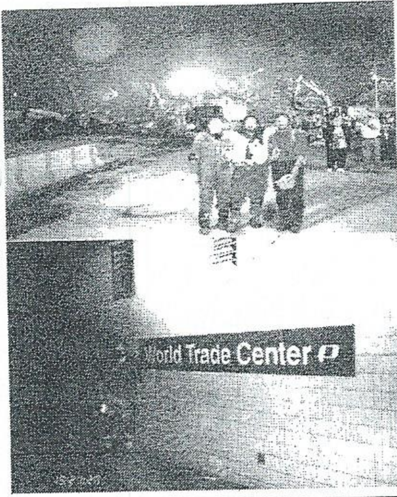
Dr Friedman



American Rescue Team International (ARTI)

www.amerrescue.org
501 (C) 3, non profit, All Volunteer Organization

"The world's most experienced rescue, disaster mitigation and disaster management organization with members in 55 countries." June 2002.

Head Office email:amerrescue@aol.com
Voice: 1-505-281-7977

Attention

Feb/18/04

Dr Robert Freidman:

Dear Bob:

My attorney Kip Purcell, has informed me of your conversation with him regarding your bill.

I want to detail my thoughts, in writing, to you. I am deeply disturbed by the facts:

> Your bill is 3 times the current rate for the same injections both in New Mexico and Canada. Originally, I was prepared to pay that amount because a) I thought you were truly helping me in a caring way, b) you had to wait for your money , c) I thought I was going to be fairly compensated by the Victim's Compensation Fund. and d) Your testimony as to the severity of my illness was crucial for my compensation from the Fund.
> Instead a whole different scenario has arisen: a) you refused to testify , in any worthwhile way regarding my illness. I believe this is because you did not want any publicity regarding your procedures (which I understand the state of NM has stopped you from administering). Your refusal to testify on my behalf was against all decency. b) When I was getting your treatments I discovered that your assistant had lied to me. She told me that I was getting 5,000 times the normal dosage of Vitamin C per injection and that accounted for the extraordinary cost. I later found out that the dosage was eqivalent to 15 Ester C pills which would cost approximately $5 at any store.c) She recently called me and told me that she was doing the injections on her own. I told her that the Fund paid me only 1/5 of what I need for medical treatment and that I would have practically nothing after paying all the costs of the economists, lawyers, accountants etc..etc.. Before I could say another word she said she had to go but would call me right back. She never did. I took it all to be part of a sham of caring. This disturbed me.
> The major cause for my brain damage as explained to me by DR Tim Smith is that you were new ' at the injections' and you gave me a dosage much stronger than a proper diagnosis would indicate.You drew far more toxins out of storage and into my bloodstream than my kidneys, liver, and sweat glands could

eliminate. This caused my brain to soak in high levels of lead, arsenic, mercury and antimony for 1 ½ months and just 'blew me away'. At one point the neuro-psych tests had me at an IQ of 78 (a drop from 162+) I was told to sue you but I didn't because of sentimental reasons but I am very distressed that you refused to help me get compensation.

I am still considering my various options which preclude nothing.

Cc Bill Reeves, Kip Purcell

Doug Copp
Rescue Chief // Disaster Manager
American Rescue Team International
PO Box 534
Sandia Park, NM, 87047
Phone: 1-505-281-7977
fax: 1-505-281-7877
amerrescue@aol.com
http://www.amerrescue.org
"The world's most experienced rescue, disaster mitigation
and disaster management organization with members in 55 countries."
Doug Copp: Dipl Praktikant ENG (Germany), BA HON PHIL (Canada), Distinction Honorifica (Universidad Nacional-Peru), Fire Capt. Station #4, CBP, Lima, (Peru), AKUT (Turkey), RCFR (Russia), KERO (Kenya), CIBS (Portugal), RAC (Taiwan), MRC (Mexico), HTN (Bulgaria). QSDRT (BRASIL), Bjelovar Fire Dept.(Croatia), UCP(Italy), BOER (Argentina)

Medical Report

IN THE MATTER OF THE CLAIM OF DOUGLAS F. COPP

ON THE SEPTEMBER 11TH VICTIM COMPENSATION FUND OF 2001

STATE OF NEW MEXICO)
) ss.
COUNTY OF Santa Fe)

CERTIFICATION OF MEDICAL RECORDS

Robert Friedman, M.D., being first duly sworn, deposes and states as follows:

1. I am the Custodian of the Medical Records of Doug Copp

2. I am providing this certification in response to a properly executed authorization for release of Douglas F. Copp's medical records.

