Phone: 818-907-7723
www.PreciseMRI.com

ANY PAPER FORMS FILLED OUT, PLEASE UPLOAD VIA FRONT DESK PORTAL @ App.RadFlow360.com/front-desk

****USE THE INCLUDED PATIENT ID AND ACCESSION # IN YOUR SYSTEM/PACS****

NAME	**LAST:** WINFORD	**FIRST:** MARISOL	**ID:** PRE1062630
PHONE	**HOME:** () -	**Cell:** (323) 697-1219	**DOB:** 4/8/1982
PATIENT ADDRESS	1510 WALNUT AVE, LONG BEACH, CA 90805		
CLINICAL HISTORY	None		
REFERRING PHY	BETTINA LIMJOCO		
EXAM LOCATION	8370 Wilshire Blvd. Suite 110, Beverly Hills CA		

Patient ID : PRE1062630 ****USE THE INCLUDED PATIENT ID AND ACCESSION # IN YOUR SYSTEM/PACS****

ACCESSION	EXAM	CPT	DX	READ TYPE	DATE / TIME
RAM1045694	MRI ABDOMEN W/O CONTRAST - RESOURCE: STAND UP	74181	R10.84	Tech Only	7/16/2025 8:00:00 AM

PLEASE HAVE PATIENT WALK OUT W/ CD

1) HAVE PATIENT FILL OUT ALL FORMS (IF ANY)
2) Obtain photo ID, ONLY if not already in the front desk portal.
3) PHOTO ID & ANY PAPER FORMS FILLED OUT, PLEASE UPLOAD VIA THE FRONT DESK PORTAL @ App.RadFlow360.com/front-desk

? HAVE A QUESTION? LIVE CHAT WITH US VIA FRONT DESK PORTAL ?

Patient can upload photo ID, e-sign liens and view appointments @ App.RadFlow360.com/patient-portal

Generated on : 6/17/2025 9:40:13 PM

Precise Imaging **FAX TO 888-777-4356**

PATIENT INFORMATION

Social Security Number:		**DOB:** 4/8/1982
Patient Name (Paciente):	WINFORD, MARISOL	**ID: PRE1062630**
Address (Domicilio):	1510 WALNUT AVE, LONG BEACH, CA 90805	
Tel # (Telefono):	**Home:** () -	**Cell:** (323) 697-1219
Why are you here today & what are your symptoms? (Por que esta aqui y cuales son sus symtomas?):		

ATTORNEY INFORMATION

Attorney Name (Abogado):	SWEET JAMES ACCIDENT ATTORNEYS		
Address (Direccion):	4220 VON KARMAN AVE SUITE 200,NEWPORT BEACH, CA 92660		
City, State, Zip (Ciudad), (Estado), (Codigo):	NEWPORT BEACH, CA 92660		
Tel# (Telefono):	(949) 644-1000	**Fax:** (949) 644-1005	
Driver's Name (Conductor):		**Date of Injury** (Fecha de Herida):	

AUTO INSURANCE INFORMATION

Insurance Carrier (compañía de seguros):			
Adjuster (Ajustador):		**Claim #** (# de Reclamo):	

***If you were in a car accident, please put the name of the person driving the car YOU were in. If you were the driver, please put your own name. (Si esto es un caso de un accidente de auto y usted fue pasajero, pon el nombre de conductor del auto que viajaba usted. Si usted era el conductor, pon su nombre)**

Sign(Firma): _____ Date(Fecha): _____

PRE1062630^019

6710 Kester Ave. #126, Van Nuys, CA 91405
Office: 818-907-7723 Fax: 888-715-7001 www.PreciseMRI.com

EMAIL TO : billing@precisemri.com

Personal Injury Technical (Imaging) Lien

TO THE LAW OFFICE OF:

SWEET JAMES ACCIDENT ATTORNEYS Tel: (949) 644-1000
4220 VON KARMAN AVE SUITE 200
NEWPORT BEACH, CA 92660

WINFORD, MARISOL

PRE1062630 **DOB: 4/8/1982**

*** * * INFORM YOUR ATTORNEY OF ALL PROCEDURE(S) PERFORMED WITH PRECISE IMAGING TO ENSURE SERVICES ARE PAID THROUGH YOUR CASE. FAILURE TO INFORM YOUR ATTORNEY MAY HOLD YOU LIABLE FOR PAYMENT OF SERVICES.(INFORME A SU ABOGADO DE TODO LES PROCEDIMIENTO(S) HECHO CON PRECISE IMAGING PARA GARANTIZAR EL PAGO DE LOS SERVICIOS A TRAVÉS DE SU CASO. DE NO INFORMAR A SU ABOGADO PUEDE HACER QUE USTED SEA RESPONSABLE DEL PAGO DE LOS SERVICIOS.) * * ***

RE: MEDICAL REPORTS, BILLS AND LIENS (REGISTROS MÉDICOS, FACTURUS Y GRAVAMENES) I hereby authorize Precise Imaging to furnish you, my attorney, all medical records, bills, and liens of the examination(s), in regards to the accident I was involved in on the below date(s) of injury. (Por la presente autorizo a Precise Imaging a proporcionarle a usted, mi abogado, todos los registros médicos, facturas y gravámenes del examen o exámenes, con respecto al accidente en el que estuve envuelto en la fecha de la herida escrito por debajo.)

