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

#### STATE OF CALIFORNIA, COUNTY OF ORANGE

I am employed in the county aforesaid; I am over the age of eighteen years and not a party to the within entitled action; my business address is 2107 N. Broadway, Suite 207, Santa Ana, CA 92706.

On 12/2/2021, I served the within progress report(s) dated 9/7/21/91/3/21 and bill regarding Sandra Roquemore

on the appropriate parties in said action by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at Santa Ana, California, addressed as follows:

Workers Defenders Law Group 8018 E.Santa Ana Cyn #100-215 Anaheim Hills, CA 92808

Ted Tribble PSY.D. 4344 Latham Street Ste. 120 Riverside, CA 92501

Claim #:
Attn.

Accident Fund Ins. Co. of America P.O. Box 40790 Lansing, MI 48901 CL#:UW2000031101 Attn.: Patricia Carruther

Next Level Administrators P.O. Box 1061 Bradenton, FL 34206 Claim #: Attn.

I declare under penalty of perjury, that the foregoing is true and correct.

Executed on 12/2/202, at Santa Ana, California.

ву:

Alina Flores

cc: File

#### Additional pages attached □

### PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Check the box(es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use <a href="DWC Form PR-3">DWC Form PR-3</a> or <a href="IMC 81556">IMC 81556</a>

☐ Periodic Report (required 45 days after last report) ☐ Change in treatment plan ☐	Discharged
	Discharged
☐ Change-in work status ☐ Need for referral or consultation ☐ Info. Requested by:	
	QUESTED
Patient: Last Roquemore First Sandra M.I. Sex Fema	DOD
Address 1763 Exposition Blvd City Los Angeles State Occupation SS# 564-92-3586 Phone ( )	Zip 90018 (323)643-4539
Claims Administrator:	
	000031101
Address P.O. Box 40790 City Lansing State	Zip48901
Phone () (877)563-4636 FAX ()  Employer name: American Guard Services (DRA) Employer Phone: ()	
Afficient State Services (DBA)	
The information below must be provided. You may use this form or you may substitute or append a na <b>Subjective Complaints</b> :	rrative report.
Ms. Roquemore reports pain in her lower back, hips, feet, and left shoulder. Patient uses a She has difficulty controlling her emotions. She tends to socially isolate and withdraw from sad, irritable, fearful, nervous, restless, anxious, depressed, and helpless. (Continue on 2 <sup>nd</sup>	n others. She feels
Objective Findings: (Include significant physical examination, laboratory, imaging, or other diagnostic	c findings )
Sad and anxious mood.	
Diagnosis:	
1. Major Depressive Dis., Single Episode, Severe w/o ICD-9 F32.2	
2. Generalized Anxiety Disorder ICD-9 F41.1	
3. Insomnia Related to Other Mental Disorder ICD-9 F51.05	
Treatment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician protype, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupulated codes is encouraged. Have there been any changes in treatment plan? If so, why?  Cognitive Behavioral Group Psychotherapy 1x week for 6 weeks. Relaxation Training/Hyllowek for 6 weeks. Follow up in 45 days. Continue with current treatment plan. (Continue of the continue of	noture. Specify noture. Use CPT onotherapy 1x
Work Status: From the psychological standpoint, this patient is psychiatrically temporarily totally disable	oled until 10/22/2021.
Restriction: To be determined when patient reaches MMI Status.	
Primary Treating Physician: (original signature, do not stamp)  I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated.	tember 7, 2021 I Labor Code § 139.3.
Signature: Cal. Lic. # PS	Y12317/PSY31773
Executed at: SANTA ANA Date:	09/37/2021
Name: Nelson J. Flores, Ph.D. QME/Nelson L. Flores, Psy.D. Speci; 'ty:	Psychology
Address: P.O. Box 6299 Laguna Niguel, CA 92607-6299 Phone:	(714) 972-0040
Next report due no later than  DWC Form PR-2 (Rev. 1/1/99)  (Use add	itional pages, if necessary)

Primary Treating Physician's Progress Report (PR-2)

RE: Sandra Roquemore Date: September 7, 2021

Page 2 of 2

#### **Subjective Complaints:**

She experiences crying episodes and, at times, she feels like crying. She has difficulty communicating, making decisions, and remembering things. She has a decreased appetite and reports she has lost weight. She has lost interest in her usual activities. She fears the worst happening. She endorses sleep difficulties, including nightmares and distressing dreams. She feels tired and has low energy throughout the day. She experiences intrusive recollections and flashbacks. She has a decreased sexual desire. She is bothered by headaches. She experiences difficulties performing her activities of daily living and sitting and standing for long periods of time. She has physical limitations. She reports gastrointestinal disturbances, including indigestion, acid reflux, diarrhea, and constipation. She has shown improvement in her mood, motivation, and ability to utilize learned skills/techniques.

#### **Treatment Plan:**

The treatment to be provided by Dr. Flores and Registered Psychological Assistants, Jennifer Lightner and Ting F. Chiu.

#### **Psychological Testing:**

Burns Depression Checklist score: <u>87 (extreme depression)</u> Burns Anxiety Inventory score: <u>86 (extreme anxiety)</u>

Psychological testing administered today: 31 minutes (testing time includes administration, scoring, and interpretation).

#### Disclosure:

The patient was informed and consented to the use of telehealth services.

Scoring and interpretation of the psychological testing were conducted by Dr. Flores/Psychological Assistants, Jennifer Lightner/Ting F. Chiu.

Time spent for this service: 20 minutes face to face time with the patient via telemedicine.

Time spent preparing this report: 1.15 hours preparing, testing score, interpretation, transcribing, and editing this report.

I have reviewed the medical records and collateral records. X 15 mins.



#### REQUEST FOR AUTHORIZATION

DWC Form RFA - California Code of Regulations, title 8, section 9785.

		r's First Report of Occup C Form PR-2, or narrative				
Expedited Review: 0	Check box if emplo	nange in Material Facts byee faces an imminent an mation of a prior oral reque		ous threat to his or h	ner health	
Employee Information	1					
Employee Name (Last,	First, Middle): Ro	quemore, Sandra	RC	QSA000		
Date of Injury (MM/DD/	YYYY): 11/03/2020	0		of Birth (MM/DD/Y	111).	11/1955
Claim Number:CL#:UW	/2000031101		Emp	loyer: American G	uard Services	(DBA)
Provider Information						
Provider Name: Nelson						
Practice Name: Psycho	logical Assessme	nt Serv.	Cont	tact Name: Ted Tril	bble PSY.D.	
Address: 2107 N Broad	way Ste 207		City:	Santa Ana		State: CA
<u>Zip Code:</u> 92706		4-972-0040	Fax	Number: 714-972-	-0477	
Provider Specialty: Psyc	chology		NPI	Number: 1831237	981	<u>'</u>
E-mail Address:						
Claims Administrator						
Claims Administrator Na		Fund Ins. Co. of America	Cont	act Name:		
Address: P.O. Box 4079						State: MI
Zip Code: 48901	<u>Phone:</u> (87)	7)563-4636	Fax	Number: 0	141/1141.1	iw
E-mail Address:					'	
		for guidance; attached a				<b>《</b> 图》的是是图》
report on which the requ	ed treatment in the	e below space or indicate t an be found. Up to five (5)	ne spe	ecific page number(	s) of the accor	npanying medical
on a separate sheet.	agotou troutmont o	an be lound. Op to live (o)	proce	budies may be enter	reu, attacii aut	allional requests
<u>Diagnosis</u>	ICD-Code	Procedure Requested	1	CPT/HCPCS Code	(Freque	Information: ency, Duration y, Facility, etc.)
Major Depressive Dis., Single	F32.2	Group Medical Psychothera	ру	90853	1X WK X D WK	S, TOTAL SESSIONS
Generalized Anxiety Disorder	F41.1	Group Medical Psychothera	ру	90853		
Insomnia	F51.05	Group Medical Psychothera	ру	90853		
Pain Dis. w/Related Psychologi	F45.42	Group Medical Psychothera	ру	90853		" "
Tracking Dh. sising Circ		My			9/13/2021	
Treating Physician Sign		Man		Dat	e: 7/13/2021	
Claims Administrator  Approved Denie Requested treatmen	ed or Modified (Se	e separate decision letter) usly denied  Liability f	or trea	Delay (See separate	te notification of	of delay)
Authorization Number (i	f assigned):		D	ate:		
Authorized Agent Name	<u>.</u>			ignature:		
Phone:	Fax Num	nber:		-mail Address:		
Comments:						

DWC Form RFA (version 07/2013)