3. The documents and things attached to this certification, numbering 35 pages, constitute true, correct, and complete photocopies of all medical records maintained by Robert Friedman, M.D. concerning Mr. Copp, as of the date of this certification.

FURTHER AFFIANT SAYETH NAUGHT.

Robert D. Friedman MD

Medical Records Custodian

On March 7th, 2003, Robert D. Friedman personally appeared before me and, having been first duly sworn, signed the foregoing instrument.

[signature]
Notary Public

July 23, 2003
My commission expires:

Robert D. Friedman, M.D.
1264-B Rodeo Rd.
Santa Fe, N.M. 87505

Telephone (505) 438-4848

2/10/03

Re: Doug Copp

To Whom It May Concern:

Doug Copp is a 51-year-old patient referred to me for the evaluation and treatment of heavy metal toxicity and chemical exposure sustained during the time he spent as a rescue worker at the 9/11 World Trade Center disaster. During the two weeks he spent at the rescue operations a significant proportion of that time was spent in the underground portions of the trade center. His exposures included contents from ruptured sewage lines, smoke and dust residues from burnt remains of plastics, building materials, jet fuels and other xenobiotics.

He began experiencing respiratory symptoms almost immediately while working at the rescue including cough and shortness of breath. These symptoms have continued to the present time. In addition, severe chronic and persistent debilitating fatigue has restricted his activities to a minimal level. Mental symptoms included depression, memory loss, disorientation, brain fog, difficulty focusing, aphasias and reduced ability to problem solve.

A thorough evaluation by Mr. Copp's primary physician, Timothy Smith, M.D. revealed the following diagnoses:

1. World Trade Center cough and syndrome
2. Reactive airways dysfunction syndrome
3. Hypersensitivity pneumonitis

4. Immunotoxicity secondary to xenobiotic exposure
5. Allergic respiratory hypersensitivity
6. Upper respiratory allergies
7. Asbestosis
8. Fractured lumbar vertebrae
9. Lower extremity pain, numbness and paresthesias
10. Lowered adrenal reserve
11. Steroid induced adrenal atrophy
12. Post-traumatic stress disorder
13. Hypothyroidism
14. Hypertension

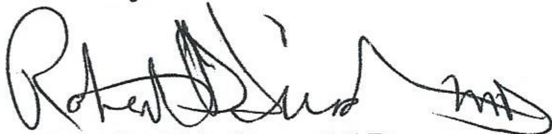
Since there was toxic exposure, which was probably responsible for many of Mr. Copp's symptoms, a heavy metal challenge test using EDTA (a heavy metal chelator) was performed on 12/27/02. The results revealed an increase of lead 15 times the upper limit of normal, and an increase in bismuth 30 times the upper limit of normal. Other milder elevations included arsenic, cadmium and gallium. A previous hair analysis for heavy metals from 10/8/02 revealed increases in barium, cadmium, lead, mercury, nickel and antimony.

Inhalation of lead dusts and transdermal absorption of organic lead salts was the presumed mode of exposure. While temporarily carried in the bloodstream, lead is at least 90% bound to erythrocytes, however only 2% or less of total body lead remains in the blood. Lead primarily deposits and accumulates in the aorta, liver, kidneys, adrenal and thyroid glands, bones and teeth. As noted by Dr. Smith, Mr. Copp has endocrine and immunological impact, which may have been exacerbated or caused by this exposure. This element also interferes with membrane functions, bonds to sulfhydryl, phosphate, hydroxyl and amino sites on proteins and enzyme cofactors, and interferes with heme synthesis, iron transport, erythrocyte lifespan and hepatic cytochrome P-450 functions. These increased lead levels may have affected Mr. Copp's liver detoxification system and been responsible for the chronic nature of his illness. Other deleterious effects, which Mr. Copp exhibits, include peripheral neuropathy and hypertension. Anemia, neuropathies and encephalopathy are end-stage conditions of severe lead excess. Sources of lead exposure include paint, gasoline additives, soldered joints in water systems, building materials, plumbing, batteries, glass, metal alloys, ceramic glazes and sewage sludge. All of these substances were present in Mr. Copp's exposure.

