

Patient Medical Record

Heath, Stephen

57 yo M, DOB: Apr 13, 1967
Account Number: 172574
10035 DRIFTWOOD PARK DR
HOUSTON, TX 77095-2381

Patient Medical Record	Page(s)
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Note: There may be certain notes which are not made available as per your physician's discretion, please contact your physician's office to obtain those.

Patient Summary for Heath, Stephen, 57 Y, male DOB:04/13/1967

Heath, Stephen

10035 DRIFTWOOD PARK DR, HOUSTON, TX, US
77095-2381

DOB: 04/13/1967 **Age:** 57 Y **Sex:** male

Home: 281-467-1852

Work:

Cell: 281-467-1852

Email: steveeheath@gmail.com

Previous Name: BOP CA1 R Foot

Advance Directive:

Primary Insurance: US DEPT OF LABOR
HOU SPA

PCP:

Account Number: 172574

Race: Declined to Specify

Ethnicity: Declined to Specify

Preferred Language: English

Care Team:

Patient Encounters

Date	Time	Provider	Facility	Reason	Diagnosis
06/13/2024	10:00 AM	Harris, Maresah	Accuhealth Houston Spa	3 month f/u	
03/13/2024	11:00 AM	Babalola, Temitope	Accuhealth	3 month f/u	S96.911A- Strain of right foot, initial encounter SNOMED: 281544003 S96.911A- Strain of right ankle, initial encounter SNOMED: 441933004
12/13/2023	10:30 AM	Harris, Maresah	Accuhealth Houston Spa	1 month f/u	S96.911A- Strain of right foot, initial encounter SNOMED: 281544003 S96.911A- Strain of right ankle, initial encounter SNOMED: 441933004
09/13/2023	01:30 PM	Harris, Maresah	Accuhealth Houston Spa	3 month f/u	S96.911A- Strain of right foot, initial encounter SNOMED: 281544003 S96.911A- Strain of right ankle, initial encounter SNOMED: 441933004
06/27/2023	08:18 AM			Orthopedic Referral	
06/21/2023	03:03 PM			Employer request for S.E. Heath (Rib Injury)	
06/21/2023	02:57 PM			Employer request 21 June 2023 for S.E. Heath (Rib Injury)	
06/13/2023	12:00 PM	Bashwani, Anum, PA-C	Accuhealth Houston Spa	1 month f/u	S96.911A- Strain of right foot, initial encounter SNOMED: 281544003 S96.911A- Strain of right ankle, initial encounter SNOMED: 441933004
04/28/2023	03:00 PM	Simpson-Camp, Lashondria, MD	Accuhealth Houston Spa	ROF	S96.911A- Strain of right foot, initial encounter SNOMED: 281544003 S96.911A- Strain of right ankle, initial encounter SNOMED: 441933004
04/08/2023	01:30 PM	Simpson-Camp, Lashondria, MD	Accuhealth Houston Spa		S96.911A- Strain of right foot, initial encounter SNOMED: 281544003

Heath, Stephen, M, 04/13/1967

620 JAMES DR , RICHARDSON, TX-75080-7407,

972-238-1976

Address 10035 DRIFTWOOD PARK DR, HOUSTON, TX-77095-2381

Patient Vaccine Administration Record

No of Immunizations 0

Vaccine	Date Given	Dose	Location	Lot No.	Manufacturer	Exp. Date	Given By
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Record generated by eClinicalWorks EMR/PM Software (www.eclinicalworks.com)

Heath, Stephen , M , 04/13/1967

Address 10035 DRIFTWOOD PARK DR, HOUSTON, TX-77095-2381

Accuhealth

620 JAMES DR , RICHARDSON, TX-75080-7407

 972-238-1976

Patient Injection Record

No of Injections 0

Record generated by eClinicalWorks EMR/PM Software (www.eclinicalworks.com)

5/13/24, 12:36 PM

Heath, Stephen 56Y , M

DOB: 04/13/1967 | **AC (MRN):** 172574

Preferred Name:	Cell Phone: 281-467-1852	
Sex: M	Home Phone: 281-467-1852	
Previous Name: BOP CA1 R Foot	Work Phone:	
Prefix:	Email: steveheath@gmail.com	
Suffix:		
<hr/>		
Primary Insurance: US DEPT OF LABOR HOU SPA	Ethnicity: Declined to Specify	
Race: Declined to Specify	Preferred Language: English	
Advance Directive:	SSN: 000-00-4590	
<hr/>		
Confidential Patient: No	Deceased: No	Inactive: No
<hr/>		
Sex Assigned at Birth:	Sexual Orientation:	Gender Identity:
Transgender:		

