PLAINTIFF'S MOTION EXHIBIT 27 Part 1

THE JAMAICA HOSPITAL

INFORMATION IN THIS RECORD IS CONFIDENTIAL DO NOT REMOVE FROM HOSPITAL

IMPORTANT

- Information in this record may not be released without approval of Medical Record Department
- Medical Records must be available at all times. Do not leave in Drawers, Cabinets, etc.
- 3. Return Medical Records promptly to Medical Record Department.

ALLERGIC TO

2014	2013	2012	2011	2010	2009	2008	2007	2006	2005	
					8					



Patient Fact Sheet

Name and Address **Employer** SCHOOLCRAFT, ADRIAN UNKNOWN 82 60 88 PL RIDGEWOOD Phone: NY 11385 (718)570-6224 М Sex: Phone: (999)999-9999 SS No: 469-97-6997 Marital Status Race: Religion: NO BirthDate: 6/21/1975 Occupation: Patient's Maiden Name: Nearest Relative Admission Data SCHOOLCRAFT, SELF Unit Number Account Number 130381874 1298984 82 60 88 PL Admit Date Admit Time ER MD RIDGEWOOD NY 11385 -BERNIER 11/1/2009 8:54 Rel: 09 Home Phone: (718)570-6224 Triage Time Prim Care MD Business Phone: Guarantor **Emergency Contact** SCHOOLCRAFT SCHOOLCRAFT, ADRIAN 82 60 88 PL RIDGEWOOD NY 11385 Home Phone (718)570-6224 Home Phone: (718)570-6224 Rel: 01 Business Phone Business Phone: Rel: SS: 999-99-9999 Occ: Employer UNKNOWN Insurance Information Ins: AETNA US HEALTHCARE SCHOOLCRAFT, ADRIAN Insured: Policy Number: BBM6PBBA Group Number: US008041009001 Rel: SELF/ PO BOX 981109 **EL PASO** 799981109 ΤX FIN Phone Number 19 (800)451-8843 Auth Number PENDING

Medical Record No. 1298984

ID 130381874

Account Number 130381874

Date 11/1/2009

Jamaica Hospital Medical Center

Emergency Department Record

History of Present	Illness				KTA		
34 Year Old Male Patient	Presents with Paranoid. se	e psychiatric asses	ssment				
Review of Systems (Symptoms and Signs not cove GU Neuro	red in the HPI)	Resp	Musculoskeletał	Hematologic/Lymphatic			
Skin Psych	Heart	GI	Endocrine	Allergic/immun ologic			
All other ROS negative			Constitutional Sxs	Eyes			
□ Vital Signs/Triage/Nursing Notes □ Hx unobtainable due to Tx □ Additional Information from Police, Ambulance, Nursing Home or Relatives □ Old Medical Records Reviewed							
Past Medical History	✓ No Relevant PMHx	Asthma [COPD CAD C	ancer CHF CV	Α		
Other PMHx		☐ Diabetes [☐ HTN ☐ Psychiatric	Renal Seizures			
Social History V No	Relevant SoHx	OH 🗍 Drugs [Smoking Additional Sx				
Family History	Relevant FmHx No Sig	nificant FMHx					
Physical Exam	Exam Time						
General Appearance							
HEENT	•						
Chest							
Abdomen							
GU							
Extremities							
Neuro							
Skin							
Back							
Neck							
Lymphatics							

Account Number 130381874

Medical Record No. 1298984

Date 11/1/2009

Diag	nostics			Specin	nen Collected	I/ECG_R	ad Ordered
MD Initials	Time		Diagnostic Ordered	Result Interpretation	Result Reviewed By	RN Initial	s Time
KTA	11/1/2009	12:59	Urinalysis	Status-Cancelled - Patient Discharged			
KTA	11/1/2009	12:59	Urine Tox	Status-Cancelled - Autocancel by LIS-not coll/rcv			
KTA	11/1/2009	12:59	CBC	Status-Interim	KTA		
KTA	11/1/2009	12:59	THC (MARIJUANA)	Status-Cancelled - Autocancel by LIS-not coll/rcv			
КТА	11/1/2009	12:59	Head CT s contrast	CTH DEPARTMENT OF RADIOLOGY Patient Name: SCHOOLCRAFT, ADRIAN MRN #: 001298984 Patient Loc; MENTAL HEALTH ER Requested by: Staff, Physician Exa CT head w/o Result Date/Time: 11/02/2009 10:45 AM Radiologists: Janczuk, Peter MD			
KTA	11/1/2009	12:59	TSH	Status-Interim	KTA		
KTA	11/1/2009	13:00	RPR	Status-Interim	KTA		
BWO	11/1/2009	13:50	Pulse Ox			BW	13:50

Recommended LOS/CPT/ICD-9 Code

Physician's LOS =

Nurse's LOS =

Diagnoses	
Paranoid	297.9 ICD-9

Admit to RN Date/

RN

Time

MD Disposition

Condition

Physician (Print)

Tariq, Khwaja (MD)

MD Time

Physician Signature

Other Physicians

Tariq, Khwaja (MD)-Peteru, Sachidanand (Psychosomatic Fellow)

Account Number 130381874

Primary RN (Print) Calise, Michael (RN CM)

Medical Record No. 1298984

Date 11/1/2009

Other Nurses

Chen, Karen (RN)~Woodruff, Brian (RN)~Okuwobi, Bukunola (LPN)~Brady, Odette (RN)~Moonsammy, Victor (RN)~Calderone, Virnalyn (RN)~Harper, Wendell (LPN)~Mero, Monica (Amb Care Rep)~Basi, Susheela (RN)~Calise, Michael (RN CM)~Arias, Carielys (Reg)~Boswell, Gwendolyn (RN)~Stancu, George (Clerk)

This chart has been electronically signed via the EmpowER software.

Medical Record No. 1298984

Account Number 130381874

Date 11/1/2009

Jamaica Hospital Medical Center

TimeEntered:	11/1/2009		16:39 Vitals Take	n By: BOK			
Temperature	Pulse		Blood Pressur	e Respirations	Pulse Ox	Pain Scale	
0 99.2	Right	81	R 112	18		No Pain	
Т	Left		L 60				
R							
TimeEntered:	11/1/2009		17:00 Vitals Take	n By: BOK			
Temperature	Pulse		Blood Pressure	e Respirations	Pulse Ox	Pain Scale	
0 99.2	Right -	81	R 112	18		No Pain	
Т	Left		L 60				
R							
TimeEntered:	11/2/2009		6:26 Vitals Take	n By: WHA			
Temperature	Pulse		Blood Pressur	e Respirations	Pulse Ox	Pain Scale	
0 98.4	Right	90	R 123	20		No Pain	
T	Left		L 73				
R							
TimeEntered:	11/2/2009		10:51 Vitals Take	n By: KCH			
Temperature	Pulse		Blood Pressure	Respirations	Pulse Ox	Pain Scale	
0 98.6	Right	88	R 127/63	18	100%	No Pain	
T	Left		L				
R							
TimeEntered:	11/2/2009		21:24 Vitals Take	п Ву: ВОК			
Temperature	Pulse		Blood Pressure	e Respirations	Pulse Ox	Pain Scale	
0 99.2	Right	93	R 124	18		No Pain	
T	Left		L 76				
R							
TimeEntered:	11/3/2009		6:29 Vitals Take	n By: VMO			
Temperature	Pulse		Blood Pressure	e Respirations	Pulse Ox	Pain Scale	
0 97`4	Right	86	R 124\60	18		No Pain	
Т	Left		L				
R							

Medical Record No. 1298984

Account Number 130381874

Date 11/1/2009

Jamaica Hospital Medical Center

TimeEnte	red: 11/3/	/2009	10:52	Vitals Taken E	By: GBO		
Temperat	ure Pu	ılse	В	lood Pressure	Respirations	Pulse Ox	Pain Scale
0 99).2 R	ight 90	R	123/68	18		No Pain
Т	L	eft	L				
R							

Medical Record No. 1298984

Account Number 130381874

Date 11/1/2009

Jamaica Hospital Medical Center

Nursing Not	es	RN	
Time Note Entered		Initials	Note
11/1/2009	13:51	BWO	Client is a 34 year old White male police officer who was BIB/NYPD in handcuffs after he was apprehended at his home. Client had an argument with his supervisor and then left the job, went home and barricaded himself in his apartment refusing to come out. Client failed his psychological exam at work one year ago and his gun was taken away. Client is reported to be paranoid believing that he has documentation to prove that his superiors are falsifying crime statistics inorder to garner promotions. Client also believes that his superiors are out to get him. Denies medical/ psych Hx. In control at this time. Will continue to monitor.
11/1/2009	15:38	BOK	pt received on bed, awake and relaxing,pt spoke to his father on phone. Pt denies suicidal or homicidal ideation safety environment maintained will continue to monitor pt
11/1/2009	20:11	вок	pt ate 100% of dinner with no sign of distress noted
11/1/2009	22:56	BOK	pt awake on bed and relaxing, pt denies suicidal or homicdal ideation .safety environment maintained will continue to monitor
11/2/2009	0:03	VMO	Received pt in bed asleep side\rails up no sign\ symptoms of distress for hold\ stabilize
11/2/2009	5:52	VMO	remains asleep in bed no sign\ symptoms of distress continue to monitor
11/2/2009	6:25	VMO	Pt awake in bed slept well v\s stable denies suicidal\ homicidal ideation calm in control little interaction for hold\ stabilize
11/2/2009	8:23	KCH	Received pt in founge, sitting, calm and cooperative. No sign of acute physical distress noted. No respiratory distress noted. Emotional support maintained. Encouraged pt to verbalize feelings and thoughts. Safety maintained. Will continue to monitor pt's behavior.
11/2/2009	10:47	KCH	Pt is in bed, awake. Calm and cooperative. No sign of acute physical distress noted. No complaint offered. Ate meal with good appetite. Able to approach staff with needs. Pt is for hold in Er. Safety maintained.
11/2/2009	13:15	ксн	Pt is in bed, awake. Calm and cooperative. No sign of acute physical distress noted. No respiratory distress noted. Ate meal with good appeitite. Pt is for hold in Er. Safety maintained.
11/2/2009	16:06	вок	pt received on bed, awake and relaxing, pt denies suicidal or homicidal ideation safety environment maintained will continue to monitor
11/2/2009	18:10	вок	pt calm and quiet, pt 100% of dinner with no sign of physical distress noted
11/2/2009	22:43	вок	pt in the founge area watching tv and pt denies hallucination or delusion safety environment maintained will continue to monitor pt
1 //3/2009	0:02	SBA	Received the pt asleep in bed, easily arousable. Not in distress. Pt was seen by family practice MD, and has been medically cleared for inpt admission. Needs financial clearance. Observation continued.
11/3/2009	3:00	SBA	Pt is seen sleeping in bed;easily arousable. No distress noted. Observation continued.
11/3/2009	6:10	SBA	Pt slept well during night. He is awake now, seen him writing something. Denies any physical comptaints. Denies any suicidal/nomicidal ideation. Has been calm and pleasant. Pt is for inpt admission, pending financial clearance.
11/3/2009	8:27	MC6	Pts. Report received from nite shift there is no behavioral changes noted at this time. He is found awake and seated in dayroom alert, responce and verbal torward staff. He has refused assistance from NYPD at this time. Requesting admission here at jamaica. He denies h/s ideations at this time. His appearence: good ADLs good, behavior even mannered verbal rate normal and volume normal, contant approiated. Cognitive: preoccupied with curerent situation and slight paranoid reguarding NYPD. He is treated and provided with support as required.

