ERIC E. GOFNUNG CHIROPRACTIC CORP.

SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION

6221 Wilshire Blvd., Suite 604 • Los Angeles, California 90048 • Tel. (323) 933-2444• Fax (323) 933-2909

PROOF OF SERVICE BY MAIL

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

I am a citizen of the United States. I am over the age of 18 years and not a party of the above-entitled action; my business address is 6221 Wilshire Blvd., Suite 604, Los Angeles, CA 90048. I am familiar with a Company's practice where the mail, after being placed in a designated area, is given the appropriate postage and is deposited in a U. S. mailbox in the City of Los Angeles, after the close of the day's business. On March 17, 2023, I served the within following letter / forms on all parties in this action by placing a true copy thereof enclosed in a sealed envelope in the designated area for out-going mail addressed as set forth above or electronically on the specified parties with email addresses as identified. I declare under the penalty of perjury that the foregoing is true and correct under the laws of the State of California and that this declaration was executed at 6221 Wilshire Blvd., Suite 604, Los Angeles, CA 90048.

On **17th** day of **March**, 2023, I served the within concerning:

Patient's Name:	**ANDROSOV, IVAN**
Claim Number:	023-27-0116
WCAB / EAMS case No:	ADJ17289751

☒MPN Notice
☒Designation of Primary Treating Physician & Authorization for Release of Medical Records
☒Financial Disclosure
☒Request for Authorization - **03/06/2023**
☒Itemized – (Billing) / HFCA - **03/06/2023**
☐QME Appointment Notification
☐Primary Treating Physician's Referral

☒Initial Consultation Report - **03/06/2023**
☐Re-Evaluation Report / Progress Report (PR-2) ____
☐Permanent & Stationary Evaluation Report – ____
☐Post P&S Follow Up - ____
☐Review of Records - ____
☐PQME / Med Legal Report - ____
☐Computerized Dynamic Range of Motion (Rom) And Functional Evaluation Report - ____

List all parties to whom documents were mailed to:

WORKERS DEFENDERS LAW GROUP
751 S WEIR CANYON RD STE 157-455
ANAHEIM CA 92808

SEDGWICK
PO BOX 14522
LEXINGTON KY 40512

I declare under penalty and perjury under the laws of the State of California, that the foregoing is true and correct, and that this Declaration was executed at Los Angeles, California on **17th** day of **March**, 2023.

ILSE PONCE

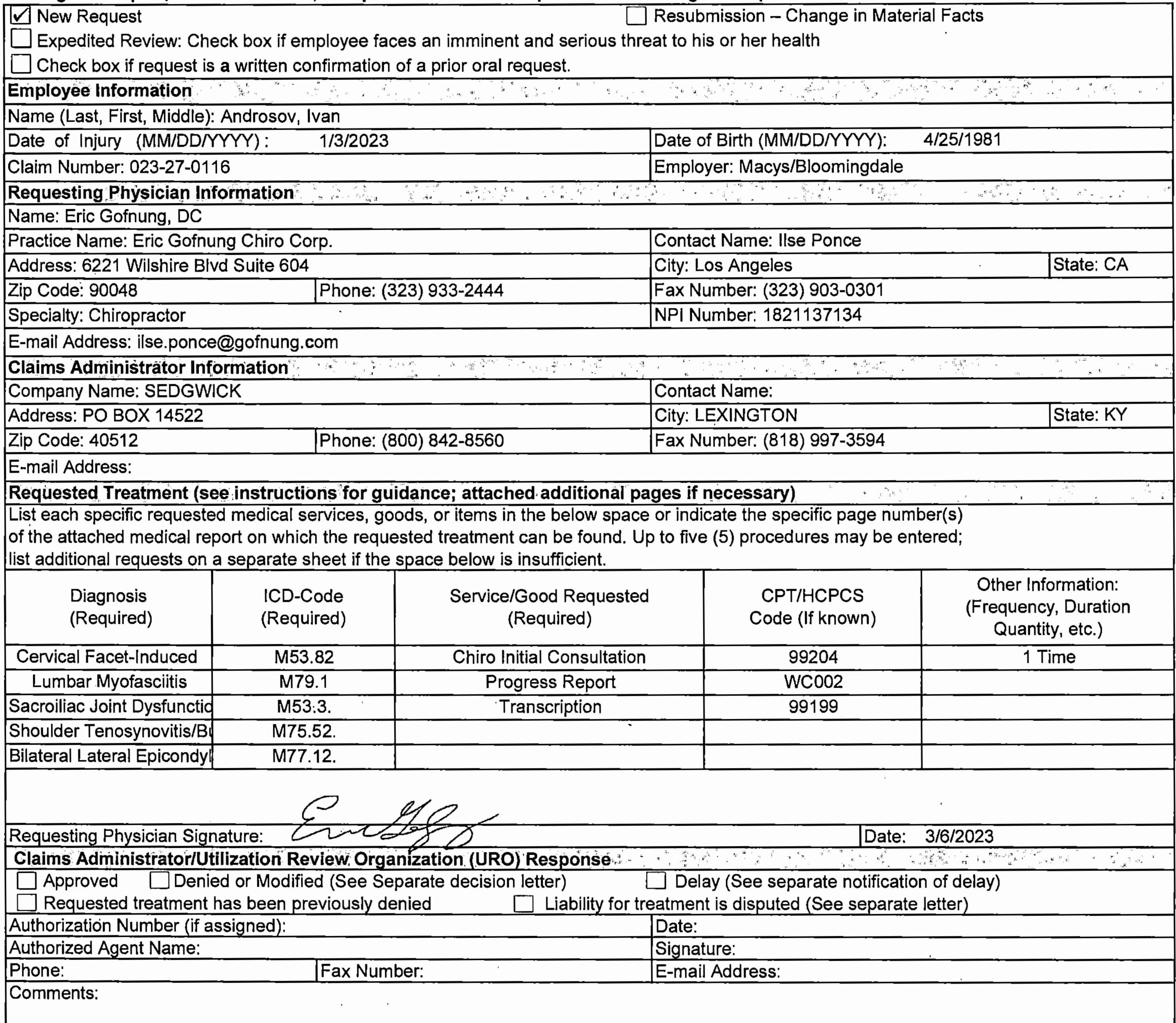
PRINT CLEAR

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): Androsov, Ivan

Date of Injury (MM/DD/YYYY): 1/3/2023	Date of Birth (MM/DD/YYYY): 4/25/1981
Claim Number: 023-27-0116	Employer: Macys/Bloomingdale

Requesting Physician Information

Name: Eric Gofnung, DC

Practice Name: Eric Gofnung Chiro Corp.		Contact Name: Ilse Ponce	
Address: 6221 Wilshire Blvd Suite 604		City: Los Angeles	State: CA
Zip Code: 90048	Phone: (323) 933-2444	Fax Number: (323) 903-0301	
Specialty: Chiropractor		NPI Number: 1821137134	

E-mail Address: ilse.ponce@gofnung.com

Claims Administrator Information

Company Name: SEDGWICK		Contact Name:	
Address: PO BOX 14522		City: LEXINGTON	State: KY
Zip Code: 40512	Phone: (800) 842-8560	Fax Number: (818) 997-3594	

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.)
Cervical Facet-Induced	M53.82	Chiro Initial Consultation	99204	1 Time
Lumbar Myofasciitis	M79.1	Progress Report	WC002	
Sacroiliac Joint Dysfunctio	M53.3.	Transcription	99199	
Shoulder Tenosynovitis/B	M75.52.			
Bilateral Lateral Epicondyl	M77.12.			

