

(631) 444-4800

THIS BILL IS FOR PHYSICIAN SERVICES

ALL PAYMENTS ARE DUE AND PAYABLE UPON RECEIPT OF THIS STATEMENT UNLESS SPECIAL ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

PLEASE USE THE REVERSE SIDE FOR SPECIAL ARRANGEMENT INFORMATION.

PATIENT NAME

WAIKSNIS, JOSEPH

BILL DATE

12/07/99

ACCOUNT NO.

M30002092

AMOUNT PAID

PLEASE INDICATE ADDRESS CORRECTION BELOW

THIS IS A STATEMENT OF SERVICES RENDERED BY

____ JOSEPH WAIKSNIS
____ 40 E HALF HOLLOWES
____ RD
____ HUNTINGTON, NY 11746

SB RADIOLOGY, P.C.
P.O. BOX 1559
STONY BROOK NY 11790-0989

Insert this portion with our name and address showing in the enclosed return window envelope with your payment. Please see reverse side for MasterCard/Visa information.

▼ ▼ DETACH THIS PORTION AT PERFORATION AND RETURN WITH REMITTANCE ▼ ▼

DATE OF SERVICE	DESCRIPTION OF SERVICE	AMOUNT
11/21/99	HAND/LEFT	37.00
11/21/99	HAND/RIGHT	37.00

DATE
12/07/99

PATIENT NAME
WAIKSNIS, JOSEPH

ACCOUNT NO.
M30002092

NEW BALANCE
74.00

PAY THIS AMOUNT ▶

▲ PAYMENTS RECEIVED AFTER THIS DATE WILL APPEAR ON YOUR NEXT STATEMENT. PLEASE DISREGARD THIS NOTICE IF PAYMENT HAS BEEN MADE.

MAKE CHECK PAYABLE TO:

SB RADIOLOGY, P.C.

MESSAGE

PLEASE REMIT PAYMENT

AN INSURANCE FORM HAS BEEN PREPARED FOR ITEMS MARKED WITH #



UNIVERSITY HOSPITAL

Health Sciences Center
State University of New York
at Stony Brook
Stony Brook, New York 11794

**Comprehensive Psychiatric Emergency
Program Telephone # 444-6050**

Discharge Instruction Sheet

WAIKSNIS, JOSEPH
ENC 10000270990 E
01/26/1963 36Y M URK
MORTIMER, MARIA
MRN 30002092 11/21/99
40SP PT SVC ENR
REF/PHI. PHYS.
UNIVERSITY HOSPITAL
SUNY AT STONY BROOK

Instructions for Psychiatric Emergency Department visit on: 11/22, 1999

Patient's Name: Joseph Waiksnis

Instructions: Pt to be discharged to his parents

Recommend (1) Get ID card so that
you can be treated at Northport VA -
outpatient psychiatric dept. 261-4400
(2) Followup = Orthopedics
for fracture in Rt hand in 5 days.

Ronald P. [Signature]
CPEP Staff Signature

I have read and understand the instructions given to me by the Psychiatric Emergency Department. I also understand that someone from the Psychiatric Emergency Department may contact me to assure that I get appropriate follow-up care.

X Joseph Waiksnis
Patient's Signature

I give my consent for University Hospital to release information on the Psychiatric Emergency Department visit to the referral sources listed above.

X Joseph Waiksnis
Patient's Signature



UNIVERSITY HOSPITAL
Health Sciences Center
State University of New York
at Stony Brook
Stony Brook, New York 11794

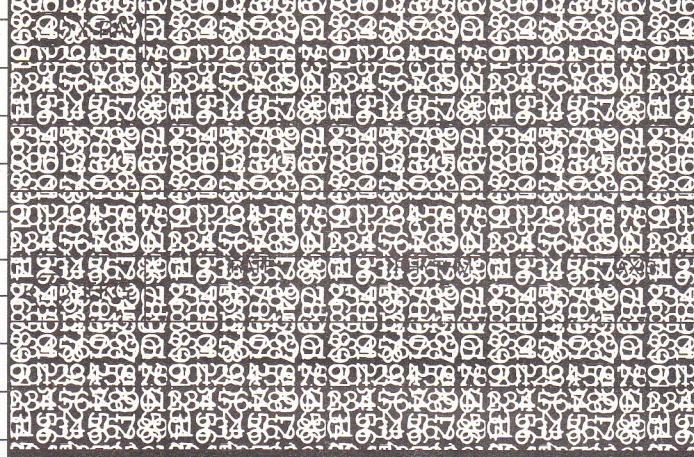
EMERGENCY
DEPARTMENT
ENCOUNTER AND
TREATMENT

ENC 10000270990
01/26/1983
ADDRESSOGRAPH
MORTIMER, MARIA
NAME MR 30002092 11/21/99
HOSP PT SVC EMP
ENC REF/PRI, PHYS. MR #
UNIVERSITY HOSPITAL
DOB SUNY AT STONY BROOK

LABORATORY RESULTS

CBC	WBC		Hct		
	Hgb		PLTS		
DIFF	PMN		Bands		
	Lymph	Mono	Eos		
URINE	SG		pH		
	Glucose		Ketone		
MICRO	WBC	RBC	Epi	Bact	
	Na	Cl	Glucose		
CHEM	K+	CO ₂	BUN	Cr	
	ABG	Time	F _I O ₂	pH	pCO ₂
CULTURE					
OTHER	<hr/> <hr/> <hr/>				

SECTION 4 OF 4



CALL BACK — PLEASE FOLLOW UP FOR

CULTURE

CLINICAL CHECK

OTHER _____

DISPOSITION

PMD WALKOUT HOME AMB. CARE ADMIT TO:

AMA OTHER _____

TRANSFER TO: _____ ACCEPTING M.D.: _____

DISCHARGE DIAGNOSIS	ICD:9 CODE	DISCHARGE DIAGNOSIS	ICD:9 CODE
1 Ref/As p/c hand contusions/abrasions	211.00		
		Depression NOS	311

PATIENT DISCHARGE INSTRUCTIONS

1. RETURN TO EMERGENCY DEPARTMENT OR CONTACT YOUR DOCTOR IF YOU ARE NOT IMPROVING OR YOUR CONDITION BECOMES WORSE.

2. FOLLOW THE INSTRUCTIONS ON BACK OF THIS SHEET FOR:

SPRAINS LACERATIONS HEAD INJURY GASTROENTERITIS CAST CARE FEVER BACK INJURY

3. *2) keep abrasions clean & dry
die to area 8 times a day
for 2 days*

3) elevate whenever possible

Follow-up with orthopedics in one week 444-2182

Keep splint on, keep dry.

DISCHARGED BY: PRACTITIONER SIGNATURE/ID # _____ CONDITION _____

DISCHARGE INSTRUCTIONS REVIEWED BY _____ ID # _____ TIME OUT _____

I have received and understand the above instructions

Patient's Signature _____ Telephone Number () _____

PATIENT

--- UNIVERSITY HOSPITAL S.U.N.Y.
--- P.O. BOX 1546
STONY BROOK NY 11790
FEI # 11-3243405

1 Patient Name					
WAIKSNIS , JOSEPH					
2	Service Date(s)	From/Through	3	Statement Date	Page
	11/21/99	11/21/99		01/21/00	1

4 This is the current insurance information on file	
<i>Please review and make corrections on the back of this form</i>	
Insurance Name	Policy #
1.	
2.	
3.	
4.	

5 If paying by CREDIT CARD, please complete this section		6 CHECK/M.O.	
Card # _____			AMOUNT ENCLOSED
Exp. Date ____/____	AMT AUTHORIZED \$ _____		
Signature _____			\$ _____

7 40 E HALF HOLLOWES
RD
HUNTINGTON NY 11746

8 UNIVERSITY HOSPITAL S.U.N.Y.
ST UNIV OF N.Y.
P.O. BOX 81
LAUREL, N.Y. 11948

9 Account Number	10 Previous Balance	11 Charges	12 Est. Ins. Coverage	13 Payments/Adj's	14 Amt Due from Pt.
10000270990	220.00	.00	.00	.00	220.00

To ensure proper credit to your account, detach top section and return with your payment

15 Account Number	16 Patient Name	17 Service Date(s)	18 Statement Date	Page
10000270990	WAIKSNIS , JOSEPH	11/21/99 11/21/99	01/21/00	1

19 Date(s)	20 Description	21 Charges	22 Est. Ins. Coverage	23 Payments/Adj's

24 Previous Balance	220.00	Column Totals:	.00	.00	.00
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Due By 02/15/00 25 Amount Due From Patient: 220.00

Contract Amount Due:

HOSP SRV:EMR
ADM DT: 112199 FINAL DX:815.03 INS CD1:
INS CD2: RESP CD: STAT DT: 012100
SECOND NOTICE...YOUR ACCOUNT IS PAST DUE
YOU MAY RECEIVE AN ADDITIONAL BILL FOR PHYS SVC.
TO PAY WITH VISA, DISCOVER OR MASTER CARD OR GIVE
ADD'L INS INFO PLSE COMPLETE THE REVERSE SIDE OF
THIS BILL, RETURN IT IN THE ENVELOPE PROVIDED.
IF YOU REQUIRE A DETAILED BILL, PLEASE REQUEST BY
MARKING "DETAIL" ACROSS FRONT OF BILL AND RETURN
TO US, OR CALL CUSTOMER SERVICE AT (516) 444-4151.

EOPU

STONY BROOK

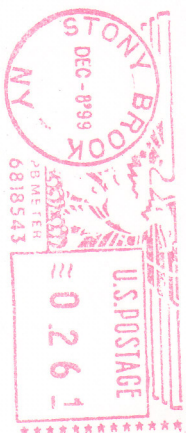
STATE UNIVERSITY OF NEW YORK

UNIVERSITY HOSPITAL AND MEDICAL CENTER
STONY BROOK, NY 11794 -7402

Joseph Walksma
40 E. HALF Hollows
Newington, NY 11746

MAILED FROM 11735 PRESORT 1ST CLASS 12-08-99

PRESORTED
FIRST CLASS



AUTO 11746





STATE UNIVERSITY OF NEW YORK
UNIVERSITY HOSPITAL
AND MEDICAL CENTER

School of Medicine
Department of Emergency Medicine

Date: 12/2/99

Re: Encounter # 10000270990
Date of ED Visit 11/21/99
Medical Record # 30002092

Dear Joseph Walksnis,

On behalf of the Emergency Department at University Hospital, I hope that you are feeling better. We have tried to reach you, but have been unsuccessful.

The xray of your hand shows a fracture. Please arrange to follow up with Orthopedics (444-4233). Return to the ER if you do not have a splint.

It is important that you follow up with your Doctor. Please continue to seek medical treatment.

Please feel free to call my office at 444-2397, Monday through Friday, between 7:00 am and 3:00 pm, if you have any questions concerning your emergency visit, or if you need assistance in obtaining follow-up care.

Sincerely,

Judy Speckhard

Follow-up Program
Emergency Department