

Re: Benetia Young vs. Star View Adolescent Center
WCAB #: ADJ12620825

(PROOF OF SERVICE BY MAIL - 1013a, 2015.5 C.C.P.)

I am a resident of/employed in the aforesaid county, State of California; I am over the age of eighteen years and not a party to the within action; my business/residence address is: 14531 Hamlin Street, Van Nuys, CA 91411.

On **12/31/2019**, I served the foregoing document described as:

Hamlin Psyche Center Progress Note, Request for Authorization for Medical Treatment Form, and Copy of Prescriptions

On the interested parties in this action by placing the true copy thereof, enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at Van Nuys, California, addressed as follows:

WCAB#:ADJ12620825
(Report served upon applicant attorney)

Applicant Attorney:
Natalia Foley, Esq.
5753 E Santa Ana Cyn Rd., Ste. G#616
Anaheim, CA 92807

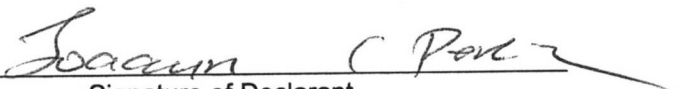
Insurance Carrier:
Athens Administrators
P.O. Box 696
Concord, CA 94522

Defense Attorney:

I certify (or declare), under penalty of perjury under the laws of the State of California, that the foregoing is true and correct.

12/31/2019

Date



Signature of Declarant

Joaquin Perez
Full Name of Declarant

THOMAS A. CURTIS, M.D.

CA Lic. #A23197 DEA #AC4289460

VAN NUYS - 818-780-4409 - MAIN OFFICE
14531 Hamlin Street, Van Nuys, CA 91411

BATCH #VP011459J

LONG BEACH - 562-513-3435
4300 Long Beach Blvd., Suite 240, Long Beach, CA 90807

LOS ANGELES - 213-352-1397
3251 W 6th St., Holmes Center, Suite B2, Los Angeles, CA 90020

No. 1036 Serial#VLP191001A01236

hep ps

DESCRIPTION OF SECURITY FEATURES ON REVERSE SIDE

Name Benetia Young D.O.B. 1/8/65
Address _____ Phone _____

Wellbutrin 100mg #60
tam/moon
depression
Quantity: 1-24 25-49 50-74
 75-100 101-150 151 and over Units 60
Refills 0 1 2 3 4 5 Do not substitute

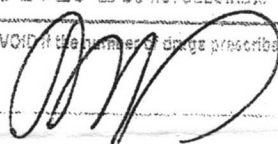
Buspar 10mg #60
bid
anxiety
Quantity: 1-24 25-49 50-74
 75-100 101-150 151 and over Units 60
Refills 0 1 2 3 4 5 Do not substitute

Ambien 5mg #14
tabs
sleep
Quantity: 1-24 25-49 50-74
 75-100 101-150 151 and over Units 14
Refills 0 1 2 3 4 5 Do not substitute

Quantity: 1-24 25-49 50-74
 75-100 101-150 151 and over Units _____
Refills 0 1 2 3 4 5 Do not substitute

Prescription is VOID if the number of doses prescribed is not noted. 1 2 3 4

SP 02



Date 11/18/19

HAMLIN PSYCHE CENTER PROGRESS NOTE

PATIENT: BENETIA YOUNG
DATE: 11/18/2019
DATE OF INJURY: CT:04/18/2019 - 10/10/2019
DOB: 1/8/1965
CLAIMS ADMINISTRATOR: ATHENS ADMINISTRATORS
ADJUSTER: TIMOTHY CHAPIN
CLAIM NUMBER: 19006760

TOTAL # OF CBT SESSIONS: _____

EXPIRY DATE: _____

TODAY'S SESSION #: _____

I. SERVICES PROVIDED

PSYCHE DIAGNOSTIC EVAL (USE FOR DISABILITY FORMS, DISABILITY EXTENSIONS, SSD, RTW, ETC.)

