



FINAL TREATMENTN REVIEW

Quality Control Department

Dear Patient:

In an effort to improve our services an increase on a daily basic 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 opinion of the services.

Patient Name:

JOSELYN MENDOZA

Telephone No.

(305) 441-1111

D.O.B.

Please briefly describe the results of your treatment.

*Estoy muy contenta, el tratamiento fue muy bueno.
y las chicas excelentes*

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

Did you received a professional and courteous treatment from start to finish...Yes No

Did everyone that you come 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?

Signature:

Joselyn Mendoza

Date:

08/30/05



SPECIAL MEDICAL EVALUATION

Medical Necessity Report. Documentation Support

For Direct access to medical record www.expertsinviens.com

Name: MENDEZ

NOEMY H

Address:

Miami

FL

Control (N005)

SSN.

4/15/2005

Date.

Friday, April 15, 2005

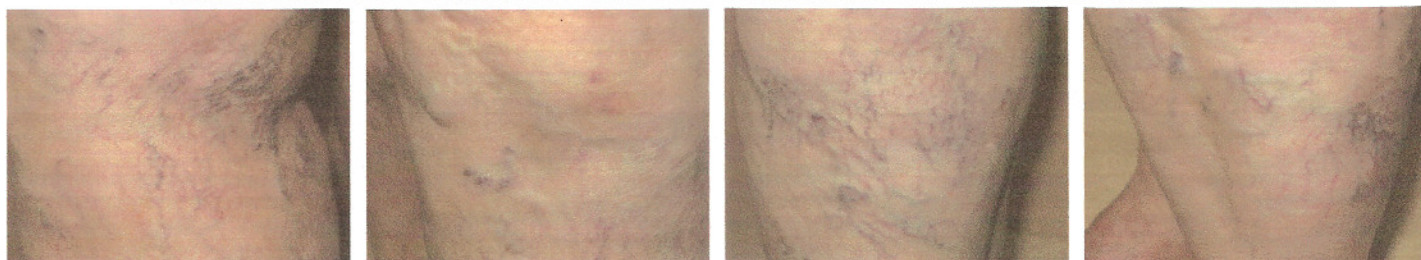
Areas: _____



Areas: _____



Areas: _____



Treatment Options Surgery []: _____

Ulcer []: _____

Sclerotherapy []: _____



SPECIAL MEDICAL EVALUATION

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Name: MENDEZ

NOEMY H

Address:

‡

Miami

FL

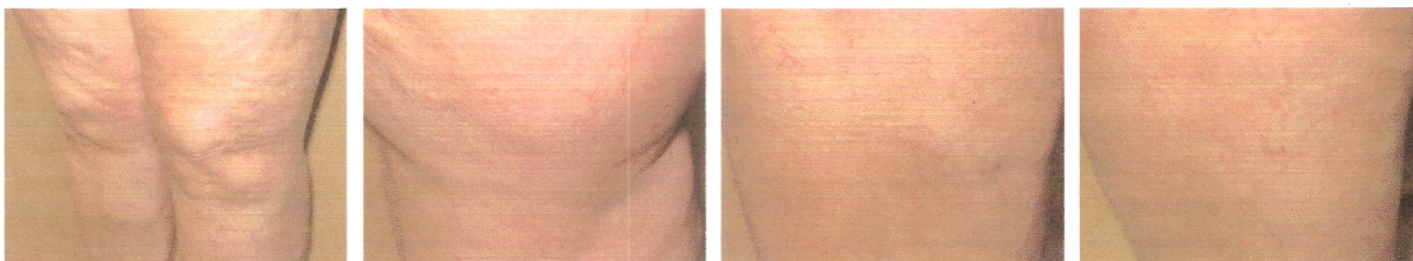
Control (N5) 2:

SSN.

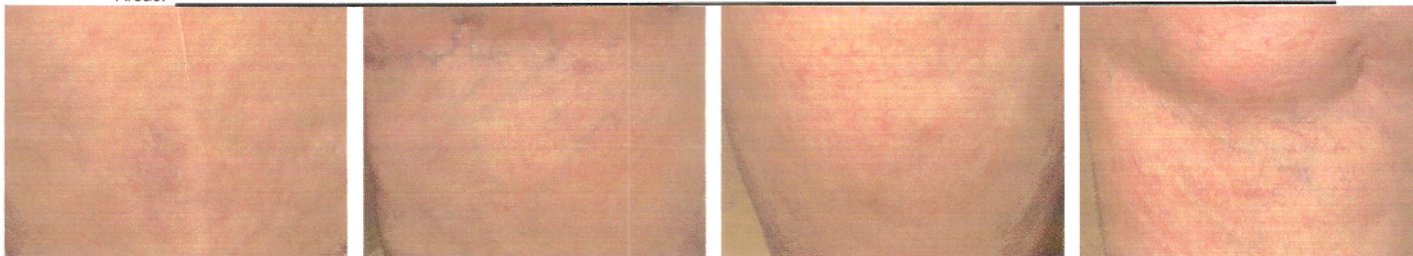
8/30/2005

Date. Tuesday, August 30, 2005

Areas: _____



Areas: _____



Areas: _____



Treatment Options Surgery []: _____

Ulcer []: _____

Sclerotherapy []: _____

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MIAMI - DADE

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MIAMI LAKES - BROWARD

8028 NW 154 ST. • PH. 305-820-5001