



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: Sonia K. Lopez
Telephone : _____, DOB: _____ Nationality : _____

Please briefly Describe the results of your treatment

Professional & courteous treatment by all staff members. I'm quite pleased w/ my results.

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 : *S. Lopez*

Date : 4/5/09

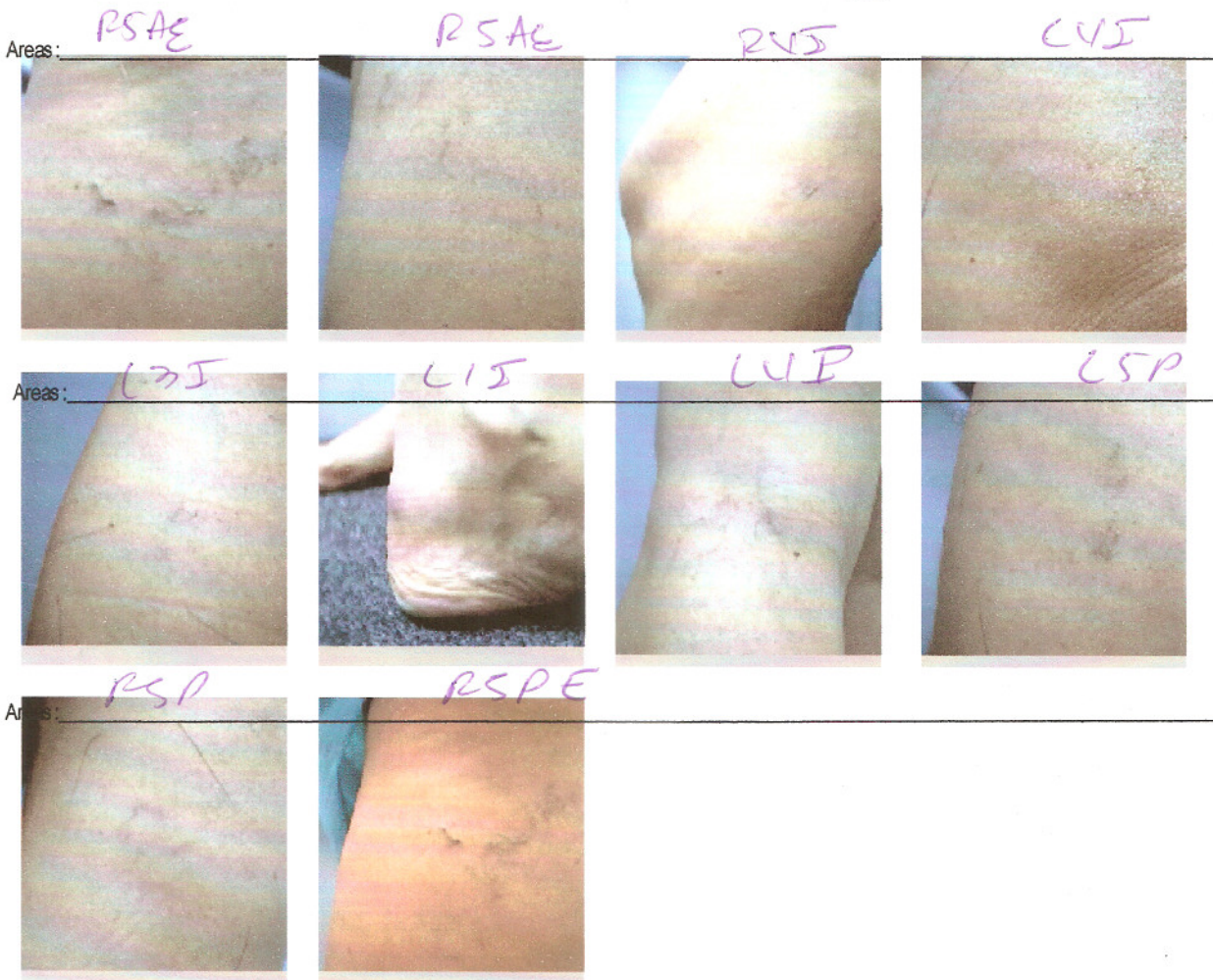


SPECIAL MEDICAL EVALUATION

Medical Necessity Report. Documentation Support

LOPEZ For Direct access: to medical records www.expertsinviens.com

Name Coral Gables FL 33134
 Address (305)
 Control No. 5/23/03 Date. SSN. Friday, May 23, 2003



Treatment Options Surgery : _____
 Ulcer : _____
 Sclerotherapy : _____





SPECIAL MEDICAL EVALUATION

Medical Necessity Report. Documentation Support

For Direct access to medical record www.expertsinviens.com

Name: LOPEZ

SONIA K.

Address: 2

Miami

FL 33129

Control No (305):

SSN.

4/27/2004

Date: Tuesday, April 27, 2004

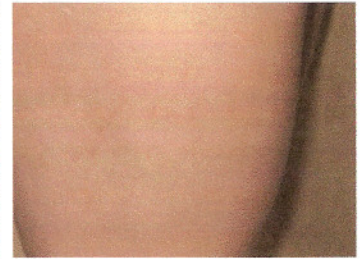
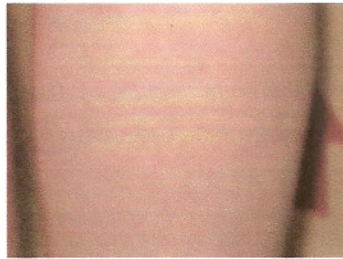
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RJAE

RJAE

RJE

RJE



Areas:

R4I

L4E

L3I

L1E



Areas:

L5I

R5PE

L5I

R5PE



Treatment Options Surgery []: _____

Ulcer []: _____

Sclerotherapy []: _____

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