- | | | | | |
|--|-----------------------------------|--|--|------------------------------------|
| <input checked="" type="checkbox"/> Med Management | <input type="checkbox"/> e-Rx | <input type="checkbox"/> Initial SDI Form | <input type="checkbox"/> SDI Extension | <input type="checkbox"/> FMLA form |
| <input type="checkbox"/> LTD/Ret Form | <input type="checkbox"/> SSD Form | <input type="checkbox"/> RTW/Disability Form | <input type="checkbox"/> Other Form | <input type="checkbox"/> Referral |

E/M SERVICE: DO NOT USE WITH PSYCHE DIAGNOSTIC EVAL

- 15 MIN 25 MIN 40 MIN

PSYCHOTHERAPY

- Ind. Therapy Biofeedback Group Therapy Telephone Therapy

II. PRESENTING COMPLAINTS—HISTORY OF DEPRESSION

- | | | |
|---|--|---|
| <input checked="" type="checkbox"/> Depression | <input checked="" type="checkbox"/> Decreased energy | <input type="checkbox"/> Pessimism |
| <input checked="" type="checkbox"/> Changes in appetite | <input checked="" type="checkbox"/> Changes in weight (up or down) | <input type="checkbox"/> Diminished self-esteem |
| <input checked="" type="checkbox"/> Lack of motivation | <input checked="" type="checkbox"/> Difficulty thinking | <input type="checkbox"/> Emptiness and inadequacy |
| <input checked="" type="checkbox"/> Difficulty getting to sleep | <input checked="" type="checkbox"/> Difficulty staying asleep | <input type="checkbox"/> Early morning awakening |

II. PRESENTING COMPLAINTS—HISTORY OF ANXIETY

- | | | |
|---|---|--|
| <input checked="" type="checkbox"/> Excessive worry | <input checked="" type="checkbox"/> Panic attacks | <input type="checkbox"/> Shaking |
| <input checked="" type="checkbox"/> Restlessness | <input checked="" type="checkbox"/> Feeling "keyed up" or on edge | <input type="checkbox"/> Chest pain |
| <input checked="" type="checkbox"/> Jumpiness | <input checked="" type="checkbox"/> Inability to relax | <input type="checkbox"/> Palpitations |
| <input checked="" type="checkbox"/> Tension | <input checked="" type="checkbox"/> Pressure | <input type="checkbox"/> Nausea |
| <input checked="" type="checkbox"/> Agitation | <input checked="" type="checkbox"/> Agoraphobia | <input type="checkbox"/> Shortness of breath |

II. PRESENTING COMPLAINTS—HISTORY OF PTSD

- Disturbing memories Reliving of the trauma Flashbacks Intrusive recollections

II. PRESENTING COMPLAINTS—HISTORY OF CONFUSION:

- Hearing voices Seeing things Paranoia Conspiracy

II. PRESENTING COMPLAINTS—HISTORY OF STRESS-RELATED MEDICAL COMPLAINTS

- | | | |
|---|---|---|
| <input checked="" type="checkbox"/> Tension headache | <input checked="" type="checkbox"/> Increased Pain | <input checked="" type="checkbox"/> Peptic acid reaction |
| <input checked="" type="checkbox"/> Muscle tension | <input checked="" type="checkbox"/> Sexual dysfunction | <input checked="" type="checkbox"/> Abdominal pain/cramping |
| <input checked="" type="checkbox"/> TMJ/jaw clenching | <input checked="" type="checkbox"/> Dermatological reaction | <input type="checkbox"/> Constipation or diarrhea (circle) |

III. IMPROVEMENTS IN SYMPTOMS AND FUNCTIONS

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Concentrate better | <input type="checkbox"/> Gets along better | <input type="checkbox"/> Less headache | <input type="checkbox"/> Less sad mood |
| <input type="checkbox"/> Comprehend TV | <input type="checkbox"/> Less time in bed | <input type="checkbox"/> Fewer GI complaints | <input type="checkbox"/> Less yelling |
| <input type="checkbox"/> Can sleep better | <input type="checkbox"/> Goes out more | <input checked="" type="checkbox"/> Less irritable | <input type="checkbox"/> Less nervous |
| <input type="checkbox"/> Less sexual dysfunction | <input type="checkbox"/> More outgoing | <input checked="" type="checkbox"/> Less panicky | <input type="checkbox"/> Less pain |

IV. OBJECTIVE BEHAVIORS—MENTAL STATUS EXAMINATION

Physical Appearance:

- Casually dressed Formally dressed Unkempt Inappropriately dressed

Initial Presentation:

- Depressed Visibly Anxious Defensive Agitated Suicidal Homicidal

Cognition:

- Distracted Rambling Defective Recall Slow In Thinking

Judgment And Motivation:

- Judgment Unimpaired Judgment Impaired Interested In TXT Not Interested In TXT

HAMLIN PSYCHE CENTER PROGRESS NOTE

V. DISABILITY STATUS

- TTD
 TPD
 Permanent and Stationary
 Future Award

Remain off work until: →

Return to work on: →

See 45-day PR-2 Form, Return to Work Form or Special or Other Report

No Restrictions →

Restrictions →

VI. DIAGNOSES

1	Major Depressive Disorder, Single Episode	ICD-10	F32.9
2	Generalized Anxiety Disorder	ICD-10	F41.1
3	Psychological Factors Affecting Other Medical Conditions	ICD-10	F54
4		ICD-10	
5		ICD-10	
6		ICD-10	
7		ICD-10	
8		ICD-10	
9		ICD-10	
10		ICD-10	

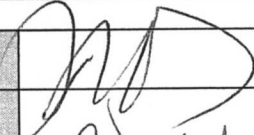
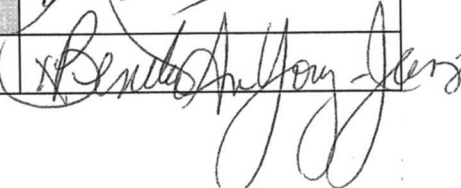
VII. TREATMENT PLAN

- Patient advised of proper sleep hygiene
 Patient advised of benzodiazepene risks

CHANGES IN TREATMENT OR MEDICATIONS, IF NEEDED EXPLAIN IN BOX

- No change
 Add (list to right)
 Discontinue (list to right)
 Increase (list to right)
 Decrease (list to right)

See ptn

THERAPIST SIGNATURE:		PHYSICIAN SIGNATURE:	
MA SIGNATURE:		INTERPRETER	
THOMAS A. CURTIS, MD		PATIENT SIGNATURE:	

State of California, Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

- New Request Resubmission – Change in Material Facts
 Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
 Check box if request is a written confirmation of a prior oral request.

Employee Information

Name (Last, First, Middle): **Young, Benetia**

Date of Injury (MM/DD/YYYY): **CT:04/18/2019 - 10/10/2019**

Date of Birth (MM/DD/YYYY): **1/8/1965**

Claim Number: **19006760**

Employer: **Star View Adolescent Center**

Requesting Physician Information

Name: **Thomas Curtis, M.D.**

Practice Name: **Hamlin Psyche Center**

Contact Name: **Stella Natelli**

Address: **14531 Hamlin Street**

City: **Van Nuys**

State: **CA**

Zip Code: **91411**

Phone: **(818) 780-4409**

Fax Number: **(818) 780-4472**

Specialty: **Psyche**

NPI Number: **1952516601**

E-mail Address:

Claims Administrator Information

Company Name: **Athens Administrators**

Contact Name: **Timothy Chapin**

Address: **P.O. Box 696**

City: **Concord**

State: **CA**

Zip Code: **94522**

Phone: **[1] 866-482-3535**

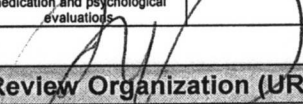
Fax Number:

E-mail Address:

Requested Treatment (see instructions for guidance; attached additional pages if necessary)

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Major Depressive Disorder, Single Episode Generalized Anxiety Disorder Psychological Factors Affecting Other Medical Conditions	F32.9 F41.1 F54	Prescription of Medications	90862	<input checked="" type="checkbox"/> no refills <input type="checkbox"/> 1 refill Wellbutrin 100mg #60 tam/moon depression Buspar 10mg #60 tbid anxiety. Ambien 5mg #14 tans/prn sleep.
		Prescriptions to be filled by a pharmacist	99605	
		Needs interpreter <input type="checkbox"/> Please provide or authorize a certified interpreter for all medication and psychological evaluations	N/A	Medical necessity and clinical rationale: To improve depression, anxiety, sleep problems, stress-intensified medical symptoms and the related functional impairment. See prior UR Reconsideration report and/or medication management reports (Please provide a copy of the decision to this office at 14531 Hamlin Street, Van Nuys, Ca 91411)

Requesting Physician Signature: 

Date: 11/18/2019

Claims Administrator/Utilization Review Organization (URO) Response

- Approved Denied or Modified (See separate decision letter) Delay (See separate notification of delay)
 Requested treatment has been previously denied Liability for treatment is disputed (See separate letter)

Authorization Number (if assigned):

Date:

Authorized Agent Name:

Signature:

Phone:

Fax Number:

E-mail Address:

Comments: