

RELEASE OF ALL CLAIMS

KNOW ALL MEN BY THESE PRESENTS:

That Daren Kessler and Sandra Kessler, as husband & wife, and single individuals

Address 1620 McKinley Avenue, Yakima, Washington 98902-2417

being of lawful age, for the sole consideration of Nine Thousand Four Hundred Ninety Three & 25/100s

Dollars (\$ 9,493.25)

to the undersigned in hand paid, receipt whereof is hereby acknowledged, do/does hereby and for my/our/its heirs, executors, administrators, successors and assigns release, acquit and forever discharge:

Kittitas County/Kittitas County Sheriff Department/Joe Mungia/Washington Counties Risk Pool

and his, her, their, or its agents, servants, successors, heirs, executors, administrators and all other persons, firms, corporations, associations or partnerships of and from any and all claims, actions, causes of action, demands, rights, damages, costs, loss of service, expenses and compensation whatsoever, which the undersigned now has/have or which may hereafter accrue on account of or in any way growing out of any and all known and unknown, foreseen and unforeseen bodily and personal injuries and property damage and the consequences thereof resulting or to result from the accident, casualty or event which occurred on or about the 29th day of

August

, 20 13, at or near:

N. 16th Avenue, Yakima, Washington

It is understood and agreed that this settlement is the compromise of a doubtful and disputed claim, and that the payment made is not to be construed as an admission of liability on the part of the party or parties hereby released, and that said releasees deny liability therefor and intend merely to avoid litigation and buy their peace.

The undersigned hereby declare(s) and represent(s) that the injuries sustained are or may be permanent and progressive and that recovery therefrom is uncertain and indefinite and in making this Release it is understood and agreed, that the undersigned rely(ies) wholly upon the undersigned's judgment, belief and knowledge of the nature, extent, effect and duration of said injuries and liability therefor and is made without reliance upon any statement or representation of the party or parties hereby released or their representatives or by any physician or surgeon by them employed.

The undersigned further declare(s) and represents(s) that no promise, inducement or agreement not herein expressed has been made to the undersigned, and that this Release contains the entire agreement between the parties hereto, and that the terms of this release are contractual and not a mere recital.

Neither this Release nor any payment pursuant thereto shall be construed as an admission of any liability, such being expressly denied, nor as a waiver by or an estoppel or any or the parties herein released to make claim for any damages which they sustained, their claims and causes of action with respect thereto being expressly reserved.

THE UNDERSIGNED HAS READ THE FOREGOING RELEASE AND FULLY UNDERSTANDS IT.

Signed, sealed and delivered this 30th day of October, 20 13

CAUTION: READ BEFORE SIGNING BELOW

Witness

Witness

Witness

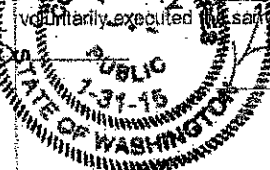
STATE OF Washington
COUNTY OF Yakima

SS

On the 30th day of October, 2013, Darren Kessler and Sandra Kessler personally appeared

to me known to be the person(s) named herein and who executed the foregoing Release and that They voluntarily executed the same.

My term expires 11/31/15, 20 15



Notary Public



U.S. PROPERTY
& CASUALTY

Mark Knowles
Managing Director, Northwest Service Center

October 15, 2013

Mike Cook
Washington Counties Risk Pool
2558 RW Johnson Rd SW
Suite 106
Tumwater, 98512-6103

Your Claim #: Not Provided
Insured: Kittitas County
Claimant: Darren and Sandra Kessler
Date of Loss: 29-Aug-2013
Our File #: 2301327

Dear Mr. Cook:

In reference to the above described-loss, this will confirm receipt of this assignment on September 25, 2013, confirm our telephone conversation on this same day, and serve as our first report.

ASSIGNMENT:

- First report due only after investigation completed
- Secure recorded statements claimant (completed)
- Confirm injury status (completed)
- Secure medical authorizations (completed)
- Secure Medicare forms (completed)
- Settle PD/Loss of Use (completed)
- Negotiate BI-settlements (completed)

DATE, TIME & PLACE:

August 29, 2013; 1:50 p.m. PST; 16th Avenue, North of Hamblen Road, Yakima, Washington

DESCRIPTION OF ACCIDENT:

The claimant was stopped behind another vehicle waiting for the vehicle to turn when the insured rear-ended the claimant vehicle.

INSURED:

1. **Kittitas County:** 205 West 5th Ave. Suite 107, Ellensburg, Washington 98926. Contact: Lisa Young, Human Resource Director; Contact No: 509-962-7084.