I hereby authorize and direct you, my Attorney, to pay directly to Precise Imaging such sums due and owing for services rendered to me, and to withhold such sums from any settlement, judgments or verdicts as may be necessary to adequately protect and fully compensate Precise Imaging. I hereby further direct my Attorney to pay in full any bills owed to Precise Imaging. (Por la presente le autorizo y le dirigo usted, mi abogado, a pagar directamente a Precise Imaging las sumas adeudadas y adeudadas por los servicios que se me presten, y que retenga dichas sumas de cualquier acuerdo, juicio o veredicto que puede ser necesarias para proteger y compensar adecuadamente a Precise Imaging. Por el presente documento, a mi abogado que pague en su totalidad todas las facturas que se adeyden a Precise Imaging.)

I fully understand that I am directly and fully responsible to Precise Imaging for all bills submitted by said entity for services rendered and that this agreement is made solely for said entity's additional protection and in consideration of the practice awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting Precise Imaging's interest, the entity will not await payment and may declare the entire balance due and payable. **Patient agrees to pay all of Precise's reasonable attorneys' fees, collection costs and expenses associated with the enforcement of this lien. If Precise is required to retain an attorney to enforce any provision of this Agreement, whether or not a legal proceeding is commenced, the substantially prevailing party shall be entitled to reasonable attorneys' fees regardless of whether at trial, on appeal, in any bankruptcy proceeding, arbitration matter or without resort to suit. In the event Precise is required to turn any outstanding unpaid amounts due under this agreement to a collection agency then Patient agrees to pay any and all costs, fees or charges imposed by said collection agency in collecting amounts due hereunder.** (Entiendo perfectamente que soy responsable directa y plenamente a Precise Imaging de todas las facturas médicas presentadas por dicha entidad por los servicios prestados y que este acuuerdo se hace unicamente por la protección adicional de dicha entidad y en consideración de la entidad a la espera de pago. Además, entiendo que dicho pago no está supeditado a ningun acuerdo, juicio o veredicto por el cual eventualmente pueda recuperar dicha tasa.Me han informado que si mi abogado no desea cooperar en la protección de los intereses de Precise Imaging, la entidad no esperará el pago y puede declarar tado el saldo adeudado y pagadero. El paciente acepta pagar todos los honorarios razonables de los abogados de Precise, los costos de cobro y los gastos asociados con la aplicación de gravámenes. Si se requiere que Precise conserve a un abogado para hacer cumplir cualquier disposición de este acuerdo, ya sea que se inicie o no un procedimiento legal, la parte que prevalece sustancialmente tendrá derecho a honorarios razonables de abogados, independientemente de si en el juicio, en la apelación, en cualquier procedimiento de quiebra, asunto de arbitraje o sin recurso a juicio. En el caso de que se requiera que Precise dé a una agencia de cobranzas cualquier cantidad pendiente de pago debida en virtud de este acuerdo, el paciente acepta pagar todos y cada uno de los costos, honorarios o cargos impuestos por dicha agencia de cobranzas al cobrar las cantidades adeudadas en virtud del presente acuerdo.)

I hereby agree to waive the running of any Statute of Limitations for an additional period of four (4) years as provided in CCP 360.5. (Por la presente acepto renunciar a la ejecución de cualquier Estatuto de Limitaciones por un período adicional de cuatro (4) años segun lo dispiesto en el CCP 360.5)

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above, and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate Precise Imaging. Attorney further agrees that in the event this lien is litigated, the prevailing party will be awarded attorney's fees and costs. I agree to provide a case status update every one hundred eighty (180) days from the first date of service. I acknowledge that failure to provide periodic case status updates may result in the patient's account(s) being referred to collections.