# State of California Division of Workers' Compensation REQUEST FOR AUTHORIZATION

DWC Form RFA - California Code of Regulations, title 8, section 9785.							
This form must accompany the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or narrative report substantiating the requested treatment.							
Expedited Review: (	Check box if emplo	hange in Material Facts byee faces an imminent and rmation of a prior oral reque		ous threat to his or l	her health		
Employee Information	1						
Employee Name (Last,	First, Middle): Ro	oquemore, Sandra	RC	DQSA000		*	
Date of Injury (MM/DD/				of Birth (MM/DD/Y	YYY): 02/	11/1955	
Claim Number: CL#:UV	V2000031101		Emp	loyer: American C	Guard Services	(DBA)	
Provider Information							
Provider Name: Nelson	J. Flores, PH.D.						
Practice Name: Psycho	ological Assessme	ent Serv.	Cont	act Name: Ted Tr	ibble PSY.D.		
Address: 2107 N Broad			City:	Santa Ana		State: CA	
<u>Zip Code:</u> 92706		14-972-0040	Fax I	Number: 714-972	2-0477		
Provider Specialty: Psy	chology		NPI	Number: 1831233	7981		
E-mail Address:							
Claims Administrator	Information						
Claims Administrator N	- 110010011	t Fund Ins. Co. of America	Cont	act Name:			
Address: P.O. Box 407			City:	Lansing		State: MI	
Zip Code: 48901	Phone:(87	77)563-4636	Fax Number:				
E-mail Address:			C				
Either state the request	ed treatment in the	s for guidance; attached a e below space or indicate the can be found. Up to five (5)	ne spe	ecific page number(	s) of the accom	npanying medical itional requests	
<u>Diagnosis</u>	ICD-Code	Procedure Requested	<u>I</u>	CPT/HCPCS Code	(Freque	nformation: ncy, Duration , Facility, etc.)	
Major Depressive Dis., Single	F32.2	Medical Hypnotherapy/Relaxation	n Tra	90880	1X WK X	S, TOTAL SESSIONS	
Generalized Anxiety Disorder	F41.1	Medical Hypnotherapy/Relaxation	n Tra	90880			
Insomnia	F51.05	Medical Hypnotherapy/Relaxation	n Tra	90880			
Pain Dis. w/Related Psychologi	F45.42	Medical Hypnotherapy/Relaxation	n Tra	90880		и и	
Treating Physician Sign	ature:	My		Dat	e: 9/13/2021		
Claims Administrator				1 200			
	ed or Modified (Se	ee separate decision letter)		Delay (See separa	te notification o	f delay)	
Authorization Number (i				ate:			
Authorized Agent Name				gnature:			
Phone:	Fax Nun	mber:	_	mail Address:			
Comments:							

DWC Form RFA (version 07/2013)



# State of California Division of Workers' Compensation REQUEST FOR AUTHORIZATION

DWC Form RFA - California Code of Regulations, title 8, section 9785.

This form must accompany the Doctor's First Report of Occupational Injury or Illness,	Form DLSR 5021, a Treating
	- ortice de la contraction de

Physician's Prog	ress Report, DWC	Form PR-2, or narrative	repo	ort substantiating t	he requested	treatment.	
Expedited Review: 0	Check box if emplo	nange in Material Facts nyee faces an imminent and mation of a prior oral reque		ous threat to his or h	ner health		
Employee Information	1						
Employee Name (Last,	First, Middle): Ro	quemore, Sandra	RC	DQSA000			
Date of Injury (MM/DD/	YYYY): 11/03/2020	0	Date	of Birth (MM/DD/Y	YYY): 02/	11/1955	
Claim Number:CL#:UW	Claim Number: CL#:UW2000031101						
Provider Information							
Provider Name: Nelson	J. Flores, PH.D.						
Practice Name: Psycho	logical Assessme	nt Serv.	Cont	act Name: Ted Tri	bble PSY.D.		
Address: 2107 N Broad	way Ste 207		City:	Santa Ana		State: CA	
<u>Zip Code:</u> 92706	Phone: 71	4-972-0040	Fax	Number: 714-972	-0477		
Provider Specialty: Psyc	chology		NPI	Number: 1831237	981		
E-mail Address:							
Claims Administrator	<u>Information</u>						
Claims Administrator Na	ame: Accident	Fund Ins. Co. of America	Cont	act Name:			
Address: P.O. Box 4079			City: Lansing State: MI				
<u>Zip Code:</u> 48901	Phone:(87'	7)563-4636	Fax Number:				
E-mail Address:							
		for guidance; attached a					
Either state the request	ed treatment in the	below space or indicate to	he sp	ecific page number(	s) of the accor	npanying medical	
on a separate sheet.	<u>Jested treatment c</u>	an be found. Up to five (5)	proce	edures may be ente	red; attach add	ditional requests	
<u> </u>				T	Others	I	
Diagnosis	ICD-Code	Procedure Requested	4	CPT/HCPCS		Information:	
<u>= 149.14016</u>	100 0000	1 1000date Requested	<u>Code</u>		(Frequency, Duration Quantity, Facility, etc.)		
Major Depressive Dis., Single	F32.2	Phone call, intermediate		99442			
Generalized Anxiety Disorder	F41.1	Phone call, intermediate		99442	ONCE	E IN 45 DAYS	
Insomnia	F51.05	Phone call, intermediate		99442		ни	
Pain Dis. w/Related Psychologi	F45.42	Phone call, intermediate		99442			
an Dis. Wittelated I sychologi	1 45.42	Priorie cail, intermediate		33442			
		V-Constitution of the Constitution of the Cons			1		
Treating Physician Sign	ature:	Mad		Dat	e: 9/13/2021		
Claims Administrator							
Approved Denie		e separate decision letter) usly denied	or trea	Delay (See separa atment is disputed	te notification of	of delay)	
Authorization Number (i	f assigned):		D	ate:			
Authorized Agent Name	<u>:</u>		S	ignature:			
Phone:	Fax Num	nber:		-mail Address:			
Comments:							

DWC Form RFA (version 07/2013)



#### **REQUEST FOR AUTHORIZATION**

DWC Form RFA - California Code of Regulations, title 8, section 9785.

This form must accor Physician's Prog	mpany the Doctor ress Report, DW	r's First Report of Occur C Form PR-2, or narrativ	ation e repo	al Injury or Illness, ort substantiating t	Form DLSR 5 the requested	021, a Treating treatment.			
Expedited Review: (	Check box if emplo	<u>hange in Material Facts</u> <u>byee faces an imminent ar</u> mation of a prior oral requ	nd seri est.	ous threat to his or	her health				
Employee Information	1								
Employee Name (Last,	First, Middle): Ro	quemore, Sandra	ROC	QSA000		14.			
Date of Injury (MM/DD/	<u>Date of Injury (MM/DD/YYYY): 11/03/2020</u> <u>Date of Birth (MM/DD/YYYY): 02/11/1955</u>								
Claim Number:			Emp	oloyer: American G	uard Services	(DBA)			
Provider Information									
Provider Name: Nelson		-							
Practice Name: Psycho	logical Assessme	ent Serv.	Con	tact Name: Ted Tri	bble PSY.D.				
Address: 2107 N Broad	lway Ste 207		City:	Santa Ana		State: CA			
<u>Zip Code:</u> 92706		4-972-0040	Fax	Number: 714-972	-0477				
Provider Specialty: Psy	chology		NPI	Number: 1831237	7981				
E-mail Address:									
Claims Administrator									
Claims Administrator N		el Administrators	Contact Name:						
Address: P.O. Box 106			<u>City:</u> Bradenton <u>State:</u> FL			State: FL			
Zip Code: 34206	<u>Phone:</u> (94	1)281-3494	Fax	Number: (941)44	4-6200				
E-mail Address:				1					
Fither state the request	(see instructions	for guidance; attached	additi	onal pages if nece	ssary)				
report on which the request	uested treatment in the	e below space or indicate to can be found. Up to five (5	ne sp	<u>ecitic page number(</u> edures may be ente	<u>s) of the accom</u> red: attach add	itional requests			
on a separate sheet.		<u> </u>	<u> </u>	saures may be crite	rea, attach add	itional requests			
<u>Diagnosis</u>	ICD-Code	Procedure Requeste	<u>d</u>	CPT/HCPCS Code	(Freque	nformation: ncy, Duration , Facility, etc.)			
Major Depressive Dis., Single	F32.2	Group Medical Psychothera	ру	90853	1X WK X WKS	S, TOTAL SESSIONS			
Generalized Anxiety Disorder	F41.1	Group Medical Psychothera	ру	90853		" "			
Insomnia	F51.05	Group Medical Psychothera	ру	90853		" "			
Pain Dis. w/Related Psychologi	F45.42	Group Medical Psychothera	ру	90853					
Treating Physician Sign		My		<u>Dat</u>	e: 9/13/2021				
Claims Administrator  Approved Denie Requested treatmen	ed or Modified (Se	e separate decision letter) usly denied Liability	or trea	Delay (See separa	te notification o	f delay)			
Authorization Number (i	f assigned):		D	ate:					
Authorized Agent Name	<u>:</u>		S	ignature:					
Phone:	Fax Num	nber:	E	-mail Address:					
Comments:									