Requesting Physician Signature: [signature] Date: 3/6/2023

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:

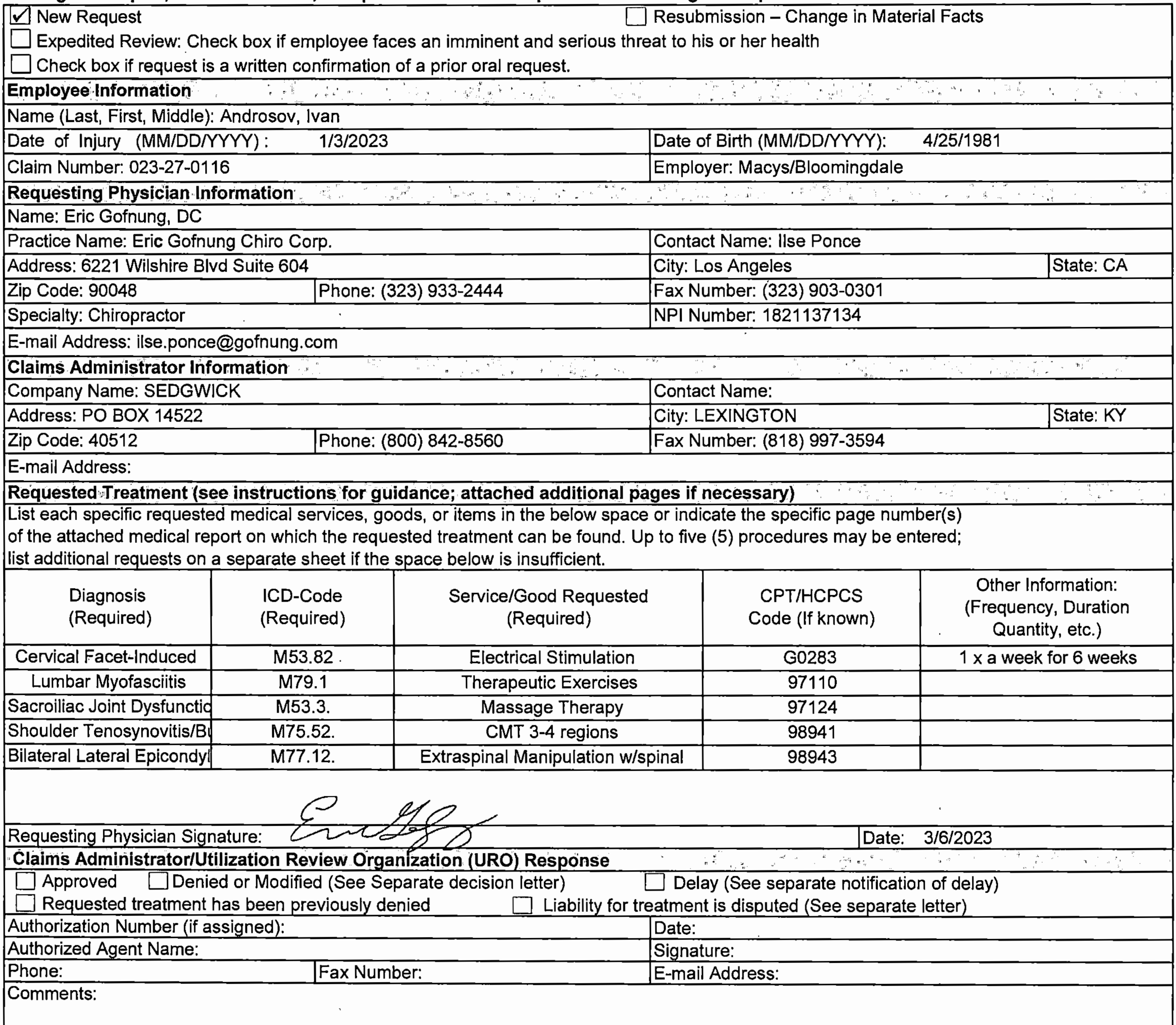
PRINT CLEAR

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): Androsov, Ivan	
Date of Injury (MM/DD/YYYY): 1/3/2023	Date of Birth (MM/DD/YYYY): 4/25/1981
Claim Number: 023-27-0116	Employer: Macys/Bloomingdale

Requesting Physician Information

Name: Eric Gofnung, DC			
Practice Name: Eric Gofnung Chiro Corp.		Contact Name: Ilse Ponce	
Address: 6221 Wilshire Blvd Suite 604		City: Los Angeles	State: CA
Zip Code: 90048	Phone: (323) 933-2444	Fax Number: (323) 903-0301	
Specialty: Chiropractor		NPI Number: 1821137134	
E-mail Address: ilse.ponce@gofnung.com			

Claims Administrator Information

Company Name: SEDGWICK		Contact Name:	
Address: PO BOX 14522		City: LEXINGTON	State: KY
Zip Code: 40512	Phone: (800) 842-8560	Fax Number: (818) 997-3594	
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.)
Cervical Facet-Induced	M53.82	Electrical Stimulation	G0283	1 x a week for 6 weeks
Lumbar Myofasciitis	M79.1	Therapeutic Exercises	97110	
Sacroiliac Joint Dysfunctio	M53.3.	Massage Therapy	97124	
Shoulder Tenosynovitis/B	M75.52.	CMT 3-4 regions	98941	
Bilateral Lateral Epicondyl	M77.12.	Extraspinal Manipulation w/spinal	98943	

Requesting Physician Signature: [signature] Date: 3/6/2023

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:		

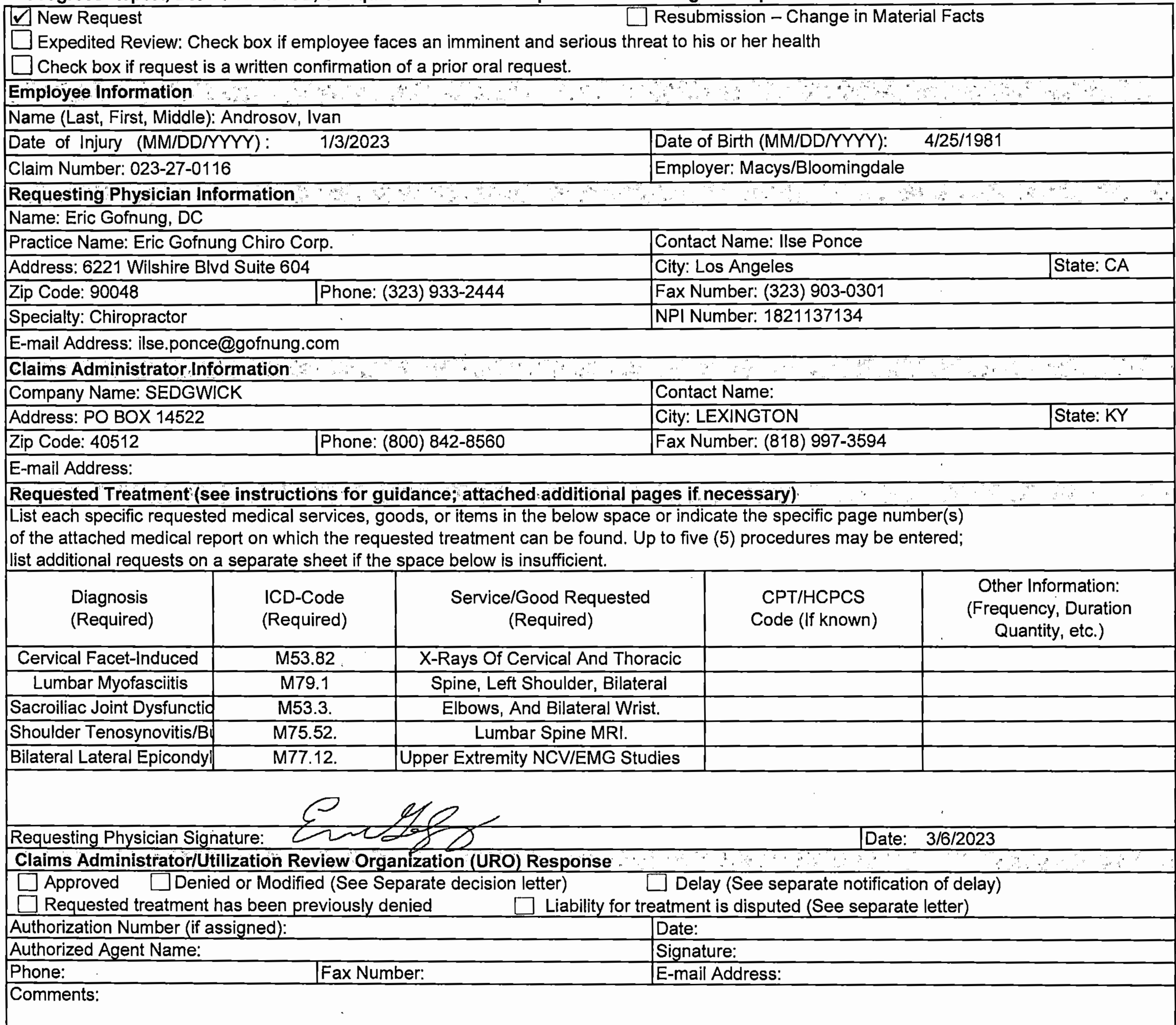
PRINT CLEAR

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): Androsov, Ivan	
Date of Injury (MM/DD/YYYY): 1/3/2023	Date of Birth (MM/DD/YYYY): 4/25/1981
Claim Number: 023-27-0116	Employer: Macys/Bloomingdale

