PATIENT AUTHORIZATION RECORD

BRIDGEPORT HOSPITAL
267 Grant Street
Bridgeport, CT 06610

Name Pedro Antonio _____ Account # 70730

AUTHORIZATION FOR TREATMENT

I hereby give authorization for performance of such surgical or medical treatment or procedures as may, in the judgement of my attending doctor, be deemed necessary.

_____ Initials

PATIENT AGREEMENT

I agree to pay you, upon discharge, your regular charges for all hospital and medical services rendered to me. My health insurance benefits may pay all or part of your charges. If so, I agree to pay those charges which are not paid by my health insurance. If I do not pay your bill, I agree to pay you your collection costs including attorney's fees and court costs.

_____ Initials

ASSIGNMENT OF BENEFITS

I assign to you in order to pay your charges and the doctor's charges any hospitalization insurance or similar benefits from third parties to which I may be entitled. Payments by these third parties may be made directly to you or to the doctors.

_____ Initials

MEDICARE AND SIMILAR BENEFITS

I agree that the information I have given you in applying for benefits under Medicare, Medicaid, or Maternal or Child Health Services is complete and accurate. You may give the Social Security Administration or its fiscal intermediaries any information about me which may be necessary to process claims for such payments. You and the doctors treating me may make direct claims for these payments.

_____ Initials

MEDICARE/CHAMPUS IMPORTANT MESSAGE

I acknowledge that I have received a copy of the Medicare/Champus Important Message to Patients and the LAMP brochure.

_____ Initials

RELEASE OF INFORMATION

There may be times when you need to give or receive information relating to this hospitalization.

1. I agree that you may give information in your medical records about me to any person involved in my medical care. If I need to be transferred to another health care facility, you may give information to that facility.
2. I also agree that you may give information to any third party who may be responsible for the review of medical necessity and/or the payment of my account or accrediting you.
3. I agree that you may obtain any information about me which you may need in order to treat or bill me from others who have provided medical care to me or who are responsible for the payment of all or part of my bill.

_____ Initials

My charges will be covered by Worker's Compensation.

_____ Initials

These authorizations are on file and apply to admissions/transfers for continuation of care.

_____ Initials

PERSONAL VALUABLES

I am responsible for property retained by me. If I wish you to hold such property, you have a vault available. However, it is my responsibility to request that you keep such property, and I must sign a form for this purpose. All valuables must be reclaimed within six months after my discharge or you may dispose of them as permitted by law.

_____ Initials

3/13/93
DATE

SIGNATURE OF PATIENT

WITNESS

SIGNATURE OF RESPONSIBLE PERSON OTHER THAN PATIENT

RELATIONSHIP TO PATIENT

91-135

FOLLOW UP CARE INSTRUCTIONS GIVEN FOR: ☐ LACERATIONS ☐ GASTROENTERITIS

E.R. # A70930

☐ SPRAINS ☐ MINOR HEAD INJURIES ☐ OTHER ☐ CLINIC FOR APPOINTMENT CALL 384–

As we discussed 1/5/12 -

I will see you in 3 days for recheck.

Understand, do not need antibiotics

INSTRUCTIONS RECEIVED AND UNDERSTOOD!

BRIDGEPORT HOSPITAL

PATIENT'S SIGNATURE

DOCTOR'S SIGNATURE

CONTROL COPY

90-640 REV 0788

82 PT-E FC-70 PAYOR-27-098 BT-0 DRG- M/B- 001

APPROVED OMB NO. 0938-0279

BRIDGEPORT HOSPITAL
267 GRANT STREET
BRIDGEPORT, CT 06610
203 384-3000

3 PATIENT CONTROL NUMBER: 99000848 | 4 TYPE OF BILL: 131

5 FED TAX NO	6 MEDICARE NO	7 MEDICAID NO	8
060646554	070010	4025003	V65.5

9 PATIENT'S LAST NAME	FIRST NAME	INITIAL	10 PATIENT'S ADDRESS	CITY	STATE	ZIP
PINTO,	ANTONIO		64 PIERMONT ST	WATERBURY	CT	06706