DWC Form RFA (version 07/2013)



# State of California Division of Workers' Compensation REQUEST FOR AUTHORIZATION

rm DEA - California Code of Bogulations, title 9, section 0795

	DWC Form KFA - Camornia Code of Regulations, title 6, section 9765.	
This form	n must accompany the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating	<u>1g</u>

Physician's Progr	ess Report, DW	C Form PR-2, or narrative	e repo	rt substantiating th	ne requested	treatment.	
X New Request R	tesubmission - C	hange in Material Facts					
		<u>oyee faces an imminent an</u>		ous threat to his or h	er health		
Check box if request	is a written confi	rmation of a prior oral requ	est.				
Employee Information							
Employee Name (Last,	First, Middle): R	oquemore, Sandra	ROC	QSA000			
Date of Injury (MM/DD/	YYYY): 11/03/202	20	Date	of Birth (MM/DD/Y)	<u>YY):</u> 02.	/11/1955	
Claim Number:			Emp	loyer: American G	uard Services	(DBA)	
Provider Information							
Provider Name: Nelson	J. Flores, Ph.D						
Practice Name: Psycho	logical Assessm	ent Serv.	Cont	act Name: Ted Tri	bble PSY.D.		
Address: 2107 N Broad	way Ste 207			Santa Ana		State: CA	
Zip Code: 92706	Phone: 7	14-972-0040	Fax I	Number: 714-972	-0477		
Provider Specialty: Psy	chology		NPII	Number: 1831237	081		
E-mail Address:				1031231	701		
Claims Administrator	<u>Information</u>						
Claims Administrator Na	ame: Next Lev	el Administrators	Cont	act Name:			
Address: P.O. Box 106			City: Bradenton State: FL				
<u>Zip Code:</u> 34206	Phone: (9)	41)281-3494	Fax Number: (941)444-6200				
E-mail Address:							
		for guidance; attached				been defined.	
		e below space or indicate					
on a separate sheet.	iested treatment	can be found. Up to five (5	) proce	edures may be enter	<u>'ed; attach add</u>	ditional reque	ests
on a separate sneet.					0.1		
<u>Diagnosis</u>	ICD-Code	Procedure Requeste	d	CPT/HCPCS		Information:	n
<u>Diagnosis</u>	IOD-Code	1 Tocedure requeste	<u>u</u>	Code	(Frequency, Duration Quantity, Facility, etc.)		
Major Depressive Dis., Single	F32.2	Medical Hypnotherapy/Relaxati	ion Tra	90880		,	ESSIONS
Generalized Anxiety Disorder	F41.1	Medical Hypnotherapy/Relaxati		90880	IX WK X VK	3, TOTAL 31	23310113
Insomnia	F51.05	Medical Hypnotherapy/Relaxati		90880		" "	
Pain Dis. w/Related Psychologi	F45.42	Medical Hypnotherapy/Relaxati		90880		и и	
an Dio. Wittelated 1 Sychologi	1 40.42	Wedical Tryphotherapy/Telaxati	on ma	30000			
		1					
Treating Physician Sign		My		Date	e: 9/13/2021		
Claims Administrator		<u> </u>					
Approved Denie		ee separate decision letter		Delay (See separat atment is disputed	e notification of	of delay)	
Authorization Number (i		daily defiled   Liability					
				ate:			-
Authorized Agent Name Phone:		mhor:		ignature:	and the same of th		
Comments:	Fax Nur	HDGI.	] <u></u>	-mail Address:			

DWC Form RFA (version 07/2013)



# State of California Division of Workers' Compensation REQUEST FOR AUTHORIZATION

TWEE STATE OF THE	DWC Form	RFA - Californ	ia Code of Regu	lations, title 8, se	ction 9785	<u>.</u>		
This form must accor Physician's Prog								ing
X New Request Frame Fram		yee faces an	imminent and		o his or he	er health		
Employee Information	1							
Employee Name (Last,	First, Middle): Ro	oguemore, Sa	ındra	ROQSA000				
Date of Injury (MM/DD/				Date of Birth (M	M/DD/YY	<u>YY):</u> 02	2/11/1955	
Claim Number:			Ē	mployer: An	nerican Gu	uard Services	(DBA)	
Provider Information								
Provider Name: Nelson	J. Flores, Ph.D							
Practice Name: Psycho	ological Assessm	ent Serv.	2	Contact Name:	Ted Trib	bble PSY.D.		
Address: 2107 N Broad	way Ste 207		2	City: Santa Ana			State: CA	
Zip Code: 92706	Phone: 7	14-972-0040	E	ax Number:	714-972-	0477		
Provider Specialty: Psy	chology		1	NPI Number:	1831237	981		
E-mail Address:								
Claims Administrator	<u>Information</u>							
Claims Administrator N	ame: Next Lev	el Administra	ators	Contact Name:				
Address: P.O. Box 106	51		(	City: Braden	ton		State:	FL
<u>Zip Code:</u> 34206	Phone: (9	41)281-3494	<u>F</u>	ax Number:	(941)444	4-6200		
E-mail Address:								
Requested Treatment								
Either state the request report on which the requon a separate sheet.								
<u>Diagnosis</u>	ICD-Code	Procedu	re Requested	CPT/H(		(Freque	Information: ency, Duratio y, Facility, etc.	
Major Depressive Dis., Single	F32.2	Phone c	all, intermediate	994	12	ONCE	E IN 45 DAYS	
Generalized Anxiety Disorder	F41.1	Phone c	all, intermediate	994	12			
Insomnia	F51.05	Phone ca	all, intermediate	994	12		ни	
Pain Dis. w/Related Psychologi	F45.42	Phone ca	all, intermediate	994	12		" "	
		1						
			100					
Treating Physician Sign	ature:	J. S.	1		Date	9/13/2021		
Claims Administrator								
Approved Deni Requested treatmer	ed or Modified (Se at has been previo			Delay (See treatment is di		notification o	of delay)	
Authorization Number (	f assigned):			Date:				
Authorized Agent Name				Signature:				
Phone:	Fax Num	nber:		E-mail Addre	SS:			
Comments:								

DWC Form RFA (version 07/2013)



#### Collections Department <collections@drnelsonflores.com>

#### Message Failed: 79895718 | 11/25/2021 11:43:54 AM PST

1 message

**FAXAGENT** <noreply@mitelcloud.com>
To: Fax 3 <collections@drnelsonflores.com>

Thu, Nov 25, 2021 at 11:59 AM

#### **Delivery Information:**

Message #:

79895718

Sender Name:

Fax 3

Sender Company:

Sender Phone:

Remote CSID:

**Total Pages:** 

6

Start Time:

11/25/2021 11:43:54 AM PST

End Time:

11/25/2021 3:58:52 AM PST

Duration:

0.000 sec

#### Successful Deliveries:

#### **Failed Deliveries:**

1941446200 - 11941446200 :

Delivered by FAXAGENT... "When Every Fax is Mission Critical"

79895718.pdf 614K

## **Fax Transmission**

To: 1941446200

From: Fax 3

Fax: 11941446200

**Date:** 11/25/2021 11:43:54 AM PST

RE: Roquemore, Sandra

Pages: 6

#### Comments:

09/07/21 PR-2 and RFAs

<sup>\*</sup>Collections\*

<sup>\*</sup>Psychological Assessment Services \* Ph. 714-972-0040 Fax 714-972-0477



#### Collections Department <collections@drnelsonflores.com>

#### Message Failed: 79895719 | 11/25/2021 11:44:22 AM PST

1 message

**FAXAGENT** <noreply@mitelcloud.com>
To: Fax 3 <collections@drnelsonflores.com>

Thu, Nov 25, 2021 at 11:59 AM

#### **Delivery Information:**

Message #:

79895719

Sender Name:

Fax 3

Sender Company: Sender Phone:

Remote CSID:

Total Pages:

6

Start Time:

11/25/2021 11:44:22 AM PST

End Time:

11/25/2021 3:58:58 AM PST

Duration:

0.000 sec

#### Successful Deliveries:

#### **Failed Deliveries:**

1941446200 - 11941446200 :

Delivered by FAXAGENT... "When Every Fax is Mission Critical"

79895719.pdf

## **Fax Transmission**

To: 1941446200

From: Fax 3

Fax: 11941446200

**Date:** 11/25/2021 11:44:22 AM PST

RE: Roquemore, Sandra

Pages: 6

#### Comments:

09/07/21 PR-2 and RFAs

\*Collections\*

<sup>\*</sup>Psychological Assessment Services \* Ph. 714-972-0040 Fax 714-972-0477

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

#### STATE OF CALIFORNIA, COUNTY OF ORANGE

I am employed in the county aforesaid; I am over the age of eighteen years and not a party to the within entitled action; my business address is 2107 N. Broadway State 207 Santa Ana, CA 92706.