CLAIMANT(S):

1. **Darren Kessler:** Age 26, social security number 538-17-7433, resides at 1620 McKinley Ave. Yakima, Washington 98902. Contact No: 509-910-1119. Married to Sandra Kessler, two children Jade-8, and Collin-4. Employed as a gutter installer for the Gutter Guys. Hourly rate \$20.00 per hour.

As this claim has now been settled, I will in brief describe the statement of Mr. Kessler. He was traveling with his wife on their way to his parent's home. They were on 16th Avenue which has four lanes of travel two south, and two northbound. They were heading NB traveling in the inside lane (number 2 on police report) when they came to complete stop behind another vehicle that was also stopped with the left turn signal on waiting for SB traffic to clear so the driver could turn left. While stopped they were rear-ended by Kittitas Co. Sheriff vehicle.

Mr. Kessler said it was two days post-accident when he started to feel the effects of the impact. He went to Regional Medical Center to be checked out.

2. **Sandra Kessler:** Age 30, social security number 538-94-6166, resides at 1620 McKinley Ave. Yakima, Washington 98902. Contact No: 509-945-7801. She is a homemaker.

In brief, Mrs. Kessler's version of the accident is consistent with her husband's statement. There were no additional facts.

Mrs. Kessler said she too started to feel the effects of the impact two days post-accident, and went with her husband to emergency room at Regional Medical Center.

Mr. & Mrs. Kessler present themselves as average hard working individuals and would make good witnesses on their own behalf.

WITNESS:

Mr. & Mrs. Kessler stated there were witnesses however; they do not believe anyone stopped.

LIABILITY:

Clear, based on our investigation to date liability clearly rest with the insured driver.

PROPERTY DAMAGE:

We received the appraisal report from IAS-Insurance Appraisal Services, and they deemed the claimant vehicle a total loss. Total cost or repairs \$3,730.47; Market Survey with tax \$3,055.36, confirms the claimant vehicle is a total loss. The high salvage bid was \$600.00.

- **Settlement:** Per your settlement authority we concluded the property damage portion of the claim as follows

Actual Cash Value:	\$2,816.00
Tax:	\$ 239.36 (covers license and transfer fees)
Less Salvage:	\$ -600.00
Total:	\$2,455.36
Loss of Use:	\$ 280.00 (14-days @\$20.00 per day)
NET PD CLAIM:	\$2,735.36

BODILY INJURY:

1. **Darren Kessler:** Treated two days post-accident. Went to the ER at Regional Medical Center where they took X-rays which came back negative for any broken or fractured bones. He was diagnosed with a cervical and back strain. He was treated and released.
2. **Sandra Kessler:** Treated two days post-accident and also went to the ER at Regional Medical Center where they took X-rays and also came back negative for any broken or fractured bones. She was diagnosed with a cervical and back strain. She was treated and released and has not been back since.

Note: Mr. Kessler stated that they did not have medical insurance. They have set up a payment plan with the hospital so their bills would not go to collection. Attached are their signed medical authorization forms.

MEDICARE ELIGIBILITY:

Mr. & Mrs. Kessler confirmed they are not Medicare recipients. Attached are their signed Medicare forms confirming same.

SPECIAL DAMAGES:

- **Medical Invoices:** We reviewed the medical invoices submitted by the claimants, and it appears there was over treatment performed by the Medical provider. Example; they performed a pregnancy test on Mrs. Kessler and she did not understand why since she told them she had her tubes tied. In short, we had the claimant's discussed the over treatment concerns with the Medical provider, and after further review they discounted the bills. Below are specials and discounts.

Washington Counties Risk Pool
Re:

Darren & Sandra Kessler v Kittitas Co.

October 16, 2013

• Darren Kessler:	Original Bill:	\$1,827.90
	Discount:	\$ 639.76
	Physician Bill:	\$ 423.00
	Radiology Bill:	\$ 61.00
	Total Specials:	\$1,123.76
• Sandra Kessler:	Original Bill:	\$4,688.93
	Discount:	\$1,644.13
	Physician Bill:	\$ 609.00
	Radiology Bill:	\$ 184.00
	Total Specials:	\$2,434.13

Note: Per your settlement authority we included the total specials above less the discounts with the claimants.

