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PERSONAL INJURY ▪ FAMILY LAW ▪ CRIMINAL DEFENSE ▪ BUSINESS MATTERS

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September 3, 2010

Via Certified Mail Return Receipt
No.: 7009 0080 0002 2564 9981

Amanda Ibarra
Liberty Mutual / Wausau Insurance
P.O. Box 168328
Irving, Texas 75016-8328

Re:	**Our Client**	**:**	**Jane Doe**
	Date of Injury	**:**	**December 13, 2009**
	Your Insured	**:**	**Restaurants Acquisition I, L.L.C. (d/b/a Black-Eyed Pea)**
	Claim Number	**:**	**P 961-045481-01**

Dear Ms. Ibarra:

In an attempt to resolve the above-referenced claim amicably, our firm hereby submits the following demand on behalf our client:

FACTS

On December 13, 2009, on a very early Sunday evening, Mrs. Jane Doe and her husband John were having dinner in your insured's establishment, i.e., the Black-Eyed Pea restaurant located at 1502 Corsicana Highway, Hillsboro, Texas 76645. Jane and John had been taking care of their 2-year-old grandson, Tom Smith, for the past week, and were meeting up with his parents, Bill and Mary Smith, to return Tom. Bill and Mary live in Frisco, while Jane and John live in Cedar Park, making Hillsboro a good halfway meeting point.

After finishing dinner, our client and the rest of the group headed out of the restaurant between 5:30 and 5:45 p.m. Although there was very minimal light outside, the restaurant's outdoor lights had not been switched on. After walking out the front door, Mrs. Doe had to turn left to walk along the sidewalk parallel to the front of the restaurant, in order to get to her vehicle, a Ford Expedition sport utility vehicle (SUV), which was parked in a handicapped space in front of the restaurant. [Note: as the medical summary below will set forth in more detail, our client had some preexisting disability issues, principally related to her ankles]

While walking along the sidewalk, Mrs. Doe came to the sloped yellow-colored handicap ramp which connected the raised sidewalk with the level of the parking lot pavement. The sloped area extended for approximately 4-5' (four to five feet) horizontally. As she walked

down the sloped and colored ramp, she suffered a very bad fall, caused by the fact that the yellow painted area was extremely slick. The exact mechanism of the fall, as she recalls, was that her left foot slid forward while her right foot slid backward, both feet going out from under her. She came down hard, with the primary impact being taken by her right knee against the hard sidewalk. This was followed by her right foot twisting outward, causing her to fall to her right side, absorbing that fall with her right palm and wrist, and also causing her right ankle to turn and hit the ground.

Our client's son, Bill, was the first to run inside and call for the manager, while the other family members helped her. Our client and her family members all distinctly recall that the first person to come outside was a waitress by the name of Lana. A few moments later, the manager, a lady by the name of Ms. Fatima Creamer, then came outside.

Lana asked Mrs. Doe, "are you all alright?" To this, our client replied, "I don't know. What was this, what did I fall on?" Lana said, "You have to be real careful, it's real slippery here [indicating to the painted ramp]. They're supposed to be coming out and repainting it." It was at this time that the manager, Ms. Creamer, was also outside, and quickly interjected, "no, it's already been repainted. They used the wrong kind of paint the first time. But yeah, it's still real slick."

Bill then asked, in response to that exchange, why this area was not blocked off if the manager knew that the painted surface was still very slippery. Ms. Creamer said she would be calling someone back out to redo the paint.

LIABILITY

Our investigation has revealed that your insured's negligence was the proximate cause of this incident, for several reasons, including but not limited to:

1) As a customer of the restaurant that evening, our client was considered an "invitee" (as that term is defined in Texas law), i.e., someone who enters a business premises at the business's invitation, with the business's consent, and for the mutual benefit of the patron and the business;

2) As an invitee, she was owed the highest duty of care by the premises owner, i.e., to be warned or made safe from any dangerous conditions on the premises which the owner either knew of or, in the exercise of reasonable diligence, should have known of;