PATIENT INFORMATION

<u>Financial Information and Consents</u>		
Account Balance: 412.50	Plan Type: (Other)	Rx History Consent: U
Patient Balance: 0.0	Don't Sent Statements: No	Release of Info: Yes
VFC Eligibility:	Exclude from Collections: No	Signature Date: 04/08/2023
Mail Order Member ID:	Don't Add Financial Charge: No	
<hr/>		
<u>Statuses</u>		
Student Status: Part-time student	Exclude from Registry Search: No	Deceased Notes: N/A
Is Native: No	Deceased: No	
Marital Status:	Deceased Date: N/A	
<hr/>		
<u>Providers and Facilities</u>		

5/13/24, 12:36 PM

PCP:	Default Facility:
Rendering Provider:	Default Lab Company:
Referring Provider:	Default DI Company:
<hr/>	
<u>External MRNs</u>	
Medical Record Number:	

RESPONSIBLE PARTY

Name	Relation	Address	Cell Phone
Heath, Stephen	Self - patient is the insured	10035 DRIFTWOOD PARK DR,HOUSTON,TX,77095-2381	281-467-1852

EMERGENCY CONTACTS

Name	Relation	Address	Preferred Phone	Guardian	HIPAA Permission
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ADDRESSES

Address Type	Status	Address line1	Address line2	City	County	State	Zip Code	Country
Mailing	Current	10035 DRIFTWOOD PARK DR		HOUSTON		TX	77095-2381	US
Street	Current							

Residence Type:

Living Situation:

INSURANCES

5/13/24, 12:36 PM

Sequence/Type	Insurance Name	State	Subscriber No	Insured	Relation	Co-Pay	Group No
Primary Insurance	US DEPT OF LABOR HOU SPA	KY	550407066	Heath, Stephen	Self - patient is the insured		

PHARMACIES

Name	Address	Type	Phone	Fax
WALGREENS DRUG STORE #04161	8206 HIGHWAY 6 N,HOUSTON,TX,77095	Retail	281-550-2169	281-550-9069

CONTACTS

Name	Relation	Address	Preferred Phone	Emergency Contact	Guardian	HIPAA Permission
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CASE MANAGERS

Name	Address	Phone	Fax	Email
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ATTORNEYS

Name	Office	Address	Phone	Fax	Contact Details
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EMPLOYERS**Employment Status:**

Employer	Employer Address
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0

5/13/24, 12:36 PM

CIRCLES OF CARE

STRUCTURED DATA

Question Name	Value	Notes
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MISC INFO

Question Name	Value
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Nature of Business

Previously Rendered Treatment

NOTES

HEATH, Stephen DOB: 04/13/1967 (57 yo M) Acc No. 172574 DOS: 06/13/2024



HEATH, Stephen

57 Y old Male, DOB: 04/13/1967

Account Number: 172574

10035 DRIFTWOOD PARK DR, HOUSTON, TX-77095-2381

Home: 281-467-1852

Guarantor: Heath, Stephen Insurance: US DEPT OF LABOR HOU

SPA Payer ID: J1438

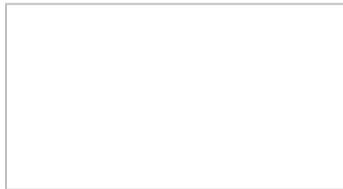
Appointment Facility: Accuhealth Houston Spa

06/13/2024

Televisit: Maresah Harris

Reason for Appointment

1. 3 month f/u



Electronically signed by Maresah Harris on 05/13/2024 at 12:35 PM CDT

Sign off status: Pending

Accuhealth Houston Spa
2000 Crawford
STE 106
HOUSTON, TX 77002-8142
Tel: 713-972-6996
Fax: 972-238-0456