Sources of bismuth exposure include low-melting temperature alloys in fuses, automatic fire sprinklers and solders, paints, semiconductors, electronic components, batteries, and metal castings. All of these compounds were present in Mr. Copp's exposure. Binding to sulfhydryl sites and enzyme inactivation may occur. Symptoms of bismuth excess include decreased appetite, general malaise and weakness, rheumatic pains and dermatitis.

Many of the symptoms, which Mr. Copp has expressed over the last 18 months, are consistent with heavy metal and chemical toxicity and the toxins impact on endocrinological and immunological systems. Because of this probability, Mr. Copp was started on as series of chelation, oxygenation and anti-oxidant treatments given intravenously. An initial six-hour post EDTA urine collection was performed for heavy metal analysis as noted above. These levels will be followed periodically to assess the progress of detoxification. Treatments were initially given 3- 4 times per week (alternating chelation and anti-oxidant IVs) and will be tapered down as lab results and clinical improvement dictates. I would expect Mr. Copp to require treatments two times per week for the next six months, with periodic tune-ups every three to six weeks for an additional one to two years. Projected costs will range from $40,000 to $50,000.

Sincerely,



Robert D. Friedman, M.D.

Treatment Record

12/26.02 to 02/27/03

Treatment Record

Patient: Doug Copp

D.O.B.: ___/___/___ **Date of 1st Treatment:** 12/26/02

Date	Ozone	EDTA	Glutathione	Vit. C Drip	Mineral I.V.	Other	Progress
1/14	125	2	1400				
1/16	125		1400	25			
1/17	125	2	1400				
1/20	125	2	1400				
1-21	125		1400	25			
1-27	125		1400	25			
1-28	125		1400	25			
2-19	AH [illegible]		1400	25			Took Glut for inhalation 50
2-24	AH [illegible]		1400	25			

COMMENTS: 2/7 - 202.71 2/14 - 145.10

Robert D. Friedman, MD

Treatment Record

Patient: Doug Copp

D.O.B.: ___/___/___ **Date of 1st Treatment:** 12/26/02

Date	Ozone	EDTA	Glutathione	Vit. C Drip	Mineral I.V.	Other	Progress
12/26	125	2gm 260	900mg 360			Glutathione 30cc to use in nebulizer TID	50cc
12/27	125			25g 206			
12/30	125	2gm	1400mg				Doing well c Glutath in nebulizer
1/2/03	125		1400mg	25g			
1-4-03	125	2gm					212.28
1-6-03	125		1400mg	25gm			305.13
1-7-03	125	2gm	1400mg				298.73
1-9-03	125		1400	25g			305.13
1-10	125	2gm	1400				298.73
1-13	125		1400	25g			305.13

COMMENTS: ______________________________

Robert D. Friedman, MD

Treatment Record

Patient: Doug Kepp

D.O.B.: ___/___/___

Date of 1st Treatment: ___/___/___

Date	Ozone	EDTA	Glutathione	Vit. C Drip	Mineral I.V.	Other	Progress
2/7/03			1400	25	full		
2/14			1400	25		Lipoic 600mg	
2/27				25			

COMMENTS: ____________________

Robert D. Friedman, MD

Medical History

Robert D. Friedman, MD
1264-B Rodeo Rd.
Santa Fe, NM 87505
Tel: 505-438-4848

DATE: Dec 26 | 2002

NAME: DOUG COPP DATE OF BIRTH: Aug-09 51

HEIGHT: 5' WEIGHT: 9½" [lost 1½" since injuring my spine at WTC

RESIDENCE: 27 Sumption Rd CITY: Sandia Park STATE: NM ZIP: 87047

MAILING ADDRESS: PO Box 534 CITY: Sandia Park STATE: NM ZIP: 87047

PHONE: H 505 281-7977 W 281-7877 FAX: 281-7877 CELL PHONE:

E-MAIL: amerrescue@aol.com

SOCIAL SECURITY # 046-46-1692 OCCUPATION: Rescue Chief / ARTI

MARITAL STATUS: S (M) D W PARTNER: Paulina Copp

IN CASE OF EMERGENCY, NOTIFY: PAULINA COPP PHONE: 505 281-7877

ADDRESS: 27 Sumption Rd. Sandia Park NM, 87047

HOW DID YOU HEAR ABOUT US?