On 10/6/2021, I served the within progress report(s) dated 6 - 15 - 21 3

and bill regarding

Sandra Roquemore

on the appropriate parties in said action by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at Santa Ana, California, addressed as follows:

Workers Defenders Law Group 8018 E.Santa Ana Cyn #100-215 Anaheim Hills, CA 92808

Ted Tribble PSY.D. 4344 Latham Street Ste. 120 Riverside, CA 92501

Claim #:
Attn.

Accident Fund Ins. Co. of America P.O. Box 40790 Lansing, MI 48901 CL#:UW2000031101 Attn.: Patricia Carruther

Next Level Administrators P.O. Box 1061 Bradenton, FL 34206 Claim #: Attn.

I declare under penalty of perjury, that the foregoing is true and correct.

Executed on 10/6/2021, at Santa Ana, California.

By:

Alina Flores

cc: File

Additional pages attached □

(Use additional pages, if necessary)

## PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Check the box(es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use <u>DWC Form PR-3</u> or <u>IMC 81556</u> ☐ Periodic Report (required 45 days after last report) ☐ Change in treatment plan ☐ Discharged ☐ Change-in work status ☐ Need for referral or consultation ☐ Info. Requested by: ☐ Change in patient's condition ☐ Need for surgery or hospitalization UR REOUESTED Patient: Last Roquemore Sandra Female DOB 02/11/1955 M.I. Sex Address City 1763 Exposition Blvd State Zip Los Angeles 90018 Occupation SS# Phone 564-92-3586 (213)677 - 8002Claims Administrator: Name Accident Fund Ins. Co. of America Claim Number CL#:UW2000031101 Address P.O. Box 40790 State Phone (877)563-4636 Employer name: American Guard Services (DBA Employer Phone: The information below must be provided. You may use this form or you may substitute or append a narrative report. **Subjective Complaints:** Ms. Roquemore reports pain in her lower back, legs, and feet. She has difficulty controlling her emotions and impulses. She tends to socially isolate and withdraw from others. She feels sad, fearful, nervous, restless, anxious, depressed, and helpless. She has lost interest in her usual activities. (Continue on 2<sup>nd</sup> page). Objective findings: (Include significant physical examination, laboratory, imaging, or other diagnostic findings.) Sad and anxious mood and nervous. Diagnosis: 1. Major Depressive Dis., Single Episode, Severe w /o F32.2 ICD-9 2. Generalized Anxiety Disorder ICD-9 F41.1 3. Insomnia Related to Other Mental Disorder ICD-9 F51.05 Treatment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture. Use CPT codes is encouraged. Have there been any changes in treatment plan? If so, why? Cognitive Behavioral Group Psychotherapy 1x week for 6 weeks. Relaxation Training/Hypnotherapy 1x week for 6 weeks. Follow up in 45 days. Continue with current treatment plan. (Continue on 2<sup>nd</sup> page). Work Status: From the psychological standpoint, this patient is psychiatrically temporarily totally disabled until 07/30/2021. Restriction: To be determined when patient reaches MMI Status. Primary Treating Physician: (original signature, do not stamp) Date of exam: I declare under penalty of perjury that this report is type and correct to the best of my knowledge and that I have not violated Labor Code § 139.3. Signature: Cal. Lic. # PSY20308/PSB94023427 Executed at: SANTA ANA Date: 06/15/2021 Name: Ted Tribble Psy.D./Stephanie T. Imp, M.A. Specialty: Psychology Address: P.O. Box 6299 Laguna Niguel, CA 92607-6299 Phone: 714) 972-0040 Next report due no later than DWC Form PR-2 (Rev. 1/1/99)

Primary Treating Physician's Progress Report (PR-2)

RE: Sandra Roquemore Date: June 15, 2021

Page 2 of 2

#### **Subjective Complaints:**

She experiences crying episodes and, at times, she feels like crying. She has difficulty communicating and remembering things. She has a decreased appetite and reports she has lost approximately 20 pounds. She fears the worst happening. She endorses sleep difficulties, including nightmares and distressing dreams. She feels tired and has low energy throughout the day. She experiences intrusive recollections and flashbacks. She has a decreased sexual desire. She is bothered by headaches and sweating sensations throughout her hands and body. She reports gastrointestinal disturbances, including heartburn, indigestion, acid reflux, diarrhea, and constipation. She has shown improvement in her ability to manage her anxiety symptoms and panic attacks and utilizing learned coping/relaxation skills.

#### **Treatment Plan:**

The treatment to be provided by Dr. Tribble, Dr. Flores, and Registered Psychological Assistants, Stephanie T. Imp and Jennifer Lightner.

#### **Psychological Testing:**

Burns Depression Checklist score: <u>94 (extreme depression)</u> Burns Anxiety Inventory score: <u>90 (extreme anxiety)</u>

Psychological testing administered today: 31 minutes (testing time includes administration, scoring, and interpretation).

#### Disclosure:

The patient was informed and consented to the use of telehealth services.

Scoring and interpretation of the psychological testing were conducted by Dr. Tribble/Psychological Assistants, Stephanie T. Imp/Jennifer Lightner.

Time spent for this service: 20 minutes face to face time with the patient via telemedicine.

Time spent preparing this report: 1.15 hours preparing, testing score, interpretation, transcribing, and editing this report.

I have reviewed the medical records and collateral records. X 15 mins.



#### **REQUEST FOR AUTHORIZATION**

DWC Form RFA - California Code of Regulations, title 8, section 9785.

Physician's Pro	ompany the Docto gress Report, DV	or's First Report of Occupa VC Form PR-2, or narrative	ational Injury or e report substant	Illness iating	, Form DLSR 5021, a Treating the requested treatment.
X New Request Expedited Review Check box if reque	: Check box if emp	<u>Change in Material Facts</u> <u>loyee faces an imminent and</u> irmation of a prior oral reque	d serious threat to	his or	her health
Employee Information	o <u>n</u>				
Employee Name (Las	st, First, Middle):	Roquemore, Sandra	ROQSA	000	
Date of Injury (MM/DI		20	Date of Birth (MN		YYY): 02/11/1955
Claim Number:	CL#:UW200003110	01	Employer:	Americ	an Guard Services (DBA)
Provider Information	Ted Tribble,	PSY.D. Nelson J. Flo			
Provider Name:	Psychological As	sessment Serv.			
Practice Name:			Contact Name:	Te	d Tribble, PSY.D.
Address: 2107 N Broa	adway Ste 207		City: Santa Ana		State: CA
<u>Zip Code:</u> 92706	Phone:	714-972-0040	Fax Number:		972-0477
Provider Specialty:	Psychology		NPI Number:	1063	8682862
E-mail Address:					
Claims Administrato	r Information	aidant Eurad Iv. C. C.			
Claims Administrator I	<u>Name:</u> D. Box 40790	cident Fund Ins. Co. of Ame	Contact Name:	,	
Address.	A1	(877)563-4636	City:		State:
Zip Code.	Phone:	(077)303-4030	Fax Number:	194	
E-mail Address:					1
Fither state the regues	t (see instructions	s for guidance; attached ac	dditional pages i	neces	ssary)
report on which the red	uested treatment in th	can be found. Up to five (5) r	e specific page nu	ımber(	s) of the accompanying medical red; attach additional requests
on a separate sheet.	- Control of the cont	san be loand. Op to live (5) p	brocedures may b	e ente	red; attach additional requests
<u>Diagnosis</u>	ICD-Code	Procedure Requested	CPT/HCF Code	<u>PCS</u>	Other Information: (Frequency, Duration Quantity, Facility, etc.)
Major Depressive Dis., Single	F32.2	Group Medical Psychotherapy	90853		1X WK X WKS, TOTAL SESSIONS
Generalized Anxiety Disorder	F41.1	Group Medical Psychotherapy	90853		н н
Insomnia	F51.05	Group Medical Psychotherapy	90853		и и
ain Dis. w/Related Psychologi	F45.42	Group Medical Psychotherapy	90853		ин
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Claims Administrator  Approved □ Den  Requested treatme	Response ied or Modified (Se nt has been previous	e separate decision letter)	treatment is disp	eparate	<u> </u>
Claims Administrator  Approved Den Requested treatme  Authorization Number (	Response ied or Modified (Sent has been previous if assigned):	e separate decision letter)	treatment is disp	eparate	<u> </u>
Claims Administrator Approved Den Requested treatme Authorization Number ( Authorized Agent Name	Response ied or Modified (Sent has been previous if assigned):	e separate decision letter) usly denied  Liability for	treatment is disp  Date: Signature:	eparate uted_	<u> </u>
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Claims Administrator  Approved Den Requested treatme  Authorization Number (  Authorized Agent Name  Phone:	Response ied or Modified (Sent has been previous if assigned):	e separate decision letter) usly denied  Liability for	treatment is disp  Date: Signature:	eparate uted_	<u> </u>

DWC Form RFA (version 07/2013)



#### **REQUEST FOR AUTHORIZATION**

DWC Form RFA - California Code of Regulations, title 8, section 9785.