Requesting Physician Information

Name: Eric Gofnung, DC			
Practice Name: Eric Gofnung Chiro Corp.		Contact Name: Ilse Ponce	
Address: 6221 Wilshire Blvd Suite 604		City: Los Angeles	State: CA
Zip Code: 90048	Phone: (323) 933-2444	Fax Number: (323) 903-0301	
Specialty: Chiropractor		NPI Number: 1821137134	
E-mail Address: ilse.ponce@gofnung.com			

Claims Administrator Information

Company Name: SEDGWICK		Contact Name:	
Address: PO BOX 14522		City: LEXINGTON	State: KY
Zip Code: 40512	Phone: (800) 842-8560	Fax Number: (818) 997-3594	
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.)
Cervical Facet-Induced	M53.82	X-Rays Of Cervical And Thoracic		
Lumbar Myofasciitis	M79.1	Spine, Left Shoulder, Bilateral		
Sacroiliac Joint Dysfunctio	M53.3.	Elbows, And Bilateral Wrist.		
Shoulder Tenosynovitis/Bi	M75.52.	Lumbar Spine MRI.		
Bilateral Lateral Epicondyl	M77.12.	Upper Extremity NCV/EMG Studies		

Requesting Physician Signature: [signature] Date: 3/6/2023

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:		

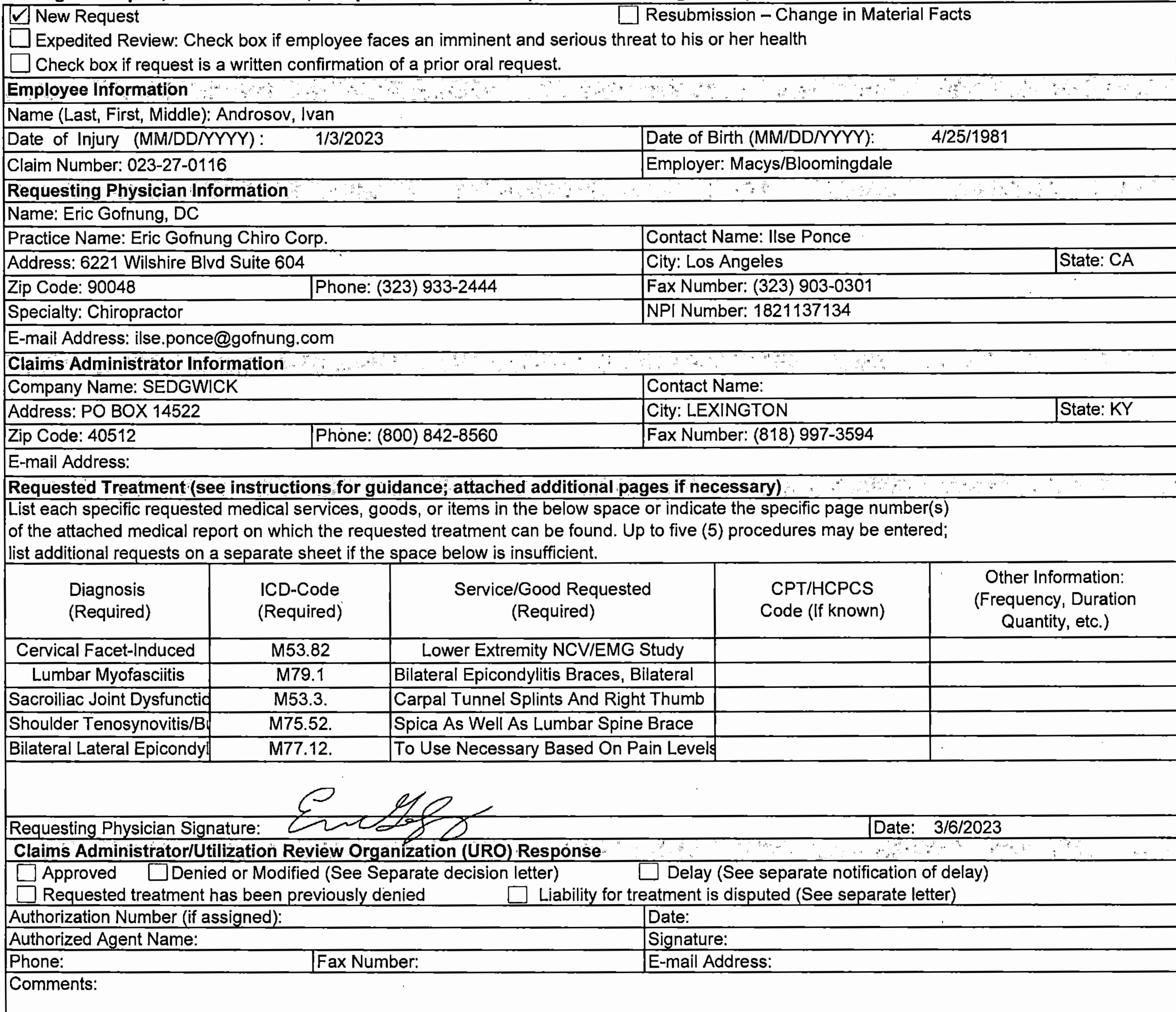
PRINT CLEAR

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): Androsov, Ivan	
Date of Injury (MM/DD/YYYY): 1/3/2023	Date of Birth (MM/DD/YYYY): 4/25/1981
Claim Number: 023-27-0116	Employer: Macys/Bloomingdale

Requesting Physician Information

Name: Eric Gofnung, DC			
Practice Name: Eric Gofnung Chiro Corp.		Contact Name: Ilse Ponce	
Address: 6221 Wilshire Blvd Suite 604		City: Los Angeles	State: CA
Zip Code: 90048	Phone: (323) 933-2444	Fax Number: (323) 903-0301	
Specialty: Chiropractor		NPI Number: 1821137134	
E-mail Address: ilse.ponce@gofnung.com			

Claims Administrator Information

Company Name: SEDGWICK		Contact Name:	
Address: PO BOX 14522		City: LEXINGTON	State: KY
Zip Code: 40512	Phone: (800) 842-8560	Fax Number: (818) 997-3594	
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.)
Cervical Facet-Induced	M53.82	Lower Extremity NCV/EMG Study		
Lumbar Myofasciitis	M79.1	Bilateral Epicondylitis Braces, Bilateral		
Sacroiliac Joint Dysfunctio	M53.3.	Carpal Tunnel Splints And Right Thumb		
Shoulder Tenosynovitis/B	M75.52.	Spica As Well As Lumbar Spine Brace		
Bilateral Lateral Epicondyl	M77.12.	To Use Necessary Based On Pain Levels		

Requesting Physician Signature: [signature] Date: 3/6/2023

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:		