SETTLEMENT AUTHORITY:

Per your settlement authority of 10/10/2013 up to \$11,300.00 to include the property damage, loss of use, specials, and general damages, we have no conclude this claim as follows:

• Darren Kessler:	PD/Loss of Use:	\$2,735.36
	Specials:	\$1,123.76
	General Damages:	\$1,600.00
	NET CLAIM:	\$5,459.12
• Sandra Kessler:	Specials:	\$2,434.13
	General Damages:	\$1,600.00
	NET CLAIM:	\$4,034.13

RECOMMENDATIONS:

- Recommend issuing one check
- Recommend including the specials so the claimants can pay their own medical bills

CHECK REQUEST:

If you concur with my recommendations above, please issue payment as follows and forward direct to address listed below. I will then exchange it for a properly executed release of all claims.

\$9,493.25; Darren Kessler & Sandra Kessler, as husband & wife, and single individuals, full and final settlement of all claims

Send check to: Crawford & Company
C/O Jim C. Rocha
4911 Prestige Ct.
Yakima, WA 98908

Washington Counties Risk Pool
Re:

Darren & Sandra Kessler v Kittitas Co.

October 16, 2013

ACTION PLAN:

- Send TD-420 to Department of Licensing confirming the claimant vehicle is a total loss, and they have retained salvage
- Exchange settlement check for release of all claims (if the county has their own release please forward it along with your settlement check)

Sincerely,
Crawford & Company

Jim C. Rocha
Adjuster

Enclosures:

- Kittitas County Claim For Damages
- Digital recorded statement-Darren Kessler (to be sent via mail)
- Digital recorded statement-Sandra Kessler (to be sent via mail)
- Summary-Darren Kessler
- Summary-Sandra Kessler
- Signed Medicare form-Darren Kessler
- Signed Medicare form-Sandra Kessler
- Signed Medical Authorization-Darren Kessler
- Signed Medical Authorization-Sandra Kessler
- Medical Invoices-Darren Kessler
- Medical Invoices-Sandra Kessler

CC: Lisa Young
Human Resource Director
Kittitas County
lisa.young@co.kittitas.wa.us



Vehicle Total Loss Claim Settlement Report

Insurance companies must notify us within 15 days of settling a total loss claim on a vehicle.
To do so, submit this completed form to:

Insurance Destroyed Desk
Department of Licensing
PO Box 9038
Olympia, WA 98507-9038

This form is not valid unless fully completed.

Registered owner name Daren R. Kessler & Sandra Kessler					
Address 1620 McKinley Avenue					
City Yakima			State WA	ZIP code 98902	
Legal owner name (Enter "SAME" unless different from registered owner) Same					
Address Same					
City Same			State	ZIP code	
Model year 1999	Make Honda	Series/Body type Civic	Vehicle Identification Number 2HGEJ6670XH563387		Plate number ACL8493
State WA					
Status ☒ Retained by owner ☐ Retained by insurance company ☐ Sold					
Based on the "salvage vehicle" definition, does this vehicle meet the following criteria: (RCW 46.04.514) • passenger car, light-duty truck with a gross weight of 12,000 pounds or less, or a sport utility vehicle, and • is at least six years old but not more than twenty years old, and • meets the current market value threshold ☐ Yes ☒ No					
The Department will brand the vehicle record (WA REBUILT), if you do not mark the Yes or No box, indicating whether the vehicle meets the market value threshold.					
Name of insurance company you are reporting for WASHINGTON COUNTIES RISK POOL					
Reported by (Insurance company or broker name) CRAWFORD & COMPANY				(Area code) telephone number (509) 388-8928	
Address 1407 116TH AVE. NE. SUITE 222					
City Bellevue			State WA	ZIP code 98004	File or claim number 2301327
Printed or typed name of Insurance company representative Jim Rocha			Date of loss 10/15/2013	Settlement date 10/10/2013	Today's date 10/15/2013

Insurance companies are required to state whether a vehicle meets the current market value threshold, when reporting vehicles that are wrecked, destroyed or damaged.

Visit dol.wa.gov or call (360) 902-4019 for the current market value threshold.

RCW 46.12.600

KITTITAS COUNTY CLAIM FOR DAMAGES

Return to:

County Auditor

205 W 5th Ave, Suite 105

Ellensburg, WA 98926

509-962-7504

Instructions:

Please read the entire form before completion. Fill out each question as completely as possible, to the best of your ability. Do not hesitate to use the back side of this form if you need more than the space provided. An incomplete response may delay the processing of your claim.

1. Name (including spouse, if married):
DAREN RHEESE KESSLER
SANDRA KESSLER
2. Phone (Home): (509-945-7801) (Work): (509-910-1119)
3. Address (include former address if at present address for less than 6 months):
1620 Mc KULEY AVE, YAKIMA, WA, 98942
Physical
SAME AS ABOVE
Mailing
4. Date of Birth: JULY 2, 1987
5. Date and Time of Incident:
AUGUST 29, 2013 @ 1:53 pm
6. Location of Incident:
N. 16TH AVE, 1200 BLOCK

7. Describe in detail the defect which caused the injury:

WAS REAR ENDED BY SHERIFF JOE D. MUNGUA
WHILE AT A COMPLETE STOP FORCING MY VEHICLE
INTO THE REAR OF VEHICLE IN FRONT OF MINE.

8. Describe in narrative form and in detail exactly how the incident occurred:

CHEVY TAHOE IN FRONT ME WAS STOPPED, CAUSING
ME TO COME TO A STOP AND SHERIFF MUNGUA
DID NOT NOTICE ME IN TIME TO STOP. THE SHERIFF
HIT MY CAR IN THE REAR CAUSING ME TO COLLIDE WITH
VEHICLE IN FRONT OF ME (CHEVY TAHOE)

9. List the names of all persons involved and contact information, if known.

DAREN R. KESSLER, ph (509) 910-1119
SANDRA KESSLER, ph (509) 945-7801
ADDRESS FOR BOTH: 1620 McKuskey Ave Yakima, WA 98902

10. Was claim investigated by a police officer? YES

Sheriff _____ State Patrol _____ City Police X

11. Description of claimant's vehicle: Honda Make 1999 Year

Model: Civic LX License No. ACL8493

12. Describe what you did after the accident occurred:

DROVE HOME

13. Describe the conversations you had, if any, with County personnel during or after the incident occurred:

THE SHERIFF WAS OBVIOUSLY CONCERNED FOR WELL-
BEING OF WIFE & MYSELF, TOLD HIM WE FELT OK.

14. Describe the damages or injuries which you sustained as a result of the incident:
BOTH SANDRA & MYSELF DIAGNOSED BY LARRY SMITH M.D.
AS HAVING THORACIC SPINE SPRAIN. FRONT AND REAR OF
CAR SUBSTANTIALLY DAMAGED AND ANXIETY ATTACK SUFFERED BY SANDRA
15. What is the amount of damages claimed? (Include estimates and bills, if available): VESSLER
MEDICAL - \$2,525.89 CAR REPAIR (AS FAR AS WHAT IS SEEN
ON OUTSIDE) - \$2,702.48 RENTAL CAR - \$549.77 PAIN & SUFFERING - TO BE
DETERMINED
16. How did you identify the County as the party responsible for your damage?
SHERIFF'S COUNTY OF KITTITAS LOGO ON VEHICLE AS
WELL AS SHERIFF MOUNGUIN IDENTIFYING HIMSELF.
17. List the names and addresses of all witnesses to the incident:
NONE LISTED ON POLICE REPORT
18. Are you covered by insurance? YES If yes, who is your insurance agent/carrier?
Parrot / 475852166

Dated this 19 Day of SEPTEMBER, 2013.

[Signature]
Signature of Claimant

Subscribed and sworn (affirmed) to before me this 9 day of OCTOBER, 2013.

Seal

Notary Public in and for the State of Washington
Residing at _____

AUTHORIZATION TO SHARE AND USE MEDICAL INFORMATION

I allow all doctors, hospitals, other health care providers, government agencies, insurers, employers, schools, training facilities, health plans, policyholders, contract holders, vendors, health and benefit plan administrators or their successors ("Records Holders") to give out my medical information as explained on this form.

This information includes, but is not limited to, any records or facts about my medical condition, treatment, supplies, employment, vocation, education training, income, and other insurance coverage including benefits paid ("Information").

I allow the Records Holders to give my Information to the following individuals or entities: Crawford & Company, its related companies, contractors, investigators, attorneys, and service consultants, authorized union representatives, health care providers treating or evaluating me or my claim, and other individuals or entities involved in administering, evaluating, analyzing and managing the plan or my claim.

I allow Crawford & Company to use and give out the Information only to evaluate, analyze, manage and/or administer my claim. I also allow Crawford & Company to give my Information to any other person or entity if needed to properly investigate my claim. I expressly waive any and all rights that I may have to be notified of these communications. Crawford & Company will tell those receiving the Information that the Information is confidential.

I understand that once my Information is given out as allowed in this form, federal privacy laws may not protect it.

I understand that this permission lasts twelve (12) months after my claim is closed, unless law requires a shorter period. If I change my mind before that time, I can tell my Records Holders in writing that I do not want them to share any more information. If I tell them in writing to stop sharing information, it will not change any actions they took before I told them.

If I do not sign this form, it will not affect how my health care providers treat me. However, if I do not sign, verification of my claim may be delayed until the required documentation can be obtained or my request for reimbursement of incurred medical expenses related to this claim may be denied.

The information released under this authorization can be submitted to the Records Holders electronically, by phone or fax, or by mail. I know I can see or copy the records given to Crawford & Company. I agree that a copy of this form may be treated as a signed original.

Claimant's Name

David J. Kessler

Date

Oct. 9, 2013

Claimant's or Legal Representative's Signature

Legal Representative's Name and Relationship

NOTICE TO RECORDS HOLDERS

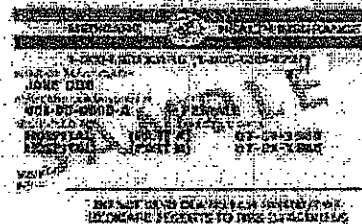
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.



Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?												☒ Yes		☐ No			
If yes, please complete the following. If no, proceed to Section II.																	
Full Name: (Please print the name exactly as it appears on your SSN or Medicare card if available.)																	
DARRIN WHEESE KESSLER																	
Medicare Claim Number										Date of Birth (Mo/Day/Year)							
NA										07/02/1987							
Social Security Number										Sex		☒ Female				☐ Male	
(If Medicare Claim Number is Unavailable)										538-17-7433							

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

DARRIN WHEESE KESSLER
Claimant Name (Please Print)

Claim Number

Name of Person Completing This Form if Claimant is Unable (Please Print)

Wheese Kessler
Signature of Person Completing This Form

10-9-13
Date

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

YakimaRegional
Medical & Cardiac Center

Darren Kessler

▶ YOUR INFORMATION

Patient Name: Darren R Kessler
Account Number: 8715903
Date of Service: September 03, 2013
Service Type: Emergency Room Services
Insurance Name:
Name of Insured:
Policy Number:
Amount Due From You: \$639.76

▶ YOUR PAYMENT OPTIONS

- ☐ Online at www.yakimaregional.com (available 24/7)
☐ By phone - 877-828-9573
☒ By credit card - complete section below and return
☒ By check - return section below with check

▶ YOUR ACCOUNT SUMMARY

Amount due from you is \$639.76 as of 09/08/2013 for Emergency Room Services performed on September 03, 2013.
Total Charges: \$1,827.90
Discounts/Adjustments Given: -\$1,188.14
Insurance Payments Received: \$0.00
Amount You Paid: \$0.00
Amount Due From You: \$639.76

▶ YOUR SUMMARY OF CHARGES

The charges listed below do not reflect the discount that you and your insurance company received.
Radiology: 1,147.40
Emergency Room: 680.50
TOTAL CHARGES: \$1,827.90

▶ A MESSAGE FOR YOU

3269-HMASTMT-1831883-1505126627-P; 7306299-1-223; 33653805-1; 1



The amount shown on this statement is outstanding at this time. Your prompt payment will be greatly appreciated.



110 S. 9th Avenue
Yakima, WA 98902

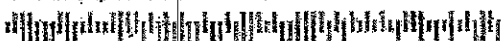


Patient Financial Services:
877-828-9573

☐ Check box if address below is incorrect or changed and indicate change(s) on back.



DAREN R KESSLER
1620 MCKINLEY AVE
YAKIMA, WA 98902-2417

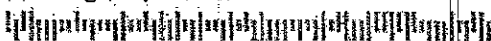


FOR CREDIT CARD PAYMENT, PLEASE FILL OUT BELOW...

☐ MASTERCARD	☐ DISCOVER	☒ VISA	☐ AMEX
CARD NUMBER		EXP.	
SIGNATURE		SECURITY CODE	
PATIENT NAME Darren R Kessler		STATEMENT DATE 09/08/2013	DATE DUE UPON RECEIPT
ACCOUNT NUMBER 8715903	AMOUNT DUE \$639.76	AMOUNT PAYING \$	

REMIT THIS PAYMENT STUB TO:

YAKIMA REGIONAL MEDICAL & CARDIAC
PO BOX 742310
Los Angeles, CA 90074-2310



00000571590300000063976DARENKLESSLER

Caledonia Financial Services, LLC
Optimal Billing Solutions, LLC
PO Box 189005
Plantation, Florida 33318-9005