Print First, Middle & All Names: (*Nombre Completo de Paciente*) *WINFORD, MARISOL*

Date(s) of Injury: (Fecha de Herida) *11/20/2024*

Driver's Name (if you were a passenger) (Nombre de Conductor (si fue pasajero) : _____

Patient's Signature *(FIRMA de Paciente)* : Date *(Fecha)* :

Attorney's Signature *(FIRMA de Abogado)* : Date *(Fecha)* :

eSign liens, submit case updates, bill balance, bill offers, and e-payments at App.RadFlow360.com

Alexander Grimm, MD, a Professional Corporation

Email Signed Lien To : liens@accurateradiology.com

PERSONAL INJURY MEDICAL RADIOLOGIST LIEN

TO THE LAW OFFICE OF:

SWEET JAMES ACCIDENT ATTORNEYS
4220 VON KARMAN AVE SUITE 200
NEWPORT BEACH, CA 92660

Tel: (949) 644-1000
Fax: (949) 644-1005

WINFORD, MARISOL

PRE1062630 **DOB: 4/8/1982**

*** * * INFORM YOUR ATTORNEY OF ALL PROCEDURE(S) DONE WITH Alexander Grimm, MD, a Professional Corporation TO ENSURE SERVICES ARE PAID THROUGH YOUR CASE. FAILURE TO INFORM YOUR ATTORNEY MAY HOLD YOU LIABLE FOR PAYMENT OF SERVICES. INFORME A SU ABOGADO DE TODO EL PROCEDIMIENTO(S) HECHO CON Alexander Grimm, MD, a Professional Corporation PARA GARANTIZAR EL PAGO DE LOS SERVICIOS A TRAVÉS DE SU CASO. DE NO INFORMAR A SU ABOGADO LE PUEDE SER RESPONSABLE PARA EL PAGO DE SERVICIOS. * * ***

RE: MEDICAL REPORTS AND DOCTOR'S LIEN (INFORME DE MÉDICO Y GRAVAMEN DE MÉDICO) I hereby authorize Alexander Grimm, MD, a Professional Corporation (provider) to furnish you, my Attorney, a full report of the examination, diagnosis, treatment, and prognosis in regards to the accident I was involved in on the below date(s) of injury. (Por la presente autorizo Alexander Grimm, MD, a Professional Corporation (proveedor) entregar a usted, mi abogado, un informe completo del examen, diagnóstico, tratamiento y pronóstico de mí mismo, en cuando estuve envuelto en un accidente en la fecha de la herida escrito por debajo.)

I hereby authorize and direct you, my Attorney, to pay directly to Alexander Grimm, MD, a Professional Corporation such sums due and owing for professional services rendered to me, and to withhold such sums from any settlement, judgments or verdicts as may be necessary to adequately protect and fully compensate Alexander Grimm, MD, a Professional Corporation. I hereby further direct my Attorney to pay in full any medical bills owed to Alexander Grimm, MD, a Professional Corporation. (Yo autorizo y le dirigo, mi abogado, para pagar directamente a Alexander Grimm, MD, a Professional Corporation tales sumas como pueden ser debida y debido por servicios profesionales proveido a mí, y retener tales cantidades de asentamiento, fallos/verdictos o sentencias como sean necesarias para proteger adecuadamente y compensar completamente Alexander Grimm, MD, a Professional Corporation. Por el presente documento, dirijo mi abogado a pagar en su totalidad cualquier facture(s) médica(s) debido a Alexander Grimm, MD, a Professional Corporation.)

I fully understand that I am directly and fully responsible to Alexander Grimm, MD, a Professional Corporation. for all medical bills submitted by said practice for services rendered and that this agreement is made solely for said practice's additional protection and in consideration of the practice awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting Alexander Grimm, MD, a Professional Corporation's interest, the practice will not await payment and may declare the entire balance due and payable.Patient agrees to pay all of Alexander Grimm, MD, a Professional Corporation's reasonable attorneys' fees, collection costs and expenses associated with the enforcement of this lien. If Alexander Grimm, MD, a Professional Corporation is required to retain an attorney to enforce any provision of this Agreement, whether or not a legal proceeding is commenced, the substantially prevailing party shall be entitled to reasonable attorneys' fees regardless of whether at trial, on appeal, in any bankruptcy proceeding, arbitration matter or without resort to suit. In the event Alexander Grimm, MD, a Professional Corporation is required to turn any outstanding unpaid amounts due under this agreement to a collection agency then Patient agrees to pay any and all costs, fees or charges imposed by said collection agency in collecting amounts due hereunder. (Entiendo perfectamente que soy directamente y plenamente responsable a Alexander Grimm, MD, a Professional Corporation todas las facturas médicas presentadas por dicha práctica por los servicios proveidos a mí y que este acuerdo se hace exclusivamente para protección adicional de dicha práctica y teniendo en cuenta la práctica en espera del pago. Y entiendo que dicho pago no es contingente sobre cualquier asentamiento, juicio o veredicto que finalmente puedo recuperar dicha sustantivo. Alexander Grimm, MD, a Professional Corporation me ha explicado que si mi abogado no quiere cooperar en la protección de intereses de Alexander Grimm, MD, a Professional Corporation, el proveedor no esperara pago (como lo haríamos con un asunto pendiente) podemos declarar la totalidad del saldo exigible y pagadera, El paciente acepta pagar todos los honorarios razonables de los abogados de Alexander Grimm, MD, a Professional Corporation, los costos de cobro y los gastos asociados con la aplicación de gravámenes. Si se requiere que Alexander Grimm, MD, a Professional Corporation conserve a un abogado para hacer cumplir cualquier disposición de este acuerdo, ya sea que se inicie o no un procedimiento legal, la parte que prevalece sustancialmente tendrá derecho a honorarios razonables de abogados, independientemente de si en el juicio, en la apelación, en cualquier procedimiento de quiebra, asunto de arbitraje o sin recurso a juicio. En el caso de que se requiera que Alexander Grimm, MD, a Professional Corporation dé a una agencia de cobranzas cualquier cantidad pendiente de pago debida en virtud de este acuerdo, el paciente acepta pagar todos y cada uno de los costos, honorarios o cargos impuestos por dicha agencia de cobranzas al cobrar las cantidades adeudadas en virtud del presente acuerdo.)