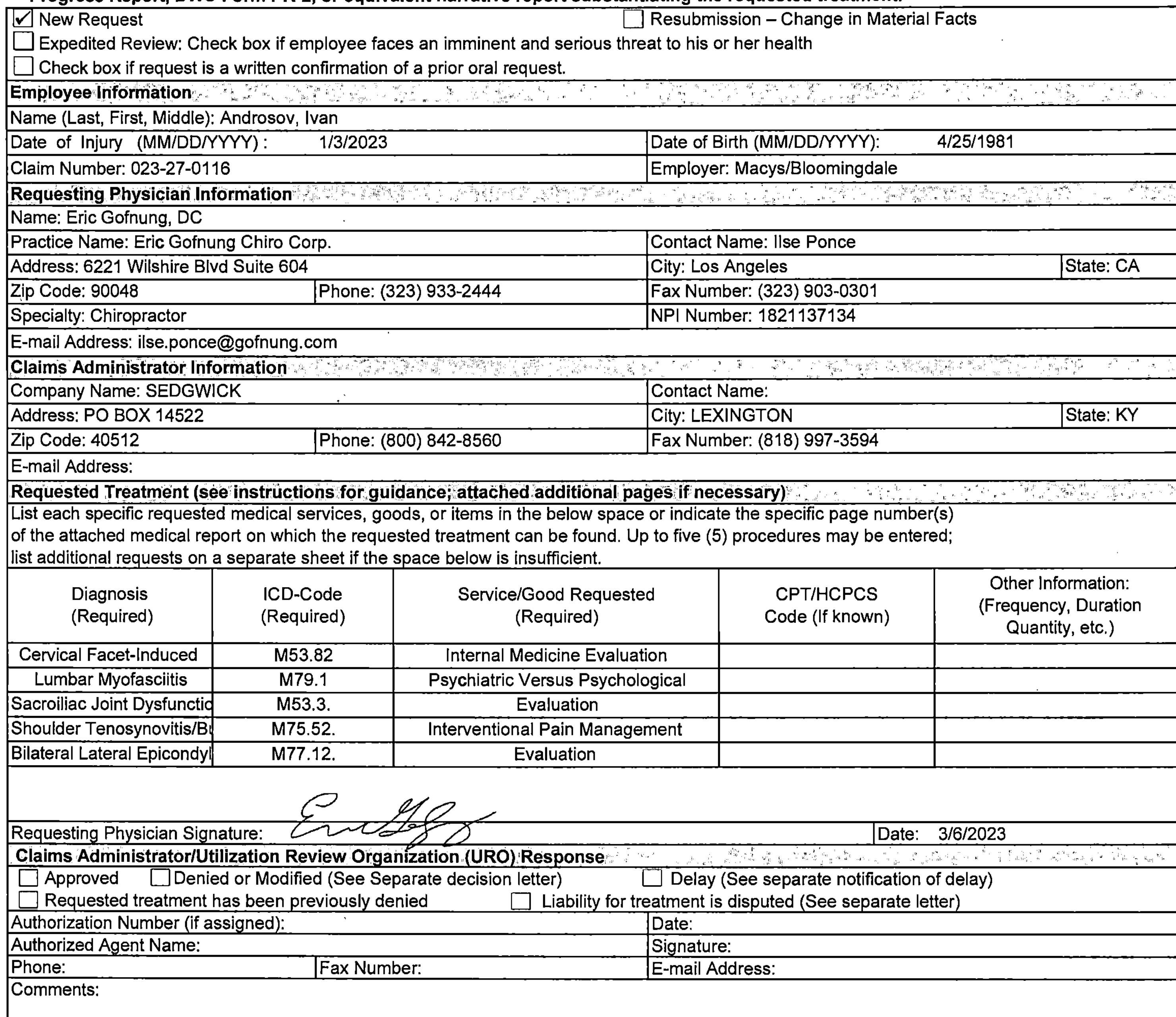
PRINT CLEAR

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): Androsov, Ivan

Date of Injury (MM/DD/YYYY): 1/3/2023 | Date of Birth (MM/DD/YYYY): 4/25/1981

Claim Number: 023-27-0116 | Employer: Macys/Bloomingdale

Requesting Physician Information

Name: Eric Gofnung, DC

Practice Name: Eric Gofnung Chiro Corp. | Contact Name: Ilse Ponce

Address: 6221 Wilshire Blvd Suite 604 | City: Los Angeles | State: CA

Zip Code: 90048 | Phone: (323) 933-2444 | Fax Number: (323) 903-0301

Specialty: Chiropractor | NPI Number: 1821137134

E-mail Address: ilse.ponce@gofnung.com

Claims Administrator Information

Company Name: SEDGWICK | Contact Name:

Address: PO BOX 14522 | City: LEXINGTON | State: KY

Zip Code: 40512 | Phone: (800) 842-8560 | Fax Number: (818) 997-3594

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.)
Cervical Facet-Induced	M53.82	Internal Medicine Evaluation		
Lumbar Myofasciitis	M79.1	Psychiatric Versus Psychological		
Sacroiliac Joint Dysfunctio	M53.3.	Evaluation		
Shoulder Tenosynovitis/B	M75.52.	Interventional Pain Management		
Bilateral Lateral Epicondyl	M77.12.	Evaluation		

Requesting Physician Signature: [signature] | Date: 3/6/2023

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:

ERIC E. GOFNUNG, D.C., QME

SPORTS MEDICINE AND REHABILITATION

6221 Wilshire Boulevard, Suite 604 ⅄ Los Angeles, California 90048 ⅄ Tel. (323) 933-2444 ⅄ Fax (323) 933-2909

Employer and/or Workers' Compensation Insurance Carrier:

Macy's Inc. DBA Bloomingdales, LLC
14060 Riverside Drive
Sherman Oaks, CA 91423

Re: Patient - Ivan Androsov
Social Security # -
Date Of Injury - CT: 01/14/2022-01/03/2023
Employer - Macy's Inc. DBA Bloomingdales, LLC
Claim Number -

Designation of Primary Treating Physician and/or Request of Change of Physician & Authorization For Release Of Medical Records

To Whom It May Concern:

I, Ivan Androsov, request a change of primary treating physician and/or request to be treated by a doctor of chiropractic and designate Dr. Eric E. Gofnung as my primary treating physician pursuant to Article 2 (commencing with section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code. Please accept my signature below as confirmation of my designation of Dr. Eric E. Gofnung as my primary treating physician. Pursuant to California Labor Code 4601, a request for change of physician may be made at any time.

I request all available present and future medical records to be forwarded to Dr. Eric E. Gofnung for review and comment. Please accept my signature below as my full authorization for release of my medical records and my authorization to release all necessary medical information regarding my condition to all parties involved, which include, but are not limited to my employer and/or their worker's compensation insurance company, to process the claim.

Please refer to the letterhead for Dr. Eric Gofnung's information.

Thank you for your assistance with this claim.

With Kind Regards,

Signature: X Printed: Ivan Androsov Date: 3/6/2023

ERIC E. GOFNUNG CHIROPRACTIC CORP.

SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION

6221 Wilshire Boulevard, Suite 604/Los Angeles, California90048/Tel. (323) 933-2444 / Fax (323) 933-2909

March 6, 2023

Workers Defenders Law Group
Natalia Foley, ESQ.
751 S. Weir Canyon Road Stuie 157-455
Los Angeles, CA 90048

Re: Patient: Androsov, Ivan
SSN: XXX-XX-0116
EMP: Macys/Bloomingdale
INS: Sedgwick
Claim #: 023-27-0116
WCAB #: ADJ17289751
DOI: CT: 01/14/22-01/03/23; 07/01/22-01/02/23
D.O.E./Consultation: March 6, 2023

Primary Treating Physician's
Initial Evaluation Report
And Request for Authorization

Time Spent Face to face:	**55 minutes**
Time Spent on Report Preparation	**30 minutes**

Dear Gentlepersons:

The above-named patient was seen for a Primary Treating Physician's Initial Evaluation on March 6, 2023, in my office located at 6221 Wilshire Boulevard, Suite 604, Los Angeles, California 90048. The following information contained in this report is derived from a review of the available medical records, as well as the oral history as presented by the patient. **Dr. Gofnung is the PTP and the patient was examined by Dr. Gofnung.**

The history of injury as related by the patient, the physical examination findings, my conclusions and overall recommendations are as follows.

Re: Patient: Androsov, Ivan
DOI: CT: 01/14/22-01/03/23; 07/01/22-01/02/23
Date of Exam: March 6, 2023

This authorization for treatment is made in compliance with Labor Code 4610 and 8 CCR 9792.6(o) and therefore serves as a written request for authorization for today's evaluation/consultation and treatment recommendations as described in this report. Please comply with Labor Code 4610, 8 CCR 9792.11 – 9792.15, 8 CCR 10112 – 10112.3 (formerly 8 CCR 10225 – 10225.2) and Labor Code 5814.6. Please comply with Sandhagen v. State Compensation Insurance Fund (2008) 44 Cal. 4 ch 230. Please comply with Jesus Cervantes v. El Aguila Food Products, Inc. and Ciga, et al., WCAB en banc, 7-0, November 19, 2009. Be aware that Labor Code 4610(b) requires the defendant to conduct utilization review on any and all requests for treatment. Furthermore, Labor Code 4610 Utilization Review deadlines are mandatory. It is the defendant's duty to forward all consultation and treatment authorization requests to utilization review. Be aware the defendant and insurance company has five working days to authorize, delay, modify or deny a request for all treatment, but 10 days for spinal surgery. Please issue timely payment for medical care and treatment rendered in order to avoid payment of interests and penalties, per labor codes referenced. Failure of the defendant or insurance company to respond in writing within five working days results in an authorization by default. Furthermore, failure to pay for "self-procured" medical care when utilization deadlines are missed triggers penalties for the defendant or the insurance company due to violation of 8 CCR 10225 – 10225.2 and Labor Code 5814/5814.6 and 4603.2b. When there is a dispute with regard to treatment, the right to proceed with the Labor Code 4062 process belongs exclusively to the injured employee. If the treatment recommendations are not authorized by the insurance carrier, this report and bill should be kept together by the Workers' Compensation carrier for the review company. The claims examiner should forward this report to the defense attorney and nurse case manager.