This form must acco	mpany the Doct gress Report, DV	or's First Report of Occup NC Form PR-2, or narrative	ation e repo	al Injury or Illness ort substantiating	, Form DLSR 5 the requested	021, a Treating treatment.
X New Request Expedited Review:	Resubmission – ( Check box if emp	Change in Material Facts oloyee faces an imminent an firmation of a prior oral requ	d seri			
Employee Informatio	<u>n</u>					
Employee Name (Last	, First, Middle):	Roquemore, Sandra	į.	ROQSA000		
Date of Injury (MM/DD	/YYYY): 11/03/20		Date	of Birth (MM/DD/Y	YYY): 02/11.	/1955
Claim Number: C	L#:UW200003110	)1		oloyer: America	an Guard Service	ces (DBA)
Provider Information	Ted Tribble,	PSY.D. Nelson J. Flo	res,	PH.D.		The state of the s
Provider Name:	Psychological As	ssessment Serv.				
Practice Name:			Conf	tact Name: Tec	d Tribble, PSY.I	D.
Address: 2107 N Broad	dway Ste 207			Santa Ana		State: CA
Zip Code: 92706	Phone:	714-972-0040		Number: 714-	972-0477	Otato. Ort
Provider Specialty:	Psychology			Number: 1063	682862	
E-mail Address:		5				
Claims Administrator	Information					
Claims Administrator N		cident Fund Ins. Co. of Am	erica Cont	act Name:		<u>I</u>
Address.		(0==) = (0   1   1   1   1   1   1   1   1   1	City: State:			
Zip Code: 4890	Phone:	(877)563-4636	Fax Number:			<u>State.</u>
E-mail Address:				101110011		
<b>Requested Treatment</b>	(see instruction	s for guidance; attached a	dditio	onal pages if neces	ssarv)	
Either state the request	ed treatment in th	ne below space or indicate the	ne spe	ecific page number/	s) of the accom	panying medical
report on which the requ	uested treatment	can be found. Up to five (5)	proce	dures may be enter	red; attach addi	tional requests
on a separate sheet.						
<u>Diagnosis</u>	ICD-Code	Procedure Requested		CPT/HCPCS Code	(Frequer	nformation: ncy, Duration
					Quantity,	Facility, etc.)
Major Depressive Dis., Single	F32.2	Medical Hypnotherapy/Relaxatio		90880	1X WK X WKS	TOTAL SESSIONS
Generalized Anxiety Disorder	F41.1	Medical Hypnotherapy/Relaxatio	n Tra	90880		ни
Insomnia	F51.05	Medical Hypnotherapy/Relaxatio	n Tra	90880		н и
Pain Dis. w/Related Psychologi	F45.42	Medical Hypnotherapy/Relaxatio	n Tra	90880		ни
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Claims Administrator		19 1000		Date	<u>.</u>	
	ed or Modified (Se	ee separate decision letter)	r trea	Delay (See separate tment is disputed	e notification of	delay)
Authorization Number (i				ite:		
Authorized Agent Name				gnature:		
Phone:	Fax Nur	mber:		mail Address:		
Comments:				mail / touress.		

DWC Form RFA (version 07/2013)



#### **REQUEST FOR AUTHORIZATION**

DWC Form RFA - California Code of Regulations, title 8, section 9785.

		r's First Report of Occup C Form PR-2, or narrative				
		hange in Material Facts byee faces an imminent an	d seri	ous threat to his or h	ner health	
		mation of a prior oral requ			ior rioditir	
Employee Informatio	<u>n</u>					
Employee Name (Last	<u>, First, Middle):</u>	Roquemore, Sandra		ROQSA000		
Date of Injury (MM/DD			Date	of Birth (MM/DD/Y)	<u> </u>	/1955
Claim Number: C	L#:UW2000031101			ioyci.	n Guard Servi	ces (DBA)
Provider Information	Ted Tribble, P	SY.D. Nelson J. Flo	ores,	PH.D.		
	Psychological Ass	essment Serv.				
Practice Name:			Cont	act Name: Ted	Tribble, PSY.	D.
Address: 2107 N Broad	dway Ste 207		City:	Santa Ana		State: CA
<u>Zip Code:</u> 92706	Phone:	714-972-0040	Fax	Number.	72-0477	
Provider Specialty:	Psychology		NPL	Number: 10630	682862	
E-mail Address:		19				
Claims Administrator	Information	dan Faritan Carlo				
Claims Administrator N	ame:	ident Fund Ins. Co. of Am	Cont	act Name:		M
Address.			City:	Lansing		State: MI
Zip Code: 4890	Phone:	(877)563-4636	Fax I	Number:		•
E-mail Address:						
Requested Treatment	(see instructions	for guidance; attached a	dditio	onal pages if neces	sary)	
report on which the request	ed treatment in the	e below space or indicate the an be found. Up to five (5)	ne spe	ecific page number(s	of the accom	panying medical
on a separate sheet.	acsted treatment c	an be lourid. Op to live (5)	proce	dures may be enter	<u>ed; attach add</u>	itional requests
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<u>Diagnosis</u>	ICD-Code	Procedure Requested		CPT/HCPCS		nformation: ncy, Duration
				<u>Code</u>		Facility, etc.)
Major Depressive Dis., Single	F32.2	Phone call, intermediate		99442		IN 45 DAYS
Generalized Anxiety Disorder	F41.1	Phone call, intermediate		99442	ONCL	" "
Insomnia	F51.05	Phone call, intermediate		99442		
Pain Dis. w/Related Psychologi	F45.42	Phone call, intermediate		99442		ни
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Requested treatmer		usly denied  Liability fo		tment is disputed		
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Authorized Agent Name	<u>:</u>		Sig	gnature:		
Phone:	Fax Num	ber:	E-	mail Address:		
Comments:						
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DWC Form RFA (version 07/2013)



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Roquemore, Sandra

Pages: 6

#### Comments:

06/15/21 PR-2 and RFAs

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\*Psychological Assessment Services \*

Ph. 714-972-0040 Fax 714-972-0477

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#### **REQUEST FOR AUTHORIZATION**

<u>DWC Form RFA - California Code of Regulations, title 8, section 9785.</u>

This form must accor Physician's Prog	npany the Docto ress Report, DW	or's First Report of Occup C Form PR-2, or narrativ	e rep	al Injury or Illness ort substantiating	, Form DLSR the requested	5021, a Treating I treatment.
Expedited Review: 0	Check box if empl	hange in Material Facts oyee faces an imminent ar rmation of a prior oral requ	nd ser lest.	ious threat to his or	her health	
Employee Information	1					
Employee Name (Last,	First, Middle):	Roquemore, Sandra		ROQSA000		
Date of Injury (MM/DD/	YYYY): 11/03/202	20	Date	e of Birth (MM/DD/Y	<u> </u>	2/11/1955
Claim Number:			Emp	oloyer: Americ	an Guard Servi	ices (DBA)
Provider Information					(47)	
	Tribble, PSY.D.	Nelson J. Flores	PH.	D.		
Practice Name: Psyc	hological Assess	ment Serv.	Con	tact Name: Ted Tr	ibble, PSY.D.	
Address: 2107 N Broad	way Ste 207		City	Santa Ana		State: CA
<u>Zip Code:</u> 92706	Phone:	714-972-0040	Fax	Number: 71	4-972-0477	
	sychology		NPI	Number: 1063682	2862	
E-mail Address:						
Claims Administrator						
Claims Administrator Na	ame:	evel Administrators	Con	tact Name:		
Address: 34206		(941)281-3494	City:	City: Bradenton State: FL		
Zip Code:	Phone:	(511)201 5151	Fax	Number: (941)	<del>444-6200</del> I	
E-mail Address:						
Requested Treatment	see instructions	for guidance; attached	additi	onal pages if nece	ssary)	
report on which the requeste	ed treatment in the	e below space or indicate to	he sp	ecific page number(	s) of the accon	npanying medical
on a separate sheet.	ested treatment t	can be found. Up to five (5)	proce	edures may be ente	red; attach add	ditional requests
<u>Diagnosis</u>	ICD-Code	Procedure Requested	<u>d</u>	CPT/HCPCS Code	(Freque	Information: ency, Duration y, Facility, etc.)
Major Depressive Dis., Single	F32.2	Group Medical Psychothera	ру	90853	1X WK X WKS	S, TOTAL USESSIONS
Generalized Anxiety Disorder	F41.1	Group Medical Psychothera	ру	90853		пи
Insomnia	F51.05	Group Medical Psychothera	ру	90853		* "
Pain Dis. w/Related Psychologi	F45.42	Group Medical Psychothera	ру	90853		и и
Traction Division Of				Ma	6/22/20	)21
Treating Physician Signa	1 + 1	16 Pay P + 7 20308		Date	<u>e:</u>	
Claims Administrator F Approved Denie Requested treatment	d or Modified (Se	e separate decision letter)	П	Delay (See separat	e notification o	f delay)
		usiy denied     Liability i	T	atment is disputed		
<u>Authorization Number (if</u> <u>Authorized Agent Name:</u>				ate:		
Phone:		hor		gnature:		
Comments:	Fax Num	iber.	E-	mail Address:		

