1.HealthNet Policy Number I038-000-115297991-01 2. Authorization Code:

2.Patient Name Mohamed Mahmoud Mohamed Khafagy

3.Patient Date of Birth & Sex 09-09-89(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0507784520

5.Nature of illness or Injury ☐ Acute ☐ Chronic ☐ Emergency

6.Are You the patient's primary physician ☐ Yes ☐ No

7.Presenting Complaints:

pc: severe pain in back since 1 week,

middle upper back

pt cant sleep well in the night because of pain.

not radiating

no other compalaint

oe: upper pack is tender.no swelling

chest is cear

no cough

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiPain in thoracic spine, Pain, unspecified ICD Code M54.6, R52

12.Etiology:

13.In case of Injury:mode of Injury/place of Injury

14.Plan / Details of Management

a.ProcedureOffice consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patients and/or familys needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.,CLOFEN ,Intramuscular injection CPT code9,0005-149902-1021,96372

b.Laboratiry Test:

c.Radiology / Investigations:

15.In Case of Hospitalization: Date of Addmission: Date of Discharge:

16.

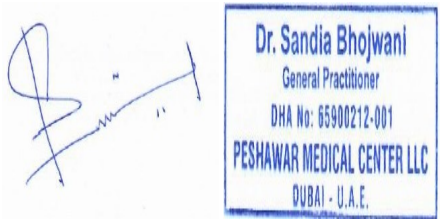
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0003-238003-1451	(DICLOFENAC ACID : 35 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (20S, BLISTER)	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others
2093-596002-0431	(DICLOFENAC DIETHYLAMINE : 23.2 MG / G GEL	GEL (50G, TUBE	10	Take 1Tablets 1 Time(s) per Day For 10 Day(s) others

Date: 07-02-25(dd/mm/yy)

Doctor's Name SANDIA

Signature and Stamp



Physician Code DHA-P-65900212 HNM Code

Authorization

I hereby authorize the Physician, Hospital or Pharmacy to file a claim for medical services on my behalf and I confirm that the above mentioned examination / investigation / therapy is given to me by the doctor. I hereby authorize any Hospital, Physician, Pharmacy or any other person who has provided medical services to me or my dependents to furnish NGI with any and all information with regard to any medical history, medical condition or medical services and copies of all medical and hospital records.

A Photocopy or teletax copy of this authorization shall be considered effective any valid as the original

Date: 07-02-25(dd/mm/yy) Signature of Insued / Claimint

NATIONAL GENERAL INSURANCE CO. (P.J.S.C)
NGI House Building, P.O. Box 154, Deira, Dubai, Tel: +971 4 211 5800, Fax: +971 4 250 2854, Email: ngico@emirates.net.ae, Website: www.ngi.ae