This medical history was obtained with the assistance of medical historian, Ms. Ana Reed.

JOB DESCRIPTION:

Mr. Androsov is employed by Macys/Bloomingdale as a sales associate at the time of the injury. They began working for this employer in October 2020. The patient works full time.

Job activities included doing makeup, consulting costumers, opening boxes and selling cosmetics.

The physical requirements consist of sitting, walking, standing, flexing, twisting, and side-bending and extending the neck, bending and twisting at the waist, squatting, climbing, crawling, and kneeling.

The patient is a right-hand dominant male and they use the bilateral upper extremities repetitively for simple grasping, power grasping, fine manipulation, keyboarding, writing, pushing, and pulling, reaching at shoulder level, reaching above shoulder level, and reaching below shoulder level.

The patient is required to lift and carry objects while at work. The patient was required to lift and carry objects weighing up to about 30 lbs.

The patient worked 8 hours per day and 5 days a week. Normal work hours were 10:45 am until 7:50 pm. Lunch break was 60 minutes. Rest break was 10-15 minutes. The job involved working 100% indoors.

He is working regular duties.

PRIOR WORK HISTORY:

Regarding prior employment, the patient worked at Neiman Marcus in cosmetics for two years.

Prior to that he worked at Nordstrom for 3-4 years as a sales associate.

HISTORY OF INJURY AND TREATMENT AS PRESENTED BY PATIENT:

CUMULATIVE TRAUMA:

The patient states that while working at their usual and customary occupation as a sales associate for the above employer they sustained a work-related injury to their neck, back, shoulders, elbows, forearms, wrist, hands, fingers and lower extremities, which the patient developed in the course of employment due to continuous trauma from 01/04/22-01/03/23.

The patient attributes the injuries due to the repetitive movements due to lifting inventory frequently standing for long periods of time and using his hands repeatedly. He had to start leaning on a table when standing too long due to increasing symptoms. He reports with the use of keyboard his finger cramps up and go numb.

In 2021, he sought treatment privately at Kaiser Permanente/Los Angeles. He was examined in and he had neck x-rays. He was given a note to give to his employer to take sitting breaks as needed. He states that his employer did not approve this. He continued to work regular duties with worsening symptoms.

The patient presents to this office for further evaluation.

CURRENT COMPLAINTS:

Neck:

There is radiating pain from the neck into the shoulders and head, and they have been experiencing frequent headaches. They are experiencing numbness and tingling or burning sensations of the left arm. The pain is slight to moderate and the symptoms frequently. There is

cracking and grinding of the neck with range of motion and twisting and turning the head and neck. The pain is aggravated with flexing or extending the head and neck, turning the head from side to side, prolonged positioning of the head and neck, forward bending, pushing, pulling, lifting, and carrying greater, and working or reaching at or above shoulder level. The patent has difficulty falling asleep and is often awakened during the night by neck pain. There are stiffness and restricted range of motion in the head and neck. The pain level varies throughout the day.

Left Shoulder/Upper Arm:

The pain is moderate and the symptoms frequently. There is instability of the shoulder, as well as clicking and grinding sensations. Patient experiences weakness and restricted range of motion for the shoulders and numbness and tingling in the shoulder, arm, and hand. Patient complains of stiffness and experiences increased pain with repetitive motion of the arms/shoulders. The pain is aggravated with backward, lateral, and overhead reaching, pushing, pulling, lifting, and carrying greater than 5-10 pounds, and repetitive use of the upper extremities. Pain level varies throughout the day depending on activities. The patient is not able to sleep on either shoulder due to the pain.

Bilateral Elbows, Forearms, Wrists And Hands:

The pain is moderate and the symptoms occur sintermittnet to frequently. The pain is aggravated with gripping, grasping, torquing motions, flexion, and extension of the wrist/hand, pinching, fine finger manipulation, driving, repetitive use of the left upper extremity pushing, pulling, and lifting, and carrying. Patient has difficulty sleeping and awakens with numbness, tingling and pain, and discomfort. Pain level varies throughout the day depending on activities.

Lower Back:

The pain radiates down the buttocks and back of thighs to feet, left side. The pain is moderate and the symptoms occur intermittently to frequently in the lower back. The pain increases with activities of standing or walking as well as sitting over 90 minutes as well as activities of kneeling, stooping, squatting, forward bending, ascending and descending stairs, forceful pushing and pulling, lifting and carrying. Patient complains of muscle spasms. Patient does awaken from sleep as a result of the low back pain. The patient self-restricts by limiting the activities. They walk with a limp due to low back symptoms. He had difficulty sleeping due to back pain.

Psyche:

The patient has episodes of anxiety, stress, and depression due to chronic pain and disability status. The patient denies suicidal ideation.

PAST MEDICAL HISTORY:

Illnesses:

The patient denies any major medical illnesses.

Injuries:

He developed slight pain on and off in his lower back while working for Neiman Marcus with sitting or standing for long periods. He went to his private doctor and provided with home exercises. He reports his pain decreased to minimal to slight and without radiation to legs.

The patient denied any non-work-related injuries.

The patient denied any new injuries.

Allergies:

The patient denied any known allergies.

Medications:

The patient is taking over the counter medication.

Surgeries:

Varicocele.

Hospitalization:

The patient denied any hospitalization.

The patient was asymptomatic and without any disability or impairment prior to the continuous trauma injury from 01/04/22-01/03/23; 07/01/22-01/02/23 as related to the neck, shoulders, fingers, back, lower extremities and stress related, but did have occasional minimal to slight back pain.

REVIEW OF SYSTEMS:

Review of systems is remarkable for trouble sleeping, muscle or joint pain, stiffness, anxiety, depressed mood, social withdrawal, emotional problems, and stress.

ACTIVITIES OF DAILY LIVING:

Self-Care - Personal Hygiene: As a result of the industrially related injury, the patient states: Difficulty self, dressing by self with a rating of 3/5.

Communication: As a result of the industrially related injury, the patient states: Difficulty with writing, typing, seeing, hearing, and speaking, with a rating of 3/5.

Physical Activities: As a result of the industrially related injury, the patient states: Difficulty with standing, sitting, reclining, walking, and going up and downstairs, with a rating of 3/5.

Sensory Function: As a result of the industrially related injury, the patient states: Difficulty with hearing, seeing, feeling (tactile feeling), taste, and smell, with a rating of 3/5.

Hand Activities: As a result of the industrially-related injury, the patient states: Difficulty with grasping or gripping, lifting, and manipulating small items with a rating of 3/5.

Travel: As a result of the industrially related injury, the patient states: Difficulty with riding in a car, bus, etc., driving a car, traveling by plane, restful night sleep pattern, and sexual function, with a rating of 3/5.

FAMILY HISTORY:

Mother is deceased and passed away from Cancer.

Father is deceased and passed away from Covid-19.

The patient has no siblings.

SOCIAL HISTORY:

Mr. Androsov is a 41-year-old single, married male with no children.

The patient completed Master's Degree from Russia, as a lawyer.

The patient consumes no alcohol and does not smoke.

The patient does exercise.

The patient does not participate in any sports activities.

The patient has no hobbies.

Physical Evaluation (March 6, 2023) – Positive Findings:

General Appearance:

Re: Patient: Androsov, Ivan
DOI: CT: 01/14/22-01/03/23; 07/01/22-01/02/23
Date of Exam: March 6, 2023

The patient is a 41-year-old, right-hand dominant who appeared reported age, and was well-developed, well-nourished, and well-proportioned. The patient appears to be alert, cooperative and oriented x3.

Vital Signs:

Pulse: 69
Blood Pressure: 136/90
Height: 5'10"
Weight: 180

Cervical Spine:

Tenderness was noted over the bilateral paravertebral and upper trapezius musculature with muscle guarding. Tenderness at C3 to C7 vertebral regions, predominantly over the bilateral facet joints.

