note cross ref file
West Florida Reg'l Hpt

FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

8704729

See 8704728

DEPARTMENT FILE NO. _____
INSURER'S CLAIM NO. 2060 M 8605

BUREAU OF RATES

1. PRIMARY INSURER NAME: Par Hcon Ins Co INSURER CODE: 4,6,1,4,2 (See Table A)

2. EXCESS INSURER NAME: _____ INSURER CODE: _____ (See Table A)

3. INSURED'S NAME: Medical Ct Clinic (Dr. Louis J. Perillo) License #: 35557
(Last Name, First and Middle Name)

STREET ADDRESS: 8333 N. Davis Highway

CITY, STATE: Pensacola FL ZIP: 32514 COUNTY CODE: 09 (See Table B)

4.	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	HPL 086	$ 10,000,000 .00	$ 30,000,000 .00
EXCESS INSURER :	_____	$ _____	$ _____

5. Is the insured physician a **Foreign Medical Graduate?** If yes, enter the **country** in which primary medical educatio was received: _____

___ (01) Yes
✓ (02) No

6. **PROFESSION OR BUSINESS:** (Check one)
___ (01) Physicians & Surgeons
___ (02) Hospitals
___ (03) Podiatrists
___ (04) Other Medical Professionals
✓ (05) Clinics
___ (06) Ambulatory Surgical Centers
___ (07) Other Health Care Facilitie

7. **SPECIALTY CODE:** 8,0,2,4,9 (See Table C) (Applies to physicians, surgeons, and other health care professionals. Use ISO Common Statistical Base Classification Codes.)

8. **BOARD CERTIFICATION:** (Check one)
___ (01) In specialty coded in Item 7, above.
___ (02) In a different specialty.
___ (03) In the specialty in Item 7 and another specialty. Enter the additional specialty code here: _____ (Table C)
✓ (04) Insured is not board certified.

9. **PLACE WHERE INJURY OCCURRED:** (Check one)
✓ (01) Hospital Inpatient Facility
___ (02) Emergency Room
___ (03) Hospital Outpatient Facility
___ (04) Nursing Home
___ (05) Physician's Office
___ (06) Patient's Home
___ (07) Other Outpatient Facility
___ (08) Other Location
___ (09) Other Hospital/Institution

10. If Place of Injury (above) is checked as (8) Other, then provide a description of the place where the injury occurred: _____

11. NAME OF INSTITUTION: West Florida Hpt **INSTITUTION CODE:** 1,0,0,2,3,1 (See Table D)

12. **LOCATION OF INSTITUTIONAL INJURY:** (Check one)
___ (01) Patient's Room
___ (02) Operating Suite
___ (03) Recovery Room
___ (04) Labor & Delivery Room
___ (05) Physical Therapy Dept.
___ (06) Nursery
___ (07) Critical Care Unit
___ (08) Special Procedure Room
___ (09) Radiology
___ (10) Emergency Room

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13. **DATE OF OCCURRENCE:** 7,5,86

DATE REPORTED TO INSURER: 10,14,86

14. **INJURED PERSON'S AGE:** 40 Years (If less than one year, then enter 01)

INJURED PERSON'S SEX: (F) (Circle one)

14.1 **INJURED PERSON'S NAME** [redacted]

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: (LEAVE BLANK)

depression & suicidal ideation — 15.

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: 16.

eloped from treatment center

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: 17.

committed suicide

18. DESCRIBE THE OPERATION, DIAGNOSTIC OR TREATMENT PROCEDURE CAUSING THE INJURY. USE NOMENCLATURE AND/OR DESCRIPTIONS OF THE PROCEDURES USED. INCLUDE METHOD OF ANESTHESIA, OR NAME OF DRUG USED FOR TREATMENT, WITH DETAIL OF ADMINISTRATION: 18.

eloped from center, alleged failure to adequately diagnose seriousness of condition

19. DESCRIBE THE PRINCIPAL INJURY GIVING RISE TO THE CLAIM. USE NOMENCLATURE AND/OR DESCRIPTIONS OF THE INJURY. INCLUDE TYPE OF ADVERSE EFFECT FROM DRUGS WHERE APPLICABLE: 19.

death

20. **SEVERITY OF INJURY:** (check only one -- rate most serious injury if several are involved.)

___(01) Emotional only - Fright, no physical damage.

___(02) Insignificant - Lacerations, contusions, minor scars, rash. No delay.
Temp- ___(03) Minor - - - - - Infections, misset fracture, fall in hospital. Recovery delayed.
orary ___(04) Major - - - - - Burns, surgical material left, drug side effect, brain damage. Recovery delayed.
___(05) Minor - - - - - Loss of fingers, loss or damage to organs. Includes nondisabling injuries.