DWC Form RFA (version 07/2013)



#### **REQUEST FOR AUTHORIZATION**

		m RFA - California Code of Regula			
This form must accompany the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or narrative report substantiating the requested treatment.					
PROPERTY AND PERSONS ASSESSED.			port substantiating	the requested treatment.	
Expedited Review:	Check box if emp	Change in Material Facts loyee faces an imminent and se irmation of a prior oral request.		her health	
Employee Informatio	n				
Employee Name (Last		Roquemore, Sandra	ROQSA000		
Date of Injury (MM/DD		20 Da	ate of Birth (MM/DD/Y	YYY): 02/11/1955	
Claim Number:	Bate of Midify (MINI/DDT+1+1).				
Provider Information					
Provider Name: Ted	Tribble, PSY.D.	Nelson J. Flores, Ph	ł.D.		
Practice Name: Psyc	chological Assess	sment Serv.	ontact Name: Ted Tr	ibble, PSY.D.	
Address: 2107 N Broad	dway Ste 207		<u>ty:</u> Santa Ana	State: CA	
Zip Code: 92706	Phone:			4-972-0477	
Provider Specialty:	Psychology	NF	PI Number: 1063682	2862	
E-mail Address:		· · · · · · · · · · · · · · · · · · ·			
Claims Administrator					
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Address: 34206	Address: City: Bradenton Ctate: 12				
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<u>Diagnosis</u>	ICD-Code	Procedure Requested	CPT/HCPCS Code	Other Information: (Frequency, Duration Quantity, Facility, etc.)	
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Generalized Anxiety Disorder	F41.1	Medical Hypnotherapy/Relaxation Tra	a 90880	ни	
Insomnia	F51.05	Medical Hypnotherapy/Relaxation Tra	a 90880	ни	
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Treating Physician Sign	ature:	1 - 16 Pay D + 91 20308		6/22/2021	
Claims Administrator		1) 10 9 8 9 1 1	Dat	e.	
		ee separate decision letter)	Delay (See separa	te notification of delay)	
Requested treatmer	nt has been previo		eatment is disputed		
Authorization Number (i	f assigned):		Date:		
	assigned).				
Authorized Agent Name			<u>Signature:</u>		

DWC Form RFA (version 07/2013)



#### **REQUEST FOR AUTHORIZATION**

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		C Form PR-2, or narrative				
Expedited Review: (	Check box if emplo	hange in Material Facts byee faces an imminent an mation of a prior oral requ	ıd seri est.	ous threat to his or h	er health	
Employee Information	1					
Employee Name (Last,	First, Middle):	Roquemore, Sandra		ROQSA000		
Date of Injury (MM/DD/	YYYY): 11/03/202	0	Date	of Birth (MM/DD/YY	YY): 02	2/11/1955
Claim Number:				loyer: America	n Guard Serv	ices (DBA)
Provider Information						
Provider Name: Ted	Tribble, PSY.D.	Nelson J. Flores	, PH.			
Practice Name: Psyc	chological Assess	ment Serv.	Cont	act Name: Ted Tri	bble, PSY.D.	
Address: 2107 N Broad	way Ste 207		City:	Santa Ana		State: CA
<u>Zip Code:</u> 92706	Phone:	714-972-0040	Fax	Number.	<del>1-972-0477</del>	
Provider Specialty:	Psychology		NPI	Number: 1063682	862	
E-mail Address:		10				
Claims Administrator						
Claims Administrator Na		evel Administrators	Cont	act Name:		El
Address: P.O. Box 1061 City Bradenton State:				State:		
<u>Zip Code:</u> Phone: Fax Number:						
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Requested Treatment	(see instructions	for guidance; attached a	dditio	onal pages if neces	sary)	
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<u>Diagnosis</u>	ICD-Code	Procedure Requested	Į.	CPT/HCPCS Code	(Freque	Information: ncy, Duration y, Facility, etc.)
Major Depressive Dis., Single	F32.2	Phone call, intermediate		99442	ONCE	IN 45 DAYS
Generalized Anxiety Disorder	F41.1	Phone call, intermediate		99442		""
Insomnia	F51.05	Phone call, intermediate		99442		пи
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Authorization Number (if				ite:		
Authorized Agent Name:				gnature:		
Phone:	Fax Num	ber:	E-mail Address:			
Comments:						

DWC Form RFA (version 07/2013)



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## **Fax Transmission**

To: 19414446200

From: Fax 3

Fax: 19414446200

**Date:** 9/21/2021 2:08:16 PM PDT

RE: Roquemore, Sandra

Pages: 6

#### Comments:

06/15/21 PR-2 and RFAs

\*Collections\*

\*Psychological Assessment Services \* Ph. 714-972-0040 Fax 714-972-0477

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

#### STATE OF CALIFORNIA, COUNTY OF ORANGE

I am employed in the county aforesaid; I am over the age of eighteen years and not a party to the within entitled action; my business address is 2107 N. Broadway, Suite 207, Santa Ana, CA 92706.

1.10.22

On 4/12/2022, I served the within progress report(s) dated 3.16.22 ar Sandra Roquemore

and bill regarding

on the appropriate parties in said action by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at Santa Ana, California, addressed as follows:

Workers Defenders Law Group 8018 E.Santa Ana Cyn #100-215 Anaheim Hills, CA 92808

Ted Tribble PSY.D. 4344 Latham Street Ste. 120 Riverside, CA 92501

Claim #:

Attn.

Accident Fund Ins. Co. of America P.O. Box 40790 Lansing, MI 48901 CL#:UW2000031101 Attn.: Patricia Carruther

Next Level Administrators P.O. Box 1061 Bradenton, FL 34206 Claim #:

Attn.

I declare under penalty of perjury, that the foregoing is true and correct.

Executed on 4/12/2022, at Santa Ana, California.

By:

Joanna Ambrocio

cc: File

## State of California

4 1 11.1 1		. 1 1	
Additional	nages	attached	
luultionai	pages	attached	

## Division of Workers' Compensation PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Check the box(es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use <a href="DWC Form PR-3">DWC Form PR-3</a> or <a href="IMC 81556">IMC 81556</a>

☐ Pariedia Depart (required 45 days ofter last report) ☐ Change in treat	mont plan	☐ Discharged
☐ Periodic Report (required 45 days after last report) ☐ Change in treat		Discharged
☐ Change-in work status ☐ Need for referral or consultation ☐ Info. Red		IID DEGLECTED
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☐	Other:	<u>UR REQUESTED</u>
Patient: Last Roquemore First Sandra M.I.	Sex	Female DOB 02/11/1955
Address 1763 Exposition Blvd City Los Angeles Occupation SS # 564-92-35	86 Phone	State Zip 90018 ( ) (213)677-8002
Claims Administrator:		
Name Accident Fund Ins. Co. of America Claim Num  Address P.O. Box 40790 City Lansing	nber C	L#:UW2000031101 State Zip 48001
		State Zip48901
	er Phone:	( )
The information below must be provided. You may use this form or you may subs		pond a parrative report
Subjective Complaints:	litute or app	pend a narrative report.
Ms. Roquemore reports pain in her back, knees, and feet. She tends to so others. She feels sad, fearful, nervous, restless, anxious, and helpless. So lost interest in her usual activities. She fears the worst happening. (Con	he has a de	ecreased appetite. She has
Objective findings: (Include significant physical examination, laboratory, imaging	g, or other o	diagnostic findings.)
Anxious mood.		
Diagnosis:		
1. Major Depressive Dis., Single Episode, Severe w/o	ICD-9	F32.2
2. Generalized Anxiety Disorder	ICD-9	F41.1
Insomnia Related to Other Mental Disorder	ICD-9	F51.05
Treatment Plan: (Include treatment rendered to date. List methods, frequency and Specify consultation/referral, surgery, and hospitalization. Identify each physician type, frequency and duration of physical medicine services (e.g., physical therapy, codes is encouraged. Have there been any changes in treatment plan? If so, which is the services of the services is encouraged.	and non-ph manipulation?	nysician provider. Specify on, acupuncture. Use CPT
Cognitive Behavioral Group Psychotherapy 1x week for 6 weeks. Relative for 6 weeks. Follow up in 45 days. Continue with current treatmet	cation Traint plan. (C	ining/Hypnotherapy 1x Continue on 2 <sup>nd</sup> page)
Work Status: From the psychological standpoint, this patient is psychiatrically tended to the status.  Restrictions: To be determined when patient reaches MMI Status.	mporarily to	stally disabled until 02/25/2022.
	of exam:	January 10, 2022
I declare under penalty of perjury that this report is true and correct to the best of my knowledge a	nd that I have	
Signature: Executed at: SANTA ANA	Cal. Lic. ; Date:	# PSY12317/PSB94026051 01/10/2022
Name: Nelson J. Flores, Rh.D, QME/Ting F. Chiu, M.A.	Specialty	
Address: P.O. Box 6299 Laguna Niguel, CA 92607-6299	Phone:	(714) 972-0040
Next report due no later than		(/11) //2 0010
DWC Form PR-2 (Rev. 1/1/99)		(Use additional pages, if necessary)