Medical Record No. 1298984

Account Number 130381874

Date 11/1/2009

Jamaica Hospital Medical Center

Primary Nurse Diagnosis			Primary Nurse Outcome	Achieved	
11/3/2009	14:06	MC6	Pt. 2 P.C. Completed and pt and documents provided to patient. Report endorsed to Psych III. He departed unit in wheelchair with cothing and escorted by security.		
11/3/2009	12:55		Pt. remains on unit resting on streatcher this time. He is quite in refused AM medications and ADLS and appearance are good. normal, cognitive. He still displays concern about NYPD actions times. Menory inatact. He is treated and provided with care and give to psyh III pending 2 P.C.	Verbal : rate normal, volume s towards him and paranoid at	

Jamaica Hos	-4 (Less Ur				
Arrival Date/Time	Triage Time	Waiting Rm Time	Exam Rm Time	Patient Name	
11/1/2009	8:57 13:44	10:34	13:44	SCHOOLCRAFT,ADRIAN	
PCP Staff Status Fa	A	T ransported b Police	y Mode Walked	Medical Record Number 1298984	
Historian Police	Police Dept Custody No	Notification Yes Beat #		Account Number 130381874	
Chief Complaint	<u></u>	Onset Time 2 Day(s)	Location	DOB 06/21/1975	
	/ D			Age 34 Years	
	/ Pertinent Histo	ry .		Gender Male Vitals Tem	
Past Medical His ✓ No Significant PMH				Oral 99.0	
Asthma CO		Cancer CHF CV	Δ	Rectal	
	Psych Renal	Seizures Substance		Tympanic	
· · · · · · · · · · · · · · · · · · ·	known		and the second of the second o	Pulse Right 115 Left Respirations	
Allergies Na Known Drug Allerg	ies	T	mmunizations UTD? Unknown B Hx, PPD Pos or No nfectious Exposures? If yes to TB or Infectious question ake precautions	Blood Pressure Right 139/80 Left	
Mental Status / Psyc	chological Eval	Glascow Coma Scale	OB/Gyn	Leit 1	
Alert Oriented		Eye Spontaneous		Pulse Ox	
Lung Sounds	Eyes R L	Verbal Oriented	G P Ab Miscarriage	xx	
R L	Equal 🗸 🗸	Motor Obeys	0 0 0 0	Weight (Kg	
Clear 🗸 🗸	Reactive	Total 15		109 Kg	
Diminished 🗌 🔲	Fixed	Skin	Extremities	Head	
Wheezes 🗌 🗎	Constricted [Color Normal	Pulses Pulses intact	Height Circumferenc	
Rales	Dilated	Temp Normal	ROM	the amount comment.	
Rhonchi 🔲 🗍	Cataract	Moist Normal	Full ROM	Pain Scale No Pain	
Retractions 🗌					
Nutrition Normal		Are you being hurt by someo with or who takes care of you	ne you live readiness t		
Fall Risk Assessment No Fall Risks Identifie	:	Yes/No NA	Assessed		
Suicide Risk Assessr		* Mandatory completion of Domestic Violence Referral.			
No risk identified			cation Barrier		
Plan MHU WR	Time 10:34	Functional D/C Planning		ranslator	
	druff, Brian (RN)	Daily Living Indepe	endent Know	wiedge Level Low	
Triage II: BWO		Living Conditions Alone	1 1		
Triage III: BWO		Going Home with Unknow	wn		
LWBS	LW Completed Tx/ Elope	AMA AMA AMA Refu	ised Patient Rights and Res given to Patient, Family	sponsibilities and Guide to Pain Management y, and/or Caretaker	

Medical Record No. 1298984

Account Number 130381874

11/1/2009

Emergency Department Pharmacy and Supply Charges

Diagnostics	
Diagnostic Ordered	Charge Code
CBC	0
Pulse Ox	0

Nurse LOS

Charge Code

Jamaica Hospital Medical Center

Medication Reconciliation

Patient Name

SCHOOLCRAFT, ADRIAN

Medical Record No.

1298984

Account Number 130381874

Date of ED Visit

11/1/2009

Allergies

No Known Drug Allergies

Home Medications

Medications Administered in the Emergency Department

Medication Prescription provided on Discharge



SCHOOLCRAFT, ADRIAN 1298984 M DOB: 06/21/1975 34Y F/C: 99 ADM: 11/01/2009 08:54 162B 130381874 ALDANA-BERNIER, LILIAN R PSYC

ASSIGNMENT AND RELEASE OF INFORMATION STATEM	ENTS
Authorization to Jamaica Hospital for release of information:	
who are financially liable for my hospitalization and medical care, a	me, to release to governmental agencies, insurance carriers, or others all information needed to substantiate payment for such hospitalization and carriers and make copies of all records relating to such care signature of Patient or Authorized Representative
Assignment to Jamaica Hospital	
	sufficient monies and/or benefits to which I may be entitled from financially liable for my hospitalization and medical care to cover the nt in said hospital.
11/2/09 Date	Signature of Insured or Authorized Representative
Safe Medical Device Act	
	nufacturer of any device that must betracked pursuant to the mandates of ill betriven my social security number only for the purpose of finding me in or used in my home is detective.
Date	Signature of Insured or Authorized Representative
holder of medical or other information about me to release to the sits intermediaries or carries any information needed for this or a re-	nent under Title XVIII of the Social Security Act is correct. I authorize the Social Security Administration and Health Care Financing Administration or lated Medicare claim. I request that payment of the authorized benefits be ician services to the physician or organization furnishing the services or Medicare for payment on my behalf.
Date	Signature of Insured or Authorized Representative
Financial Agreement	
undersigned (jointly and severally, if more than once) hereby as charges as submitted by the Hospital on the account of said pa- at and Hospital. It is further arrend that the charges as incurre	d by the Jamalca Hospital, to the patient whose name appears below, the gree(s) to be fully and totally responsible to the hospital for payment of all tient and make payment in accordance with the policy of payment of bills of represent the fair and reasonable value of services rendered and are in a available upon request. Payment may be demanded at any time, and let o my (our) immediate responsibility for payment.
The undersigned has read the above, been informed of its na received a copy of this agreement.	ature and significance and acknowledges the contents of same and has
Dated	Guarantor
SCHOOLCRAFT, ADRIAN	
Name of Pahent 11/01/2009 08:54	Address - Guarantor
Hospital No. Date of Admission	Telephone - Guarantor
Date of Discharge	Witness Date

FORM NO. J00123



SCHOOLCRAFT, ADRIAN 1298984 M DOB: 06/21/1975 34Y ADM: 11/01/2009 162B 99 130381874 ALDANA-BERNIER, LILIAN R PSYC

CONSENTS	
PERMISSION FOR TREATMENT	
I HEREBY AUTHORIZE THE JAMAICA HOSPITAL, THROUGH ITS MEDICAL STAFF, WHOSE NAME ARPEARS HEREIN, SUCH MEDICAL AND SURGICAL SERVICES, S THERAPY UNDER ANESTHESIA OR OTHERWISE, AS MAY BE DEEMED NECESSA	URGICAL OPERATION AND/OR OTHER PROCEDURES OR
PATIENTI PLATIVE OR GUARDIAN	WITNESS
SIGNATURE	SIGNATURE
PHIRT NAME	PRINT NAME /W - 09
RELATIONSHIP, IF SIGNED BY PERSON OTHER THAN PATIENT	1
ARANTEE OF PAYMENT	PRIS
FOR AND IN CONSIDERATION OF SERVICES RENDERED OR TO BE RENDERED TO PAY THE JAMAICA HOSPITAL, THE FULL AND ENTIRE AMOUNT OF ANY AND I HEREBY ANTHORIZE THE HOSPITAL TO RELEASE ALL MEDICAL INFORMATION TREATMENT	ALL BILLS RENDERED FOR SAID TREATMENT.
PATIENT RELATIVE OR GUARDIAN	WITNESS
SIGNATURE	SIGNATURE
PRINT NAME	PRINT NAME
RELATIONSHIP, IF SIGNED BY PERSON OTHER THAN PATIENT	DATE
AUTHORIZE OF PAYMENT	
FROM THE GOVERNMENT AGENCIES, INSURANCE CARRIERS, AND OTHERS WE CARE TO COVER THE COSTS OF THE CARE AND TREATMENT RENDERED TO	VHO ARE FINANCIALLY LIABLE FOR MY HOSPITALIZATION AND MEDICAL
PATIENT/RELATIVE OR GUARDIAN	WITNESS
SIGNATURE	SIGNATURE
FRINT NAME	PRINT NAME
	DATE

FORM NO. J00018-2C



Marianias

SCHOOLCRAFT, ADRIAN 1298984 M DOB: 06

DOB: 06/21/1975 34Y

ADM: 11/01/2009 162B

ALDANA-BERNIER, LILIAN R PSY@9 130381874

ACKNOWLEDGEMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the Hospital and the facilities listed on the back of this form, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the hospital, its staff, and the facilities listed at the back of this form.

Signature of patient or authorized representative
Relationship to patient
Date
AFFIRMATION OF PRIOR RECEIPT
By signing below, I acknowledge that <u>I have already received</u> a copy of the Notice of Privacy Practices, and have given my consent for the use of my health information for the purposes noted above. <u>I do not wish to receive</u> another copy of the Notice Privacy Practices at this time.
Signature of patient or authorized representative
Relationship to patient
Date
THIS FORM IS PART OF THE MEDICAL RECORD



M00011 9/06



Jamaica Hospital Medical Center 8900 Van Wyck Expressway, Jamaica, New York 11418 Telephone # 718 206-6000

LIMITED POWER OF ATTORNEY TO PURSUE PAYMENT AND APPEALS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION ("LIMITED POWER OF ATTORNEY")

By signing this document. I give the Health Care Provider, identified below, a Limited Power of Attorney to pursue payment from my health insurer, health maintenance organization, self-insurance plan, governmental program, or other payer ("Heath Plan") for medical services provided to me by the Health Care Provider, and I authorize the release of medical information.

I, the undersigned Patient/Principal, appoint JAMAICA HOSPITAL MEDICAL CENTER ("Health Care Provider"), located at 8900 VAN WYCK EXPRESSWAY, JAMAICA. N.Y. 11418 my Attorney-In-Fact and authorized representative to act in any way which I myself could do, if I was personally present, and to take all reasonable action, as determined by the Health Care Provider, to pursue payment from my Health Plan and/or pursue any appeals available to me under my Health Plan's policies or procedures and all applicable law, including but not limited to External Appeals under all State and Federal laws, relating to bealth care services provided by the Health Care Provider. The Health Care Provider, as my agent, may pursue payment and/or appeal, only when my Health Plan has denied payment based on medical necessity. The Health Care Provider will not charge me for its services in pursuing payment and/or an appeal on my behalf. I agree that my Health Plan will pay any amount owed directly to the Health Care Provider for these services. In pursuing such payment and/or an appeal:

I authorize the Health Care provider and my Health Plan to release all relevant medical information, including (if applicable) any HIV-related information, mental health treatment information, or alcohol/substance abuse treatment information, relating to my treatment which is necessary to pursue payment from my Health Plan. I understand that this information may be released, but only as necessary, to my Health Plan, an external appeal agent, arbitrator, court of law, and/or other third party reviewer ("Independent Reviewer") responsible for deciding if the Health Care Provider's claim for services should be paid. I understand that my Health Plan and/or the Independent Reviewer will use this information to make a decision about payment to the Health Care Provider. I also understand that the decision by the Independent Reviewer will be final and binding on me, the Health Care Provider, and the Health Plan, and:

I authorize the Health Care Provider to complete, execute, acknowledge, seal, and to deliver any consent, demand, request, application, agreement, authorization or other documents necessary, to request, on my behalf, payment and/or appeal to my Health Plan and, if applicable, to the Independent Reviewer, the New York State Department of Health, the State Insurance Department, the U.S. Department of Health and Human Services, the U.S. Department of Labor, and/or any other applicable agency or body.

This Limited Power of Attorney shall not be affected by my subsequent disability or incompetence and MAY BE REVOKED BY ME AT ANY TIME upon prior notice to the Health Care Provider. This Limited Power of Attorney, including authorization for release of medical information, will terminate one (1) year from today's date unless I agree to extend it beyond that date.

Any person or entity receiving	this document may rely on a copy as if it	were and executed original.	
IN WITNESS WHEREOF,	have signed my name this d	ay of 10,2	00 Z.
at	YOU SIGN HERE		
Porc	PRINTED NAME SCHOOLCRA	AFT ADRIAN	
	ADDRESS: 82 60 88 PL	RIDGEWOOD	NY 11385
	MEDICAL RECORD#1298	3984	
WITNESS:	MAN	4 moust T	\wedge
PRINT NAME/TITLE:	, , ,		
ADDRESS: 8900 Var	Wyck Expressway, Jamaica, New	York 114,08	
Control to the state of the state of this			Form No. 10007



SCHOOLCRAFT, ADRIAN

1298984 M DOB: 06/21/1975 34Y F/C: 99

ADM: 11/01/2009 08:54 162B 130381874

ALDANA-BERNIER, LILIAN R PSYC

ACKNOWLEDGEMENT OF THE REQUEST FOR EXTERNAL APPEAL AND RELEASE OF MEDICAL RECORDS TO BE SIGNED BY THE PATIENT.