FRIEND.

PAYMENT IS EXPECTED AT THE TIME OF YOUR VISIT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

AS A COURTESY TO OUR ALLERGY PATIENTS, PLEASE REFRAIN FROM WEARING ANY SCENTED PRODUCTS WHILE VISITING THIS OFFICE. YOUR COOPERATION IS APPRECIATED.

History of Present Illness

Please list the symptoms for which you are seeking help:

Toxic Exposure at WTC

Give a brief history of these problems including how long they have troubled you:

See 16 page report of 'medical summary' prepared by Dr. Tim Smith.

What treatments have you recently received for the above problems? (Please include physicians names and specialty, medications, diagnostic procedures):

DR Garcia, (Primary); DR. Tim Smith (Primary-Toxicology), DR VOJDANI (immunologist), DR HINDS (ANNATHESIOLOGIST - 2 spinal procedures) DR Eisner (Pulmonary Specialist, DR Hu (ORTHOPEDIC SURGEON) - 3 other

Have you ever been hospitalized? Please describe:

Respiratory Attack Date: Sept 30 th

Chest pains (not heart attack but respiratory complications) Date: - Oct

Date:

Are there any past medical problems for which you have been successfully treated?

Prior to WTC - I was in excellent health.

Comments:

I was very energetic, robust, adventures and 'full of life' prior to WTC. Since then I have been very sick; in constant pain and multiple symptoms.

Please reference and supply the following indicators:

1 = mild (monthly) 2 = moderate (weekly) 3= severe (daily)

SKIN

- ____ Urticana
- ____ Eczema
- 2 Rash
- 2 Hives
- 2 Acne
- 3 Itching
- 2 Redness

Comments: infections continuous - immune system weak

CARDIOVASCULAR

- ____ Rapid heart
- ____ Palpitations
- ____ Skipped beats
- ____ Extrasystoles
- 3 Hypertension
- ____ Hypotension
- ____ Fainting spells

Comments: Hypertension from overwork other organs damaged.

NEUROLOGICAL

- 2 Restless
- ____ Nervous
- 2 Mental Confusion
- ____ Depression
- ____ Irritability
- ____ Lethargy
- 3 Undue fatigue
- 3 Abnormal sleepiness
- ____ Insomnia
- ____ Amnesia
- ____ Learning disability
- ____ Behavior problems
- ____ Phobia / panic reaction
- 3 Numbness
- 3 Tingling
- ____ Flushing
- ____ Chilling
- 2 Sweating spells

Comments: lot of pain, very tired

EYES, EARS, NOSE, THROAT

- 3 Headache
- 2 Dizziness
- 2 Vertigo
- 2 Unsteadiness
- ____ Floating
- ____ Lightheaded
- ____ Ear Noises
- ____ Deafness
- 3 Blocked ears
- ____ Crusting ears
- ____ Draining ears
- 2 Blurred vision
- ____ Watering eyes
- ____ Photophobia
- ____ Edema of eyelids
- ____ Itching palate
- ____ Rhinorrhea
- ____ Post nasal drip

Comments: frequent drug interactions

RESPIRATORY

- ____ Dyspnea 2.
- ____ Hoarseness
- ____ Laryngeal edema
- 3 Dry cough
- 2 Productive cough
- 2 Wheezing
- 3 Bronchitis
- 3 Sinusitis
- 2 Sore throat
- 3 Respiratory infection

Comments: 10 types of fungus in lungs, lungs lining burned, WTC syndrome.

MUSCLE - JOINT

- 3 Swollen joints
- ____ Muscle cramps
- 3 Weakness in limbs
- ____ Stiff joints
- ____ Leg aches
- ____ Arthritis

Comments: spine fractured, partial paralysis, swollen.

Robert D. Friedman, MD

SLEEP

___ Muscle twitching	___ Very light	___ Disturbing dreams
✓ Awaken tired	✓ Heavy	___ Dreamless
___ Insomnia	___ Difficulty falling asleep	✓ Frequent wakening
___ Narcolepsy	___ Difficulty staying asleep	___ Medication
✓ Snoring	___ Restless	___ Other

Comments: Become very tired and must sleep - Everyday I become as tired as if I hadn't slept for 3 days.

