



**CITY OF RIALTO  
LIABILITY  
CLAIM FOR DAMAGES  
TO PERSON OR PROPERTY**

CITY CLERK'S DATE STAMP

CITY OF RIALTO

2023 SEP 15 AM 11:04

RECEIVED  
CITY CLERK

1. Claims for death, injury to person, or to personal property must be filed not later than six (6) months after the occurrence (Gov. Code §911.2).
2. Claims for damages to real property must be filed not later than one (1) year after the occurrence (Gov. Code §911.2).
3. READ ENTIRE CLAIM FOR BEFORE FILING
4. ATTACH SEPARATE SHEETS, IF NECESSARY, TO GIVE FULL DETAILS

**RETURN TO:**

**Rialto City Clerk's Office**

Mail: 150 S. Palm Ave., Rialto, CA 92376

Address: 290 W. Rialto Ave., Rialto, CA 92376

**CLAIMANT INFORMATION:**

KEVIN MCCONICO  
FULL NAME

DATE OF BIRTH

HOME ADDRESS INCLUDING CITY, STATE & ZIP

Rialto  
Ca 92377

HOME TELEPHONE NO.

BUSINESS ADDRESS INCLUDING CITY, STATE & ZIP

( )  
BUSINESS TELEPHONE NO.

ADDRESS AT WHICH CLAIMANT DESIRES TO RECEIVE  
NOTICES OR COMMUNICATIONS REGARDING THIS CLAIM  
(if different from home address provided above):

Rialto Ca 92377

1. WHEN DID DAMAGE OR INJURY OCCUR? DATE: 01/11/2023 TIME: 11:45 ☐ AM ☒ PM

2. PLACE OF ACCIDENT (OCCURRENCE) BE SPECIFIC - Describe fully and (if applicable) locate on diagram on reverse side of this sheet.  
Where appropriate, give street names and addresses, measurements and landmarks.

CECILE AND BASELINE

3. HOW DID DAMAGE OR INJURY OCCUR?

I WAS WRONGLY DETAINED BY POLICE AND ASSAULTED  
WHEN PLACED IN HANDCUFFS

4. WERE POLICE AT THE SCENE? ☒ YES ☐ NO

WERE PARAMEDICS AT THE SCENE? ☐ YES ☒ NO

5. WHAT PARTICULAR ACT OR OMISSION DO YOU CLAIM CAUSED THE INJURY OR DAMAGES? Give the name of the city/town employee causing the injury or damage, if known.

Rialto police handcuff me and the handcuff was extremely tight, I was having trouble breathing I was handcuffed two hours in the back of the police car

6. GIVE TOTAL AMOUNT OF CLAIM Include estimate of amount of any prospective injury or damage

\$75,000

HOW WAS THE ABOVE AMOUNT COMPUTED? Be specific, list doctor bills, repair estimates, etc. Please attach 2 estimates.

DAMAGES INCURRED TO DATE:

Item/Date:

01-16-2023

Amount: \$

100,000

Item/Date:

Still treating with DR.

Amount: \$

TOTAL AMOUNT CLAIMED AS OF PRESENTATION OF THIS CLAIM:

\$100,000

ESTIMATED PROSPECTIVE DAMAGES, AS FAR AS KNOWN:

Item/Date: 01-18-2023

Amount: \$

Item/Date: ON going

Amount: \$

TOTAL ESTIMATED AMOUNT PROSPECTIVE DAMAGES:

\$100,000

7. WITNESSES TO DAMAGE OR INJURY List all persons known to have information (attach additional pages, if necessary)

NAME: UNKNOWN

NAME:

ADDRESS:

ADDRESS:

TELEPHONE: ( )

TELEPHONE: ( )

8. IF INJURED, PROVIDE NAME, CONTACT INFORMATION AND DATE/TIME DOCTOR(S) OR HOSPITAL(S) VISITED:

NAME: METROPOLITAN FAMILY MEDICAL CLINIC NAME: OPTUM

ADDRESS: 425 E Tenthall Blvd. Rialto CA 92376 ADDRESS:

TELEPHONE: 909 546

TELEPHONE: ( )