PLEASE LOGON ON TO WWW.DOCBILLPAY.COM TO UPDATE OR ADD
INSURANCE INFORMATION AND REVIEW/CONFIRM DEMOGRAPHICS

BILLING QUESTIONS PLEASE CALL

877 693-5700

ACCOUNT NUMBER

YAK 000009775

STATEMENT DATE

09/26/13

BALANCE DUE

\$423.00

Responsible Party:



STM:007289
Daren R Kassler
1620 McKinley Ave
Yakima WA 98902-2417

MAKE CHECKS PAYABLE TO:

WASHINGTON EMER PHYS PRTN PLLC
PO BOX 975213
DALLAS TX 75397-5213

YAK 000009775 000023009

DETACH AT PERFORATION - RETURN THIS PORTION WITH PAYMENT

ACCOUNT NUMBER YAK 000009775

WE ACCEPT



AND



AND



OR



Please see back of form for
Insurance and credit card information.

DATE	DR NO	PATIENT'S NAME	PS	CPT CODE	DIAG CODE	SERVICE DESCRIPTION	AMOUNT
09/03/13	1	DAREN		23 99283		EMERGENCY DEPT VISIT	423.00

STATEMENT DATE

09/26/13

BALANCE DUE

423.00

DOCTOR LEGEND

COMMENTS

1 SMITH, LARRY O., M.D.

The balance due is your responsibility.
If you have insurance, please complete
the information on the back of the
coupon and mail it to us. Thank You

WASHINGTON EMER PHYS PRTN PLLC
PO BOX 538445
ATLANTA, GA 30353-8445

PRIMARY INSUR: SELF PAY
SECONDARY INSUR:
LOCATION OF SVC: YAKIMA REG MED CTR

877 693-5700

STATEMENT

Yakima Valley Radiology, P.C.
PO Box 2925
Yakima WA 98907-2925

Office Hours: 8:00am - 4:00pm Monday - Friday
Phone: 509/248-6633 Toll Free: 800/510-5551

CHECK CREDIT CARD USING TOP PAYMENT AND PAY DATED NOW		
☐	☐	
CARD NUMBER	SECURITY CODE	
NAME ON CARD (PLEASE PRINT)	EXP. DATE	
SIGNATURE	AMOUNT	
STATEMENT DATE 09/10/2013	ACCOUNT # YVR81885	PAY THIS AMOUNT \$61.00

0001



AMOUNT PAID

Pay online at www.ePayitOnline.com
CodeID: YAKIMA11 Access #: 3379970-1-88
Patient: DAREN R KESSLER



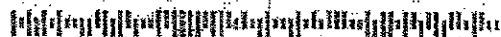
3323 1 AT 0381 *13

03323



Daren R Kessler YVR81885
1620 McKinley Avenue
Yakima WA 98902-2417

MAKE CHECK PAYABLE & REMIT TO:



Yakima Valley Radiology, P.C.
PO Box 2925
Yakima WA 98907-2925

PLEASE CHECK BOX IF ABOVE ADDRESS IS INCORRECT AND INDICATE CHANGES ON BACK.

DETACH HERE

AND RETURN THIS TOP PORTION WITH YOUR PAYMENT
USING THE RETURN ENVELOPE ENCLOSED

DATE	POST DATE	CODE	DESCRIPTION OF SERVICE	CHARGE	PAYMENT	ADJ	BALANCE
09/03/13		72070	XRAY THORACIC SPINE 2 VWS	\$61.00			\$61.00
				Total Balance: \$61.00			
				Insurance Pending: \$0.00			
				AMOUNT DUE NOW: \$61.00			
Patient: DAREN R KESSLER			Account Number: YVR81885		Statement Date: 09/10/2013		
Location: YAKIMA REGIONAL							

Yakima Valley Radiology, P.C.
315 Holton Avenue, Suite 102
Yakima WA 98902-3240

YAKIMA11-0358717-0003323-3379970-001-000088-#003644-0001

Phone: 509/248-6633 Toll Free: 800/510-5551 IRS# 91-0861108

AUTHORIZATION TO SHARE AND USE MEDICAL INFORMATION

I allow all doctors, hospitals, other health care providers, government agencies, insurers, employers, schools, training facilities, health plans, policyholders, contract holders, vendors, health and benefit plan administrators or their successors ("Records Holders") to give out my medical information as explained on this form.

This information includes, but is not limited to, any records or facts about my medical condition, treatment, supplies, employment, vocation, education training, income, and other insurance coverage including benefits paid ("Information").