3) Your insured breached this duty because the completely spontaneous utterances of both Lana (the waitress) and Fatima Creamer (the manager) clearly establish that there was prior knowledge of a problem with excessive slipperiness of the painted yellow surface on the handicap ramp;

4) If the statement of Lana is taken as true, then there was prior knowledge that the yellow painted ramp was "real slippery" and that workers were supposed to be coming back out to repaint it;

5) Alternatively, if the statement of Ms. Creamer is taken as true, then there was prior knowledge that workers had already been out twice to paint the surface, but it was still "real slick," and furthermore there was a tacit admission by Ms. Creamer that there was a continued problem when, in response to Bill's question, she stated that the workers needed to be called out a third time;

6) Despite all this prior knowledge, especially Lana's statement that, "You have to be real careful here," there was neither any barrier to walking down the handicap ramp, nor even a sign, orange cone, or other type of basic warning placed there to alert customers;

7) Because of the slick nature of the paint, it was clearly foreseeable that someone could slip on the ramp, and as it turns out, it was our client who did indeed slip on it and suffer injury as a result;

8) This negligence was made all the more glaring precisely because this was a handicap ramp, expressly made for people who already have disabilities of some kind and who need extra care taken on their behalf; and,

9) Further negligence exists in the fact that the outside lights of the restaurant were not turned on. In this regard, please note that sunset time in Hillsboro, Texas was 5:24 p.m. (CST) on the date of December 13, 2009 (enclosed with this correspondence is a sunrise / sunset calendar with this information). Accordingly, it was well past sunset time when our client walked outdoors and this incident occurred. Proper lighting may have highlighted the slick-surface nature of the yellow paint. Please refer to the photographs taken by our client's family at the scene, and in particular, the photographs labeled 'untitled' and 'untitled2.' These photographs demonstrate, via the light coming from the car's headlights (after the incident itself), the extremely shiny and slick-surface look of the yellow paint in question. Had the restaurant's own outdoor lights been on, our client may very well have seen this for herself and avoided the ramp.

Furthermore, there is no contributory negligence on the part of our client, nor any outside influences beyond your insured's control, that can be blamed for this incident. In this regard, please note the following:

1) Our client was not wearing slick or otherwise inappropriate shoes for walking down this ramp. Please see the enclosed photographs of the sandals that our client was wearing, which demonstrate good rubber soles with deep treads, to provide more than adequate traction for walking on any inclining or declining surface; and,

2) There was no moisture on the yellow painted surface, either from rain or otherwise. Please see the enclosed weather almanac records, demonstrating that there was absolutely no precipitation in Hillsboro, Texas at any time on December 13, 2009.

Accordingly, we are confident that any jury (if this case should proceed to litigation) will find full liability on the part of your insured.

The injuries caused by your insured's negligence are set forth in detail below:

INJURIES

Mrs. Doe was given bags of ice by Lana that she could use on the ride back home, to numb the pain and swelling in the various areas of her body. On the ride back to Cedar Park with her husband, she noted that her primary areas of injury and pain complaint were:

1) A nasty abrasion on the right knee;

2) A smaller scrape on the right ankle, and swelling of the right ankle;

3) Swelling of the right wrist;

4) Pain and soreness in both hips, from falling down in a "splits" position; and,

5) Pain in her neck and upper back from jerking her head backwards during the fall.

She spent the rest of that night icing those areas, and taking over-the-counter Tylenol for the pain. The next day, she began calling some of her existing doctors in order to make an appointment for her symptoms. At least two different medical clinics told her point-blank that they would not accept her health insurance coverage because this was a third-party liability incident. She did not have the ability to pay 100% out-of-pocket, nor leave bills remaining unpaid that would potentially go to collections. After a couple of days of making calls, she was able to get an appointment with an orthopedic clinic, Orthopaedic Associates of Central Texas. In the meantime, she continued to take Tylenol, and use alternating ice and heat at home. She was aware of her own medical problems and knew that she was (a) diabetic, and (b) had stomach problems that disallowed her from taking anti-inflammatory medications, e.g., Motrin or prescription NSAID's (non-steroidal anti-inflammatory drugs).