Primary Treating Physician's Progress Report (PR-2)

RE: Sandra Roquemore Date: January 10, 2022

Page 2 of 2

#### **Subjective Complaints:**

She endorses sleep difficulties, including distressing dreams. She feels tired and has low energy throughout the day. She is bothered by blurred vision and headaches. She reports gastrointestinal disturbances, including diarrhea and constipation. With treatment, she has noticed some improvement in her headaches. She has shown improvement in her motivation, insight, and ability to utilize learned coping/relaxation skills.

#### **Treatment Plan:**

The treatment to be provided by Dr. Flores and Registered Psychological Associates, Jennifer Lightner-Farrell and Ting F. Chiu.

#### **Psychological Testing:**

Burns Depression Checklist score: <u>81 (extreme depression)</u> Burns Anxiety Inventory score: <u>92 (extreme anxiety)</u>

Psychological testing administered today: 31 minutes (testing time includes administration, scoring, and interpretation).

#### Disclosure:

The patient was informed of and consented to the use of telehealth services.

Scoring and interpretation of the psychological testing were conducted by Dr. Flores/Psychological Associates, Jennifer Lightner-Farrell/Ting F. Chiu.

Time spent for this service: 20 minutes face to face time with the patient via telemedicine.

Time spent preparing this report: 1.15 hours preparing, transcribing, and editing this report.

I have reviewed the medical records and collateral records. X 15 mins.

## State of California Division of Workers' Compensation

#### **REQUEST FOR AUTHORIZATION**

DWC Form RFA - California Code of Regulations, title 8, section 9785.

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

Expedited Review: (	Check box if emplo	nange in Material Facts yee faces an imminent al mation of a prior oral requ		ous threat to his or h	er health	
Employee Information	<u>n</u>	,				
Employee Name (Last,	First, Middle): R	oquemore, Sandra	R	OQSA000		
Date of Injury (MM/DD/	YYYY): 11/03/2020	0		of Birth (MM/DD/Y)	<u>(YY):</u> 02	/11/1955
Claim Number: CL#:U	W2000031101		Empl	loyer: American (	Guard Services	(DBA)
Provider Information						
Provider Name: Nelso	n J. Flores, PH.D.					
Practice Name: Psych	nological Assessm	ent Serv.	Cont	act Name: Ted Ti	ribble PSY.D.	
Address: 2107 N Broad	dway Ste 207		City:	Santa Ana		State: CA
Zip Code: 92706	Phone: 7	14-972-0040	Fax I	Number: 714-97	2-0477	•
Provider Specialty: Ps	ychology		NPI	Number: 183123	7981	
E-mail Address:			•			
Claims Administrator	Information					
Claims Administrator N	lame: Accider	nt Fund Ins. Co. of Amer	ic Cont	act Name:		
Address: P.O. Box 40		*	City:	Lansing		State: MI
Zip Code: 48901	Phone: (8	77)563-4636	Fax 1	Number:	(941) 444	-11200
E-mail Address:					1	
Requested Treatment	(see instructions	for guidance; attached	additio	onal pages if neces	ssary)	
		e below space or indicate				
	uested treatment of	an be found. Up to five (5	) proce	edures may be enter	red; attach add	litional requests
on a separate sheet.				T	Т	
<u>Diagnosis</u>	ICD-Code	Procedure Requeste	<u>ed</u>	CPT/HCPCS		Information:
				Code		ncy, Duration y, Facility, etc.)
Major Depressive Dis., Single	F32.2	Group Medical Psychother	apy	90853	Quantity	ncy, Duration y, Facility, etc.)
Major Depressive Dis., Single Generalized Anxiety Disorder	F32.2 F41.1	Group Medical Psychother			Quantity	ncy, Duration
		Group Medical Psychother	ару	90853	Quantity	ncy, Duration (, Facility, etc.) s, TOTAL SESSIONS
Generalized Anxiety Disorder	F41.1		ару	90853 90853	Quantity	ncy, Duration (, Facility, etc.) s, TOTAL SESSIONS
Generalized Anxiety Disorder Insomnia	F41.1 F51.05	Group Medical Psychother	ару	90853 90853 90853	Quantity	ncy, Duration y, Facility, etc.) s, TOTAL SESSIONS
Generalized Anxiety Disorder Insomnia	F41.1 F51.05	Group Medical Psychother	ару	90853 90853 90853	Quantity	ncy, Duration y, Facility, etc.) s, TOTAL SESSIONS
Generalized Anxiety Disorder Insomnia	F41.1 F51.05 F45.42	Group Medical Psychother Group Medical Psychother Group Medical Psychother	ару	90853 90853 90853	Quantity  1X WK X	ncy, Duration (, Facility, etc.)  S, TOTAL SESSIONS  ""  ""
Generalized Anxiety Disorder Insomnia Pain Dis. w/Related Psychologi  Treating Physician Sigr	F41.1 F51.05 F45.42	Group Medical Psychother	ару	90853 90853 90853 90853	Quantity  1X WK X	ncy, Duration (, Facility, etc.)  S, TOTAL SESSIONS  ""  ""
Generalized Anxiety Disorder Insomnia Pain Dis. w/Related Psychologi  Treating Physician Sigr Claims Administrator	F41.1 F51.05 F45.42  nature: Response ied or Modified (Se	Group Medical Psychother Group Medical Psychother Group Medical Psychother	rapy rapy	90853 90853 90853 90853	Quantity 1X WK X	ncy, Duration y, Facility, etc.) s, TOTAL SESSIONS "" ""
Generalized Anxiety Disorder Insomnia Pain Dis. w/Related Psychologi  Treating Physician Sign Claims Administrator  Approved Deni	F41.1 F51.05 F45.42  nature: Response ied or Modified (Sent has been previo	Group Medical Psychother Group Medical Psychother Group Medical Psychother	apy apy apy for trea	90853 90853 90853 90853 Date	Quantity 1X WK X	ncy, Duration y, Facility, etc.) s, TOTAL SESSIONS "" ""
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Generalized Anxiety Disorder Insomnia Pain Dis. w/Related Psychologi  Treating Physician Sign Claims Administrator Approved Deni Requested treatme Authorization Number (	F41.1 F51.05 F45.42  mature: Response ied or Modified (Sent has been previous if assigned):	Group Medical Psychother Group Medical Psychother Group Medical Psychother Group Medical Psychother  e separate decision lette usly denied Liability	r) Team Diagraps	90853 90853 90853 90853 Date  Delay (See separate atment is disputed ate:	Quantity 1X WK X	ncy, Duration y, Facility, etc.) s, TOTAL SESSIONS "" ""

#### State of California

Division of Workers' Compensation

#### REQUEST FOR AUTHORIZATION

DWC Form RFA - California Code of Regulations, title 8, section 9785.