Bilateral shoulder depression tests are positive. Cervical compression tests are unremarkable.

Ranges of motion of the cervical spine were decreased and painful.

Cervical Spine Range of Motion Testing		
Movement	Normal	Actual
Flexion	50	**40**
Extension	60	**30**
Right Lateral Flexion	45	**20**
Left Lateral Flexion	45	**18**
Right Rotation	80	**45**
Left Rotation	80	**40**

Shoulders & Upper Arms:

Deformity, dislocation, edema, swelling, erythema, surgical scars and lacerations are not present upon visual examination of the shoulders. The shoulders are held in a nonantalgic position.

Right Shoulder:

Tenderness and spasm are not present over the supraspinatus musculature, infraspinatus musculature, teres (minor/major) musculature, subscapularis musculature, periscapular musculature and deltoid musculature. There is no tenderness over the subacromial bursa and subdeltoid bursa. The acromioclavicular joint, glenohumeral joint and clavicle are not tender.

The triceps and biceps brachii muscles are without tenderness and spasm and appear intact and without evidence of rupture.

Apprehension, Dugas, Hawkins and Impingement Signorthopedic tests are negative bilaterally.

Left Shoulder:

Tenderness was noted over the deltoid, supraspinatus, teres musculature as well as supraspinatus tendon near the insertion and anterior shoulder as well as subacromial and subdeltoid bursa and acromioclavicular joint with tenderness also at the triceps, mid belly and at the insertion of the shoulder.

Left Apprehension and Hawkins test were positive. Dugas test was negative.

Ranges of motion of the right shoulder were within normal limits. **Left shoulder ranges of motion were decreased and painful.**

Shoulder Ranges Of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	180	**170**	180
Extension	50	**45**	50
Abduction	180	**165**	180
Adduction	50	**45**	50
Internal Rotation	90	**80**	90
External Rotation	90	**75**	90

Elbows & Forearms:

Tenderness is noted over the bilateral lateral epicondyles and flexor muscle group.

Bilateral Tinel's sign is positive.

Bilateral Cozens' test is positive.

Ranges of motion of the bilateral elbows were within normal limits.

Elbow Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	140	140	140
Extension	0	0	0
Supination	80	80	80
Pronation	80	80	80

Wrists & Hands:

Deformity, dislocation, amputation, edema, swelling, erythema, scars, and lacerations are not present upon visual examination of the wrists and hands.

Left Wrist:

Tenderness is noted over the volar over the carpal tunnel and carpals.

Left Tinel's sign is positive. Finkelstein's test is negative.

Right Wrist:

Tenderness is noted over the volar crease of the carpal tunnel and carpals, radial styloid, anatomic snuff box and thenar region.

Right Tinel's and Finkelstein's tests are positive.

Ranges of motion of the left wrist were normal with discomfort. **Right wrist ranges of motion were decreased and painful.**

Wrist Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	60	60	**55**
Extension	60	60	**52**
Ulnar Deviation	30	30	**20**
Radial Deviation	20	20	**14**

Finger ranges of motion were performed without pain. Triggering of the digits and mechanical block is not present. Tenderness is not present at the digits. Thumb abduction is 90 degrees bilaterally. Thumb adduction reaches the head of the 5th metacarpal bilaterally **with the exception of tenderness at the right thumb at the carpometacarpal and metacarpophalangeal joint.**

Bilateral hand digital ranges of motion were grossly within normal limits with pain at the right thumb during extremes of ranges of motion.

Grip Strength Testing:

Grip strength testing was performed utilizing the Jamar Dynamometer at the third notch, measured in kilograms, on 3 attempts and produced the following results:

Left: 0/0/0
Right: 0/0/0

Motor Testing of the Cervical Spine and Upper Extremities:

Deltoid *(C5)*, Biceps *(C5)*, Triceps *(C7)*, Wrist Extensor *(C6)*, Wrist Flexor *(C7)*, Finger Flexor *(C8)* and Finger Abduction *(T1)* motor testing is normal and 5/5 bilaterally **with the exception of left shoulder 4/5, left triceps 4/5, bilateral finger flexion 4/5.**

Deep Tendon Reflex Testing of the Cervical Spine and Upper Extremities:

Biceps *(C5, C6)*, Brachioradial *(C5, C6)* and Triceps *(C6, C7)* deep tendon reflexes are normal and 2/2 bilaterally.

Sensory Testing:

C5 *(deltoid)*, C6 *(lateral forearm, thumb & index finger)*, C7 *(middle finger)*, C8 *(little finger & medial forearm)*, and T1 *(medial arm)* dermatomes are intact bilaterally as tested with a Whartenberg's pinwheel **with the exception of hypoesthesia in the right hand median nerve distribution.**

Upper Extremity Measurements in Centimeters		
Measurements	Left	Right
Biceps	**33**	**33.5**
Forearms	**20**	**20.5**

Thoracic Spine:

Gross edema, swelling, erythema and scars are not present upon visual examination of the thoracic spine. The thoracic spine has a normal kyphotic curvature.

Tenderness and spasm is not present over the paravertebral musculature, trapeziums, rhomboid, latissimus dorsi musculature and interscapular region bilaterally. Tenderness and hypomobility is not present over the vertebral regions from T1 to T12.

Kemp's test is negative.

Thoracic spine ranges of motion were restricted due to low back pain.

Lumbar Spine:

Tenderness was noted over the bilateral paravertebral musculature with tenderness at the bilateral sacroiliac joints with hypomobility noted. Tenderness at bilateral sciatic

notches, greater on the left side. Tenderness and hypomobility is noted over the L2 to L5 vertebral regions.

Bilateral sacroiliac joint compression tests are positive. Milgram's test is positive.

Straight Leg Raising Test performed supine was positive bilaterally for back pain with radiation of pain to the left lower extremity extending to the foot. Braggard's procedure increased the low back pain and radiation.

Right: 70 degrees
Left: 60 degrees

Lumbar spine ranges of motion were decreased and painful.

Lumbar Spine Range of Motion Testing		
Movement	Normal	Actual
Flexion	60	**44**
Extension	25	**16**
Right Lateral Flexion	25	**18**
Left Lateral Flexion	25	**10**

Hips & Thighs:

Deformity, dislocation, edema, swelling, erythema, scars and lacerations are not present upon visual examination of the hips and thighs.

Tenderness and spasm is not present over the greater trochanteric region, hip bursa, hip abductor, hip adductor, quadriceps, biceps femoris musculature and femoroacetabular joint bilaterally.

Bilateral Patrick Fabere test is positive for back pain.

Hip ranges of motion were performed without pain and spasm.

Hip Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	120	120	120
Extension	30	30	30
Abduction	45	45	45
Adduction	30	30	30
External rotation	45	45	45
Internal rotation	45	45	45

Knees & Lower Legs:

Visual examination of knees and lower legs does not identify deformity, dislocation, edema, swelling, erythema, scars and lacerations.

Tenderness is not present over the quadriceps tendon, patella, infrapatellar tendon, tibial tuberosity, medial joint line, lateral joint line and popliteal fossa bilaterally. Palpation of the lower leg muscles/regions was unremarkable for tenderness at the gastrocnemius, tibialis anterior *(dorsiflexion & inversion)* and peroneal musculature *(lateral ankle-eversion)* bilaterally.

McMurray's test, Varus Stress test, anterior drawer test and posterior drawer test are negative.

Range of motion of the knees was without pain, spasm, weakness, crepitus or instability bilaterally.

The patient was able to squat without knee pain or weakness.

Knee Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	135	135	135
Extension	0	0	0

Ankles & Feet:

Examination of ankles and feet did not demonstrate gross deformity, dislocation, amputation, edema, swelling, erythema, scars, lacerations, hallux valgus and hammertoes. The foot arch height is normal and without pes planus and pes cavus.

Tenderness is not present of digits 1 through 5, including metatarsals, cuneiforms, navicular, cuboid, talus and calcaneus. Tenderness is not present at the distal tibia, distal fibula, talonavicular joint, anterior talofibular ligament and deltoid ligament. There is no medial ankle instability or lateral ankle instability bilaterally. The Achilles tendon is intact. Tenderness is not present over the tarsal tunnel, sinus tarsi and tibialis posterior tendons *(medial ankle-plantarflexion & inversion)* bilaterally.

Anterior drawer test, posterior drawer test and Tinel's sign are negative bilaterally. The dorsalis pedis pulses are present and equal bilaterally.