12 BIRTH DATE	13 SEX	14 MS	ADMISSION 15 DATE	16 HR	17 TYPE	18 SRC	19 A.H	20 D.H	21 STAT	STATEMENT COVERS PERIOD FROM	THROUGH	23 COV D	24 N-C D	25 C-I D	26 L-R D	27
08 17 69	M	S	03 13 93	07	1	7	10	09	01	03 13 93	03 13 93					

28 OCCURRENCE CD	DATE	29 OCCURRENCE CD	DATE	30 OCCURRENCE CD	DATE	31 OCCURRENCE CD	DATE	32 OCCURRENCE CD	DATE	33 OCCURRENCE SPAN CD	FROM	THROUGH
02	03 13 93	11	03 13 93									

PINTO, ANTONIO
64 PIERMONT ST

WATERBURY CT 06706

CONDITION CODES 35 36 37 38 39 | BLOOD RECORD (PINTS) 40 FURN 0 | 41 REPL 0 | 42 NOT BP | 43 DED | 44 SP PROG | 45 0434217

46 VALUE CD	AMT	47 VALUE CD	AMT	48 VALUE CD	AMT	49 VALUE CD	AMT

50 DESCRIPTION		51 R CODE	52 S UNITS	53 TOTAL CHARGES	54 27-098	55	56
THIGH FEMUR	73550	320	1	55 76	55 76		
EMERGENCY VISIT B	99201	450	1	86 93	86 93		
PART B LIMITED/NEW	99282	981	1	51 71	51 71		
TOTAL CHARGES		001	3	194 40	194 40		
UNCOMPENSATED CARE ASSESSMENT		080		16 32			
INCLUDED IN TOTAL							

FORWARD TO YOUR INSURANCE CO.

DEAR PATIENT -
"YOUR HOSPITAL BILL HAS HISTORICALLY INCLUDED A SHARE OF THE COSTS OF PROVIDING CARE WHICH WAS NOT FULLY REIMBURSED. STATE LAW HAS ESTABLISHED A NEW MECHANISM FOR FUNDING THESE SERVICES. THIS NOTICE OF ASSESSMENT IS INCLUDED IN YOUR HOSPITAL BILL IN ACCORDANCE WITH STATE AND FEDERAL LAW". IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE PATIENT ACCOUNTS DEPARTMENT AT 384-3990.

	57 PAYER	58 REL INFO	59 ASG BEN	60 DEDUCTIBLE	61 CO-INSURANCE	62 EST RESPONSIBILITY	63 PRIOR PAYMENTS	64 EST AMOUNT DUE
A	NFT NO FAULT	Y	Y			194 40		194 40
B								
C								

DUE FROM PATIENT ▶

	65 INSURED'S NAME	66 SEX	67 P REL	68 CERT-SSN-HIC ID NO	69 GROUP NAME	70 INSURANCE GROUP NO
A	PINTO, ANTONIO	M	01	048726809	NO FAULT	
B						
C						

71 E/D	72 ESC	73 EMPLOYER NAME	74 EMPLOYEE ID	75 EMPLOYER LOCATION		
AP	1	CICAS INC		56 EAGLE ST	WATERBURY	CT

76 PRINCIPAL AND OTHER DIAGNOSES DESCRIPTIONS: PERSN W FEARED COMPLAINT

77 PRIN CODE: V65.5

OTHER DIAGNOSES CODES 78 79 80 81:

82 PC	83 PRINCIPAL AND OTHER PROCEDURES DESCRIPTIONS	84 PRINCIPAL PROCEDURE CD	DATE	85 OTHER PROCEDURE CD	DATE	86 OTHER PROCEDURE CD	DATE
9							

FSRO UR DATA 87 CD	88 APP FROM	89 APP THROUGH	90 GNC	91 TREATMENT AUTH	92 ATTENDING PHYSICIAN ID	93 OTHER PHYSICIAN ID
1					1171222 KUNKEL, JOEL W	

94 REMARKS
NO FAULT
XX
XX XX 99999
ATT. X

VERIFIED N.C. STAY DATES FROM THROUGH | FOR INTERMEDIARY USE ONLY PPS PSC D

AMT REIMBURSED | N PYM CD | APPROV BY | DATE APPROV

95 I CERTIFY THAT THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

PROVIDER REPRESENTATIVE X COMPUTER GENERATED 96 DATE 03/23/93

UB-82 HCFA-1450 PAYER COPY

00532

UB82 D

ANCP BY ANCHOR BUSINESS FORMS, INC

COMPANY A 242 ENGINEER COMBAT BATTALION
NATIONAL GUARD ARMORY
63 ARMORY ROAD
STRATFORD, CONNECTICUT 06497-1702

16 March 1993

SUBJECT: Authorization for Medical Treatment.