This form must accompany the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or narrative report substantiating the requested treatment. X 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** Employee Name (Last, First, Middle): Roquemore, Sandra ROQSA000 02/11/1955 Date of Injury (MM/DD/YYYY): 11/03/2020 Date of Birth (MM/DD/YYYY): Claim Number: CL#:UW2000031101 American Guard Services (DBA) Employer: **Provider Information** Provider Name: Nelson J. Flores, PH.D. Practice Name: Psychological Assessment Serv. Contact Name: Ted Tribble PSY.D. Address: 2107 N Broadway Ste 207 City: Santa Ana State: CA 714-972-0040 714-972-0477 Phone: Zip Code: 92706 Fax Number: Provider Specialty: Psychology NPI Number: 1831237981 E-mail Address: Claims Administrator Information Claims Administrator Name: Accident Fund Ins. Co. of Americ Contact Name: MI State: Address: P.O. Box 40790 Lansing City: Zip Code: 48901 Fax Number: Phone: (877)563-4636 E-mail Address: Requested Treatment (see instructions for guidance; attached additional pages if necessary) Either state the requested treatment in the below space or indicate the specific page number(s) of the accompanying medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; attach additional requests on a separate sheet. Other Information: CPT/HCPCS **Diagnosis** ICD-Code Procedure Requested (Frequency, Duration Code Quantity, Facility, etc.) WKS. TOTAL & SESSIONS 90880 1X WK X F32.2 Major Depressive Dis., Single Medical Hypnotherapy/Relaxation Tra 90880 F41.1 Medical Hypnotherapy/Relaxation Tra Generalized Anxiety Disorder

insomnia	F51.05	Medical Hyphotherapy/Relaxation Tra	90000	
Pain Dis. w/Related Psychologi	F45.42	Medical Hypnotherapy/Relaxation Tra	90880	" "
P 5.1				
		l,		
Treating Physician Signatu	ıre:	Very	Date:	3/16/2022
Claims Administrator Re	sponse	•		
			Delay (See separate i	notification of delay)
Requested treatment h	as been prev	riously denied  Liability for trea	atment is disputed	
Authorization Number (if a	ssigned):	Da	ate:	
Authorized Agent Name: Signature:				
Phone: Fax Number:			-mail Address:	
Comments:				

#### State of California

#### **Division of Workers' Compensation**

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Comments:

W



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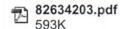
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## **Fax Transmission**

**To:** 19414446200

From: Fax 3

Fax: 19414446200

**Date:** 4/6/2022 4:14:43 PM PDT

RE: Roquemore, Sandra

Pages: 6

#### Comments:

01/10/22 PR-2 and RFAs

<sup>\*</sup>Collections\*

<sup>\*</sup>Psychological Assessment Services \* Ph. 714-972-0040 Fax 714-972-0477

#### <u>State of California</u> <u>Division of Workers' Compensation</u>

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## State of California Division of Workers' Compensation

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Comments:

## State of California Division of Workers' Compensation

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E-mail Address:

Phone: Comments: Fax Number:



#### Message Sent: 82634179 | 4/6/2022 4:13:47 PM PDT

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Wed, Apr 6, 2022 at 4:54 PM

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82634179.pdf 584K

## **Fax Transmission**

To: 19414446200

From: Fax 3

Fax: 19414446200

**Date:** 4/6/2022 4:13:47 PM PDT

RE: Roquemore, Sandra

Pages: 6

#### Comments:

01/10/22 PR-2 and RFAs

Ph. 714-972-0040 Fax 714-972-0477

<sup>\*</sup>Collections\*

<sup>\*</sup>Psychological Assessment Services \*

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

#### STATE OF CALIFORNIA, COUNTY OF ORANGE

I am employed in the county aforesaid; I am over the age of eighteen years and not a party to the within entitled action; my business address is 2107 N. Broadway, Suite 207, Santa Ana, CA 92706.

, I served the within psychological testing report dated C/21/22On 8/10/2022 and bill regarding Sandra Roquemore

on the appropriate parties in said action by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at Santa Ana, California, addressed as follows:

Workers Defenders Law Group 8018 E.Santa Ana Cyn #100-215 Anaheim Hills, CA 92808

Ted Tribble PSY.D. 4344 Latham Street Ste. 120 Riverside, CA 92501

Accident Fund Ins. Co. of America P.O. Box 40790 Lansing, MI 48901 CL#:UW2000031101 Attn.: Patricia Carruther

Next Level Administrators P.O. Box 1061 Bradenton, FL 34206 Claim #:

Attn.

Attn.

Claim#:

I declare under penalty of perjury, that the foregoing is true and correct.

Executed on 8/10/2022, at Santa Ana, California.

Joanna Ambrocio

cc: File

#### PSYCHOLOGICAL ASSESSMENT SERVICES

CLINICAL & FORENSIC PSYCHOLOGY

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#### CONFIDENTIAL MATERIAL

The highly complex nature of the information contained in this report can result in serious misunderstandings if revealed to the patient. This could not only harm the patient but also the doctor-patient relationship. Consequently, it is strongly suggested that this report is not released to the patient without consulting the undersigned.

June 22, 2022

Workers Defenders Law Group 8018 E.Santa Ana Cyn #100-215 Anaheim Hills, CA 92808

RE: Sandra Roquemore vs. American Guard Services DBA

#### PSYCHOLOGICAL TESTING REPORT-PERMANENT AND STATIONARY

Dear Gentlepersons:

Your client, Ms. Roquemore, agreed to Telemedicine Services. She was mailed a battery of Psychological Testings. The test were applied via Telemedicine from my office in Santa Ana, California on June 21, 2022. The psychological tests were scored by this examiner.

The time spent for the psychological testing evaluation services by physician or other qualified health care professional, including administration, scoring, integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning, and report and interactive feedback to the patient was <u>4.25</u> hours.

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This complex psychological testing was administered for diagnostic purposes as well as to thoroughly explore issues of personality, cognition, malingering, and/or exaggeration.

A post-treatment complex psychological testing was recommended as it goes beyond the routine screening battery. As stated in the Psychiatric Protocol adopted by the Industrial Medical Council on July 16, 1992, and amended on March 18 and October 25, 1993, "Complex Psychological testing gives an in-depth view of the patient. Routine testing relying upon self-administered inventories may be insufficient in cases where elaboration; reading language and intellectual barriers; or confusional states exist," (pp. 9-10).

The basis of this report comes from the following sources of data: Clinical Interview, Review of Records, Medical and Psychiatric Symptom Checklist, Beck Anxiety Inventory (BAI), Beck Depression Inventory-II (BDI), Adult Neuropsychological Questionnaire, Epworth Sleeping Scale, and Insomnia Severity Index, along with my clinical interpretation.

On the Medical and Psychiatric Symptom Checklist, the patient reported a variety of symptoms indicating depression, anxiety, sleep difficulties, memory problems, attention span deficits, gastrointestinal disturbances, and physical complaints.

The Beck Anxiety and Beck Depression Inventories are each a 21-item, self-report questionnaire in which respondents rate their subjective experience of anxiety and depression. A total score is obtained from the responses by summing the items. Ultimately, the Beck Anxiety and Beck Depression Inventories scores can range from 0 to 63.

On the post-treatment BAI, Ms. Roquemore obtained a score of 28, indicative of severe levels of anxiety.

On the post-treatment BDI, the patient obtained a score of 49, indicative of severe levels of depression.

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On the Neuropsychological Questionnaire, Ms. Roquemore reported no neuropsychological

disturbances. However, it is cautioned that this questionnaire is only a screening device.

The Epworth Sleepiness Scale is an 8-item self-report questionnaire that measures an individual's

general level of daytime sleepiness. On this test, the patient obtained a score of 23, which is

indicative of severe excessive daytime sleepiness.

The Insomnia Severity Index is a 7-item self-report questionnaire that assesses the nature,

severity, and impact of a patient's sleep difficulties including sleep onset, sleep maintenance, and

interference on daytime functioning. The patient obtained a score of 28, which is indicative of

severe clinical insomnia.

**SUMMARY OF TEST RESULTS:** 

Ms. Roquemore was administered a comprehensive psychological test battery to assess her

psychological functioning after her participation in psychotherapy. The testing exam was also

oriented to obtain necessary data in order to more objectively evaluate the patient's levels of

psychological disability/impairment.

Ms. Roquemore completed the psychological tests in a cooperative manner. She showed no

perceptual or thought disorder. There does not appear to be an indication that the patient may be

experiencing neuropsychological disturbances.

The results of the psychological tests suggest that Ms. Roquemore is reporting severe clinical

levels of anxiety and severe clinical levels of depression.

On the Epworth Sleepiness Scale, there is an indication that the patient is experiencing severe

excessive daytime sleepiness.

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On the Insomnia Severity Index, there is an indication that the patient is experiencing severe clinical insomnia.

The time spent in application scoring and interpretation is as follows:

	Administration & Scoring	Test Evaluation Services
Checklist Questionnaire	15	30
Beck Anxiety	15	30
Beck Depression	15	30
Neuropsych	20	30
ESS	15	20
ISI	15	20
Subtotal	95min = (1.58 hours)	160min = (2.66 hours)
Total	255min = (4.25hours)	

The test results suggest that the patient's anxious and depressive symptoms have chronically developed. The test data supports the patient's complaints, her subjective perception of improvement, and my diagnostic and clinical impressions. However, it is necessary to synthesize the data yielded here with clinical and archival data gathered in a clinical evaluation in order to assess the patient's current psychological functioning and degree of psychological disability/impairment.

#### **DISCLOSURE**:

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I 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 (LC '4628j).

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Please do not hesitate to contact me if you may have questions or if I may be of further assistance in this case.

Truly yours,

Nelson J. Flores, Ph.D., QME, DABPS Licensed Clinical Psychologist Qualified Medical Evaluator

Board Certified in Forensic Clinical Psychology PSY 12317 / QME 909038 / DABPS 13796

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