On December 18, she presented for a first evaluation to Jay Borick, M.D., an orthopedic specialist with the above-mentioned clinic. She discussed her fall five days prior, in exactly the same manner as described above, and related her chief complaints of pain being right knee and right wrist. You will also note that our client was never the least bit deceptive or withholding as to her prior medical history, all of which she disclosed to her doctors related to this incident.

Prior Medical: As you are entitled to know, and as can be seen from the medical records, our client had the following procedures done in her past:

(1) Two (2) previous right knee arthroscopy procedures, with the most recent one being done well more than 15 years prior to this injury;

(2) An injury causing a displaced right ankle fracture in 2001, which necessitated an open reduction internal fixation (ORIF) procedure, i.e., plate and screws. That hardware was removed approximately a year later after the healing of the fracture. As can be seen in the photographs, the surgical scar remains visible on her right ankle. Some disability remains in her ankle from that healing process.

Mrs. Doe indicated that her right wrist pain was minimal, and right knee pain was virtually non-existent, before suffering this new aggravating injury on December 13. The knee injury in particular was noted by Dr. Borick to be causing her evident distress and causing her to walk with an antalgic gait. Upon examination of the knee, Dr. Borick noted the eschar (i.e., dead tissue) sloughing off and healing (from the abraded skin she suffered in the fall), as well as her tenderness over the medial joint line of the knee. On the right wrist, Dr. Borick noted the well-healed surgical incision on the radial aspect of the wrist. After taking X-ray views, Dr. Borick prescribed her to wear a wrist immobilizer, and apply topical gel in order to provide anti-inflammatory relief for the swelling. He also referred her to do aquatic physical therapy to rehabilitate and strengthen the right knee.

Mrs. Doe began making calls regarding setting up the physical therapy. However, before she could go in, she felt the onset of significantly worse pain in the left hip since this incident. She went back in to see Dr. Borick on December 23, five days after her initial visit. During that visit, she did mention to Dr. Borick that she had suffered the symptoms of trochanteric bursitis in the left hip, years in the past, and had received some steroid injections in the left hip, but had not had such injections or recurrence of symptoms within the last several years. Upon range of motion testing and palpation, Dr. Borick noted that she was suffering tenderness along the left hip (greater trochanter area), and also had pain with external rotation of the hip (which was completely understandable, given the mechanism of her fall into a "splits" position). Dr. Borick opted to administer a steroid injection into the hip at that time to provide relief. He also advised her to continue with her plan to do therapy on the knee, and add exercises for the hip while at therapy. He also had her continue with using the wrist immobilizer for at least another two weeks.

Mrs. Doe presented as scheduled for first physical therapy evaluation and treatment plan, on January 4, 2010, at the St. Bill's Rehabilitation outpatient clinic (Cedar Park), managed and overseen by the Round Rock Medical Center. After taking note of the patient's full surgical and medical history, it was noted that onset date of the most recent medical problems, for which she had been referred to therapy, was December 13, 2009. The primary complaints were of pain, ache, and stiffness in the right knee and left hip. She had limited mobility and decreased strength in those areas. The therapists (Renee Grigar, P.T. and Adriane O'Hara, P.T.) set her up on a reasonable and conservative regimen of therapeutic exercises in water, on land, and in a gym. She was also instructed in a home exercise plan. The treatment plan consisted of some no-impact lap swimming, some targeted stretches of the hip, some resistance-band exercises, and some squats.

Mrs. Doe diligently attended the scheduled therapy sessions over the next 2-3 weeks, and supplemented that with the swimming and the at-home exercise plan. By January 15, she was reporting "much improved" in the left hip, but still in pain and discomfort in the right knee. Some of the exercises had also caused her cervical spine pain to flare-up. She of course had pre-existing issues with herniated discs in the neck, but the fall on December 13 had certainly exacerbated her neck pain. It was noted that her doctor was referring her for a repeat MRI on the cervical spine to investigate further injury.