Commander
Naval Submarine Medical Center
Naval Submarine Base
New London, CT 06240

1. The individual named below is authorized medical care at a federal medical treatment facility and the following information is furnished in accordance with para 8c, NGR 40-30.

a. PINTO, ANTONIO P. 048-72-6809 SPC 242 ENGR CBT BN
b. Individual is a member of the Connecticut Army National Guard
c. Unit: CO A 242 Engr Cbt Bn, NG Armory, Stratford, CT 06497-1702
d. Duty was being performed at Stratford, CT
e. Date: 13 Mar 93 Diagnosis: Contusions to left leg, and right side of torso.
f. Was performing duty under 32 USC 502.
g. Individual is authorized medical care under provisions of Para 6, NGR 40-3.
h. Injury was sustained in Line of Duty.
i. Soldier was driving to drill at 0630 on 13 Mar 93 during snow storm and was in automobile accident.

2. POC at the unit for further information is SFC DANIEL J. ONEILL JR. at Tel: 579-6736.

WILLIAM H. ADAMS
CPT IN CTARNG
Adjutant

NSN 7540-00-634-4178 600-108

HEALTH RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
17 MAR 1993	MILITARY MEDICINE DEPARTMENT NAVAL HOSPITAL, GROTON, CT 06349
	TIME IN: 1120 TIME OUT: _____
	TEMP: 97.1 BP: 128/78 PULSE: 56
	RESP: 12 ALLERGIES: NKDA
	CHIEF ~~COMPLAINT~~ complaint NA
	23 yo ♂ Pt c/o MVA Car Accident - (R) thigh burns, (R) lower ribs and scar spot under chin x 5 days
	23 yo ♂ Pt c/o MVA (R) thigh injury (R) lower ribs
	4/0 (R) costal margin rib Px, (L) femur Px - S/P MVA 13 MAR 93. Pt was restrained driver. X-rays femur done @ Bridgeport Hosp ER + all neg. Tx'd c NSAIDs. C/O pain with
	O) (R) rib cage - (+) TTP over T7 rib @ mid clavicle line
	E) ecchymoses.
	(L) thigh 5 ecchymoses.
	mild TTP c/o pain. Full ROM knee/hip R/L
	A) deep contusions
	P) Ibuprofen 400 mg TID prn pain
	Ice pack
	F/U prn Fluids as tolerated 2-3 qt

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT: K. K. MUELLER LT MC USNR 508 98 7726

PATIENT'S NAME *(Last, First, Middle Initial)*		SEX
PINTO		male
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
	AD	E-4
SPONSOR'S NAME	ORGANIZATION	
	Stratford	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH
USA	6809	17 Aug 69

CHRONOLOGICAL RECORD OF MEDICAL CARE — STANDARD FORM 600 (REV. 5-84) Prescribed by GSA and ICMR FIRMR (41 CFR) 201-45.505

BRIDGEPORT HOSPITAL

267 Grant Street
P.O. Box 5000
Bridgeport, CT 06610
Telephone: 203 384-3000

03/28/93

PINTO, ANTONIO
64 PIERMONT ST
WATERBURY CT 06706

PATIENT: PINTO, ANTONIO
ACCOUNT NUMBER: 99000848
ADMISSION DATE: 03/13/93
DISCHARGE DATE: 03/13/93
AMOUNT DUE: $ 194.40

Dear ANTONIO PINTO,

At Bridgeport Hospital we value our customers, patients, and work hard to please them. We cannot bill your no fault carrier directly for out patient services. Unfortunately your insurance company requires you to submit a first report of accident prior to processing claims.

Starting on our next billing cycle, the bill will become your responsibility. Please forward this bill directly to your no fault carrier. In the meantime, your remittance payable to Bridgeport Hospital would be greatly appreciated.