Progress Note: Maresah Harris 06/13/2024

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

HEATH, Stephen DOB: 04/13/1967 (57 yo M) Acc No. 172574 DOS: 03/13/2024



HEATH, Stephen

56 Y old Male, DOB: 04/13/1967

Account Number: 172574

10035 DRIFTWOOD PARK DR, HOUSTON, TX-77095-2381

Home: 281-467-1852

Guarantor: Heath, Stephen Insurance: US DEPT OF LABOR HOU

SPA

Appointment Facility: Accuhealth

03/13/2024

Televisit: Temitope Babolola

Current Medications

Taking

- Meloxicam 15 MG Tablet 1 tablet Orally Once a day
- Fluticasone Propionate 50 MCG/ACT Suspension 1 spray in each nostril Nasally Once a day
- Montelukast Sodium 10 MG Tablet 1 tablet Orally Once a day
- Simethicone 80 MG Tablet Chewable 1 tablet after meals and at bedtime as needed Orally Four times a day
- Loratadine 10 MG Tablet 1 tablet Orally Once a day
- Omeprazole 20 MG Capsule Delayed Release 1 capsule 30 minutes before morning meal Orally Once a day
- Olodaterol HCl 2.5 MCG/ACT Aerosol Solution 2 puffs Inhalation Once a day
- Mometasone Furoate 370 MCG Implant as directed Nasally
- Albuterol
- Losartan Potassium 50 MG Tablet 1 tablet Orally Once a day
- Cyclobenzaprine HCl 10 MG Tablet 1 tablet at bedtime Orally Once a day

Review of Systems

Respiratory:

Admits Asthma. Denies Shortness of breath, denies. Denies Shortness of breath at rest. Denies Shortness of breath with exertion.

Cardiovascular:

Denies Chest pain. Denies Chest pain at rest. Denies Chest pain with exertion.

Gastrointestinal:

Denies Abdominal pain. Denies Blood in stool.

Genitourinary:

Denies Blood in urine. Admits Kidney problems.

Musculoskeletal:

Admits Trauma to knee(s). Denies Weakness.

Podiatric:

Admits Foot pain.

Psychiatric:

Reason for Appointment

1. 3 month f/u

Assessments

1. Strain of right foot, initial encounter - S96.911A (Primary)
2. Strain of right ankle, initial encounter - S96.911A

Treatment

1. Strain of right foot, initial encounter

Continue Cyclobenzaprine HCl Tablet, 10 MG, 1 tablet at bedtime, Orally, Once a day, 30 days, 30 Tablet, Refills 0

2. Others

Notes:

Case is in short form closure.

1. Patient is encouraged to continue HEP and other conservative treatment measures such as heat/ice, rest, and massage. Goals of treatment are pain relief, improve function, strength, gait and improve activities of daily living.

2. Imaging: MRI right foot and ankle was ordered to evaluate extent of injury was reviewed with the patient and the diagnosis updated to reflect the findings.

3. DME: none at this time

4. Referral: none at this time

5. Patient states R foot/ankle has healed itself due to being off work on another case and not doing long hours of walking in work boots.

6. WORK STATUS: continue full duty. Patient is off work for another case.

7. No changes in current treatment plan. Follow-up in 3 months

Patient is explained course of disease, treatment options discussed, and questions were answered.

Supervising Physician: Lashondria Simpson-Camp, MD.

Progress Note: Temitope Babolola 03/13/2024

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

HEATH, Stephen DOB: 04/13/1967 (57 yo M) Acc No. 172574 DOS: 03/13/2024

Admits Anxiety. Admits Depressed mood.

Follow Up

3 Months

History of Present Illness

DOI:

03/25/23 03/25/23.

Case Type:

Case Type: CA-1 .

OCCUPATION:

Job Title: Correctional Officer , Correctional Officer.
FBOP FBOP.

MECHANISM OF INJURY:

Mr.Heath is a right-handed male who has been employed by FBOP for almost 2 years as a Correctional Officer. He works Tuesday-Saturday from 3pm-11pm. His daily duties consist of Computer entry, supervising the activities of inmates and performing regular headcounts, walking up and down the stairs on concrete floors, doing rounds every 30 minutes, responding quickly to de-escalate confrontational situations and conducting regular searches in inmates cells, showers and recreation areas to find unauthorized items.