Ankle ranges of motion were performed without pain, spasm, weakness, crepitus or instability bilaterally.

Ankle Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual

Metatarsophalangeal joint (MPJ) Extension	60	60	60
MPJ Flexion	20	20	20
Ankle Dorsiflexion	20	20	20
Ankle Plantar Flexion	50	50	50
Inversion (Subtalar joint)	35	35	35
Eversion (Subtalar joint)	15	15	15

Motor, Gait & Coordination Testing of The Lumbar Spine and Lower Extremities:

Ankle Dorsiflexion *(L4)*, Great Toe Extension *(L5)*, Ankle Plantar Flexion *(L5/S1)*, Knee Extension *(L3, L4)*, Knee Flexion, Hip Abductor and Hip Adductor motor testing was normal and 5/5 **with the exception of bilateral great toe extension 4/5.**

Squatting is positive for back pain.

Heel and toe walking was positive for back pain.

The patient's gait broad based but did not favor either lower extremity.

Deep Tendon Reflex Testing of The Lumbar Spine and Lower Extremities:

Ankle *(Achilles-S1)* and Knee *(Patellar Reflex-L4)* deep tendon reflexes are normal and 2/2.

Sensory Testing:

L3 *(anterior thigh)*, L4 *(medial leg, inner foot)*, L5 *(lateral leg and midfoot)* and S1 *(posterior leg and outer foot)* dermatomes are intact bilaterally upon testing with a pinwheel with the exception of hypoesthesia in the left L4 and L5 dermatomal innervation.

Girth & Leg Length (Anterior Superior Iliac Spine to Medial Malleoli) measurements were taken of the lower extremities, as follows in centimeters:

Lower Extremity Measurements Circumferentially & Leg Length in Centimeters		
Measurements (in cm)	Left	Right
Thigh - 10 cm above patella with knee extended	**48.5**	**49.5**
Calf - at the thickest point	**36**	**36.5**
Leg Length - Anterior Superior Iliac Spine To Medial Malleolus	**100**	**100**

Re: Patient: Androsov, Ivan
DOI: CT: 01/14/22-01/03/23; 07/01/22-01/02/23
Date of Exam: March 6, 2023

Diagnostic Impressions:

1. Cervical spine myofasciitis, M79.1.
2. Cervical facet-induced versus discogenic pain, M53.82.
3. Lumbar spine myofasciitis, M79.1.
4. Bilateral sacroiliac joint dysfunction, sacroiilitis, M53.3.
5. Lumbar facet-induced versus discogenic pain, M47.816.
6. Lumbar radiculitis/sciatica left-sided, M54.16/ M54.32.
7. Left shoulder tenosynovitis/bursitis, M75.52.
8. Left shoulder impingement syndrome, M75.42.
9. Left triceps musculotendinuous injury.
10. Bilateral lateral epicondylitis, M77.12.
11. Bilateral brachioradialis tendinitis, S56.811D.
12. Bilateral cubital tunnel syndrome, G56.20.
13. Right thumb de Quervain stenosing tenosynovitis, M65.4.
14. Bilateral carpal tunnel syndrome, G56.03.
15. Hypertension, I10.
16. Anxiety and depression, F41.9, F34.1.

Treatment Plan:

The patient is recommended comprehensive treatment course consisting of chiropractic manipulations and adjunctive multimodality physiotherapy to include myofascial release, hydrocollator, infrared, cryotherapy, electrical stimulation, ultrasound, strengthening, range of motion (active / passive) joint mobilization, home program instruction, therapeutic exercise, intersegmental spine traction and all other appropriate physiotherapeutic modalities **for cervical,**

and lumbar spine, left shoulder, left upper arm, bilateral elbows, bilateral wrist and hand and right thumb at once a week for six weeks with a followup in six weeks.

Diagnostic studies recommended:

1) The patient is recommended **x-rays of cervical and thoracic spine, left shoulder, bilateral elbows, and bilateral wrist.**
2) The patient is recommended **lumbar spine MRI**.
3) The patient is recommended **upper extremity NCV/EMG studies** to rule out carpal tunnel syndrome and cubital tunnel syndrome and to rule out cervical radiculopathy. The patient is recommended **lower extremity NCV/EMG study** for further workup of lumbar spine radiculopathy.

The patient is **recommended bilateral epicondylitis braces, bilateral carpal tunnel splints and right thumb spica as well as lumbar spine brace to use necessary based on pain levels.**

Specialty evaluation recommended:

1. The patient is recommended **internal medicine evaluation** for further workup of hypertension related to causation, nature and extent.
2. The patient is recommended **psychiatric versus psychological evaluation** for further workup of psych-related complaints related to causation, nature and extent.
3. The patient is recommended **interventional pain management evaluation** for pharmacological management to explore the need for interventional pain management procedure such as injection.

Medical Causation Regarding AOE/COE:

In my opinion, it is within a reasonable degree of medical probability that the causation of this patient's injuries, resultant conditions, as well as need for treatment with regards to neck, bilateral upper extremities, back, left lower extremity are industrially related and secondary to continuous trauma from 01/04/2022-01/03/2023 while working for Macys/Bloomingdale as a sales associate.

Causation related to hypertension is deferred to internist.

Causation related to psych issues is deferred to psychiatrist versus psychologist.

I concluded my opinion based on this patient's job description, history of injury as reported, medical records (if any provided), as well as the patient's complaints, my physical examination findings and diagnostic impressions, and absent evidence to the contrary.

Re: Patient: Androsov, Ivan
DOI: CT: 01/14/22-01/03/23; 07/01/22-01/02/23
Date of Exam: March 6, 2023

Permanent and Stationary Status:

The patient's condition is not permanent and stationary.

Work Status/Disability Status:

The patient was returned to modified duty on 3/6/23, precluding work at or above shoulder height. Precluding lifting in excess of 10 pounds. Precluding repeated bending and stooping. No forceful gripping, grasping, torqueing, pulling and pushing. The patient should sit as needed based on pain levels. If modified duty as indicated is not provided, then the patient is considered temporarily totally disabled until reevaluation in six weeks.

Disclosure:

I derived the above opinions from the oral history as related by the patient, revealed by the available medical records, diagnostic testing, credibility of the patient, examination findings and my clinical experience. This evaluation was carried out at 6221 Wilshire Boulevard, Suite 604, Los Angeles, California 90048. I prepared this report, including any and all impressions and conclusions described in the discussion.

I performed the physical examination, reviewed the document and reached a conclusion, of this report which was transcribed by Acu Trans Solution LLC and I proofread and edited the final draft prior to signing the report in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (J) of Section 139.2.

In compliance with recent Workers' Compensation legislation (Labor Code Section 4628(J)): "I declare under penalty of perjury that the information contained in this report and it's attachments, if any, is true and correct to the best of my knowledge and belief, except as to information I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true."

In compliance with recent Workers' Compensation legislation (Labor Code Section 5703 under AB 1300): "I have not violated Labor Code Section 139.3 and the contents of this report are true and correct to the best of my knowledge. This statement is made under penalty of perjury and is consistent with WCAB Rule 10978."

The undersigned further declares that the charges for this patient are in excess of the RVS and the OMFS codes due to high office and staff costs incurred to treat this patient, that the charges are the same for all patients of this office, and that they are reasonable and necessary in the circumstances. Additionally, a medical practice providing treatment to injured workers experiences extraordinary expenses in the form of mandated paperwork and collection expenses, including the necessity of appearances before the Workers' Compensation Appeals Board. This

office does not accept the Official Medical Fee Schedule as prima facie evidence to support the reasonableness of charges. I am a board-certified Doctor of Chiropractic, a state-appointed Qualified Medical Evaluator, a Certified Industrial Injury Evaluator and certified in manipulation under anesthesia. Based on the level of services provided and overhead expenses for services contained within my geographical area, I bill in accordance with the provisions set forth in Labor Code Section 5307.1.

NOTE:The carrier/employer is requested to immediately comply with 8 CCR Section 9784 by overnight delivery service to minimize duplication of testing/treatment. This office considers "all medical information relating to the claim" to include all information that either has, will, or could reasonably be provided to a medical practitioner for elicitation of medical or medical-legal opinion as to the extent and compensability of injury, including any issues regarding AOE/COE - to include, but not be limited to, all treating, evaluation, and testing reports, notes, documents, all sub rosa films, tapes, videos, reports; employer-level investigation documentation including statements of individuals; prior injury documentation; etc. This is a continuing and ongoing request to immediately comply with 8 CCR Section 9784 by overnight delivery service should such information become available at any time in the future. Obviously, time is of the essence in providing evaluation and treatment. Delay in providing information can only result in an unnecessary increase of treatment and testing costs to the employer.