In fact, it was on January 19 that she went back in for review of her neck issues, to Dr. Richard Wupperman, a spine specialist with the Central Texas Spine Institute (via referral from Dr. Don Davis, who was her primary care provider). Dr. Wupperman noted that she had suffered a fall on December 13, which had badly aggravated her chronic, but previously managed, neck and upper back issues. She had already undergone an MRI of the thoracic spine (January 12), but had not had a repeat cervical spine MRI.

Prior Medical: As you will of course see from her medical records, which we have enclosed, our client had pre-existing problems with her cervical spine, dating back to approximately 1997. She was in a motor vehicle accident in 1997, which caused neck pain and related symptoms, most likely in the form of bulging or herniated cervical disc. In 1997, she underwent some physical therapy and her neck complaints essentially resolved. There was a flare-up of neck symptoms in roughly 2003, during which time she underwent another course of physical therapy. This also provided essential relief. The last time her symptoms flared up (prior to the December 2009 fall) was in early 2008.

She underwent a cervical spine MRI on January 30, 2008, a copy of which is enclosed with this demand packet. She also underwent further physical therapy evaluations in March of 2008 (copies of Select Physical Therapy records also enclosed). She was also referred for some pain management treatment relating to her cervical spine and associated symptomatology (records from Pain Management Consultants enclosed).

Dr. Wupperman recommended her to undergo a repeat MRI of the cervical spine, in order to compare and contrast with her last cervical spine MRI, done in January of 2008. Mrs. Doe underwent the repeat MRI on January 20, 2010. As you can see from comparison of the two MRI's, there are some changes that would be consistent with aggravation of injury by the December 2009 fall. For example, in the January 2008 MRI, it was noted that there was a "small, broad-based disc bulge" at C5-6, with underlying annular tear. However, there was no mention of extrusion of disc material into the thecal space. By contrast, the January 2010 MRI notes, at C5-6, "right paramedian disc herniation which is slightly extruded just below the level of the interspace." As you know, extrusion of disc material makes the problem much more serious, as the material begins coming into direct contact with highly sensitive nerve endings along the spinal cord. Also, in the January 2008 MRI, it was noted that there was another small

broad-based disc bulge at C6-7, with "mild effacement of the ventral thecal sac." There was noted to be only mild central canal stenosis, and very mild left foraminal stenosis associated with that bulge, no significant right foraminal stenosis. By contrast, the January 2010 MRI noted, at the C6-7 level, spondylosis abutting the ventral aspect of the spinal cord, as well as "moderate to advanced narrowing of both foramina."

Based on these findings, she was referred to go back and consult with the same pain management and neurosurgical specialists that she had seen in the 2008 time period, with regard to her neck.

By January 22, she was documented to have made decent progress toward goals in the right knee and left hip. The pain in the hip was infrequent now, and some days not at all. The right knee pain was mostly gone, but was still in a constant condition of being "stiff" with certain motions, particularly with waking up, getting up from a sitting position, lifting, etc.

She went for a follow-up / progress evaluation to Dr. Borick with the orthopedic clinic, on January 25. On this visit, she noted that her right wrist pain had been persistent and not improved at all, even from keeping the wrist brace on and keeping the wrist immobile for three weeks or more. Dr. Borick examined and noted the wrist to be tender to palpation in the TFCC region (i.e., the triangular fibro-cartilage complex, which is the meniscal-type ligamentous process that "triangularly" connects the base of the pinkie finger bone to the wrist, to the radius, and to the ulna) and the DRUJ region (i.e., the distal radial-ulnar joint). Due to the specific tenderness and pain with motion localized in the TFCC region, Dr. Borick recommended her to undergo an MR arthrogram of the right wrist to investigate possible TFCC tear.

On February 3, she underwent that right wrist study, which showed some objective findings in the form of (as Dr. Borick suspected) peripheral TFCC tear, as well as tear in the scapholunate ligament. On February 9, she followed back up with the orthopedic clinic and was seen by Dr. Jennifer Lord with regard to the wrist. Dr. Lord also noted the pain in the TFCC area, as well as pain with full flexion and supination of the wrist. Dr. Lord believed that this was a flare-up of her lunate-triquetral arthritis, and administered a combination injection of steroidal medication with lidocaine, into the lunate-triquetral joint.