I hereby agree to waive the running of any Statute of Limitations for an additional period of four (4) years as provided in CCP 360.5.Yo estoy de acuerdo de renunciar a la diversión de cualquier estatuto de limitaciones por un período adicional de cuatro (4) años como proporcionar en 360.5 CCP

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above, and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate Alexander Grimm, MD, a Professional Corporation. Attorney further agrees that in the event this lien is litigated, the prevailing party will be awarded attorney's fees and costs.

Print First, Middle & All Names: (*Nombre Completo de Paciente*) *WINFORD, MARISOL*

Date(s) of Injury: (Fecha de Herida) *11/20/2024*

Driver's Name (if you were a passenger) (Nombre de Conductor (si fue pasajero) : _____

Patient's Signature *(FIRMA de Paciente)* :

Date *(Fecha)* :

Attorney's Signature *(FIRMA de Abogado)* :

Date *(Fecha)* :

5101 Santa Monica Blvd Suite 8 PMB 54, Los Angeles ,CA 90029 , FAX:

eSign liens, submit case updates, bill balance, bill offers, and e-payments at App.RadFlow360.com

Anil Date, MD

27141 Hidaway Ave. Ste. 106
Canyon Country, CA 91351
Ph: (661) 252-8469 Fax: (661) 252-6506

REFERRAL

Name: Marisol Winford DOB: 4/8/1982

Attorney: Sweet James Phone#: (323) 697-1219

REFER TO SPECIALTY:

☑ Pain Management	☐ Orthopedic	☑ Acupuncture	☑ PT/OT	☑ Podiatry
☑ Neurology	☑ Chiropractor	☑ Extra Massage	☐ Psychiatry	
☐ ENT	☐ Plastic SX	☐ Audiology	☐ Pediatrician	

☑ Other PT 3x/week x 6 weeks, Ortho extremity

IMAGING:

(OPEN MRI) Patient is claustrophobic

☑ **MRI (No Contrast)** ☐ **MRI (W/Contrast)**

☐ Brain	☑ Cervical	☑ Thoracic	☑ Lumbar	☑ R / L Shoulder
☐ R / L Elbow	☑ R / L Wrist	☑ R / L Hand	☑ R / L Knee	
☑ R / L Ankle	☑ R / L Foot	☐ Other		

☐ **CT Scan w/out Contrast** _____

☐ **Ultrasound** _____

☑ **X-Ray:**

☐ R / L Rib Series Bilateral	☐ Chest	☐ R / L Tibia/Fibula	☑ R / L Hip/Pelvis
☐ R / L Elbow	☐ R / L Wrist	☐ R / L Hand	☐ R / L Knee
☐ R / L Ankle	☐ R / L Foot	☐ R / L Shoulder	☐ Other _____

☐ **EKG**

☐ Other _____

DIAGNOSIS/PAIN:

☑ R51 Headache/Concussion	☑ (M54.2) Neck	☑ (M54.6) Upper/mid Back	☑ (M54.5) Lower Back
☑ R / L (M79.641) / (M79.642) Hand/Fingers	☑ R / L (M25.531) / (M25.532) Wrist	☐ R / L (M25.521) / (M25.522) Elbow	☑ R / L (M79.671) / (M79.672) Shoulder
☑ R / L (M25.551) / (M25.552) Hip/Pelvis	☑ R / L (M25.561) / (M25.562) Knee	☑ R / L (M25.571) / (M25.572) Ankle	☑ R / L Foot

☑ (F41.9) Anxiety

☐ Other _____

ICD-10 _____

X _____ Date 11/20/2024