I allow the Records Holders to give my Information to the following individuals or entities: Crawford & Company, its related companies, contractors, investigators, attorneys, and service consultants, authorized union representatives, health care providers treating or evaluating me or my claim, and other individuals or entities involved in administering, evaluating, analyzing and managing the plan or my claim.

I allow Crawford & Company to use and give out the Information only to evaluate, analyze, manage and/or administer my claim. I also allow Crawford & Company to give my Information to any other person or entity if needed to properly investigate my claim. I expressly waive any and all rights that I may have to be notified of these communications. Crawford & Company will tell those receiving the information that the information is confidential.

I understand that once my information is given out as allowed in this form, federal privacy laws may not protect it.

I understand that this permission lasts twelve (12) months after my claim is closed, unless law requires a shorter period. If I change my mind before that time, I can tell my Records Holders in writing that I do not want them to share any more information. If I tell them in writing to stop sharing information, it will not change any actions they took before I told them.

If I do not sign this form, it will not affect how my health care providers treat me. However, if I do not sign, verification of my claim may be delayed until the required documentation can be obtained or my request for reimbursement of incurred medical expenses related to this claim may be denied.

The information released under this authorization can be submitted to the Records Holders electronically, by phone or fax, or by mail. I know I can see or copy the records given to Crawford & Company. I agree that a copy of this form may be treated as a signed original.

Claimant's Name

Gaudin, J. J.

Date:

10-9-13

Claimant's or Legal Representative's Signature

Legal Representative's Name and Relationship

NOTICE TO RECORDS HOLDERS

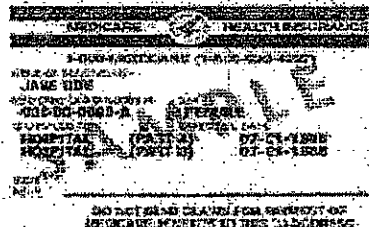
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.



Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?												☐ Yes		☐ No			
If yes, please complete the following. If no, proceed to Section II.																	
Full Name: (Please print the name exactly as it appears on your SSN or Medicare card if available.)																	
SANDRA KESSLER																	
Medicare Claim Number: N/A												Date of Birth (Mo/Day/Year) 08-01-1983					
Social Security Number: (If Medicare Claim Number is Unavailable) 533-94-6166												Sex		☒ Female		☐ Male	

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

SANDRA KESSLER

Claimant Name (Please Print)

Claim Number

Name of Person Completing This Form If Claimant is Unable (Please Print)

Sandra Kessler

Signature of Person Completing This Form

10-9-13

Date

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.



Sandra Kessler

YOUR INFORMATION

Patient Name Sandra Kessler
Account Number 8715900
Date of Service September 03, 2013
Service Type Emergency Room Services
Insurance Name
Name of Insured
Policy Number
Amount Due From You \$1,641.13

YOUR ACCOUNT SUMMARY

Amount due from you is \$1,641.13 as of 09/08/2013 for
Emergency Room Services performed on September 03,
2013.

Total Charges	\$4,688.93
Discounts/Adjustments Given	\$3,047.80
Insurance Payments Received	\$0.00
Amount You Paid	\$0.00

Amount Due From You \$1,641.13

YOUR PAYMENT OPTIONS

- ☐ Online at www.yakimaregional.com
(available 24/7)
- ☐ By phone - 877-828-9573
- ☒ By credit card - complete section below and return
- ☒ By check - return section below with check

YOUR SUMMARY OF CHARGES

The charges listed below do not reflect the discount that
you and your insurance company received.

Lab	116.26
Radiology	3,892.17
Emergency Room	680.50
TOTAL CHARGES	\$4,688.93

MESSAGE FOR YOU

3286-HMASTMT-1831683-15051266244; 7806299-1-222; 33653305-1; 1



The amount shown on this statement is outstanding at this time. Your prompt
payment will be greatly appreciated.



110 S. 9th Avenue
Yakima, WA 98902



Patient Financial Services:
877-828-9573

☐ Check box if address below is incorrect or changed and indicate change(s) on back.

SANDRA KESSLER
1620 MCKINLEY AVE
YAKIMA, WA 98902-2417



FOR CREDIT CARD PAYMENT, PLEASE FILL OUT BELOW...

