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: MERCEDES · L · PEÑA

Telephone No: ______ D.O.B: __/__/__

Please briefly describe the results of your treatment.

VERY Good, I'm VERY HAPPY, AND VERY ~~PROFESSIONAL~~ PROFESSIONAL STAFF.
THANK YOU VERY MUCH.

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?

______

Patient Signature: [signature]
Date: 2/11/06

SPECIAL MEDICAL EVALUATION

Medical Necessity Report. Documentation Support

For Direct access to medical record www.expertsinviens.com

Name: PENA MERCEDES

Address: Miami FL

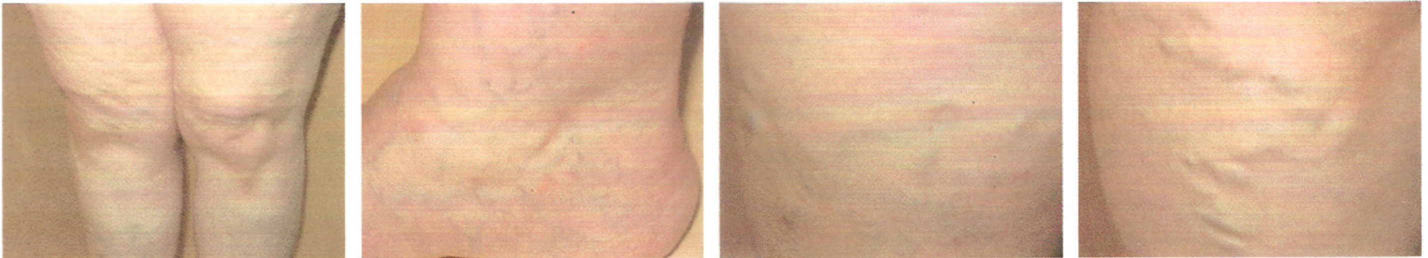
Control No. (305)

SSN.

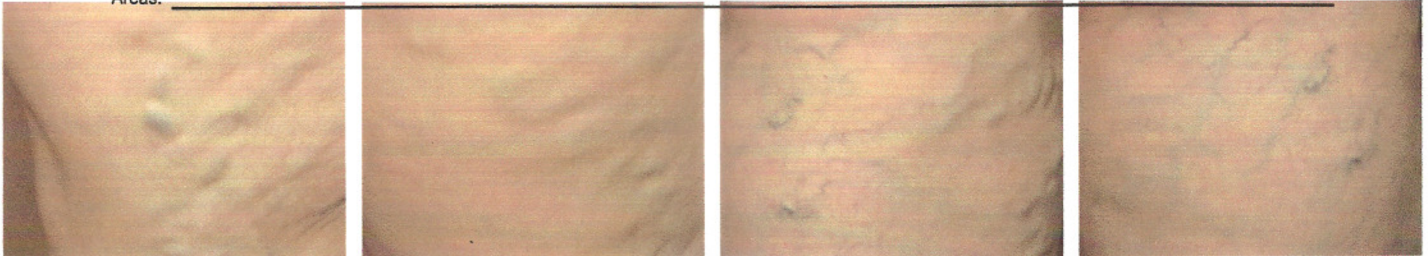
9/7/2005

Date. Wednesday, September 07, 2005

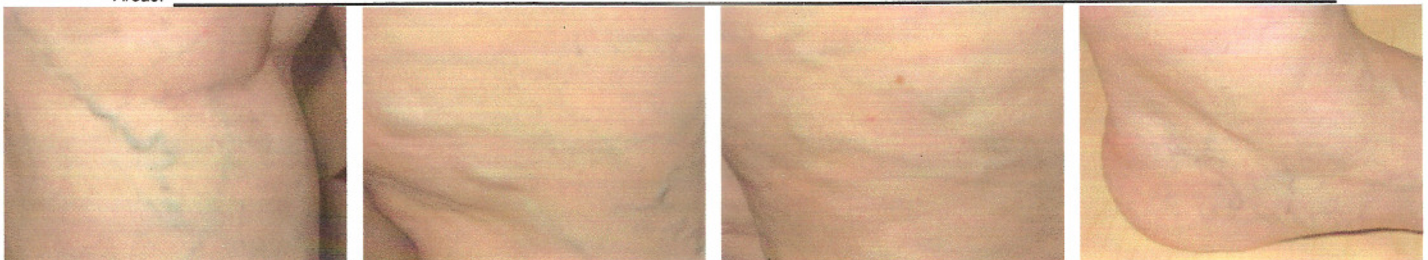
Areas: ______



Areas: ______



Areas: ______



Treatment Options Surgery [ ] : ______

Ulcer [ ] : ______

Sclerotherapy [ ] : ______

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: PENA MERCEDES

Address. Miami FL

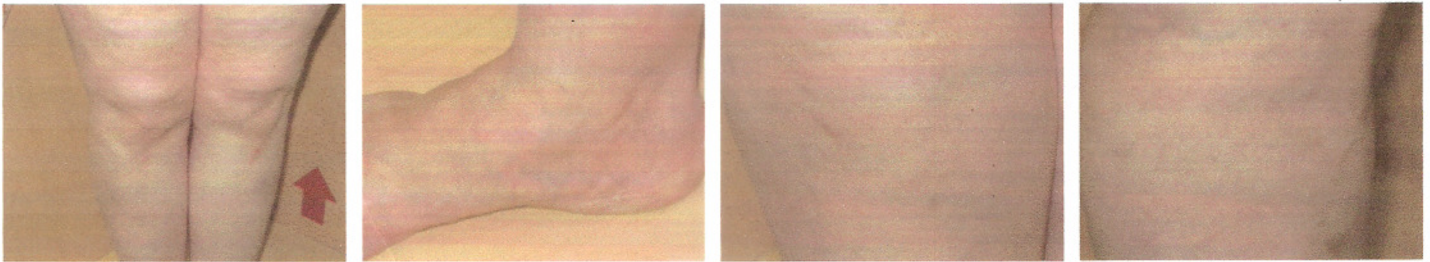
Control No. (30

2/11/2006

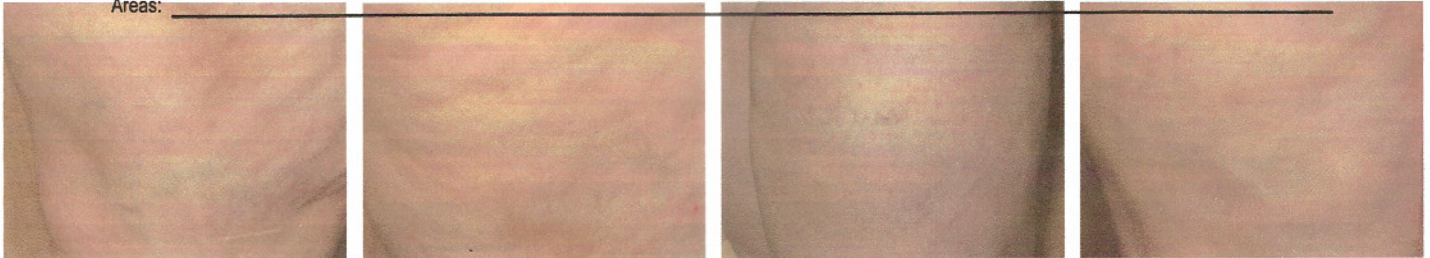
SSN.

Date. Saturday, February 11, 2006

Areas: ______



Areas: ______



Areas: ______

Treatment Options Surgery [ ] : ______

Ulcer [ ] : ______

Sclerotherapy [ ] : ______

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