

FINAL TREATMENT REIVEW

Quality Control Department

Dear Patient

Patient Name: From

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

Telephone :	, DOB:	Na	ationality:	
Please briefly Describe the resul				
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		:		
Would you recommend the servi	ces to a frie	end or fai	mily Yes [x] No []	
Did you receive a professional a start to finish				
Did every one that you came in explanation of there services				
Is there any suggestions that yo could make our services better	ou would lik	ce to give	us that	
Signature: Date: $\frac{3}{3}/04$				
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SPECIAL MEDICAL EVALUATION

Medical Necessity Report. Documentation Support

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8028 NW 154 ST. PH. 305-820-5001

MIAMI LAKES - BROWARD



SPECIAL MEDICAL EVALUATION

Medical Necessity Report. Documentation Support

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