In order for a provider to appeal a health plan's payment denial for a patient's treatment, the patient must sign and date the following consent to the release of medical records. A certified external appeal agent assigned by the New York State Insurance Department will use this consent to obtain the patient's medical information relating to the external appeal request from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I <u>SCHOOLCRAFT</u> <u>ADRIAN</u>, acknowledge that my health care provider may request or is requesting an external appeal because of a retrospective adverse determination of my health plan. I authorize my HMO, insurer, or provider to release all relevant medical or treatment records, including my name and other personal identifying information, date of admission, assessment results and history, summary of treatment plan, progress and compliance, treatment recommendations, any HIV-related information, mental health treatment information, or alcohol/substance abuse treatment information, related to my provider's external appeal, to the external appeal agent. I authorize the external appeal agent to use this information solely to make a determination on my provider's appeal.

I understand that my records are protected under federal and/or state law and cannot be disclosed without my written consent unless otherwise provided for in regulations. I understand that information disclosed pursuant to this authorization may no longer be protected by federal privacy regulations, however, state privacy protections may still apply. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I understand that I may revoke this consent at any time, except to the extent that action has already been taken in reliance on it, by contacting the New York State Insurance Department in writing.

If you have any questions contact the New York State Insurance Department at: 1-800-400-8882 or visit our Web site at www.lns.state.ny.us.



Form No. J00027



SCHOOLCRAFT, ADRIAN

1298984 M DOB: 06/21/1975 34Y F/C: 99

ADM: 11/01/2009 08:54 162B 130381874

ALDANA-BERNIER, LILIAN R PSYC

Please provide the following information and sign the patient certification so we may accurately bill Medicare. ----ALL PATIENTS---t. How old are you?____ __ Birth Date ___/_ 4. Is this service for the treatment of an illness/accident for which another party could be held responsible?

Yes

No 2. Are you eligible for any programs (including government If yes, please provide the following information: programs) which could pay for this service? e.g.: Black Lung Medical Benefits or Veteran's Administration Name and Address of no fault/liability insurer:____ ☐ Yes ☐ No If Yes, Name of Program: Policy #: _____ Date of Accident:____/___/___/____/ Is this service for treatment of work related injury/accident?

Uses In No. If yes, date of Injury Accident _____/___/ Type of Accident: Employer Name and Address: Name of insured: 5. Are you currently enrolled in a hospice \(\mathbb{Q}\) Yes \(\mathbb{Q}\) No Name and Address of Worker's Compensation plan-If yes, Name and Address of facility_ File/Case # (if available) Do you have a revocation letter? D Yes D No Medicure #: PATIENTS UNDER AGE 65 PATIENTS OVER AGE 65 Are you currently employed (including self-employment)?

☐ Yes ☐ No If no, Disability Date ___/__/ t. Are you currently employed (including self-employment)?

□ Yes □ No If no, Retirement Date ___/__/___/ If yes, does your employer have: (please include Part and If yes, does your employer have: (please include Part and Full time employees) Full time employees) ☐ Less than 20 employees ☐ 20-99 employees Less than 20 employees ■ 20-99 employees □ 100 employees or more □ 100 employees or more All PATTENTS 1. Are you married? \square Yes \square No \square Widower or Widow. If yes, is your spouse working? \square Yes \square No If yes, does your spouse's employer have: (please include Part and Full time employees) Less than 20 employees □ 20-99 employees □ 100 employees or more Spouse's Retirement Date: ___/__/ 3. Do you have insurance coverage through employee group health plan based on your current employment or a family member's current employment? Yes No If yes, Name of Policy Holder:_ Relationship to patient, (Self, Spouse)_ Name and Address of Employer: Name and Address of Insurance Company: Group/Policy Number: 4. Are you a member of an HMO? (Please note if HMO authorization guidelines are not followed. Medicare will not pay, the heneficiary will be responsible for payment). \square Yes \square No If Yes, is this coverage through an Employer Group Health Plan?

Yes

No 5. Have you received a kidney transplant or dialysis treatments?

Yes No If Yes, Date of Transplant Date maintenance dialysis begins ____i ___ / ___ Have you received self-dialysis training? □ Yes □ No Patient or Guarantor Certification I have answered the above questions completely and accurately to the best of my knowledge. I understand that inaccurate information can affect the amount of payment ultimately made by Medicare and other insurance carriers for covered services. Patient/Guarantor Signature: Date: Hospital Representative/Witness:____

FORM NO. M00003



SCHOOLCRAFT, ADRIAN

1298984 M DOB: 06/21/1975 34Y F/C: 99

ADM: 11/01/2009 08:54 162B 130381874

ALDANA-BERNIER, LILIAN R PSYC

COORDINATION OF BENEFITS QUESTIONNAIRE

	Section 1	- Member Ins	surance Info	mation		
Are any family members that are co the policy above covered under an health insurance policy (currently or past 2 years)?	other group	O Yes		edicare Only RD	○ Medicaid ○ CHAMPUS / TRICARE	O No
		Complete sections 2 - 7	Complet 5 ar	e sections 3 - d 7	Skip to section 7	Skip to section 7
_	Section	2 - Other Ins	urance Infor	mation		
ndicate name of other insuranc NOTE: If more than one other cov			her carrier inf	ormation from	this section on add	ditional pag
Aetna / Us Health Care E	Blue Shield of N	ENA Ó	COPHP	Oci	IGNA (Эен
HIP Horizon BC of NJ	OMVP	(Oxford		Ounited Health	Care
Other (Name of Carrier) Customer Service Telephor	l l l	<u> </u>			<u> </u>	
Numbe		J_ [_}	
Type of enrollment (fill in only one): Olidividual	○Fa	mily	Employee	& Spouse	Parent & Child(ren)
Type of coverage (fill in all that apply): Hospital	OM€	edical	OPrescripti	on Drug		
Oental	Ovi	sion	○Mental He	alth / Substand	e Abuse	
Effective date of the other coverage:	Effective Date	e (mmddyyyy)			n Date (mmddyyyy) pppliceble)	
Section	3 - Primary C	ontact Holder	Information	of Other Ins	urance	
Primary Contract Holder on the Po	icy Last Nan	10		First Na	mə	
indicated in Section 2:						
identification Number or Med number: (Include all letters and						
Group Num (if available						
Relationship of this contract holds	or to the contra	ct holder listed	at the top of			
◯ Self	Spouse	"SPOUSE", Indica) Dependent		Ex-Spouse or Legally Separated Spouse	
_	•			SUMUS		
_		mployer offering o Long Term Disabl				
\circ	ed from employer	Long I tim Disabi	-	etired, date		

Services provided by Empire Health Choice HMO. Inc. and/or Empire Health Choice Assurance, Inc., licensees of Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Association.

Form No. M00017J



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FORM NO M00001



LOCATION. 162B

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THE JAMAICA HOSPITAL MEDICAL CENTER

MENTAL HEALTH CLEARANCE FORM

TODAY'S DATE: 10-02-09	REASON FOR REFERRAL
To:	Eligibility
FROM:	Authorization
Patients Name 13038187	Y PECL Admission Date
HOspital &	469-97-6997
Notification of Impending Referral Received Vis:	6-21-1975
Mail Fax Brought in Pi	noned in
INSURANCE INFORMATION	
G 1	CRAFI, ARIAN
INSURANCE COMPANY NAME: AFTN	A
CONTACT PERSON:	
INSURANCE CO. TELEPHONE NO: (800) 451-8843	
INSURANCE COMPANY ADDRESS:	
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EXPLANATION OF MENTAL HEALTH BENEFITS (# of days author PRIOR OUT & PRIOR OF ONE OF ON	identities to parturit
ACTIVE CON AETHA LATI	1631788 EFF 11-01-2007
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AUTHORIZATION NO.: PRE CERT. C	OORDINATOR NAME:
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PHYSICIAN NOTES:	
V	
PHYSICIAN NAME: MR.	·
H A A	
* Financial Investigation (White Copy) * Mental Health Clinician (Pink	Copy) • Social Work (Yellow Copy)
3/12/98 (MHAUTHZ, WK3) FIN, INV.INS, UNIT	

THE JAMAICA HOSPITAL MEDICAL CENTER

Eligibility TO: Admission Date Notification of Impending Referral Received Via: Brought in Phoned in_ INSURANCE INFORMATION NAME OF INSURED: INSURANCE COMPANY NAME: CONTACT PERSON: INSURANCE CO. TELEPHONE NO: INSURANCE COMPANY ADDRESS: EXPLANATION OF MENTAL HEALTH BENEFITS(# of days authorized, etc.): PRE CERT. COORDINATOR NAME: DISPOSITION OF INSURANCE INQUIRY: APPROVED [7] DENIED PENDING PHYSICIAN CONTACT PHYSICIAN NOTES: PHYSICIAN NAME: * Social Work (Yellow Copy)

3/12/96 (MHAUTHZ, WK3) FIN. INV.INS. UNIT

	Emdeon,	Inc.	
Batch: Assistant	·		Page 1 - 5
11/03/09 13:49:35	T000188-CARIAS	11/03/2009	
Scatus: CDOSED	Id:176.1 Record: 1	Covg Level	Limitations IND
	Aetna	covg bever	Individual
	Eligibility v2.2	Service Type Code	30
		Health Benefit P	lan Coverage
		Period	Lifetime
Input / Res	sponse Information	In-Network	Yes
Provider ID	111631788	Message UNLIMITED LIPET	IME BENEFITS
Subscriber ID		Benefit	
(On File) Date Of Service	BBM6PBPA 11/03/2009		Eligibility
SSN SELVICE	469976997		Service
Date Of Birth	06/21/1975	11/03/2009	- 11/03/2009
Last Name	SCHOOLCRAFT		Limitations
First Name	ADRIAN	Covg Level	FAM
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	Information	Health Benefit P	lan Coverage
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Group/Policy	US0080410090011 PACES - CITY OF N Y		Eligibility
up/Policy	PACES - CITY OF N Y		-
Plan ID	5691654		Service
Sub Last Name	SCHOOLCRAFT	11/03/2009	- 11/03/2009 Limitations
Sub First Name	ADRIAN		FAM
Sub Middle Name Sub Birth Date	06/21/1975	Covg Level	Family
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Identification (Code Facility Identifier	11/03/2009	- 11/03/2009
	Other Source of Data Benefit		tive Coverage
	Eligibility		FAM
	11/14/2005		Pamily 33
		Service Type Code	Chiropractic
Covg Level	FAM		OMH
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Service Type Co	lth Benefit Plan Coverage		Eligibility
Insurance Type	Code HI	1	
Health Maint	enance Organization (HMO)	100/000	Service
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	-Benefit	- coad never	Individual
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	servic		Chiropractic

Yes

In-Network

Service Type Code Professional (Physician) Visit -Office isage 1 COPAY/SVC based on PROV type Eligibility Service 11/03/2009 - 11/03/2009 Limitations Covg Level Family Service Type Code Professional (Physician) Visit -Office Message 1 COINS/SVC based on PROV type ~~----PCP~----Period Start 07/09/2008 Name HERTZEL SURE Phone 718-760-0797 Covg Level FAM Family Vice Type Code 30 Health Benefit Plan Coverage Insurance Type Code Health Maintenance Organization (HMO) -----Gateway Provider-----Eligibility Service 11/03/2009 - 11/03/2009 intification Code 1083727762 SURE, HERTZEL , MD 9425 60TH AVE UNIT B4 ELMHURST NY 11373 Covg Level FAM Family Service Type Code Health Benefit Plan Coverage Ensurance Type Code Health Maintenance Organization (HMO) Receipt of this information does not guaranty payment under state law. Should Provider wish to obtain verification that payment will be made, or if member information returned differs from Provider's patient records, call Aetna Member Services. ARRESTMES Transaction State PERSONNEL Query: - PASS

CARTAS 11/03/09 13:49:35

EMDEON ASSISTANT

Page 1 of 3 Status: CLOSED

ID: T000188

Aetna - Subscriber Eligibility v2.2

SEARCH INFORMATION: INFOT Provider ID:

111631788

Subscriber ID:

пвибрвра

Date Of Service: SSNt Date Of Birth:

11/03/2009 469976997 06/21/1975 **ECHOOLCRAFT**

Pirst Name: Svc/Proc Code:

Last Name:

ADRIAN

ABTMA INFORMATION
Plan Newk ID: GN01

Group/Policy: Group/Policy: US0080410090011 PACES - CITY OF N Y

Plan ID:

5691654

Sub Name: Sub Birth Date: 06/21/1975

SCHOOLCEAFT, ADRIAN P

Sub Gender:

MALE

55 92ND ST APT E2 BROOKLYN, NY 11209

Dates:

Eligibility - 11/01/2007

Service - 11/03/2009 - 11/03/2009

CHIROPRACTIC Matwork Coverage Type

Additional Info Message: Chiro

Individual

Co-Insurance 100 \$20.00 Co-Payment

Message: Chiro

\$20.00 Day Co-Payment

Message: Specialist Chiro Office Visita

FIMO

Family Active

Coverage

Limitations

Message: 1 COPAY/SVC based on PROV

EMERGENCY SERVICES

Network Coverage
Individual

Family

Válue

100

additional Info Message: Emergency Room Copay

\$75.00 Admisson Co-Payment \$75.00 Co-Payment Co-Payment \$35.00

Message: Urgent Care Copay Message: Emergency Room Message: Emergency Room Copay Message: Urgent Care Copay

Coverage

Active

Cost

Co-Insurance

Message: 1 COPAY/SVC based on PROV

Limitations

t.ype Message: 1 COINS/SVC based on PROV

Limitations

Message: Limitations Limitations Message: call 1/800-624-0756 Limitations

HEALTH BENEFIT PLAN COVERAGE
Network Coverage Type & Value Period

Family To

Additional Info Message: NO PENALTY FAILURE TO

PRECERT'

Containment Individual Limitations 1n

Message: UNLIMITED LIFETIME Lifetime

Family Active BENEFITS

Coverage

Insurance Type Code: HM

Health Maintenance Organization

(HMO) HMO

type

Message: Commercial

Message: NO NON-EMERGENCY COVG CON

Limitations

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CARTAS
                                    EMDEON ASSISTANT
                                                                             Page 2 of 3
                    Limitations
                                                     Message: Plan req referral and
HOSPITAL - INPATISMT
Network Coverage
                                                     Additional info
                                    Value Period
         Individual
                    Co-Insurance
                                      100
                                                     Message: Facility Inpatient
                                                      Hospital
                    Co-Payment
                                  $300.00
                                                      Message: Facility Inpatient
                                                      Hospital
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                    Active
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                    Limitations
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HOSPITAL OUTPATIENT
Network Coverage Type
                                                      Additional Tato
Message: Hospital - O/P Surgery
         Individual
                    Co-Insurance
                                                      Message: HOSPITAL OUTPATIENT
                     Co-Payment
                                   $75.00
                                                      Message: Hospital - O/P Surgery
                                                      Message: HOSPITAL OUTPATIENT
                     Co-Payment
                                   $20.00
         Family
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                     Limitations
                                                      Message: 1 COINS/SVC based on PROV
                     Limitations
                                                      type
 PROFESSIONAL (PRYSICIAN) VISIT -
Network Coverage Type
                                                      Additional Info
                                                      Message: PCP After Hours
         Individual
                                      100
                                                      Message: PCP During Hours
                                                      Message: PCP After Hours
                     Co-Payment
                                   $20.00
                                                      Message: PCP During Hours
                     Co-Payment
                                   $15.00
                                                      Message: Specialist Off Visit
                     Co-Payment
                                   $20.00 Day
                                                      Consult
          Pamily
                     Active
                                                      HMO
                     Coverage
                                                      Message: 1 COPAY/SVC based on PROV
                     Limitations
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                     Limitations
                                                      type
                    BENBPIT
                       Eligibility
                       Service
                       11/03/2009 - 11/03/2009
                       000000119
                       Facility
                       Facility Identifier
 Identification Code:
                       Other Source of Data
 PCP Period Start - 07/09/2008
                   HERTZEL SURE
                   718-760-0797
                   FAM - Family
 Covg Level:
                  30 - Health Benefit Plan Coverage
HM - Health Maintenance Organization (HMO)
 Service Type:
 Insurance Type:
 CATEMAY PROVIDER
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Eligibility

JHMC 30

CAPTAS

EMDEON ASSISTANT

Page 3 of 3

Service

11/03/2009 - 11/03/2009

Identification Code:

1083727762

Nameı

SURE, HERTZEL , MD 9425 GOTH AVE UNIT B4 ELMHURST, NY 11373

Covg Level:

FAM - Family

Service Type:

30 - Health Benefit Plan Coverage

Insurance Type:

HM - Health Maintenance Organization (HMO)

DISCLAIMED

Receipt of this information does not guaranty payment under state law. Should Provider wish to obtain verification that payment will be made, or if member information returned differs from Provider's patient records, call Actna Member Services.

TRANSACTION STATS

Query: - PASS

P() 1 of 2 ePACP^a JAMAICA HOSPITAL MED CTR - 1225176175 Claims Change Provider: JAN

Find Opens

F Change Provider: JAMAICA HOSPITAL MED CTR - 1225176175 Frank Look From Secret Clare Parties Frank Industry Frank Responses Eligibility Information: Sydney Restronger
MEVS

Eligibility Remotes

Eligibility Responses

SA Remotes

SA Remotes Subscriber/Insured Not Found 5. Client Information: 6/21/19/9 Client ID; Date of Birth: SCHOOL CASET ADDIAN Client Name: Gender: M Office: Medicaid Coverage Information: Prior Approval Support Files
-- Projektion
-- Other Payer Coverage Level: Date of Service: 11/93-3000 Insurance Type: Anniversary: Receptification pulposityes Medicald Managed Care . Medicald Restricted Recipient Pian Name: Restriction Type: Carrier Code:

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Co-Payment Information

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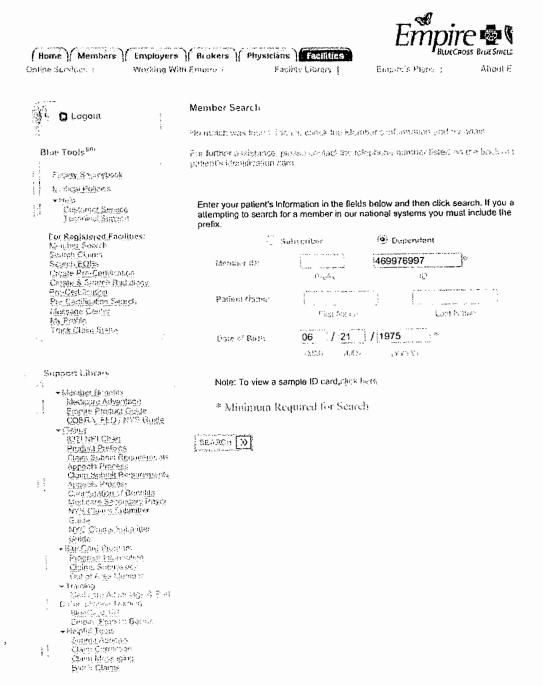
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Emdeon, Inc.

Batch: Assistant

Page 1 - 1

11/02/09 17:48:51 T000188-MMERO1 Status: RETRY Id:1350.1 Record: 1

Medicare Eligibility v2.3

Input / Response	Information
Provider ID	1245370717
Medicare HIC #	469976997A
Begin DOS	11/02/2009
End DOS	11/02/2009
Date Of Birth	06/21/1975
Last Name	SCHCOLCRAFT
First Name	ADRIAN
Gender	M
Service Type	42
Service Type 2	47
Service Type 3	15
Service Type 4	14
Service Type 5	ĀG
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SCHOOLCRAFT, ADRIAN

1298984 M DOB: 06/21/1975

081X STAFF, PHYSICIAN

ADM: 10/31/2009

130381015

01

CONSULTATION REPORT

THIS SECTION TO BE FULLY COMPLETED BY THE REQUESTING PHYSICIAN
REQUEST TO: Dr. Patel / D. Lwin DEPT/DIVISION: Psychiotry ER
REQUEST FROM: D. Nwaishie nyii DEPT/DIVISION: Medical SR
IMPRESSION: psychotic disordor, NOP
REASON FOR CONSULTATION:
GCONSULTATION ONLY GCONSULTATION WITH ORDERS GCONSULTATION WITH FOLLOW-UP
SIGNATURE: DATE: U/1/09 TIME: 6:30 am
OPINION OF CONSULTANT:
34 years old ringle white mole, police officer, living by
himself was brought in by NYPD of 81" Precint, in
hand copy to medical ER with complaint of ebelominal
hand could to medical ER with complaint of ebolominal
Nyquīl.
Prych consult was called and reported as patient acting
bizzare, hand culted and in Police instody.
As per patient, he was not beeling well yesterday, had
turning pain / Abdomiral poin and fold his spervisor that ho is
leaving Potient ways while sleeping in his bed, Lond bord
open the door and his colleagues entered and hand culted
and brought him to Temoica hospital, He says he is warried
short the ritration going on. Jays this is hoppening because
he has been reporting to his superiors and commissioner about
internal affairs of police department d'ays he knows his
Jupervisors are hidiry robbery and arreall cases to
get higher menter/ position. Days he has poper documentation
get higher menter/position. Dogs he has paper documentation about this crime and reporting since last year.
· continue

Signature:

ORIGINAL - MEDICAL RECORD

CARBON COPY - CONSULTANT

Consultant Print Name:

Time:



SCHOOLCRAFT, ADRIAN 1298984 M DOB: 06/21/1975 34Y ADM:10/31/2009 081X 130381015 01 STAFF, PHYSICIAN

CONSULTATION REPORT CONTINUATION

Denies post pay hor	pitalization (or) treatm	rent (or) then	mi'ci'dal
attempt.			
As per Jargent Ja	mes of 81 Prec	int, pati	ent complaine
of not feeling well	yesterday afternoon	in and ls	oft his work
early ofter getting	egitated and enroit	ng superv	isor. They
follow hi'm home a			
the door had to be egreed to go with t	them for exclustion	but once	outvide,
he ran and hed	to be chased and	brought	to The
medical ER, Land			
In the medical ER	, he be came cgi	total, une	o operative
and verbally abruit	ve over telephone	use and	told his
Freating MD that!	they are all egains	t me. Am	ic. L
As per Sergeont To	mer, he was ever	clusted by	NYPD
prychiatrist and a			
nearly a year.			
Denies any drug (o	m) Alcohol abuse		
Denies any history	of Jamily mental	illhear	
No acute medical p	roblem complaine	ed of cha	domi'tal
pain yesterday and	! has rinunitis.		
Mental status Exami	Notion - 34 year	ri old, w	hite mole
appropriately dressed or	d groomed, appears	to his stet	ed age.
He is coherent, releve good eye confect.	ant with goal dir	ected spee	ch and
good eye confact. 1	He is irritable with	approprie	ted abbect
He denies hallowingto	in . He i'm ? paran	oid abort	t his
supervisors He denie	es suicidal idention,	homicidal	idention ct
		_	- Cute
Consultant Print Name:	Signature:	Date:	Time:

ORIGINAL - MEDICAL RECORD CARBON COPY - CONSULTANT



SCHOOLCRAFT, ADRIAN 1298984 M DOB: 06/21/1975 34Y ADM:10/31/2009 081X 130381015 01

CONSULTATION REPORT CONTINUATION

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the present time. His , He is alert and or	memory and concentr	elian 19 intact
He is alert and or	Tented . His insight	rand inalgoment are
impured.		~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Dicgrony		
Axis I psychotic	disorder, NOS	
II deferred		
III . SIn Abdor	minal pain, chronic	vinneite:
w conflict	at worksite	
(V) 40		
Recommendation		
) continue 1:1 obse	rvotion for unner	edictable behaviour
and escape sish		
) Transfer to pry E	Ralter medical c	lecronce
Case discussed with Dr.	The Potal	VC4 GZCANT 3 VNC4
Cope discovered points	Dr. 1 aler	
		Khin Mar Lwin, MD Psychiatric Resident
1609 Comme à allowe	Dr c 17 semend	alieur.
, Am	J- Be	DO (I MALL)
		1
Consultant Print Name:	Signature:	Date: Time:
		