On February 4, Mrs. Doe returned to Dr. J. Lowell Haro, the pain management specialist that she had consulted in the early 2008 time period for some injections into the cervical spine, at the Pain Management Consultants clinic. As you can see from the billing ledger of that clinic, Mrs. Doe last received any type of injection for the cervical spine in May of 2008, and <u>never again</u> from that point onward. She also made only one office visit for follow-up with Dr. Haro in May of 2009, but for a completely <u>unrelated complaint of foot pain</u> (record enclosed), which had to do with neuropathy from her diabetes more than anything else. She therefore underwent <u>no injections or visits for cervical spine symptoms during the entire calendar year of 2009, and nothing also since May of 2008</u>. Therefore, her cervical complaints seemed to be very well under control – that is, until suffering this new fall in December of 2009. After evaluating her on February 4, 2010, and assessing her to have suffered new and serious flare-ups of the cervical spine pain and associated symptomatology, Dr. Haro prepared a plan for another round of epidural steroid injections into the cervical spine.

Because of her documented issues with diabetes and the possible complications and side effects of excess steroid injections, Mrs. Doe wished to get a second opinion. Her primary care physician, Dr. Don Davis, referred her to go back and see Dr. Matthew Hummel, of the Neurosurgical Specialists clinic, whom she had also briefly consulted in that early 2008 time period for her neck symptoms (Dr. Hummel's previous note of February 27, 2008 is enclosed). Mrs. Doe went to see Dr. Hummel on February 24, 2010. He noted her history as having received previous epidural steroid injections some time ago, which had improved her symptomatology. He then noted, "patient has apparently been stable since then, but recently developed some recurrent pain" (emphasis added). Of course, the recent recurrence had directly to do with her fall in December of 2009. Dr. Hummel noted that she had a repeat cervical spine MRI, but no additional injections since her recent episode of exacerbation. He did not believe those findings were of a nature that would make surgical intervention feasible. It was Dr. Hummel's opinion for her to proceed with the additional steroid injections contemplated by Dr. Haro, since they had worked for her in the past.

She underwent her first and only epidural steroid injection for the cervical spine since this new injury, on March 2, 2010, performed by Dr. Haro. She recalls feeling fairly good relief from that injection, and was scheduled to follow up with him in April.

The wrist injection performed by Dr. Lord at the Orthopedic Associates of Central Texas was not providing our client sustained relief, and she was noticing pain in the TFCC area of her wrist which had not bothered her at any time prior to this fall injury at the restaurant. She therefore talked to her primary care physician, Dr. Don Davis, and got a referral to go back and see a hand specialist that she had consulted years prior to the accident, for a second opinion as to her new symptoms. On March 22, she went for that appointment to see Dr. Bill Green, a specialist with the Hand Center of San Antonio.

Prior Medical: Again, as you can see from the medical records, our client had the following issues in the past, specifically with regard to the wrist:

(1) Previous diagnosis of arthritis in the scaphoid region of the right wrist, along with a procedure for release of her De Quervain's tendinitis (i.e., painful constricting of the tendons attached to the base of the right thumb), four (4) years prior to this injury.

(2) MRI for the right wrist, for the chJohnic pain that was occurring in the 2005-2007 timeframe.

Dr. Green made mention of these prior issues in his March 22, 2010 note. He had himself administered to her steroid injections in the CMC and STT joints back in December of 2007 (December 2007 records of Dr. Green are included in this demand packet), which had provided her good relief of her prior symptoms. It is worth noting that the CMC (carpo-metacarpal) joints and the STT (scapho-trapezio-trapezoid) joints do not relate to the TFCC region pain that she was now experiencing since the December 13, 2009 fall. In addition, we are