ENERGY

✓ Low (___ constant ___ intermittent)	___ Listless mental /physical
___ High	___ Lack of drive (✓ recent ___ always)
✓ Exhaustion, not refreshed by sleep	___ Listless (___ during ___ after exercise)
✓ Fatigue (___ during ___ after exercise) NONE	___ Other

Comments: I need to be high energy now I am always exhausted.

CRAVINGS

___ Water	___ Tobacco
___ Sweets and chocolates	___ Salt
___ Coffee or Tea	___ Sugar
___ Bread	___ Other None
___ Alcohol	

FAVORITE FOODS

Bacalao, posole, Turkey, paella, DONAIR, FISH & CHIPS,

Comments: I don't eat red meat, sugar, processed foods, I eat a lot of vegetables, fresh foods, non chemical - NO preservatives. I take supplements every day.

SUBCLINICAL HYPOTHYROID SYNDROME

- ✓ Increase in weight
- ____ Decreased appetite
- ✓ Fatigue easily
- ____ Ringing in ears
- ✓ Sleepy during day
- ____ Sensitive to cold
- ✓ Dry or scaly skin
- ____ Constipation
- ✓ Mental sluggishness
- ____ Hair coarse, falls out
- ____ Headaches upon rising, wear off during day
- ____ Slow pulse, below 65
- ✓ Frequency of urination
- ✓ Impaired hearing
- ____ Reduced initiative
- ✓ Failing memory

Comments: take thyroid medicine daily.

SUBCLINICAL HYPOADRENAL SYNDROME

- ✓ Weakness, dizziness
- ✓ Chronic fatigue
- ____ Low blood pressure
- ____ Nails weak, ridges in nails
- ____ Tendency to hives
- ____ Arthritis tendencies
- ____ Perspiration increase
- ____ Intestinal trouble
- ____ Circulation poor
- ✓ Kidney trouble (edema)
- ____ Crave salt
- ✓ Allergies, tendency to asthma
- ____ Weakness after colds, influenza
- ✓ Exhaustion, muscular and nervous
- ✓ Respiratory disorders
- ✓ Legs feel tired

Comments: see above.

HYPOGLYCEMIA SYNDROME

- ____ Inward trembling
- ____ Irritable before meals
- ____ Sweating spells
- ____ Craving for sweets
- ✓ Can't get started in morning, need coffee
- ____ Drink ___ cups of coffee daily
- ____ Eat often or get hunger pains / faintness
- ____ Eat when nervous
- ____ Eating relieves fatigue and tiredness
- ____ Faintness if meals delayed
- ✓ Lack energy or energy drive
- ____ Insomnia
- ____ Moods of depression, blues, melancholy
- ✓ Chronic fatigue
- ____ Crave coffee or candy in afternoon
- ____ Cry easily for no reason
- ____ Get shaky if hungry
- ____ Heart palpitations
- ____ Highly emotional
- ____ Sleepy during the day
- ____ Sleepy after meals

Comments: ____________

CANDIDA SYNDROME

- ____ History of antibiotics
- ____ History of birth control pills
- ✓ History of steroids (for asthma)
- ✓ History of athletes' foot, ringworm
- ✓ Fatigue / lethargy
- ✓ Poor memory
- ____ Spacy
- ____ Abdominal pain, constipation
- ✓ Bloating
- ____ Vaginal discharge
- ____ Prostatitis, impotence
- ____ P.M.S.
- ____ Endometriosis
- ✓ Decreased sexual drive / desire
- ✓ Drowsiness
- ____ Irritability, mood swings
- ✓ Headache
- ✓ Poor concentration
- ____ Depression

Comments: have 10 different fungus and yeasts in lungs.