On 03/25/2023 Mr. Heath was walking down the unit on large rectangle/concrete floors. He began to feel a sharp pain and achy sensation at bottom right side of his right foot and on top. He dismissed the pain because he didn't want the inmates to know he was hurting. He finished his shift and went home to try to relax. The next morning he woke up with more pain and some swelling on his right foot. He tried to stay off his feet that Sunday and Monday to get some relief, however, his foot has been hurting since then on a constant basis. He reported the incident around March 29, 2023, and a Ca1 case was filed. Mr.Heath is a right-handed male who has been employed by FBOP for almost 2 years as a Correctional Officer. He works Tuesday-Saturday from 3pm-11pm. His daily duties consist of Computer entry, supervising the activities of inmates and performing regular headcounts, walking up and down the stairs on concrete floors, doing rounds every 30 minutes, responding quickly to de-escalate confrontational situations and conducting regular searches in inmates cells, showers and recreation areas to find unauthorized items.

On 03/25/2023 Mr. Heath was walking down the unit on large rectangle/concrete floors. He began to feel a sharp pain and achy sensation at bottom right side of his right foot and on top. He dismissed the pain because he didn't want the inmates to know he was hurting. He finished his shift and went home to try to relax. The next morning he woke up with more pain and some swelling on his right foot. He tried to stay off his feet that Sunday and Monday to get some relief, however, his foot has been hurting since then on a constant basis. He reported the incident around March 29, 2023, and a Ca1 case was filed.

Examination

General Examination:

PSYCH: judgement and insight good.
No PE on Televisit.

Visit Codes

99213 Office Visit, Est Pt., Level 3. Modifiers: GT

Progress Note: Temitope Babolola 03/13/2024

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

5/13/24, 12:36 PM

HEATH, Stephen DOB: 04/13/1967 (57 yo M) Acc No. 172574 DOS: 03/13/2024

Electronically signed by Temitope Babalola on 04/14/2024 at 11:31 PM CDT

Electronically co-signed by Lashondria Simpson-Camp, MD on 04/30/2024 at 10:54 AM CDT

Sign off status: Completed

**Accuhealth
620 JAMES DR
RICHARDSON, TX 75080-7407
Tel: 972-238-1976
Fax: 972-238-0456**

Progress Note: Temitope Babolola 03/13/2024

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

HEATH, Stephen DOB: 04/13/1967 (56 yo M) Acc No. 172574 DOS: 12/13/2023



Heath, Stephen

56 Y old Male, DOB: 04/13/1967

Account Number: 172574

10035 DRIFTWOOD PARK DR, HOUSTON, TX-77095-2381

Home: 281-467-1852

Guarantor: Heath, Stephen Insurance: US DEPT OF LABOR HOU

SPA

Appointment Facility: Accuhealth Houston Spa

12/13/2023

Maresah Harris

Current Medications

Taking

- Meloxicam 15 MG Tablet 1 tablet Orally Once a day
- Fluticasone Propionate 50 MCG/ACT Suspension 1 spray in each nostril Nasally Once a day
- Montelukast Sodium 10 MG Tablet 1 tablet Orally Once a day
- Simethicone 80 MG Tablet Chewable 1 tablet after meals and at bedtime as needed Orally Four times a day
- Loratadine 10 MG Tablet 1 tablet Orally Once a day
- Omeprazole 20 MG Capsule Delayed Release 1 capsule 30 minutes before morning meal Orally Once a day
- Olodaterol HCl 2.5 MCG/ACT Aerosol Solution 2 puffs Inhalation Once a day
- Mometasone Furoate 370 MCG Implant as directed Nasally
- Albuterol
- Losartan Potassium 50 MG Tablet 1 tablet Orally Once a day
- Cyclobenzaprine HCl 10 MG Tablet 1 tablet at bedtime Orally Once a day

Review of Systems

Respiratory:

Admits Asthma. Denies Shortness of breath, denies. Denies Shortness of breath at rest. Denies Shortness of breath with exertion.

Cardiovascular:

Denies Chest pain. Denies Chest pain at rest. Denies Chest pain with exertion.

Gastrointestinal:

Denies Abdominal pain. Denies Blood in stool.

Genitourinary:

Denies Blood in urine. Admits Kidney problems.

Musculoskeletal:

Admits Trauma to knee(s). Denies Weakness.

Podiatric:

Admits Foot pain.

Psychiatric:

Reason for Appointment

1. 3 month f/u

Assessments

1. Strain of right foot, initial encounter - S96.911A (Primary)
2. Strain of right ankle, initial encounter - S96.911A

Treatment

1. Strain of right foot, initial encounter

Continue Cyclobenzaprine HCl Tablet, 10 MG, 1 tablet at bedtime, Orally, Once a day, 30 days, 30 Tablet, Refills 0

2. Others

Notes:

Case is in short form closure.