Perma- ___(06) Significant - - Deafness, loss of limb, loss of eye, loss of one kidney or lung.
nent ___(07) Major - - - - - Paraplegia, blindness, loss of two limbs, brain damage.
___(08) Grave - - - - - Quadraplegia, severe brain damage, lifelong care or fatal prognosis.
X (09) Death

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21. **DATE OF SUIT, IF ANY:** 2/1/87

22. LIST OTHER DEFENDANTS INVOLVED IN THIS CLAIM, THE INSURER'S NUMBER AND THE COMPANION CLAIM FILE ID NUMBER:

	DEFENDANT'S NAME (Last Name, First Name)	INSURER CODE NO.	INSURER FILE ID.
1)	West Florida Medical Center	46140	60-PL 86-0466
2)			
3)			
4)			
5)			

(* Note Report is sent on cross ref file w Fl. Hosp)

23. WAS PLAINTIFF REPRESENTED BY AN **ATTORNEY?** (Check one)
___(01) Yes ✓(02) No

24. **DATE OF FINAL CLAIM DISPOSITION:** 10/1/87

25. **FINAL METHOD OF CLAIM DISPOSITION:**
✓(01) Settled by parties.
___(02) Disposed of by a court.
___(03) Disposed of by arbitration.

26. **SETTLEMENT:** (Check one)
___(01) Within the presuit period as set forth in Section 768.57, Florida Statute (usually within 90 days).
___(02) After arbitration is initiated or prior to suit being filed.
___(03) Within 90 days of suit being filed.
✓(04) More than 90 days after suit is filed and prior to or during the course of mandatory settlement conference.
___(05) Prior to completion of the swearing of the jury.
___(06) Prior to filing of the notice of appeal.
___(07) After notice of appeal is filed or post-judgment relief or action is required for recovery.
___(08) During appeal.
___(09) After appeal.
___(10) Claim or suit abandoned.

27. **COURT:** (Check one)
✓(01) No court proceedings.
___(02) Directed verdict for plaintiff.
___(03) Directed verdict for defendant.
___(04) Judgment notwithstanding the verdict for the plaintiff.
___(05) Judgment notwithstanding the verdict for the defendant.
___(06) Judgment for the plaintiff.
___(07) Judgment for the defendant.
___(08) Judgment for the plaintiff after appeal.
___(09) Judgment for the defendant after appeal.
___(10) Other.
___(11) Summary judgment for the plaintiff.
___(12) Summary judgment for the defendant.

28. **ARBITRATION:** (Check one)
✓(01) Claim not subject to arbitration.
___(02) Claim subject to arbitration, but previously coded disposition reached in lieu of award.
___(03) Award for plaintiff.
___(04) Award for defendant.

29. WAS THERE AN ITEMIZED **VERDICT** UNDER FLORIDA STATUTE 768.48? (Check one)
___(01) Yes ✓(02) No (If yes, please attach copy of settlement or verdict.)

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30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: - $ 96,995 [illegible] .00

31. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: - - - - - - - - - - - - - - - - - - $ 0 .00

32. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL: - $ 2,550 .00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: - $ 800 .00

34. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: - - - - - - - - - - - - - - - - - - X day

35. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS: - - - - - - - - - - - - - - - - X day

36. INJURED PERSON'S GROSS WEEKLY INCOME: - $ 770 .00

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:

	MEDICAL	WAGE LOSS	OTHER EXPENSES
A) INCURRED TO DATE	$ ____ .00	$ ____ .00	$ ____ .00
B) ESTIMATED FUTURE	$ ____ .00	$ ____ .00	$ ____ .00

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: - $ 96,995 50/.00

39. IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM:

A) PRESENT VALUE OF PERIODIC PAYMENTS - $ ____ .00

B) COST TO THE INSURER OF THE PAYMENTS - $ ____ .00

C) TOTAL EXPECTED PAYMENT TO PLAINTIFF - $ ____ .00

D) DID YOU PURCHASE AN **ANNUITY**? ___ (01) Yes ___ (02) No

See cross ref for details annuity file

40. BRIEFLY DESCRIBE THE STRUCTURED SETTLEMENT INCLUDING HOW IT IS FINANCED:

Physician paid $96,995 & the hospital paid: $13,504.50 (cash)
$277,482.00 (annuity cost)
$290,986.50

41. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: _____

CONTACT PERSON: Pat Wood ADDRESS Box 24179 Nashville TN 37202
TELEPHONE: (800) 251-2561