PSYCHOLOGICAL STRESS INDEX

____ Frequently keyed up and jittery
____ Go to pieces easily over little things
____ Constantly worried about health
____ When nervous ___ perspire, ___ feel light-headed, ___ hyperventilate
____ Extremely shy or sensitive, uncomfortable with strangers or new situations
____ Misunderstood by others; feel victimized by by:
___ friends, ___ family, ___ associates
✓ Feelings of hostility and anger on many occasions – towards WTC Bureaucracy
✓ justified ___ without apparent cause, ___ inner driven
____ Easily flare to anger:
___ then it passes ___ hold onto it ___ continue to rage
____ Consistent irritability
___ friends, ___ employees/workers ___ family
✓ Unable to perform work ✓ at home ✓ on the job ___ distractability ✓ fatigue
✓ concentration problems ✓ memory problems
____ Addiction difficulties
___ illicit drugs ___ prescription drugs ___ alcohol ___ food ___ past ___ present
____ Family difficulties with: ___ spouse ___ parents ___ children ___ other ________
___ past ___ present
____ Depression ___ sadness ___ cry easily ___ disappointment ___ self blame
___ suicidal thoughts ___ feel and look unattractive ___ sleep too much
___ get up early, insomnia ___ no appetite
____ Feel insecure about life
____ Fearful, expect the worse ___ panic attacks ___ phobic traits
____ Hyperactive
____ Hallucinations ___ drug induced ___ hospitalized

LIFE STRESS INDEX	LAST 6 MONTHS	WITHIN LIFETIME	IN NEAR FUTURE
____ Death of spouse			
____ Death of child			
____ Divorce			
____ Jail			
____ Death of family member or close friend			
____ Personal injury			
____ Marriage			
____ Loss of employment			
____ Pregnancy			
____ Sexual difficulties			
____ Financial reversals / gains			
____ Residence change / moving			

have experienced more stress than imaginable.

Comments: Have counselled individuals with Post Disaster Stress Syndrome. Even our team psychologist cracked after 2 major disasters. I have worked more than 100. I find strength in my own courage and faith in God to maintain sanity and

Robert D. Friedman, MD

GASTROINTESTINAL	GENITO - URINARY

- ___ Canker Sores
- ✓ Nausea
- ___ Vomiting
- ✓ Indigestion
- ✓ Flatus
- ___ Abdominal cramps
- ✓ Diarrhea
- ___ Nervous stomach
- ___ Irritable bowel
- ___ Mucous colitis
- ___ Ulcerative colitis
- ___ Constipation
- ✓ Bloating

Comments: am taking many medications

- ___ Premenstrual tension
- ___ Premenstrual cramps
- ___ Heavy flow
- ___ Scant flow
- ___ Irregular menses
- ___ Vaginal itch / burn
- ___ Vaginal discharge
- ___ Burning on urination
- ___ Impotency
- ___ Enuresis
- ___ Incontinence
- ✓ Frequency
- ___ Dysuria
- ___ Nocturia

Comments: defacate 6 times per day urination 5 - 9 times per day

ALLERGIES

- [ ] Animals
- [ ] Pollens
- [x] Molds
- [ ] Aerosols
- [x] Perfumes
- [ ] Air conditioning
- [x] Auto exhaust
- [x] Industrial / Chemical
- [x] Foods
- [ ] Sugar
- [ ] Wine and alcohol
- [x] Food additives
- [x] Milk products
- [x] Antibiotics (penicillin)
- [ ] Aspirin
- [x] Asthma
- [ ] Allergic Rhinitis
- [ ] Urticania (hives)
- [ ] Conjunctivitis
- [ ] Other

ALLERGY SYMPTOMS

Have you been previously tested and treated? heightened due to collapse of immune system

Shots? ______ How long? Since WTC Physician: DR Tim Smith.

My head inflammed 9 times with temples bulging and head turning red.

Is your allergy condition:

- [x] constant
- [ ] seasonal
- [ ] only indoors
- [ ] only outdoors
- [x] both indoors and outdoors
- [x] food related
- [ ] immediately after meals
- [ ] delayed up to 24 hours

Is there one worse season? Summer - the heat draws the toxi from my body fat. - much harder to heal

ALLERGIC CONDITIONS:

Hay fever: Describe: ______

Skin: Describe: pimples on head and neck under hair.

Asthma: Describe: like symptoms from multiple respiratory problems.

Sneezing / runny nose: Describe: ______

Gastrointestinal: Describe: heart burn constant for month on end after WTC.