1. Patient is encouraged to continue HEP and other conservative treatment measures such as heat/ice, rest, and massage. Goals of treatment are pain relief, improve function, strength, gait and improve activities of daily living.

2. Imaging: MRI right foot and ankle was ordered to evaluate extent of injury was reviewed with the patient and the diagnosis updated to reflect the findings.

3. DME: none at this time

4. Referral: none at this time

5. Patient states R foot/ankle has healed itself due to being off work on another case and not doing long hours of walking in work boots.

6. WORK STATUS: continue full duty. Patient is off work for another case.

7. No changes in current treatment plan. Follow-up in 3 months

Patient is explained course of disease, treatment options discussed, and questions were answered.

Supervising Physician: Lashondria Simpson-Camp, MD.

Progress Note: Maresah Harris 12/13/2023

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

HEATH, Stephen DOB: 04/13/1967 (56 yo M) Acc No. 172574 DOS: 12/13/2023

Admits Anxiety. Admits Depressed mood.

Follow Up

3 Months

History of Present Illness

DOI:

03/25/23 03/25/23.

Case Type:

Case Type: CA-1 .

OCCUPATION:

Job Title: Correctional Officer , Correctional Officer.
FBOP FBOP.

MECHANISM OF INJURY:

Mr.Heath is a right-handed male who has been employed by FBOP for almost 2 years as a Correctional Officer. He works Tuesday-Saturday from 3pm-11pm. His daily duties consist of Computer entry, supervising the activities of inmates and performing regular headcounts, walking up and down the stairs on concrete floors, doing rounds every 30 minutes, responding quickly to de-escalate confrontational situations and conducting regular searches in inmates cells, showers and recreation areas to find unauthorized items.

On 03/25/2023 Mr. Heath was walking down the unit on large rectangle/concrete floors. He began to feel a sharp pain and achy sensation at bottom right side of his right foot and on top. He dismissed the pain because he didn't want the inmates to know he was hurting. He finished his shift and went home to try to relax. The next morning he woke up with more pain and some swelling on his right foot. He tried to stay off his feet that Sunday and Monday to get some relief, however, his foot has been hurting since then on a constant basis. He reported the incident around March 29, 2023, and a Ca1 case was filed. Mr.Heath is a right-handed male who has been employed by FBOP for almost 2 years as a Correctional Officer. He works Tuesday-Saturday from 3pm-11pm. His daily duties consist of Computer entry, supervising the activities of inmates and performing regular headcounts, walking up and down the stairs on concrete floors, doing rounds every 30 minutes, responding quickly to de-escalate confrontational situations and conducting regular searches in inmates cells, showers and recreation areas to find unauthorized items.

On 03/25/2023 Mr. Heath was walking down the unit on large rectangle/concrete floors. He began to feel a sharp pain and achy sensation at bottom right side of his right foot and on top. He dismissed the pain because he didn't want the inmates to know he was hurting. He finished his shift and went home to try to relax. The next morning he woke up with more pain and some swelling on his right foot. He tried to stay off his feet that Sunday and Monday to get some relief, however, his foot has been hurting since then on a constant basis. He reported the incident around March 29, 2023, and a Ca1 case was filed.

Examination

General Examination:

PSYCH: judgement and insight good.

Visit Codes

99214 Office Visit, Est Pt., Level 4.

5/13/24, 12:36 PM

HEATH, Stephen DOB: 04/13/1967 (56 yo M) Acc No. 172574 DOS: 12/13/2023



Electronically signed by Maresah Harris on 12/13/2023 at 10:01 AM CST

Electronically co-signed by Lashondria Simpson-Camp, MD on 12/13/2023 at 01:21 PM CST

Sign off status: Completed

Accuhealth Houston Spa
2000 Crawford
STE 106
HOUSTON, TX 77002-8142
Tel: 713-972-6996
Fax: 972-238-0456