also providing you with records of her previous hand treatment with Dr. Edward Seade, a hand and upper extremity physician with the Orthopedic Specialists of Austin clinic. In those records, you can see that the prior MRI of the right wrist, done on January 10, 2006, demonstrated no previous tear of the TFCC (see Austin Health Imaging's MRI report: "The triangular fibrocartilage complex appears to maintain integrity…"). Furthermore, the scapholunate ligament at that time was described to be "abnormally frayed," but there was no definitive finding of tear. By contrast, the MR of the right wrist on February 3, 2010, referenced above, did state peripheral TFCC tear, as well as definitive objective findings of tear in the scapholunate ligament. Clearly, there was serious exacerbation and aggravation of her right wrist issues (including an injury to a new portion of her right wrist which had been giving no previous problems) from the December 2009 slip and fall. It is also worth noting, throughout the records of her therapeutic treatment and visits with Dr. Seade, in the late 2005 area, that they all consistently referred to tenosynovitis in the De Quervain's region. As any anatomy website will show, the De Quervain's region deals with the tendons attached to the base of the right thumb, which is on the polar opposite side of the wrist from the areas which had been bothering her since this December 2009 injury.

In view of the foregoing, on that March 22, 2010 visit, Dr. Green administered an injection specifically into the ulno-carpal joint of the right wrist, which seemed to provide some more lasting relief to Mrs. Doe. Thankfully, after receiving this injection, she did not have to return for any further right wrist complaints to either Dr. Green in San Antonio, the orthopedic clinic in Austin, or anywhere else, subsequent to the December 2009 injury.

On April 1, she returned for follow-up with Dr. Haro, to assess the relief provided by the epidural steroid injection in the cervical spine. It was noted that she had felt at least a good 10% relief of her symptoms by this point. It was also noted that a home exercise regimen was already in place for her to continue working on her neck issues. Because of her diabetes, and the danger of repeat steroid medication, Dr. Haro recommended that if symptoms persisted or worsened, a median branch block injection would be the next option. She has not proceeded with that option, however, and appears to be managing her cervical spine symptoms well enough with a combination of exercises, pain medication, and the relief provided by the steroid injection on March 2.

What was not resolving, however, was her persistent right knee issues. She had continued to do at-home exercises for the knee, as instructed by the therapists at St. Bill's, consisting of stretching, Pilates-style exercises, and other resistance-type exercises (such as squats) for the knee. However, her knee flexion pain was significant throughout the months of March and April. She returned to see Dr. Borick at Orthopedic Associates of Central Texas, on April 22, at which time Dr. Borick noted significant discomfort in the lateral aspect of the right knee, aggravated by flexion. She had roughly 40 degrees of impairment in her range of motion upon flexion, as well as objectively noted signs of tenderness along the tibio-femoral joint line, and pain in the lateral joint line upon McMurray testing. In view of the persistent nature of the right knee issues since the fall, Dr. Borick recommended her to undergo an MRI of the knee.

On April 23, she underwent the knee MRI, which demonstrated the following objective findings: (1) intermediate signal extending from the previous partial medial meniscectomy (as

we noted above, and as the patient reported to her doctors, she had arthroscopic surgery done on her right knee some 15+ years prior to this fall), giving reason to believe there was new or extended tearing; (2) knee joint effusion (which, as you know, is a tell-tale sign of recent knee joint trauma, precisely the sort of trauma that occurred in this fall); and (3) some degenerative changes in the kneecap (e.g., chondromalacia patella, etc.).

She returned on April 26 to review these results with Dr. Borick. He elicited the same signs of pain and tenderness upon palpation and range of motion testing, although there was noted to be "slight improvement" since her last visit. Dr. Borick did not feel that there was evidence of a new tear caused by the fall, but he did specifically note the symptoms were due to a combination of her mild osteo-arthritis and contusion to the lateral tibio-femoral region (which would have been sustained in this fall upon the right knee, and which would also be perfectly consistent with the knee joint effusion objectively noted in the MRI report). He felt that Mrs. Doe could continue with her at-home exercise regimen and pain medication as needed, and that her symptoms would decrease over time. Thankfully, since late April of this year, she has not had to return for further in-office treatment on the knee due to the fall.