I will assume the accuracy of any self-report of the examinee's employment activities, until and unless a formal Job Analysis or Description is provided. Should there be any concern as to the accuracy of the said employment information, please provide a Job Analysis/Description as soon as possible.

I request to be added to the Address List for Service of all Notices of Conferences, Mandatory Settlement Conferences and Hearings before the Workers' Compensation Appeals Board. I am advising the Workers' Compensation Appeals Board that I may not appear at hearings or Mandatory settlement Conferences for the case in chief. Therefore, in accordance with Procedures set forth in Policy and Procedural Manuel Index No. 6.610, effective February 1, 1995, I request that defendants, with full authority to resolve my lien, telephone my office and ask to speak with me.

The above report is for medicolegal assessment and is not to be construed as a report on a complete physical examination for general health purposes. Only those symptoms which I believe have been involved in the injury, or might relate to the injury, have been assessed. Regarding the general health of the patient, the patient has been advised to continue under the care of and/or to get a physical examination for general purposes with a personal physician.

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Should you have any questions with regard to this consultation please contact me at my office.

Re: Patient: Androsov, Ivan
DOI: CT: 01/14/22-01/03/23; 07/01/22-01/02/23
Date of Exam: March 6, 2023

Sincerely,

Eric E. Gofnung, D.C.
Manipulation Under Anesthesia Certified
State Appointed Qualified Medical Evaluator
Certified Industrial Injury Evaluator

Signed this 6th day of March, 2023, in Los Angeles, California.

EEG:svl

ERIC E. GOFNUNG, D.C., QME

SPORTS MEDICINE AND REHABILITATION

6221 Wilshire Boulevard, Suite 604 ⅄ Los Angeles, California 90048 ⅄ Tel. (323) 933-2444 ⅄ Fax (323) 933-2909

Date: 3 / 6 / 2023

To Employer: Macy's Inc. DBA Bloomingdales, LLC
Sedgwick

RE: Employee/ Injured worker: Ivan Androsov
SS# and/or Date of birth 04/25/1981
Date of Injury: CT: 01/14/2022-01/03/2023
Claim #:
WCAB #:
EAMS Case #: ADJ17289751

The patient named above has designated: [X] **Eric Gofnung, D.C.** [ ] **Mayya Kravchenko, D.C.** [ ] **Jyrki Suutari, D.C.** as their Primary Treating Physician. The patient is being scheduled to be seen in our office for evaluation and treatment of their industrially related injuries.

Please inform us if you have an established Medical Provider Network (MPN)? Please provide us with the following information so that we can inform and provide the injured worker with the proper information on how to select a treating physician from the employer's MPN.

Per Title 8 CCR 9767.5 an employer's MPN must have at least three (3) physicians in my area of specialty, of Chiropractic, to treat the injured worker. These three chiropractors must be within 30 minutes or 15 miles of a covered employee's residence or workplace.

Please list the names and phone numbers of these three (3) Chiropractors on the following lines:

________________, D.C.; (______) ______-__________
________________, D.C.; (______) ______-__________
________________, D.C.; (______) ______-__________

If this list of three Chiropractors in the employer's MPN is not forwarded to our office within five (5) days, we will take this to mean that you do not have three chiropractors on your MPN list within 30 minutes or 15 miles of the covered employee's residence or workplace.

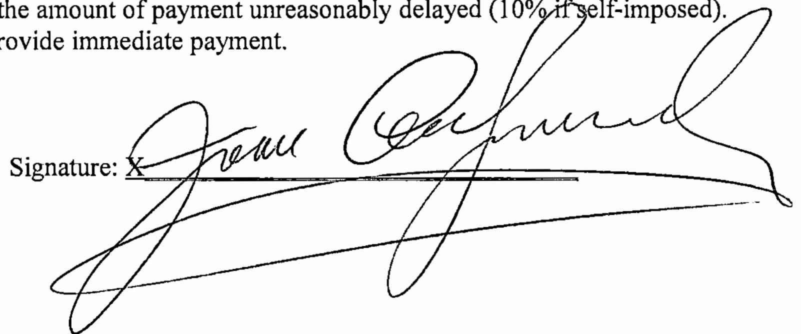
If so, then the patient has requested this office to evaluate and to treat his/her industrially related medical needs and we will proceed to evaluate and treat the injured worker as needed on an industrial basis.

If you, the insurance company/employer, fail or refuse to furnish treatment to the injured worker, then the expense incurred for medical services furnished will be due as per Section 5402, subdivision (b) and (c). Labor Code 5402 (b)(c), requires the employer to authorize all appropriate medical care up to $10,000 until the liability for the claimed injury is accepted or rejected. If payment of this bill is denied; we will pursue provisions under L.C. 4603.2

As of 06/01/04, Labor code 5814 mandates a 25% penalty on the amount of payment unreasonably delayed (10% if self-imposed). Accordingly, it would be requested that the employer please provide immediate payment.

Patient's name: Ivan Androsov

Signature: X



ERIC E. GOFNUNG CHIROPRACTIC CORP.

SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION

6221 Wilshire Blvd., Suite 604 • Los Angeles, California 90048 • Tel. (323)933-2444• Fax (323) 933-2909

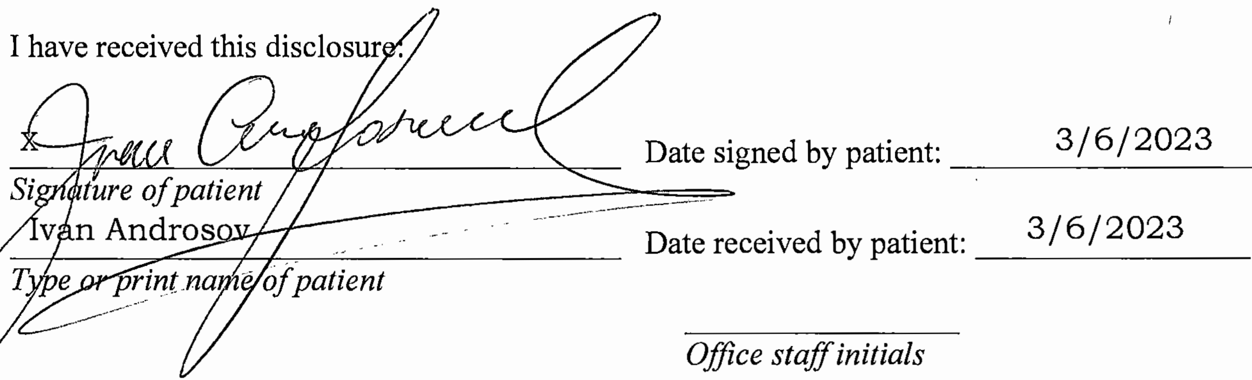
Disclosure. You may be referred to one or more of the physicians or other health care practitioners listed below. They or their family members may provide services to or have another financial interest directly or indirectly with each other.

Eric Gofnung, DC, David Feder, LAc. Mayya Kravchenko, DC.

If you would like to know of alternatives to any of them or to any other health care practitioner or facility you are referred to, please let your examining or treating doctor or his or her office staff know.

Complaints. If you have any questions, concerns, or complaints regarding any referral or any other service, please contact your doctor or his or her office manager. Your confidential communications will be protected. You have the right to file a complaint with the doctor's state licensing agency: for a chiropractor, it would be the Board of Chiropractic Examiners, 2525 Natomas Park Drive, Suite 260, Sacramento, CA 95833; for a podiatrist, the Board of Podiatric Medicine, 2005 Evergreen Street, Ste. 1300, Sacramento, CA 95815-3831; for an allopathic physician (M.D.), the Medical Board of California, 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815; for an acupuncturist, the California Acupuncture Board, 1747 N. Market Blvd, Suite 180, Sacramento, CA 95834, and for an osteopath (D.O.), the Osteopathic Medical Board of California, 1300 National Drive, Suite #150, Sacramento, CA 95834-1991.

I have received this disclosure.



x ______________________ Date signed by patient: 3/6/2023

Signature of patient

Ivan Androsov Date received by patient: 3/6/2023

Type or print name of patient

____

Office staff initials