EXHIBIT K

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document that in the computer.

Q All right. So you might take notes while you're meeting with a patient?

A (Indicating.)

Q And then when do you enter it into a computer?

A I'd say the majority of the time it's either right after if I can, if I have time, or at lunch if I can. If it's at the end of the day, it would probably be the next morning. I'd show up at least an hour early to do the afternoon notes in the morning, the following morning. But there are occasions where I catch up a good day or two later on the weekends.

Q It doesn't sound like you're a person who dictates?

A No, I don't dictate.

Q So you, yourself, are the one who enters it --

A Yeah.

Q -- into a computer?

A Yes.

Q And do you make a notation when you enter it into the computer as to the time you entered it relative to the time the information was taken?

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A No.

Q So, for example, in old school medical records where it might say dictated on a later date, your system doesn't reflect that?

A I have to go in -- there might be a thing that says when it was signed.

Q So there was a provision for an electronic signature?

A Yeah, I mean, I electronically sign all the notes. So that might say the time. I guess I look at it.

Q And what is the purpose in your mind of keeping good records of your patient visits?

A One, so that I or somebody else can see what happened at the visit to see what happened and get an idea of what happened in the past and what to do going forward.

Q Fair to say it's important for purposes of future treatment of that patient, correct?

A Yes.

Q For example, medications need to be well documented?

A Yes.

Q And complaints of symptoms would be documented?

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A Um-hum, yes.

I would say that the majority of the notes get done immediately because the medical assistant is writing down in the, oh, the HPI section why they're there. And the assessments, I do everything electronic. I put all the orders in. I put all the labs in, medications, and I make sure that the assessment plan is laid out that -- that day so that if I do get behind, I have to do it later or a couple days later on the weekend.

Basically it's just clicking a button, but all of the pertinent information is already filled out in the assessment plan.

Q Okay.

A So it's mostly done. I would say if they're not done, they're 70 percent complete and I just -- there's a lot of radial buttons for us to click to complete the medical record.

Q Okay. And I presume during the course of your work as a resident and then at Saint Thomas More, you strive to keep accurate records in your practice?

A Yes.

Q You've been trained to do that?

A Yes.

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Q All right. Do you know how you came to be the doctor for Virginia Giuffre?

A No. I -- she would have filled out a new patient packet and showed up for a new patient appointment for a particular reason. I reviewed it. It was essentially getting refill of medications and, you know, to address her problems.

Q Do you know where that new patient packet is now?

A It's going to be scanned in the computer. If you don't have it, I brought my computer. I can probably scan it and print it out or just print it out.

Q Is that among the documents that you have next to you?

A The new patient packet isn't here, but I have it -- I should have it on my computer. I could probably log in and print it, to be honest. It wouldn't be that hard. I assumed that the hospital is taking care of all the documentation that was requested. So I didn't actually bring it.

Q I understand.

A I actually have it, happen to have it with me.

Q All right. Why don't we -- we can