☐ MASTERCARD	☐ DISCOVER	☒ VISA	☐ AMEX
CARD NUMBER			
SIGNATURE			
PATIENT NAME		STATEMENT DATE	DATE DUE
Sandra Kessler		09/08/2013	UPON RECEIPT
ACCOUNT NUMBER	AMOUNT DUE	AMOUNT PAYING	
8715900	\$1,641.13	\$	

REMIT THIS PAYMENT STUB TO:

YAKIMA REGIONAL MEDICAL & CARDIAC
PO BOX 742310
Los Angeles, CA 90074-2310



00000871590000000164113SANDRAKESSLER

Caledonia Financial Services, LLC
Optimal Billing Solutions, LLC
PO Box 189005
Plantation, Florida 33318-9005

PLEASE LOGON ON TO WWW.DOCBILLPAY.COM TO UPDATE OR ADD
INSURANCE INFORMATION AND REVIEW / CONFIRM DEMOGRAPHICS
BILLING QUESTIONS PLEASE CALL

877 693-5700

ACCOUNT NUMBER
YAK 000009843

Responsible Party:

STM>007990
Sandra Kessler
1620 McKinley Ave
Yakima WA 98902-2417

MAKE CHECKS PAYABLE TO:

WASHINGTON EMER PHYS PRTN PLLC
PO BOX 975213
DALLAS TX 75397-5213

STATEMENT DATE

09/26/13

BALANCE DUE

\$609.00

YAK 000009843 0000007005

DETACH AT PERFORATION - RETURN THIS PORTION WITH PAYMENT

ACCOUNT NUMBER YAK 000009843

WE ACCEPT



AND



AND



OR



Please see back of form for
insurance and credit card information.

DATE	DR NO.	PATIENT'S NAME	PS	CPT CODE	DIAG CODE	SERVICE DESCRIPTION	AMOUNT
09/03/13	1	SANDRA		23 99284		EMERGENCY DEPT VISIT	609.00

STATEMENT DATE BALANCE DUE

09/26/13

609.00

DOCTOR LEGEND

COMMENTS

1 SMITH, LARRY O., M.D.

The balance due is your responsibility.
If you have insurance, please complete
the information on the back of the
coupon and mail it to us. Thank You

WASHINGTON EMER PHYS PRTN PLLC
PO BOX 538445
ATLANTA, GA 30353-8445

PRIMARY INSUR: SELF PAY
SECONDARY INSUR:
LOCATION OF SVC: YAKIMA REG MED CTR

877 693-5700

STATEMENT

Yakima Valley Radiology, P.C.
PO Box 2925
Yakima WA 98907-2925

CHECK CREDIT CARD USING FOR PAYMENT AND FILL OUT BELOW		
☐	☐	
CARD NUMBER	SECURITY CODE	
NAME ON CARD (PLEASE PRINT)	EXP. DATE	
SIGNATURE	AMOUNT	
STATEMENT DATE 09/10/2013	ACCOUNT # YVR81883	PAY THIS AMOUNT \$184.00

0001



AMOUNT PAID

Office Hours: 8:00am - 4:00pm Monday - Friday
Phone: 509/248-6633 Toll Free: 800/510-5551

Pay online at www.ePayitOnline.com
CodeID: YAKIMA11 Access #: 3379970-1-87
Patient: SANDRA KESSLER



3322 1 AT 0.381 *13

03322



Sandra Kessler YVR81883
1520 McKinley Avenue
Yakima WA 98902-2417

MAKE CHECK PAYABLE & REMIT TO:



Yakima Valley Radiology, P.C.
PO Box 2925
Yakima WA 98907-2925

PLEASE CHECK OFF IF ABOVE ADDRESS IS INCORRECT AND INDICATE CHANGES ON BACK.

DETACH HERE

AND RETURN THIS TOP PORTION WITH YOUR PAYMENT
USING THE RETURN ENVELOPE ENCLOSED

DATE	POST DATE	CODE	DESCRIPTION OF SERVICE	CHARGE	PAYMENT	ADI	BALANCE
09/03/13		72070	XRAY THORACIC SPINE 2 VWS	\$61.00			\$61.00
09/03/13		72040	XRAY CERVICAL SPINE 3VWS	\$61.00			\$61.00
09/03/13		72100	XRAY LUMBOSACRAL 2 OR 3 V	\$62.00			\$62.00
							Total Balance: \$184.00
							Insurance Pending: \$0.00
							AMOUNT DUE NOW: \$184.00

Patient: SANDRA KESSLER

Account Number: YVR81883

Statement Date: 09/10/2013

Location: YAKIMA REGIONAL

Yakima Valley Radiology, P.C.
315 Holton Avenue, Suite 102
Yakima WA 98902-3240

YAKIMA11-0360717-0003322-3379970-001-000087-0003543-0001

Phone: 509/248-6633 Toll Free: 800/510-5551 IRS# 91-0861108