ORIGINAL - MEDICAL RECORD

CARBON COPY - CONSULTANT

FORM: 112 ITEM: 1875 REV. 1/07

JHMC 45

JAMAICA HOSPITAL MEDICAL CENTER

PATIENT CLOTHING/VALUABLES INVENTORY

- 1. ALL PATIENTS CLOTHING/VALUABLES/SENT HOME
- 2. DENTURES TAKEN HOME BY FAMILY MEMBER

YES	E NO
VEC	TI NO

SCHOOLCRAFT, ADRIAN 1298984 M DOB: 06/21/1975 ADM:10/31/2009 081X 13038 STAFF, PHYSICIAN 34Y 130381015 01

·			ISSION	TI	RANSFER		TRANSFER
·		DATE	TIME: 11-01-09	DATE/TIME:		DATE	
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IN	VENTORY OF ITEMS KEP				Decoipy	- \$	
9	UPPER DENTURE	DUMBLY	DESCRIPTION (ABELED CUP PROVIDED D/	OMMULLA	DESCRIPT	8	<u> </u>
TURES	LOWER	1-	/LABELED CUP PROVIDED d		—— 2	SEALED	WWNER.)
DENTO	PARTIAL	1	LABELED CUP PROVIDED B		8332	2	0
-	COAT/JACKET	\ -	,		─	13	
	DRESS/HOUSECOAT					MIA	
A.	PAJAMAS/NIGHTGOWN		7 65 =			BEEN HETURKED, TO, THE DEPOSITOR, INTACT, AND	IVE
FOOTWEA	SLACKS/PANTS/JEANS	17	13 3 2 6 15			USII	u u
9	BLOWSE/T-SHIRT/SWEATER		18			99	9
	SKIRT/SHORTS		3	K		E	X X
OUTWEAR	UNDERWEAR/BRA	1/	12 10 1/20	> 0		10	N N N N N N N N N N N N N N N N N N N
ž	GLASSES/CONTACTS		L'IL	C.	,	a	THDRAW CEPOSIT
3	HAT/GEOVEO/TIE/BELT		857	M.		E	de de
I	PANEYHOSE/SOCKS	No.	6 2 6 0	8		쀼	
CLOTHIN	BATHROBE	7	10 10 10 10 10 10 10 10 10 10 10 10 10 1	E -	E	SEEN	-
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	BOOTS/SLIPPERS		3 9 20		Z		
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	CELL PHONE/BEEPER					-: 5	
	OTHER:						
	ENVELOPE RECEIPT #		83325			, T	
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		THE TANK	#12	HONT KAMERION		PRINT NAMEZ	
	TIENT/SIGNIFICANT OTHER:	X		SIGNITUE:		SIGNITUE:	
ST	AFF RECEIVING PROPERTY	121	Lew est PCA 5	- ~		}	
WIT	NESS/TRANSFERRING STAFF:	Pomie	Dec. Xh	SO/TITLE:		SCHILE:	
		HELD	IN SECURITY/CASHIER FOR N	O MORE THA	N 30 DAYS AFTER	DISCHAI	RGE
	CURITY/CASHIER SIGNATUR	PRI	YT HAMEGRON:		:		
	AFF MEMBER RELEASING P		топ начерске ТҮ:				
	HENT/FAMILY MEMBER REC		PRINT MANE STON;		RELATION	SHIP:	
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Date of Discharge

SCHOOLCRAFT, ADRIAN 1298984 M DOB: 06/21/1975 34Y F/C: 01 ADM: 10/31/2009 23:03 081X 130381015 STAFF, PHYSICIAN

ASSIGNMENT AND RELEASE OF INFORMATION STATEMENTS

Authorization to Jamaica Hospital for release of informatio	
who are financially liable for my hospitalization and medical cal	ed me, to release to governmental agencies, insurance carriers, or others re, all information needed to substantiate payment for such hospitalization and examine and make copies of all records relating to such care
Date	Signature of Patient or Authorized
Date	Representative
Assignment to Jamaica Hospital	
	pital sufficient monies and/or benefits to which I may be entitled from are final cially liable for my hospitalization and medical care to cover the indention said hospital.
Date	Signature of Insured or Authorized Representative
Safe Medical Device Act	•
	manufacturer of any device that must betracked pursuant to the mandates of er will be given my social security number only for the purpose of finding me in edy, or used in my home is defective.
Date	Signature of Insured or Authorized
Date	Representative
holder of medical or other information about me to release to t its intermediaries or carries any information needed for this or	ayment under Title XVIII of the Social Security Act is correct. I authorize the he Social Security Administration and Health Care Financing Administration or a related Medicare claim. I request that payment of the authorized benefits be hysician services to the physician or organization furnishing the services or to Medicare for payment on my behalf.
Date	Signature of Insured or Authorized Representative
Financial Agreement	
undersigned (jointly and severally, if more than once) hereby charges as submitted by the Hospital on the account of said at said Hospital. It is further agreed that the charges as income as incom	ered by the Jamaica Hospital, to the patient whose name appears below, the y agree(s) to be fully and totally responsible to the hospital for payment of all patient and make payment in accordance with the policy of payment of bills urred represent the fair and reasonable value of services rendered and are in are available upon request. Payment may be demanded at any time, and uisite to my (our) immediate responsibility for payment.
The undersigned has read the above, been informed of its received a copy of this agreement.	s nature and significance and acknowledges the contents of same and has
Dated	Guarantor
SCHOOLCRAFT, ADRIAN	- Quaranton
Name of Patient 10/31/2009 23:0.	Address - Guarantor
Hospital No. Date of Admission	Telephone - Guarantor

Witness

Date



SCHOOLCRAFT, ADRIAN

1298984 M DOB: 06/21/1975 34Y

ADM: 10/31/2009 081X 01 130381015 STAFF, PHYSICIAN

CONSENTS	
PERMISSION FOR TREATMENT	
I HEREBY AUTHORIZE THE JAMAICA HOSPITAL, THROUGH ITS MEDICAL STAF WHOSE NAME APPEARS HEREIN, SUCH MEDICAL AND SURGICAL SERVICES, THERAPY UNDER ANESTHESIA OR OTHERWISE, AS MAY BE DEEMED NECESS	SURGICAL OPERATION AND/OR OTHER PROCEDURES OR
PATIFICATIVE OR GUARDIAN	WITNESS
SIGNATURE	SIGNATURE
PRINT NAME	PRINT NAME
RELATIONSHIP, IF SIGNED BY PERSON OTHER THAN PATIENT	DATE
ARANTEE OF PAYMENT	
FOR AND IN CONSIDERATION OF SERVICES RENDERED OR TO BE RENDEREI TO PAY THE JAMAICA HOSPITAL, THE FULL AND ENTIRE AMOUNT OF ANY AN I HEREBY AUTHORIZE THE HOSPITAL TO RELEASE ALL MEDICAL INFORMATIC TREATMENT.	D ALL BILLS RENDERED FOR SAID TREATMENT.
PATIE TIRELATIVE OR GUARDIAN	WITNESS
CIQNATURE	SIGNATURE
PRINT NAME	PRINT NAME
RELATIONSHIP, IF SIGNED BY PERSON OTHER THAN PATIENT	DATE
AUTHORIZE OF PAYMENT	
EREBY ASSIGN, TRANSFER AND SET OVER TO THE JAMAICA HOSPITAL SU FROM THE GOVERNMENT AGENCIES, INSURANCE CARRIERS, AND OTHERS I CARE TO COVER THE COSTS OF THE CARE AND TREATMENT RENDERED TO	WHO ARE FINANCIALLY LIABLE FOR MY HOSPITALIZATION AND MEDICAL
PATIENT/RELATIVE OR GUARDIAN	WITNESS
SIGNATURE	SIGNATURE
PRINT NAME	PRINT NAME
RELATIONSHIP, IF SIGNED BY PERSON OTHER THAN PATIENT	DATE



SCHOOLCRAFT, ADRIAN

1298984 М

DOB: 06/21/1975

ADM: 10/31/2009 081X STAFF, PHYSICIAN

130381015

ACKNOWLEDGEMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the Hospital and the facilities listed on the back of this form, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the hospital, its staff, and the facilities listed at the back of this form.

Signature of patient or authorized representative
Signature of patient of authorized representative
Relationship to patient
Date
AFFIRMATION OF PRIOR RECEIPT
By signing below, I acknowledge that <u>I have already received</u> a copy of the Notice of Privacy Practices, and have given my consent for the use of my health information for the purposes noted above. <u>I do not wish to receive</u> another copy of the Notice Privacy Practices at this time.
Signature of patient or authorized representative
Polationship to nation
Relationship to patient
Date
THIS FORM IS PART OF THE MEDICAL RECORD





Jamaica Hospital Medical Center 8900 Van Wyck Expressway, Jamaica, New York 11418 Telephone # 718 206-6000

LIMITED POWER OF ATTORNEY TO PURSUE PAYMENT AND APPEALS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION ("LIMITED POWER OF ATTORNEY")

By signing this document, I give the Health Care Provider, identified below, a Limited Power of Attorney to pursue payment from my health insurer, heath maintenance organization, self-insurance plan, governmental program, or other payer ("Heath Plan") for medical services provided to me by the Health Care Provider, and I authorize the release of medical information.

I, the undersigned Patient/Principal, appoint <u>JAMAICA HOSPITAL MEDICAL CENTER</u> ("Health Care Provider"), located at <u>8900 VAN WYCK EXPRESSWAY</u>, <u>JAMAICA</u>, <u>N.Y. 11418</u> my Attorney-In-Fact and authorized representative to act in any way which I myself could do, if I was personally present, and to take all reasonable action, as determined by the Health Care Provider, to pursue payment from my Health Plan and/or pursue any appeals available to me under my Health Plan's policies or procedures and all applicable law, including but not limited to External Appeals under all State and Federal laws, relating to health care services provided by the Health Care Provider. The Health Care Provider, as my agent, may pursue payment and/or appeal, only when my Health Plan has denied payment based on medical necessity. The Health Care Provider will <u>not</u> charge me for its services in pursuing payment and/or an appeal on my behalf. I agree that my Health Plan will pay any amount owed directly to the Health Care Provider for these services. In pursuing such payment and/or an appeal:

I authorize the Health Care provider and my Health Plan to release all relevant medical information, including (if applicable) any HIV-related information, mental health treatment information, or alcohol/substance abuse treatment information, relating to my treatment which is necessary to pursue payment from my Health Plan. I understand that this information may be released, but only as necessary, to my Health Plan, an external appeal agent, arbitrator, court of law, and/or other third party reviewer ("Independent Reviewer") responsible for deciding if the Health Care Provider's claim for services should be paid. I understand that my Health Plan and/or the Independent Reviewer will use this information to make a decision about payment to the Health Care Provider. I also understand that the decision by the Independent Reviewer will be final and binding on me, the Health Care Provider, and the Health Plan, and:

I authorize the Health Care Provider to complete, execute, acknowledge, seal, and to deliver any consent, demand, request, application, agreement, authorization or other documents necessary, to request, on my behalf, payment and/or appeal to my Health Plan and, if applicable, to the Independent Reviewer, the New York State Department of Health, the State Insurance Department, the U.S. Department of Health and Human Services, the U.S. Department of Labor, and/or any other applicable agency or body.

This Limited Power of Attorney shall <u>not</u> be affected by my subsequent disability or incompetence and MAY BE REVOKED BY ME AT ANY TIME upon prior notice to the Health Care Provider. This Limited Power of Attorney, including authorization for release of medical information, will terminate one (1) year from today's date unless I agree to extend it beyond that date.

Any person or entity receiving this document may rely on a copy as if it were and executed original.

IN WITNESS W	HEREOF, I have signed my name this day of, 200
	YOU SIGN HERE:
	PRINTED NAME: SCHOOLCRAFT ADRIAN
	ADDRESS:
	MEDICAL RECORD # 1298984
WITNESS:	
PRINT NAME/	TITLE:
ADDRESS:	8900 Van Wyck Expressway, Jamaica, New York 11418



SCHOOLCRAFT, ADRIAN 1298984 M DOB: 06/21/1975 34Y F/C: 01 ADM: 10/31/2009 23:03 081X 130381015 STAFF, PHYSICIAN

ACKNOWLEDGEMENT OF THE REQUEST FOR EXTERNAL APPEAL AND RELEASE OF MEDICAL RECORDS TO BE SIGNED BY THE PATIENT.