DAMAGES

As a direct and proximate result of this incident, our client has incurred the following economic damages:

Medical Expenses

1.	Orthopaedic Associates of Central Texas	$ 2,009.00
2.	St. Bill's Rehabilitation (through Round Rock Medical Center)	$ 1,777.00
3.	Central Texas Spine Institute	$ 80.00
4.	Pain Management Consultants	$ 1,716.50
5.	Neurosurgical Specialists	$ 175.00
6.	Austin Radiological Association	$ 3,262.00
7.	Hand Center of San Antonio	$ 489.50
	Total Medical Expenses:	**$ 9,509.00**

Summary

Mrs. Doe has suffered miserably due to the fall on your insured's premises on December 13, 2009. She has had to undergo a very costly and very painful regimen of doctor's visits,

specialist referrals, repeat MRI's, steroid injections into the wrist and neck, physical therapy both in the clinic and at home, and a great deal of frustration and mental anguish over the state of her health. All of this most recent treatment was as a direct result of the negligence of your insured with regard to its handicap ramp.

It is important to understand that you will not be able to rest on the argument that our client was already suffering from pain and disabilities at times before this fall, and therefore you are not liable for part or all of her substantial medical bills and pain and suffering since then. In the first place, the very fact that she already had some pre-existing disability issues makes it all that much more glaring that the handicap ramp at your insured's restaurant was not more safely and carefully maintained. The type of paint used was completely inappropriate for a ramp used by individuals who must take extra time and care to walk up and down.

Secondly, the detailed and thorough medical summary above makes clear what objective issues our client had before the fall, versus what she had after the fall, and some clear differences can be noted:

(1) She never complained of, nor had MRI findings to suggest, injury or tear of the TFCC region in her right wrist. All wrist treatment prior to this fall (the most recent of which was on December 10, 2007, a full two years before the fall) was localized in the other side of her wrist, e.g., De Quervain's region at the base of the right thumb, as well as injections along the carpo-metacarpal joint areas. Therefore, there was not only aggravation of previous complaints, but also evidence of new injury, in the right wrist due to this fall.

(2) She had received no knee treatment whatsoever for a good 15 years prior to this accident. Her knee was doing fine until the fall internally contused her joint (according to Dr. Borick), and externally scraped her skin, leaving a scar. The enclosed photographs demonstrate that, even as of March 31, 2010, more than three (3) full months after the fall, the scar on her right knee was not fully healing. Therefore, the aquatic and physical therapy on the knee would not have been necessary, but for this fall injury.

(3) She had received no neck injections of any kind since May of 2008, and no neck treatment or office visits whatsoever from mid-2008 up until the time of this fall. Her cervical spine symptoms were well under control, until the aggravation and exacerbation of her neck and upper back by the jerking motion caused by her fall and struggle to balance herself as she went down. Also, there were some objective findings of aggravated injury when comparing the January 2008 cervical spine MRI to the January 2010 one.

In any case, our client is prepared at this time to submit the following demand:

DEMAND

Demand is hereby made for reimbursement of Mrs. Jane Doe's medical expenses, and compensation for her physical pain and suffering, physical impairment, physical disfigurement, and mental anguish, in the amount of **$25,000.00**, in exchange for a full and final release of all claims against your insured.

It is requested and expected that a response be made to this demand within fourteen (14) days of your receipt of this correspondence and enclosed documentation.

ENCLOSURE

In order to assist you in evaluating this demand, we have enclosed copies of all of the following items on CD-ROM:

a) The business card our client received from the store manager, Ms. Fatima Creamer;

b) Photographs of the scene of the incident, the slippery sidewalk, our client's injuries, and other related items;

c) A sunrise / sunset calendar for Hillsboro, Texas, for the month of December 2009;

d) Local weather almanac information for Hillsboro, Texas on the date of this incident;

e) All medical records and itemized bills for our client's injury treatment; and,

f) All relevant medical records for our client's medical treatment prior to this incident, including certification information for her handicapped parking placard.

Please contact the undersigned if you have any additional questions. We look forward to working with you to resolve this matter promptly.

Sincerely yours,

Ali A. Akhtar
Attorney at Law

Austin Office
AAA/ns
Enclosure