Sincerely,

Patient Account Analyst

PATIENT

PINTO, ANTONIO

ACCOUNT NO	STATEMENT DATE
01-04-99000843	03/31/93

BRIDGEPORT RADIOLOGY ASSOC. PC 06-086012
P.O. BOX 766
SOUTHPORT CT 06490

IRS NO

BILLING OFFICE PHONE 203/261-144

DATE	•	EXAM CODE	DESCRIPTION	DX CODE	AMOUNT
03/13/93	4	73550-26	FEMUR 2 VIEWS	V655	38.00

REFERRING PHYSICIAN	DATE ADMITTED	DATE DISCHARGED	PATIENT PHONE NO	BALANCE DUE
KUNKEL, JOEL	03/13/93	03/13/93	203/758-0580	38.00

PLACE OF SERVICE: BRIDGEPORT HOSPITAL
267 GRANT STREET BRIDGEPORT C

NOTE

IF YOU HAVE INSURANCE, PLEASE SIGN THE INSURANCE COPY OF THIS STATEMENT AND MAIL IT TO YOUR INSURANCE CARRIER. RESPONSIBILITY FOR PAYMENT IS YOURS.

* PLACE OF SERVICE
1 INPATIENT HOSPITAL
2 OUTPATIENT HOSPITAL
3 DOCTOR'S OFFICE
4 EMERGENCY ROOM

DATE OF BIRTH	INJURY DATE
08/17/69	

EMPLOYER ▶ DICAS INC
PRIMARY INSURANCE ▶
SECONDARY INSURANCE ▶ 048726809
ATTENDING PHYSICIAN ▶ KAYE, A.D. M.D.

STATEMENT

RETURN THIS PORTION WITH PAYMENT

ACCOUNT NO	STATEMENT DATE
01-04-99000843	03/31/93

AMOUNT REMITTED $

MAKE CHECK PAYABLE TO:

BRIDGEPORT RADIOLOGY ASSOC.
P.O. BOX 766
SOUTHPORT CT 06490

You are reminded that health insurance coverage varies and that all services may not be covered. We cannot be responsible for negotiating payments with your insurance company and, while terms such as customary, reasonable, and/or prevailing may be used to limit coverage, payment of the charge remains your obligation.

BILL TO:

ANTONIO PINTO
64 PIERMONT ST
WATERBURY, CT 06706

BRIDGEPORT HOSPITAL

STATEMENT OF ACCOUNT

For Questions Regarding This Statement-
Please call Patient Accounts at (203) 384-3410
between 8:00AM and 4:30PM, Monday thru Friday.

PATIENT'S NAME	PT TYPE	FC	ACCOUNT NO.	ADMISSION DATE	DISCHARGE DATE	STATEMENT DATE
PINTO, ANTONIO	EMR	95	000099000848	03/13/93	03/13/93	05/10/93

PLEASE SEE REVERSE SIDE FOR IMPORTANT INSTRUCTIONS.

VISA, MASTERCARD AND AMERICAN EXPRESS ACCEPTED
PLEASE COMPLETE CHARGE INFORMATION ON REVERSE SIDE

TRANSACTIONS MADE AFTER
THIS STATEMENT DATE
WILL APPEAR ON
YOUR NEXT STATEMENT

BILL TO:

PINTO, ANTONIO
64 PIERMONT ST
WATERBURY CT 06706

AMOUNT DUE
194.40
ENTER AMOUNT ENCLOSED

DETACH HERE — PLEASE RETURN TOP PORTION ONLY — DETACH HERE

PATIENT'S NAME	PT TYPE	FC	ACCOUNT NO.	ADMISSION DATE	DISCHARGE DATE	STATEMENT DATE
PINTO, ANTONIO	EMR	95	000099000848	03/13/93	03/13/93	05/10/93

DATE	TRANSACTION	AMOUNT

PLEASE PAY THIS AMOUNT	194.40

THIS ACCOUNT IS NOW PAST DUE. PLEASE REMIT THE FULL AMOUNT TODAY OR CONTACT THE PATIENT ACCOUNTS DEPARTMENT IF THERE ARE ANY PROBLEMS WITH PAYMENT.

Make checks payable to:

BRIDGEPORT HOSPITAL
P.O. BOX 5000
BRIDGEPORT, CT 06610

BPHO 1F