Progress Note: Maresah Harris 12/13/2023

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

HEATH, Stephen DOB: 04/13/1967 (56 yo M) Acc No. 172574 DOS: 09/13/2023



Heath, Stephen

56 Y old Male, DOB: 04/13/1967

Account Number: 172574

10035 DRIFTWOOD PARK DR, HOUSTON, TX-77095-2381

Home: 281-467-1852

Guarantor: Heath, Stephen Insurance: US DEPT OF LABOR HOU SPA

Appointment Facility: Accuhealth Houston Spa

09/13/2023

Televisit: Maresah Harris

Current Medications

Taking

- Cyclobenzaprine HCl 10 MG Tablet 1 tablet at bedtime Orally Once a day
- Meloxicam 15 MG Tablet 1 tablet Orally Once a day
- Fluticasone Propionate 50 MCG/ACT Suspension 1 spray in each nostril Nasally Once a day
- Montelukast Sodium 10 MG Tablet 1 tablet Orally Once a day
- Simethicone 80 MG Tablet Chewable 1 tablet after meals and at bedtime as needed Orally Four times a day
- Loratadine 10 MG Tablet 1 tablet Orally Once a day
- Omeprazole 20 MG Capsule Delayed Release 1 capsule 30 minutes before morning meal Orally Once a day
- Olodaterol HCl 2.5 MCG/ACT Aerosol Solution 2 puffs Inhalation Once a day
- Mometasone Furoate 370 MCG Implant as directed Nasally
- Albuterol
- Losartan Potassium 50 MG Tablet 1 tablet Orally Once a day

Reason for Appointment

1. 3 month f/u

Assessments

1. Strain of right foot, initial encounter - S96.911A (Primary)
2. Strain of right ankle, initial encounter - S96.911A

Treatment

1. Strain of right foot, initial encounter

Continue Cyclobenzaprine HCl Tablet, 10 MG, 1 tablet at bedtime, Orally, Once a day, 30 days, 30 Tablet, Refills 0

2. Others

Notes:

Case is in short form closure.

TELEMEDICINE: 15 mins

1. Patient is encouraged to continue HEP and other conservative treatment measures such as heat/ice, rest, and massage. Goals of treatment are pain relief, improve function, strength, gait and improve activities of daily living.

2. Imaging: MRI right foot and ankle was ordered to evaluate extent of injury was reviewed with the patient and the diagnosis updated to reflect the findings.

3. DME: none at this time

4. Referral: none at this time

5. Patient states R foot/ankle has healed itself due to being off work on another case and not doing long hours of walking in work boots.

6. WORK STATUS: continue full duty. Patient is off work for another case.

7. No changes in current treatment plan. Follow-up in 3 months

Patient is explained course of disease, treatment options discussed, and questions were answered.

Supervising Physician: Lashondria Simpson-Camp, MD.

Progress Note: Maresah Harris 09/13/2023

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

HEATH, Stephen DOB: 04/13/1967 (56 yo M) Acc No. 172574 DOS: 09/13/2023

Follow Up

3 Months

History of Present Illness

DOI:

03/25/23 03/25/23.

Case Type:

Case Type: CA-1 , CA-1.

OCCUPATION:

Job Title: Correctional Officer , Correctional Officer.
FBOP FBOP.

MECHANISM OF INJURY:

Mr.Heath is a right-handed male who has been employed by FBOP for almost 2 years as a Correctional Officer. He works Tuesday-Saturday from 3pm-11pm. His daily duties consist of Computer entry, supervising the activities of inmates and performing regular headcounts, walking up and down the stairs on concrete floors, doing rounds every 30 minutes, responding quickly to de-escalate confrontational situations and conducting regular searches in inmates cells, showers and recreation areas to find unauthorized items.

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On 03/25/2023 Mr. Heath was walking down the unit on large rectangle/concrete floors. He began to feel a sharp pain and achy sensation at bottom right side of his right foot and on top. He dismissed the pain because he didn't want the inmates to know he was hurting. He finished his shift and went home to try to relax. The next morning he woke up with more pain and some swelling on his right foot. He tried to stay off his feet that Sunday and Monday to get some relief, however, his foot has been hurting since then on a constant basis. He reported the incident around March 29, 2023, and a Ca1 case was filed.

Examination

General Examination:

PSYCH: judgement and insight good.
No PE on televisit.