Neurological (i.e. headache, sleepiness, etc.): Describe: had splitting headache for 11 weeks, frequent headaches (none prior to WT[illegible]

Comments: Very Sick with multiple symptoms and multiple medical problems.
I am determined not to be self-pitying or depressed. I am complete

Medications presently in use and / or treatment used in past 6 months

Name of Medication	Name of Medication
✓ Antacid	___ For Heart Disease
✓ Antibiotic	___ For Cholesterol
___ Antispasmodic	___ For Cancer
___ Laxative / Cathartics	___ For Tuberculosis
___ Antihistamine	___ Cough/Cold Medication
___ Muscle Relaxant	___ For Ulcers
___ Tranquilizer	✓ For liver
✓ Nasal Decongestant Steroid)	✓ For Thyroid
✓ Pain pill/Analgesic	✓ For Blood Pressure
___ Aspirin	___ Cortisone
✓ Anticonvulsant	___ Contraceptive Pill
✓ B-12 Injection	✓ Anti-Inflammatory
✓ Steroids	___ Hormone Pill
___ Sedative	✓ Asthma Medication
___ Sleeping Pill	___ Potassium Chloride
___ Antidepressant	___ For Hypoglycemia
___ Stimulant	___ Chemotherapy
___ Diet / Weight Pill	___ Radiation
___ Water Pill / Diuretics	___ Other

Vitamins and other supplements presently used:

See attached list.

Comments: At maximum point taking 127 capsules, pills, tablets, powders, inhalants and drops prescribed doses per day

Robert D. Friedman, MD

SMOKING

___ Yes. How much? ___________ How long?

✓ No

ALCOHOL

___ Yes. How frequently? ___ Daily, quantity ______ ___ weekly.

___ Social drinking (Monthly or less) ___ Only with meals

___ wine ___ beer ___ spirits

___ no

___ Treatment for drinking problem: ___ past ___ present

Comments: I am drinking almost nothing - due to liver and fungal problems.

ACTIVITY & EXERCISE:

✓ Sedentary life style. Describe: None, breathing and moving difficulties.

✓ Walking: Describe: for many months, could walk no further than 10-20 ft.

___ Gym: Describe: ___________

___ Sports: Describe: None.

Comments: I am in constant pain and become out of breath (even from sitting or eating).

HISTORY OF WEIGHT PROBLEMS

Record in space for how long.

___ Gain and / or lose at least 3-4 lbs. in one day.

___ Weight control needed constantly

___ Difficult to control despite calorie counting

___ Compulsive eating (especially under emotionally stressful situations)

___ Underweight always

___ Overweight always (as child, adolescent, adult)

___ Cholesterol problems. On medication

___ Bulimia (secretive, have had treatment)

___ Anorexia (hospitalized)

___ Fluid retention

___ Frequent dieting

Comments: Have gained 50-60 lbs since WTC Injuries.

Family History

Father:

If alive, age: ________ Health problems (check below)

If deceased, age at death: 29 Cause of death: Brain Tumour

Mother:

If alive, age: 73 Health problems (check below)

If deceased, age at death: ________ Cause of death: ________

Brothers:

Ages: 41 – 58 Health problems (check below)

Sisters:

Ages: None Health problems (check below)

FAMILY ILLNESSES (Mark P for parents, mark GP for grandparents & S for sibling)

_____ allergies
_____ psoriasis
GP eczema
_ bronchitis
_ obesity
_____ asthma
_____ thyroid (high __ low __)
_____ alcoholism
_____ stroke
_____ heart attack
_____ high blood pressure
_____ ulcerative colitis
_____ Chron's disease
_____ cancer
_____ hypoglycemia

S diabetes
_____ chronic headaches
_____ severe migraines
_____ drug addiction
_____ excessive medication
_____ epilepsy
_____ violent episodes
_____ arthritis
_____ gout
_____ rheumatism
GP nervousness
_____ depression
_____ mental breakdown w / hospitalization
_____ schizophrenia
_____ other

Comments: My grandmother was nervous, my mother overweight.