DATE: 01-18-2023 TIME: 9:00 AM PM

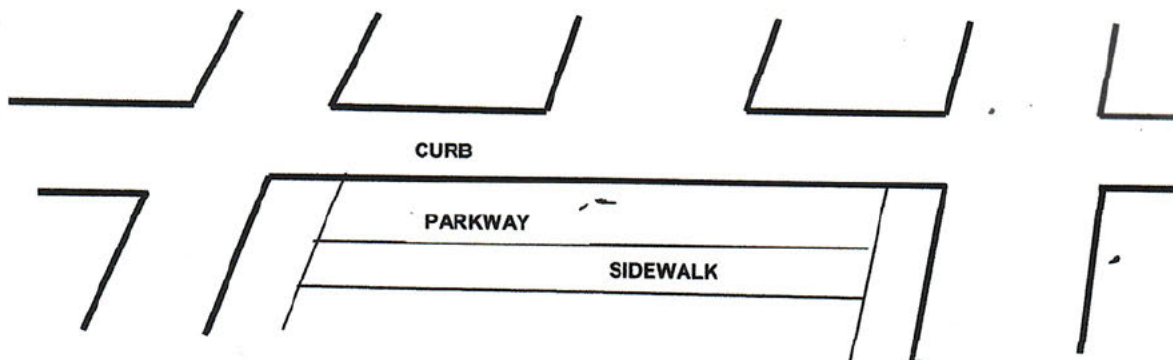
DATE: TIME: AM PM

9. PLEASE READ THE FOLLOWING CAREFULLY:

For all vehicle accident claims, place on the following diagram, the names of streets, including NORTH, EAST, SOUTH AND WEST directions. Indicate place of accident by "X" and by showing house numbers or distances to street corners.

If a city/town vehicle was involved, designate by letter "A" location of the City/Town vehicle when you first saw it, and by "B" location of yourself or your vehicle when you first saw City/Town vehicle; location of City/Town vehicle at time of accident by "A-1" and location of yourself or your vehicle at the time of the accident by "B-1" and the point of impact by "X".

NOTE: IF THE DIAGRAM BELOW DOES NOT FIT THE SITUATION, PLEASE ATTACH A PROPER DIAGRAM SIGNED BY THE CLAIMANT.



I HAVE READ THE FOREGOING CLAIM AND KNOW THE CONTENTS THEREOF; AND CERTIFY THAT THE SAME IS TRUE OF MY OWN KNOWLEDGE EXCEPT AS TO THOSE MATTERS WHICH ARE HEREIN STATED UPON MY INFORMATION AND BELIEF; AND AS TO THOSE MATTERS I BELIEVE THEM TO BE TRUE.

I CERTIFY (OR DECLARE) UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT.

SIGNATURE OF CLAIMANT OR AGENT

KEVIN MCCOINCO

TYPE OR PRINT NAME

SELF

RELATIONSHIP TO CLAIMANT

01-2-2023  
DATE

NOTE: PRESENTATION OF A FALSE CLAIM IS A FELONY (CA PENAL CODE 72)  
RETURN CLAIM TO: RIALTO CITY CLERK'S OFFICE - 150 S. PALM AVE., RIALTO, CA 92376



# San Bernardino Redlands Grove Loma Linda Open MRI Imaging Request Form

SCHEDULING: (909) 789-3696 FAX: (909) 789-3696

Appointment Date: \_\_\_\_\_ Appointment Time: \_\_\_\_\_ Today's Date: 1/20/2023  
 Patient's Name: Kevin McConico Date of Birth: \_\_\_\_\_  
 Clinical History/Reason for Exam: Shoulder Pain  
 Insurance Information: Caremore Healthplan Patient's Phone: 909-789-3696 Alternate Phone: \_\_\_\_\_  
 Referring Physician: Jesus Patis Physician Signature: \_\_\_\_\_ Phone: \_\_\_\_\_

[CT Contrast Studies Only] Labs needed if: ☐ Diabetes ☐ Renal Disease  
 If Labs have been completed within the past 30 days please provide values and fax lab results: Creatinine / GFR: \_\_\_\_\_ / \_\_\_\_\_  
☐ Call in STAT results ☐ STAT/Wet Read ☐ Previous Films (Y) (N) location: \_\_\_\_\_  
☐ Additional Report to: \_\_\_\_\_ ☐ Send CD with Patient ☐ Other: \_\_\_\_\_

**MR**

**MRI**  
☐ Contrast as Indicated  
☐ 3D Rendering as Indicated  
☐ With & Without Contrast  
☐ With Contrast  
☐ Without Contrast  
☐ Contrast, as Indicated  
☐ 3D Recon  
☐ Brain  
☐ w/special attention to IAC  
☐ w/special attention to Pituitary  
☐ NeuroQuant  
☐ Orbits  
☐ TMJ  
☐ Neck - Soft Tissue  
☐ Spine:  
     Cervical Thoracic Lumbar  
☐ Extremity: Joint Left Right  
 Specify body part \_\_\_\_\_  
☐ Extremity: Non-joint Left Right  
 Specify body part \_\_\_\_\_  
☐ Breast CAD  
☐ Mass Implant  
☐ MR Guided Breast Biopsy  
☐ Chest  
☐ Abdomen  
☐ Adrenals MRCP  
☐ Pelvis Bony Pelvis Soft Tissue  
☐ CSF Flow Study  
☐ Enterography  
☐ Prostate  
☐ Other: \_\_\_\_\_

**MR Angiography**  
☐ With & Without Contrast  
☐ Without Contrast  
☐ Contrast, as Indicated  
☐ Brain  
☐ Neck - Carotids  
☐ Chest  
☐ Abdomen  
☐ Aorta Renal  
☐ Aorta and runoff vessels  
☐ Pelvis  
☐ Extremity: Left Right  
☐ Other: \_\_\_\_\_

**MR Arthrography** Left Right  
☐ Shoulder  
☐ Elbow  
☐ Wrist  
☐ Hip  
☐ Knee  
☐ Ankle  
☐ Other: \_\_\_\_\_

**CT**

**Diagnostic CT**  
☐ Contrast as Indicated  
☐ 3D Rendering as Indicated  
☐ With & Without Contrast  
☐ With Contrast  
☐ Without Contrast  
☐ 3D Recon  
☐ Brain  
☐ Orbits  
☐ IAC Middle Ear  
☐ Maxillofacial - Facial Bones  
     Bones Implants  
☐ Sinus (Maxillofacial)  
☐ Neck (soft tissue)  
☐ Spine:  
     Cervical Thoracic Lumbar  
☐ Extremity: Left Right  
 Specify body part \_\_\_\_\_  
☐ Chest  
☐ Abdomen  
☐ Abdomen and Pelvis  
☐ Urogram (abdomen/pelvis)  
☐ Pelvis  
☐ Treatment Plan:  
☐ Dental Planning  
☐ Enterography  
☐ Myelogram  
☐ Other: \_\_\_\_\_

**CTA (Angiography)**  
☐ Head  
☐ Neck  
☐ Extremity: Upper Lower  
☐ Chest  
☐ Aorta and runoff vessels  
☐ Abdomen  
☐ Pelvis  
 Coronary Calcium Score EP Plan  
 Creatinine: \_\_\_\_\_  
 Bun: \_\_\_\_\_  
 Lab Date: \_\_\_\_\_

**Ultrasound**

☐ Abdomen  
☐ Abdomen Limited  
☐ Liver Gallbladder  
☐ Right Upper Quadrant  
☐ Abdomen w/Doppler if Indicated  
☐ Renal:  
☐ w/bladder  
☐ Bladder:  
☐ Aorta/Retroperitoneal  
☐ Pelvic Ultrasound (Transabdominal and Transvaginal)  
☐ Pelvic Ultrasound Complete (Transabdominal only)  
☐ Pelvic Ultrasound (Transvaginal only)  
☐ Scrotum w/Doppler  
☐ Thyroid  
☐ Biopsy/Aspiration/Injection Area  
☐ Hysterosonogram  
☐ Other: \_\_\_\_\_

**Vascular Studies**  
☐ Arterial Doppler (Duplex)  
☐ Carotid Doppler (Duplex)  
☐ Venous Doppler (Duplex)  
☐ Venous Mapping  
☐ Venous Insufficiency/Varicose Veins  
☐ Extremity  
     Upper Lower L R Bil  
☐ Other: \_\_\_\_\_

**OB Ultrasound**  
☐ OB Ultrasound (TV if Indicated)  
☐ Limited (Viability, Heart Beat, Position, Fluid, Placental Location)  
☐ Follow-up (specify documented problem) \_\_\_\_\_

**Fluoroscopy**  
☐ Arthrography  
 Specify body part: \_\_\_\_\_  
☐ IVP  
☐ Esophagram  
☐ Hysterosalpingogram (HSG)  
☐ UGI  
☐ UGI w/SBFT  
☐ Small Bowel  
☐ Barium Enema  
☐ Other: \_\_\_\_\_

**PET/CT**

☐ PET/CT, Skull Base to Mid-thigh  
☐ PET/CT, Whole Body (Melanoma)  
☐ PET/CT, Brain  
☐ NAF bone

**Nuclear Medicine**  
☐ Bone Scan  
     Whole Body Limited 3-phase  
☐ Bone SPECT  
☐ Thyroid Uptake and Scan  
☐ Parathyroid  
☐ Liver/Spleen  
☐ Gallbladder (HIDA) with EF  
☐ Gallbladder (HIDA) without EF  
☐ GI Emptying  
☐ Renal Captopril Lasix  
☐ Other: \_\_\_\_\_

**X-Ray**  
☐ Head:  
     Skull Orbits Sinuses  
☐ Spine:  
     Cervical Thoracic Lumbar  
☐ Chest: PA PA/LAT  
☐ Ribs:  
     Unilateral Bilateral w/PA Chest  
☐ Abdomen: KUB Two Views  
☐ Pelvis  
☐ Hips w/AP pelvis, bilateral  
     Unilateral Left Right  
☐ Extremity:  
     Left Right Bilateral  
 Specify Body Part: Shoulder  
☐ Other: \_\_\_\_\_

**DEXA**  
☐ Bone Density  
 Reason for bone density: \_\_\_\_\_  
 Date of last exam: \_\_\_\_\_

**Breast Imaging**  
 \*Mammography referral sheet available

**METROPOLITAN FAMILY MEDICAL CLINIC**  
 425 E FOOTHILL BLVD, RIALTO CA 92376  
 PH 909-546-1850/FAX 909-546-1061

Please bring this form and your insurance card with you on the day of your exam.

RadNetImaging.com