In order for a provider to appeal a health plan's payment denial for a patient's treatment, the patient must sign and date the following consent to the release of medical records. A certified external appeal agent assigned by the New York State Insurance Department will use this consent to obtain the patient's medical information relating to the external appeal request from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I SCHOOLCRAFT ADRIAN , acknowledges or is requesting an external appeal because of my health plan. I authorize my HMO, insurer, or provide treatment records, including my name and other personal admission, assessment results and history, summary of compliance, treatment recommendations, any HIV-relatinformation, or alcohol/substance abuse treatment information, to the external appeal agent. I authorize the elinformation solely to make a determination on my provided to the external appeal agent.	f a retrospective adverse determination of der to release all relevant medical or anal identifying information, date of of treatment plan, progress and ated information, mental health treatment ormation, related to my provider's external external appeal agent to use this
I understand that my records are protected under disclosed without my written consent unless otherwise that information disclosed pursuant to this authorization privacy regulations, however, state privacy protections health plan cannot condition treatment, enrollment, eligform. I understand that I may revoke this consent at all has already been taken in reliance on it, by contacting Department in writing.	provided for in regulations. I understand in may no longer be protected by federal may still apply. I understand that my gibility, or payment on whether I sign this my time, except to the extent that action
This release is valid for one year from	(today's date).
Signature of Patient (or legal representative)	(Date)
Description of legal representative's authority to act or	n behalf of the patient.
Patient's Health Plan ID#:	

If you have any questions contact the New York State Insurance Department at: 1-800-400-8882 or visit our Web site at www.ins.state.ny.us.



						- SCHOOLCRAFT, 1298984 M ADM: 10/31/2009 - STAFF, PHYSICIA	DOB: 06/21/19 081X 01	975 34Y 130381015
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Patient Fact Sheet

Name and Address **Employer** SCHOOLCRAFT, ADRIAN UNEMPLOYED 82 60 88 PL RIDGEWOOD Phone: NY 11385 (718)570-6224 Phone: (999)999-9999 Sex: М SS No: 469-97-6997 Marital Status Race: Religion: NO BirthDate: 6/21/1975 Occupation: UNEMPLOYED Patient's Malden Name: **Nearest Relative** Admission Data SCHOOLCRAFT, SELF Account Number Unit Number 82 60 88 PL 130381015 1298984 Admit Date Admit Time | ER MD RIDGEWOOD 11385 10/31/2009 23:03 FF, PHYSI Home Phone: (718)570-6224 Rel: 01 Triage Time Prim Care MD NA Business Phone: **Emergency Contact** Guarantor SCHOOLCRAFT, ADRIAN **SCHOOLCRAFT** 82 60 88 PL RIDGEWOOD NY 11385 (718)570-6224 Rel: 01 Home Phone Home Phone: (718)570-6224 Business Phone **Business Phone:** Rel: SS: 999-99-9999 01 Occ: UNEMPLOYED Employer UNEMPLOYED Insurance Information ins: NO COVERAGE/CHARITY CA insured: SCHOOLCRAFT, ADRIAN Group Number: Policy Number: SELF/ 82 60 88 PL RIDGEWOOD NY 11385 FIN 99 Phone Number (718)570-6224 Auth Number

Medical Record No. 1298984

Account Number 130381015

Date 10/31/2009

Jamaica Hospital Medical Center

ID 130381015

Emergency Department Record

History of	f Present Illness	SNW
unknown du Denies Ano Patient is a	Male Patient Presents with Abdominal Pain Epigastric for 15 Hour(s). The Onset is Sudden. The symptoms a ration. Symptoms improve with without treatment. Additional Symptoms or Pertinent History also involve. Non exia; Fever; Genital Pain; Back Pain;. Patient states exacerbating Factors that occur are unknown. Radiating s Police Officer brought in handcuff by his colleagues. As per Patient he wasn't feeling well about 15hrs ago and at he was leaving for home. His colleagues from his Prescinct went to his home and hand cuff because the EM	e. Furthermore, the Patient/Family Symptoms include No Radiations at about 2 pm he told his
Review of	ystems	
	Signs not covered in the HPI)	
GU Neg		ymphatic Neg
Skin Neg	Psych Neg Heart Neg GI Neg Endocrine Neg Allergic/Imm	nunologic Neg
All other	OS negative Constitutional Sxs Neg	Eyes Neg
	s/Triage/Nursing Notes	Old Medical Records Reviewed
Past Medic	Il History No Relevant PMHx Asthma COPD CAD Cancer CHF	□ CVA
Other PMH;		izures
ORIGIT IVIII		
Social Hist	ry ✓ No Relevant SoHx ☐ ETOH ☐ Drugs ☐ Smoking Additional Sx	
Family Hist	ory V No Relevant FmHx No Significant FMHx	
Physica	Exam Exam Time 0:05	snw
General App	earance Awake A&Ox3	ı
HEENT	PERRL EOMI Moist Mucous Membranes No Icterus	
Chest	RRR No M Lungs CTA No Ret Chest Wall NT	j
Abdomen	No Pulsating Masses BS-NL/No Bruits Tenderness-None	
GU		
Extremities	Throughout all extremities erythematous impressions on the wrist bilaterally at the site of handcuffs ROM-Full mild tenderness on the wrist where the hancuffs were applied	application CBR < 2 sec Active
Neuro		
Skin	No pallor/ rashes warm & moist	
Back	NT no CVAT, Back Flexion 90	
Neck	NT Full ROM No JVD	
Lymphatics	No LAD	
Repeat	or Additional Clinical Notes	
MD	Notes	Time
SNW	The following Life or Limb Threatening Differential Diagnosis were considered: Appendicitis; AAA Leaking or Rupture; Incarcerated Hernia; Mesenteric Ischemia or Thrombosis; Myocardial Infarction or CAD; Testicular Ovarian or Salping Torsion; Large or Small Bowel Volvulus; Liver Failure Pancreatitis; Rupture Viscous (Liver Spleen Bowel); Intraabdominal Abscess; Ectopic Pregnancy; Intussusception; Hemolytic Uremic Syndrome;	11/1/2009 0:03
SNW	Looks Comfortable; Not III Appearing; No Peritoneal Signs; Genitals Non Tender; No Hernias; No Pulsating Masses; Murphy's Sign Negative; McBurneys & Rovsing Sign Neg; Femoral Pulses 2+ Bilaterally; Psoas Sign Negative; Obturator Sign Negative;	11/1/2009 0:03
SNW	Pt $Sx(s)$ improving. No $Sx(s)$ or Objective findings that are life or limb threatening. Medically Screened and Stable for disposition(Transfer) from the ED.	11/1/2009 0:14

Medical Record No. 1298984

Account Number 130381015

Date 10/31/2009

SNW ·	Psychiatry consult called	11/1/2009	1:43
SNW	Patient seen by Psychiatry team led by Dr Patel who recommended transfering Patient to Psychiatry ER after medical clearance	11/1/2009	6:50

Account Number 130381015

Medical Record No. 1298984

Date 10/31/2009

Diag	nostics		Specin	nen Collected	I / ECG .Ra	d Ordere
MD Initials	Time	Diagnostic Ordered	Result Interpretation	Result Reviewed By	RN Initials	Time
GLE	10/31/200 23:10	Pulse Ox	97%	SN	GLE	23:10
SNW	11/1/2009 0:12	Amylase	Amylase-44,Status-FINAL	SN	VCA	0:14
SNW	11/1/2009 0:12	Troponin	Cancel	SN	VCA	0:14
SNW	11/1/2009 0:12	CBC	WBC-12.3,Hgb-14.8,Hct-44.0,Platelets-251,Neut-82.4,Lymph- 11.0,Eos-0.2,Baso-0.7,Mono-5.7,MCH-29.4,MCHC-33.6,MCV- 87.6,MPV-8.5,RBC-5.02,RDW-13.7,Abs Baso-0.1,Abs Eos- 0.0,Abs Lymph-1.3,Abs Mono-0.7,Abs Segs-10.1,Smear Review Completed,Nucleated RBC-0,NRBC Inst0.00,Status-FiNAL	SN	VCA	0:14
SNW -	11/1/2009 0:12	Chem 20/CMP	AGPK-14.10,Na-138,K-4.1,Cl-104,CO2-24,BUN-14,CR- 1.0,Glucose-94,Ca-9.4,AST-46,ALT-51,Alk Phos-57,Albumin- 4.7,T-bili-0.6,Protein-8.2,Anion Gap-10.00,Status-FINAL	SN	VCA	0:14
NRI	11/1/2009 0:22	Lipase	Lipase-55,Status-FINAL	SN	NRI	0:33

Medi	cal Orders				
MD Initials	Time	Order	RN Initials Time	Location-Response-Quantity	RN Remarks
SNW	11/1/2009 0:14	Heplock	VCA 0:14		

MD Pr	ocedures			
Proced	lure Description		Comments	
Time	6:57	MD GLE		
Pulse Ox				94760-26 CPT

Recommended LOS/CPT/ICD-9 Code

Physician's LOS =

4 99284-26

Nurse's LOS =

5 612 APC

Diagnoses	
Abdominal Pain	789.00 ICD-9
Psychosis NOS	298.9 ICD-9

Admit to RN Date/ MD MD Time RN Time

Disposition SNW 6:56 Transfer Psychiatric ED

11/1/2009 VCA

6:58

Condition

SNW

6:56

Stable

VCA 6:58

Physician (Print)

Nwaishienyi, Silas (MD)

Physician Signature

Other Physicians Nwaishienyi, Silas (MD)~Lwin, Khin Mar (RES)

Account Number 130381015

Primary.RN (Print) Calderone, Virnalyn (RN)

Medical Record No. 1298984

Date 10/31/2009

Other Nurses

Ledbetter, Glenda (RN)-Calderone, Virnalyn (RN)-Shankar, Koesmawatie (PIR)-Rinehart, Nedie (RN)-Ward, Germaine (Reg)-West, Juanita (RN)-Charran, Donna (PIR)-Paris-Taylor, Elyane (WC)-Bido-Rosa, Ana (Reg)-Stancu, George (Clerk)

This chart has been electronically signed via the EmpowER software.

Medical Record No. 1298984

Account Number 130381015

Date 10/31/2009

Jamaica Hospital Medical Center

Emergency Department Nursing Notes and Vital Sign

TimeEnt	ered:	11/1/2009		4:52 Vitals Taken B	By: NRI		
Tempera		Pulse		Blood Pressure	Respirations	Pulse Ox	Pain Scale
О 9	8.0	Right Left	81	R 125/77 L	21	100%	Discomfort 1 - 2
R							

Nursing Note	es	RN			
Time Note Entered		Initials	Note		
11/1/2009	0;00	VCA	Brought in per stretcher by EMT on Police custody.A & O x3. Unlabored resp.(+)Left Lower quadrant abd. Pain 3-4/10 x 15 hrs ago.Denies nausea & vomiting.Abd, soft, non-tender. BS(+)normoactive. Skin warm, moist, intact. w/ good capillary refill.		
11/1/2009	2:00	NRI	Noted w/ redness on the Rt wrist with the hand cuff.Polce officer made aware.& requested to loosen a lttle bit yet refused.Will closely monitor for poor circulation.		
11/1/2009	4:39	NRI	pt. Resting;A & O x 3, no distress waiting for evaluation and disposition under police custody.		
11/1/2009	5:54	VCA	Psyche consult in progress w/ recommendation to transfer to Ps cleared.Pt. Verbalized, "My wrist is numb, I dont feel anything rion bed.Avoid unneccessary movements Conversant to his father	ight now."Encouraged to stay still	
11/1/2009	6:58	VCA	Psyche ED made aware of pt. For transfer,ML pulled out.Awaitin	ng transfer.	
Primary Nurse Diagn	osis		Primary Nurse Outcome	Achieved	
Comfort, Altered			Demonstrate Decrease S & S		