DR Friedman's Bill
(on his form)

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Copp, Doug

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

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13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 854
2. 985
3. 957
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.	A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	12 26 02				90780	IV therapy		330 73					
2	12 27 02				90780	"		219 78					
3	12 30 02				90780	"		298 73					
4	01 02 03				90780	"		305 13					
5	01 04 03				90780	"		213 38					
6	01 06 03				90780	"		305 13					

25. FEDERAL TAX I.D. NUMBER SSN EIN: 555240545 [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 1672 88

29. AMOUNT PAID $

30. BALANCE DUE $ 1,672 88

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED [signature] MD DATE 2/25/03

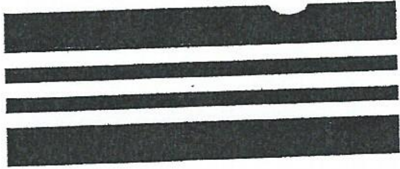
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Robert Friedman MD
1264 B Rodeo Rd
Santa Fe, NM 87505

PIN# GRP#

PLEASE DO NOT STAPLE IN THIS AREA



APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Copp, Doug

3. PATIENT'S BIRTH DATE MM DD YY — SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse / Child / Other

7. INSURED'S ADDRESS (No., Street)

CITY — STATE

8. PATIENT STATUS: Single / Married / Other; Employed / Full-Time Student / Part-Time Student

CITY — STATE

ZIP CODE — TELEPHONE (Include Area Code) ( )

ZIP CODE — TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M F

b. AUTO ACCIDENT? YES NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 964
2. 985
3. 987
4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.	A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	01 09 03						298 93					
2	01 09 03						305 13					
3	01 10 03						298 93					
4	01 13 03						305 13					
5	01 14 03						298 93					
6	01 16 03						305 13					

25. FEDERAL TAX I.D. NUMBER: 585 24 0545 — SSN EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $1,811 58

29. AMOUNT PAID $

30. BALANCE DUE $1,811 58

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

[signature] MD 2/25/03

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

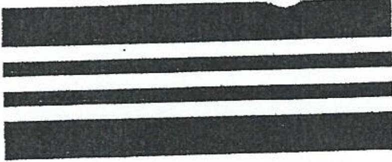
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Robert Friedman MD
1264 B Rodeo Rd
Santa Fe, NM 87505

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

PLEASE DO NOT STAPLE IN THIS AREA



APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Copp, Doug

3. PATIENT'S BIRTH DATE MM DD YY — SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ — Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ________ DATE ________

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ________

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15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 984
2. 985
3. 987
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 17 03				90780 IV therapy		298 73					
2 01 20 03				90780 "		298 73					
3 01 21 03				90780 "		305 13					
4 01 27 03				90780 "		305 13					
5 01 28 03				90780 "		305 13					
6 02 07 03				90780 "		202 71					

25. FEDERAL TAX I.D. NUMBER: 585 240545 — SSN ☒ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $ 1,118 10

29. AMOUNT PAID $

30. BALANCE DUE $ 1,118 10

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED [signature] MD DATE 2/25/03

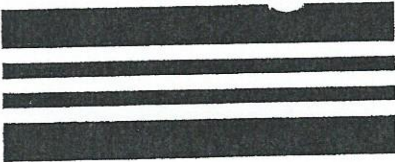
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Robert Friedman MD
1264 B Rodeo Rd
Santa Fe, NM 87505

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500



PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

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5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ / Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM | DD | YY — SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM | DD | YY — SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes,* return to and complete item 9 a-d.

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16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM | DD | YY TO MM | DD | YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM | DD | YY TO MM | DD | YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

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2. 985
3. 987
4.

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02 14 03				90780 IV therapy		145 10					
02 19 03				90780 IV "		251 78					
02 24 03				90780 IV "		198 44					
02 24 03				99070 supplies		317 93					

25. FEDERAL TAX I.D. NUMBER SSN EIN: 585 24 0545 ☒ SSN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $ 888 30

29. AMOUNT PAID $

30. BALANCE DUE $ 888.30

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED [signature] DATE 2/25/03

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33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Robert Friedman MD
1264 B Rodeo Rd
Santa Fe, NM 87505

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

O2 Prescription

Robert D. Friedman, M.D
Spiral-Chi & Yogaia Wave Medicine
Post Office Box 5054
Santa Fe, New Mexico 87502
tel 505-982-1682

Doug Copp

Rx

Date: 4/1/03

Please refill pts. O_2 tanks

Dx: Pneumonitis

Run @ 2 L/m prn

DEA# BF6854889
NM License# 84-182

Refills PRN R Fried MD