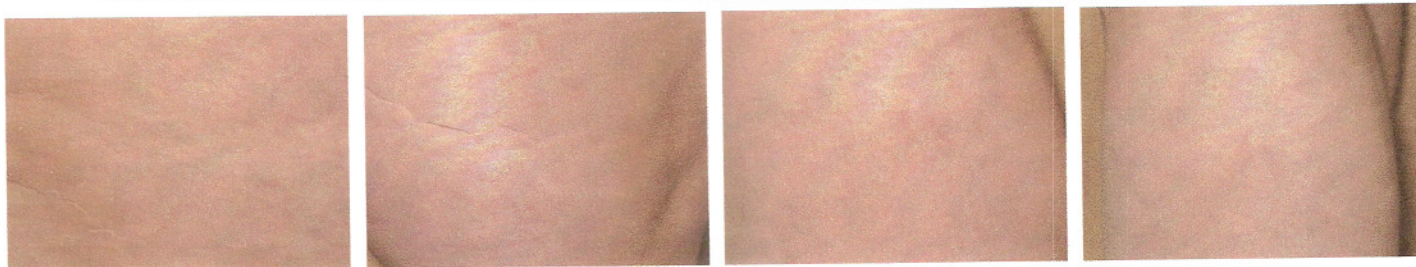
Areas: _____



Areas: _____



Areas: _____



Treatment Options Surgery [] : _____

Ulcer [] : _____

Sclerotherapy [] : _____



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MIAMI - DADE

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