



FINAL TREATMENT REIVEW

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: Esther Diaz Lopez
Telephone : _____, DOB: _____ Nationality : _____

Please briefly Describe the results of your treatment

When I first came to Crown - I had experienced a very ~~good~~ unsatisfactory experience with this kind therapy. - After 11 year and almost two years of treatment I had seen a notable improvement on my condition and therefore I am extremely satisfied !!

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

Keep up the good work

Signature : *Esther Diaz Lopez*

Date : 10/09/04



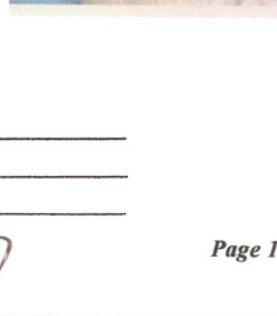
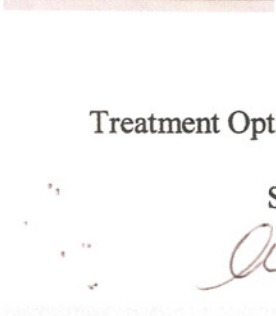
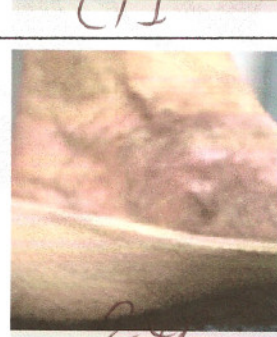
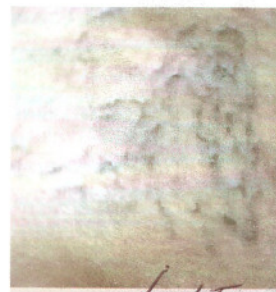
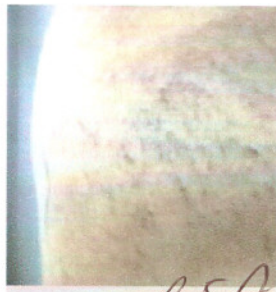
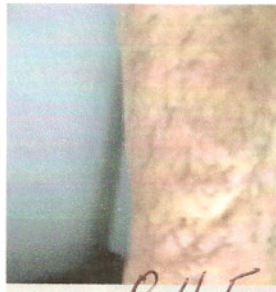
SPECIAL MEDICAL EVALUATION

Medical Necessity Report. Documentation Support

For Direct access: to medical record WWW.expertsinviens.com

Name DIAZ-ALEJO ESTHER
 Address. 106 Miami FL 33172
 Control No. (305) SSN.
 2/14/03 Date. Friday, February 14, 2003

Areas: RIA RBA RVI RBE



Treatment Options Surgery : _____
 Ulcer : _____
 Sclerotherapy : _____

Quelby, RST men 2/14/03



SPECIAL MEDICAL EVALUATION

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Name: DIAZ-ALEJO

ESTHER

Address:

Miami

FL 33172

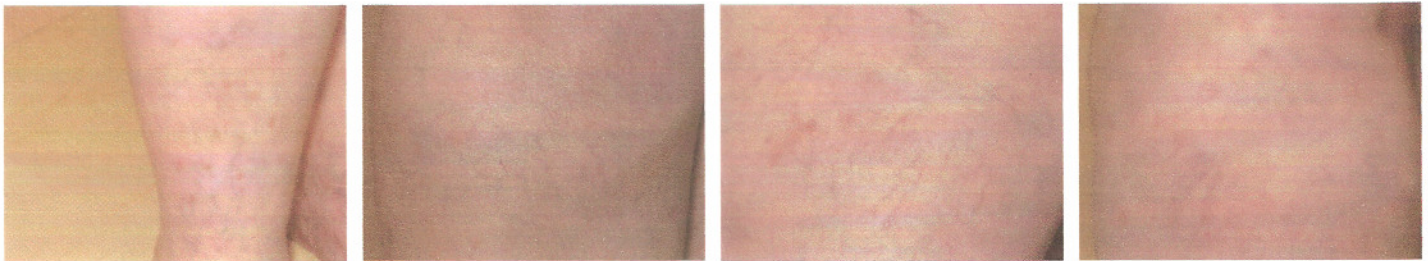
Control No(305)

SSN.

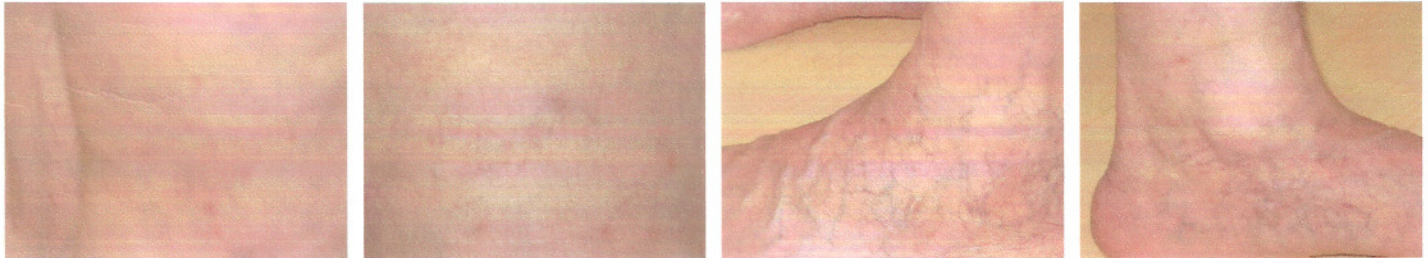
10/9/2004

Date. Saturday, October 09, 2004

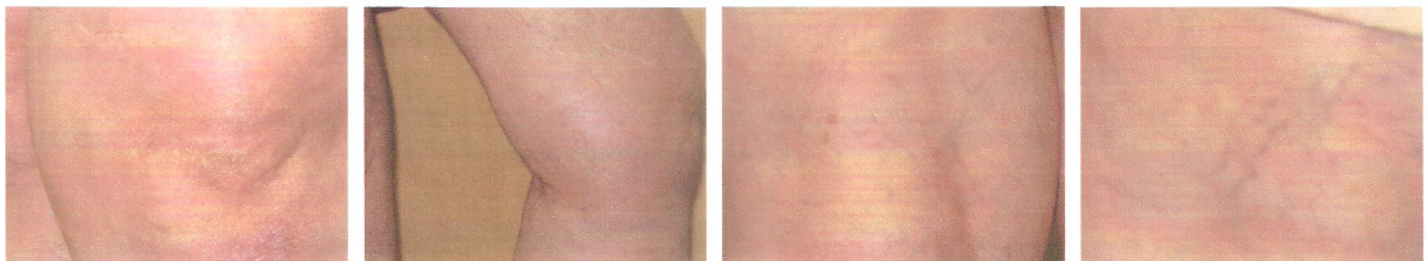
Areas: _____



Areas: _____



Areas: _____



Treatment Options Surgery [] : _____
Ulcer [] : _____
Sclerotherapy [] : _____