Jamaica Hosp	oitai Medicai C	zenter i nage	Category	3 ESI-3 (Urgent)
Arrival Date/Time	Triage Time	Waiting Rm Time	Exam Rm Tir	ne Patient Name
10/31/2009 23	23:03		23:03	SCHOOLCRAFT,ADRIAN
PCP Staff Status Fan	nily Physician	Transported	•	Medical Record Number
None NA	-Police Dept	JHMC Ambula	nce Stretcher	1298984
Historian Self	•	lotification Beat #	# PCT- 81, #27009	Account Number
Chief Complaint	14	Onset Time	Location	130381015
Abdominal Pain (Lower)	14 Hour(s)	Logation	DOB 06/21/1975
Associated Sxs /	Pertinent Histor	v		Age 34 Years
	and the second second	ustody, Pt became anxious with	h increased BP @ the sc	Gender Male
l.				Vitals
Past Medical His	tor Additional:			Tem
✓ No Significant PMHx	44			Oral 99.0
Asthma COP	_	ancer CHF C	V A	Rectal
DM HTN	Psych Renal	Seizures Substance	ce Abuse	Tympanic
Medications				Pulse
No Meds 🗌 Unk	nown			Right
				Left 115
ļ,				Respirations
Allergies		1 5	Immunizations UTD? UT TB Hx, PPD Pos or	1118
No Known Drug Allergie	es		Infectious Exposures?	Blood Pressure
		·	*If yes to TB or Infection	s question Right
L			take precautions	Left 139/80
Mental Status / Psych	nological Eval	Glascow Coma Scale	OB/Gyn	1255/00
Alert Oriented		Eye		Pulse Ox
Lung Sounds	Eyes R L	Verbal	G P Ab M	scarnages 97%
RL	Equal 🔲 🔲	Motor	i i	Weight (Kg
Clear 🔽 🗹	Reactive	Total 0		109 Kg
Diminished 🗌 🗍	Fixed 🔲 🗌	Skin	Extremities	Head
Wheezes 🗌 🗍	Constricted [Color Normal	Pulses	Height Circumferenc
Rales 🗌 🗌	Dilated	Temp Normal		
Rhonchi 🔲 🔲	Cataract	Moist Normal	ROM	Pain Scale
Retractions 🔲 🔲				Mild 3 - 4
Nutrition		Domestic Violence Assess	ment As	sessing Patient's, Child's or Parent's
Normal		Are you being hurt by some	one you live re	adiness to learn
Fall Risk Assessment		with or who takes care of y	ou? P	rimary Language English
No Fall Risks Identified		Yes/No No		Assessed Disability No Disability
Sulcide Risk Assessm	ent	* Mandatory completion of Domestic Violence Referral.		Communication Barrier
No risk identified		Functional D/C Planning		Language Translator
Plan	Time 23:03	Functional D/C Flanting		Motivation Level Med
A3-09 Triage Nurse: Ledbe		Daily Living Indep	pendent	Knowledge Level Med
		Living Conditions Alone	Co	mprehension Ability Med
Triage II: GLE		Going Home with Self		•
	W. Connected at 7 / 51		unod	te and Depose ibilities and Cuide to Dain Management
LI LWBS I L	W Completed Tx/ Elope	i∏ AMA ∏ AMA Ref	used 😿 Patient Righ	ts and Responsibilities and Guide to Pain Management

Medical Record No. 1298984

Account Number 130381015

10/31/2009

Emergency Department Pharmacy and Supply Charges

Interventions				
Intervention Name		Comments	Charge Code	
Heplock				·-·-
Diagnostics	<u>-</u>			
Diagnostic Ordered			Charge Code	
Pulse Ox			0	
CBC			0	
Nurse LOS	5	612 APC	Charge Code	0

Jamaica Hospital Medical Center

Medication Reconciliation

Patient Name

SCHOOLCRAFT, ADRIAN

Medical Record No.

1298984

Account Number 130381015

Date of ED Visit

10/31/2009

Allergies

No Known Drug Allergies

Home Medications

Medications Administered in the Emergency Department

Medication Prescription provided on Discharge

	JHILL JHILL	ePCR	5581845
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Authorization for Billing / Release of Patient Information / Assumption of Financial Responsibility: Treduct this payment of subscrizes Medicare-Medicard and/or once increases benefits be made to the pre-Insight during provider ("Pavilder") for any services femished to me. Tourises any holder of baseline to moderal information about me to be released to the Provider. Content for Medicare and Internal Senance and tour information and the internal senance and the internal senance and their advantage medicare and internal senance.

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JAMAICA HOSPITAL
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CONSULTATION REPORT

SCHOOLCRAFT, ADRIAN
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081X STAFF, PHYSICIAN
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THIS SECTION TO BE FULLY COMP	PLETED BY THE REQUESTING PHYSICIAN
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SIGNATURE:	DATE 11/1/09 TIME: 8:30 am

DENINONOF CONSULTANT:

34 years old ringle white male, police officer, living by himself was brought in by NYPD of 81" Precint, in hand could to Medical ER with complaint of chalaminal pain, naure and dizzinen and patient intered he took.

Nyquil.

Proper consult was colled and reported on patient acting bizzare, hand coffeed and in Police antody.

As per patient, he was not feeling well yesterday had temmy pain! Abdominal poin and feld his approvisor that ha is leaving Patient ways while sleeping in his bead, landford apen the door and his colleagues entered and hand coffeed and breight him to Temorica harpital, He rays he is overried about the stratem going on. Says this is happening be come has been reporting to his superiors and commissioner about internal affects of police department. Says he knows his superiors are hiding robbery and arroult course of get higher ranks / position. Jogs he has paper documentation about this arime and reporting since lost year.

— continhe

ORIGINAL - MEDICAL RECORD CARBON COPY - CONSULTANT

Signature:

Date:

Time:

FORM: 110 ITEM: 849 REV. 1/07

Consultant Print Name:



SCHOOLCRAFT, ADRIAN 1288984 M DOB: 06/21/1975 34Y ADM:10/31/2009 081X 130381015 01 STAFF, PHYSICIAN

CONSULTATION REPORT CONTINUATION

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Consultant Port Name	Signature:	Date:	Time:

ORIGINAL - MEDICAL RECORD CARBON COPY - CONSULTANT

FORM: 112 ITEM: 1875 REV. I/07



SCHOOLCRAFT, ADRIAN 1298984 M DOB: 06/21/1975 3-IY ADM:10/31/2009 081X 130381015 01

CONSULTATION REPORT CONTINUATION

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Khin Mar Lwin, MD Psychlatric Resident
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GAM I PROD (I PARTY)
Consultant Print Name: Signature: Date: Time:

ORIGINAL - MEDICAL RECORD

CARBON COPY - CONSULTANT

FORM: 112 ITEM: 1875 REV. 1/07

JAMAICA HOSPITAL MEDICAL CENTER
PATIENT CLOTHINGWALUABLES INVENTORY

1. ALL PATIENTS GLOTHINGWALUABLES/SENT HOME
2. DENTURES TAKEN HOME BY FAMILY MEMBER

YES.	E NO
VES	D NO

SCHOOLCRAFT, ADRIAN 1298984 M DOB: 06/21/1975 34Y ADM:1103/12/009 081X 130381015 0' STAFF, PHYSICIAN

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SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y F/C: 01
ADM: 10/31/2009 23:03 081X 130381015
STAFF, PHYSICIAN

ASSIGNMENT AND RELEASE OF INFORMATION STATEMENTS

ho are financially liable for my hospitalization and media	g treated me, to release to governmental agencies, insurance carriers, or others loat care, all information needed to substantiate payment for such hospitalization and eof to exemine and make copies of all records relating to such care
Date	Signature of Patient or Authorized Representative
ssignment to Jamaica Hospital	
	a Hospital sufficient monies and/or benefits to which I may be entitled from who are finglicially liable for my hospitalization and medical care to cover the dependent of baild hospital.
Date	Signalure of Insured or Authorized Representative
ele Medical Device Act	
	to the manufacturer of any device that must betracked pursuant to the mandales of ufacturer will be given my social security number only for the purpose of finding me in my body, or used in my home is defective.
Date	Signature of Insured or Authorized
	Representative r the payment under Title XVIII of the Social Security Act is correct. I euthorize the
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SCHOOLCRAFT, ADRIAN 1298984 M DOB: 06/21/1975 34Y ADM: 10/31/2009 081X 01 130381015 STAFF, PHYSICIAN

No. of	
CONSENTS	
PERMISSION FOR TREATMENT	
WHOSE NAME APPEARS HEREIN, SUCH MEDICAL AND SURGICAL S	DICAL STAFF, TO PERFORM OR HAVE PERFORMED, UPON THE PATIENT SERVICES, SURGICAL OPERATION AND/OR OTHER PROCEDURES OR IED NECESSARY IN RELATION TO EMERGENCY TREATMENT ON THIS DATE.
PATIENT/RELATIVE OR GUARDIAN	WITNESS
SIGNATURE	SIGNATURE
PRINT NAME	FROT NAME
NULATIONS NO. IF SIGNED BY PERSON OF MERTINAL PATIENT	DATE
ARANTEE OF PAYMENT	
TO PAY THE JAMAICA HOSPITAL, THE FULL AND ENTIRE AMOUNT	RENDERED TO THE HEREIN NAMED PATIENT, I DO HEREBY GUARANTEE OF ANY AND ALL BILLS RENDERED FOR SAID TREATMENT. NFORMATION NEEDED TO SUBSTANTIATE PAYMENT FOR SUCH CARE AND
PATIFATIVE OR GUARDIAN	WITNESS
CONATURE	SIGNATURE
PRINT HAME	PRINT NAME
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AUTHORIZE OF PAYMENT	
	OSPITAL SUFFICIENT MONIES AND/OR BENEFITS TO WHICH I MAY BE ENTITLED DOTHERS WHO ARE FINANCIALLY LIABLE FOR MY HOSPITALIZATION AND MEDICAL IDERED TO MYSELF OR MY DEPENDENT.
PATIENT/REJATIVE OR GUARDIAN	WITNESS
SIGNATURE	SIGNATURE
PRINT NAME	PRINT NAME
MELATIONSHIP IF SIGNED BY PERISON OTHER THAN FATIENT	DATE

FORM NO. J00018-2C



BENT BURELE

SCHOOLCRAFT, ADRIAN

298984 M

DOB: 06/21/1975

34Y

ADM: 10/31/2009 081X STAFF, PHYSICIAN

130381015

ACKNOWLEDGEMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the Hospital and the facilities listed on the back of this form, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the hospital, its staff, and the facilities listed at the back of this form.

A	
Signature of patient or authorized representative	
Relationship to patient	
Date	
AFFIRMATION OF PRIOR RECEIPT	
By signing below, I acknowledge that <u>I have already received</u> a copy of the Notice o Privacy Practices, and have given my consent for the use of my health information fo the purposes noted above. <u>I do not wish to receive</u> another copy of the Notice Privacy Practices at this time.	r
Signature of patient or authorized representative	
Relationship to patient	
Date	
THIS FORM IS PART OF THE MEDICAL RECORD	



M00011 9/06



Jamaica Hospital Medical Center 8900 Van Wyck Expressway, Jamaica, New York 11418 Telephone # 718 206-6000

LIMITED POWER OF ATTORNEY TO PURSUE PAYMENT AND APPEALS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION ("LIMITED POWER OF ATTORNEY")

By signing this document, I give the Health Care Provider, identified below, a Limited Power of Attorney to pursue payment from my health insurer, health maintenance organization, self-insurance plan, governmental program, or other payer ("Health Plan") for medical services provided to me by the Health Care Provider, and I authorize the release of medical information.

I, the undersigned Patient/Principal, appoint JAMAICA HOSPITAL MEDICAL CENTER ("Health Care Provider"), located at 8900 VAN WYCK EXPRESSWAY, JAMAICA, N.Y. 11418 my Attorney-In-Fact and authorized representative to act in any way which I myself could do, if I was personally present, and to take all reasonable action, as determined by the Health Care Provider, to pursue payment from my Health Plan and/or pursue any appeals available to me under my Health Plan's policies or procedures and all applicable law, including but not limited to External Appeals under all State and Federal laws, relating to health care services provided by the Health Care Provider. The Health Care Provider, as my agent, may pursue payment and/or appeal, only when my Health Plan has denied payment based on medical necessity. The Health Care Provider will not charge me for its services in pursuing payment and/or an appeal on my behalf. I agree that my Health Plan will pay any amount owed directly to the Health Care Provider for these services. In pursuing such payment and/or an appeal:

I authorize the Health Care provider and my Health Plan to release all relevant medical information, including (if applicable) any HIV-related information, mental health treatment information, or alcohol/substance abuse treatment information, relating to my treatment which is necessary to pursue payment from my Health Plan. I understand that this information may be released, but only as necessary, to my Health Plan, an external appeal agent, arbitrator, court of law, and/or other third party reviewer ("Independent Reviewer") responsible for deciding if the Health Care Provider's claim for services should be paid. I understand that my Health Plan and/or the Independent Reviewer will use this information to make a decision about payment to the Health Care Provider. I also understand that the decision by the Independent Reviewer will be final and binding on me, the Health Care Provider, and the Health Plan, and:

I authorize the Health Care Provider to complete, execute, acknowledge, seal, and to deliver any consent, demand, request, application, agreement, authorization or other documents necessary, to request, on my behalf, payment and/or appeal to my Health Plan and, if applicable, to the Independent Reviewer, the New York State Department of Health, the State Insurance Department, the U.S. Department of Health and Human Services, the U.S. Department of Labor, and/or any other applicable agency or body.

This Limited Power of Attorney shall <u>not</u> be affected by my subsequent disability or incompetence and MAY BE REVOKED BY ME AT ANY TIME upon prior notice to the Health Care Provider. This Limited Power of Attorney, including authorization for release of medical information, will terminate one (I) year from today's date unless I agree to extend it beyond that date.

Any person or entity receiving this document may rely on a copy as if it were and executed original.

IN WITNESS V	VHEREOF, I have signed my name this day of, 200
	YOU SIGN HERE:
	PRINTED NAME: SCHOOLCRAFT ADRIAN
	ADDRESS:
	MEDICAL RECORD # 1298984
WITNESS:	
PRINT NAME	TITLE:
ADDRESS:	8900 Van Wyck Expressway, Jamaica, New York 11418
	Farm No. J0002



SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y F/C; 01
ADM: 10/31/2009 23:03 081X 130381015
STAFF, PHYSICIAN

ACKNOWLEDGEMENT OF THE REQUEST FOR EXTERNAL APPEAL AND RELEASE OF MEDICAL RECORDS TO BE SIGNED BY THE PATIENT.

In order for a provider to appeal a health plan's payment denial for a patient's treatment, the patient must sign and date the following consent to the release of medical records. A certified external appeal agent assigned by the New York State Insurance Department will use this consent to obtain the patient's medical information relating to the external appeal request from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I <u>SCHOOLCRAFT</u> <u>ADRIAN</u>, acknowledge that my health care provider may request or is requesting an external appeal because of a retrospective adverse determination of my health plan. I authorize my HMO, insurer, or provider to release all relevant medical or treatment records, including my name and other personal identifying information, date of admission, assessment results and history, summary of treatment plan, progress and compliance, treatment recommendations, any HIV-related information, mental health treatment information, or alcohol/substance abuse treatment information, related to my provider's external appeal, to the external appeal agent. I authorize the external appeal agent to use this information solely to make a determination on my provider's appeal.

I understand that my records are protected under federal and/or state law and cannot be disclosed without my written consent unless otherwise provided for in regulations. I understand that information disclosed pursuant to this authorization may no longer be protected by federal privacy regulations, however, state privacy protections may still apply. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I understand that I may revoke this consent at any time, except to the extent that action has already been taken in reliance on it, by contacting the New York State Insurance Department in writing.

This release is valid for one year from	(today's date).				
W					
Signature of Patient (or legal representative)	(Date)				
Description of legal representative's authority to act on be	thalf of the nation				
besorption of legal representative a datasety to determine	nan or the patient.				
Patient's Health Plan ID#:					

If you have any questions contact the New York State Insurance Department at: 1-800-400-8882 or visit our Web site at www.ins.state.ny.us.



Form No. J00027

PATIENT HISTORY REPORT

Jamaica Hospital Medical Ctr Department of Clinical Laboratories 8900 VanWyck Expressway, Jamaica, NY 11418 Pathologist Name, Medical Director

PATIENT: SCHOOLCRAFT, ADRIAN

MRN#: J1298984 ADMIT: 10/31/09 Loc/Rm/Bed: J081X--

DOB: 06/21/1975 AGE: 34 SEX: M

ADM: ,

ACCT#: J130381015

HEMATOLOGY

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	· -+		-+
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RBC	*5.02		[4.50-5.90 M/uL
HGB	*14.8		14.0-18.0 g/dL
нст	*44.0]42.0-52.0 %
MCV	*87.6		80.0-94.0 EL
MCH	*29.1		27.0-31.0 pg
м	 *33.6		32.0-36.0 g/dL
MPV	*8.5		7.2-10.4 fL
RDW	*13.7		11.5-14.5 %
Platelet Count	·251		130-400 K/uL
Smear Review:	*Completed		I
M1: Troponin was can	celled on 11/01/	2009 at	00:12 by HIS; KEANE HIS# 2
ORDERED			
KEANE			
Meutrophils Auto	*82.4	H	44.0-80.0 %
Lymphocytes Auto.	*11.0	L	13.0-43.0 %
Monocytes Auto	·5.7		2.0-15.0 %
Eosinophils Auto	*0.2		0.G-3.0 %
Basophils Auto.	1.0.7		0.0-3.0 %
Segs, Absolute	*10.1		2.1-8.6 K/uL
Lymphs, Absolute	*1.3		0.6-4.6 K/uL
Mr s, Absolute	. *0.7		0.1-1.6 K/uL
E. Absolute	0.0		0.0-0.9 K/uL
Basos, Absolute	*0.1		[0.0-0.4 K/uL
Absolute MRBC Instrumer	· [* C . O O		None %/100 WBC
_	*Agree w/Auto		1
Manual	Diffe	r e	ntıal
Nucleated RBC	* 0		None /100 WBC
NRBC Absolute	*0.00		None K/uL

Att Phy: NWAISHIENYI, SILAS MRN#: J1298984

Loc/Rm/Bed: J081X--

PRINTED: 04/20/2010 10:39

MRN#: J1298984 PATIENT: SCHOOLCRAFT, ADRIAN

PAGE: 1 of 2

PATIENT HISTORY REPORT

Jamaica Hospital Medical Ctr Department of Clinical Laboratories 8900 VanWyck Expressway, Jamaica, NY 11418 Pathologist Name, Medical Director

PATIENT: SCHOOLCRAFT, ADRIAN

MRN#: J1298984 ADMIT: 10/31/09 Loc/Rm/Bed: J081X--

DOB: 06/21/1975 AGE: 34 SEX: M

ADM: ,

ACCT#: J130381015

CHEMISTRY

	D1010113-111	-
COLLECTED	11/01/09 00:22	REFERENCE RANGE
PRIORITY, PHYSICIAN	STAT NWAISHIENYI, S	ILA
	+	+
Glucose	*94	74-106 mg/dl
BUN	*14	9-20 mg/dL
Creatinine	1*1.0	0.7-1.3 mg/dL
Sodium	*13B]137-145 mEq/L
Põtassium	 *4.1	3.5-5.1 mEq/L
Chloride	* 104	98-107 mEg/L
c .	*24	22-30 mEq/L
Calcium	*9.4	8.4-10.2 mg/dL
Protein	*8.2	6.3-8.2 g/dL
Albumin	 *4 .7	3.5-5.0 g/dL
Bilirubin (Total)	*0.6	0.2-1.3 mg/dL
ALT (SGPT)	 *51	21-72 U/L
AST (SGOT)	*46	17-59 U/L
Alkaline Phosphatase	*57	37-126 U/L
Lipase	* 55	23-300 U/L
Anion Gap With K	*14.10	mmoL/L
Anion Gap	*10.00	, mEq/L
Amylase	 *44	30-110 U/L

M1: Troponin was cancelled on 11/01/2009 at 00:12 by HIS; KEANE HIS# 2 ORDERED

KEANE

+ - RESULT REPORTED FIRST TIME KEY FOR ABNORMAL COLUMN: L-LOW, H-HIGH, AB-ABNORMAL, P-PANIC

Att Phy: NWAISHIENYI, SILAS

Loc/Rm/Bed: J081X--

PRINTED: 04/20/2010 16:39

MRN#: J1298984

PATIENT: SCHOOLCRAFT, ADRIAN

PAGE: 2 of 2



Jun 3/22/0 pretatur

FACE SHEET

	ACCOUNT NUMBER 130381874		MEDICAL 129898	RECORD NU	IMBER	1	DMIT DATE				BAR C	ODE-M	EDICAL R	ECORD NUM	BER
	LOCATION FIN CLAS						DISCHARGE DATE & TIME			BAR C	BAR CODE-ACCOUNT NUMBER				
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	LAST NAME SCHOOLCRAFT		FIRST NAME ADRIAN			M.I. AKA			(A				VETERAN N		
Z	DATE OF BIRTH AGE	SEX	REL.	MAR ST.	RACE	PLACE OF	BIRTH			LANGUAGE				INTERPR	ETER NEEDED
Ш	06/21/1975 34Y	М	NO	S	W	NY				ENG		··			N
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۷	82 60 88 PL TELEPHONE NUMBER			OCCUF		GEWOO	<u>ں</u>			NY SOCIAL	SECURIT	ry num		385	
Δ.	(718)570-6224									***_*					
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! i	NEXT OF KIN		RE	LATIONSHIP		ADDRESS			C	TY	STAT	 Έ	ZIP		99-9999 DNE NUMBER
	SCHOOLCRAFT, SELF			09	82 60					EWOOD	N		385	(718)5	70-6224
; ;	EMERGENCY CONTACT NAME		RE	LATIONSHIP		ADDF	ESS								NE NUMBER
Ĺ	SCHOOLCRAFT,			09										(718)5	70-6224
	ATTENDING PHYSICIAN / CODE		 -			PVT./SER	/. OTHER	R PHYSIC	CIAN / CO	DE		_		MEDICAL	
A	HOVANESIAN, SHUSHAN		-	590	4	S	,							PS	Y
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_	GÜARANTOR NAME														
						RELATIONS	HIP			OCCUP	ATION		SC	CIAL SECUP	ITY NUMBER
TOR	SCHOOLCRAFT, ADRIAN					01	:HIP				ATION			999-99	-9999
RANTOR	SCHOOLCRAFT, ADRIAN ADDRESS			CIT	Y	01	:HIP 	STATI		ZIP	ATION		TELEPHO	999-99 DNE NUMBER	9999 R
UARANTOR	SCHOOLCRAFT, ADRIAN		DDRESS	-		01 DD	TY	STATI			ZIP	·	TELEPHO (718)	999-99	9 -99 99
GUARANTOR	SCHOOLCRAFT, ADRIAN ADDRESS 82 60 88 PL		DDRESS	-	Y	01 DD			E	zip 11385			TELEPHO	999-99 DNE NUMBER 570-6224	9 -99 99
GUARANTOR	SCHOOLCRAFT, ADRIAN ADDRESS 82 60 88 PL EMPLOYER UNKNOWN		DDRESS	RIDG	EWOC	01 DD ci				ZIP 11385 STATE	ZIP		TELEPHO (718): TELEPHO (999):	999-99 DNE NUMBER 570-6224 DNE NUMBER 999-9999	9 -99 99
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./13/2009

UIS Data System

Attestation Statement

Page 1 of 1

Coder: vdorch

Medical Center Patient Ctrl Num Medical Rec Num

amaica Hospital

Patient Name

ape Admit Dt/Hr Exempt Discharge Dt/Hr IPC Gend

Admit Source Disposition

130381874

11/03/2009 15

7 - ER

1298984

SCHOOLCRAFT, ADRIAN

06/21/75 11/06/2009 14

01 - DC Home

Payors

Primary:

HMO INSURANCE

ALC Days: ALC Type:

Acute Days: 0

Leave Days:

ALC Date:

LOS:

ATTENDING PHYSICIAN: 003819

ISAKOV, ISAK LIC#: 00220352

Admit DX: 2989

PSYCHOSIS NOS

Cause DX:

Prin DX: 30924 (Y) ADJUSTMENT DIS W ANXIETY

Place DX:

Secondary DXs (PoA)

DRG Information-

DRG: 427

NEUROSES EXCEPT DEPRESSIVE

MDC: 19

MENTAL DISEASES & DISORDERS

NYS Version: 026

Short Trim: 2

Long Trim: 11

Weight:

0.73860

Avg LOS: 5.0

(ALC) =

Total

(Base) \$3,693.00

\$0.00

\$3,693.00

PROCEDURE

DATE

SURGEON

1 - 9438 SUPPOR VERBAL PSYCHOTHER 2 - 9425 PSYCHIAT DRUG THERAP NEC 11/03/2009 -- 003819 ISAKOV, ISAK 11/03/2009 -- 003819 ISAKOV, ISAK LIC #: 00220352 LIC #: 00220352