Visit Codes

99213 Office Visit, Est Pt., Level 3. Modifiers: GT

Progress Note: Maresah Harris 09/13/2023

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

5/13/24, 12:36 PM

HEATH, Stephen DOB: 04/13/1967 (56 yo M) Acc No. 172574 DOS: 09/13/2023



Electronically signed by Maresah Harris on 09/13/2023 at 01:54 PM CDT

Electronically co-signed by Lashondria Simpson-Camp, MD on 09/14/2023 at 09:14 AM CDT

Sign off status: Completed

Accuhealth Houston Spa
1725 MAIN ST
STE 2
HOUSTON, TX 77002-8142
Tel: 713-485-5200
Fax: 972-238-0456

Progress Note: Maresah Harris 09/13/2023

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

HEATH, Stephen DOB: 04/13/1967 (57 yo M) Acc No. 172574 DOS: 06/27/2023



HEATH, Stephen

56 Y old Male, DOB: 04/13/1967
10035 DRIFTWOOD PARK DR, HOUSTON, TX, US 77095-2381
Home: 281-467-1852
Provider: ,

Web Encounter

Answered by Troup, Marc Date: 06/27/2023
Time: 08:18 AM

Caller Stephen Heath

Reason Orthopedic Referral

Message Addressed To: Simpson-Camp,Lashondria

Good morning Dr. Camp,
I am inquiring about the Orthopedic referral regarding my rib(s) injury. I have not been contacted by them to set up an appointment as of this date. Just checking on the progress.
Thank you,
S.E. Heath
281 467-1852

Provider: , 06/27/2023

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

HEATH, Stephen DOB: 04/13/1967 (57 yo M) Acc No. 172574 DOS: 06/21/2023



HEATH, Stephen

56 Y old Male, DOB: 04/13/1967
10035 DRIFTWOOD PARK DR, HOUSTON, TX, US 77095-2381
Home: 281-467-1852
Provider: ,

Web Encounter

Answered by Troup, Marc Date: 06/21/2023
Time: 03:03 PM

Caller Stephen Heath

Reason Employer request for S.E. Heath (Rib Injury)

Message Addressed To: Simpson-Camp,Lashondria

Dr. Camp (and Ms. Bashwani),
*(I also forwarded this message to Ms. Bashwani.)
I sent an email with attachments to Laury Rivera, Houston at 1:34 PM today. I requested that she forward it to you both asap for completion. The email was from my employer, FDC Houston, TX, which included attached letter / forms. This information is requested to assist my employer in providing a waiver for training over an extended amount of time, rather than having to request one each month and/or after each class. The school automatically reschedules me if I have not attended the next one scheduled. As noted on my last CA-17, dated 14 June 2023, I am unable to return to work due to my injuries (until fully healed). I still have rib pains while sleeping and leaning in an arm chair, to include left lung capacity restriction. As discussed, I am expecting a referral and a phone call from an Orthopedic doctor to determine the next steps. I have yet to receive one. Just waiting.
Please forward the completed documents to my HR department as soon as possible. The fax number is noted near the end of the letter.
Thank you both for your help in this request.
R,
S.E. Heath (281) 467-1852

Provider: , 06/21/2023

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

HEATH, Stephen DOB: 04/13/1967 (57 yo M) Acc No. 172574 DOS: 06/21/2023



HEATH, Stephen

56 Y old Male, DOB: 04/13/1967
10035 DRIFTWOOD PARK DR, HOUSTON, TX, US 77095-2381
Home: 281-467-1852
Provider: ,

Web Encounter

Answered by Troup, Marc Date: 06/21/2023
Time: 02:57 PM

Caller Stephen Heath

Reason Employer request 21 June 2023 for S.E. Heath (Rib Injury)

Message Addressed To: Bashwani,Anum

Ms. Bashwani (and Dr. Camp),
I sent an email with attachments to Laury Rivera, Houston at 1:34 PM today. I requested that she forward it to you both asap for completion. The email was from my employer, FDC Houston, TX, which included attached letter / forms. This information is requested to assist my employer in providing a waiver for training over an extended amount of time, rather than having to request one each month and/or after each class. The school automatically reschedules me if I have not attended the next one scheduled. As noted on my last CA-17, dated 14 June 2023, I am unable to return to work due to my injuries (until fully healed). I still have rib pains while sleeping and leaning in an arm chair, to include left lung capacity restriction. As discussed, I am expecting a referral and a phone call from an Orthopedic doctor to determine the next steps. I have yet to receive one. Just waiting.
Please forward the completed documents to my HR department as soon as possible. The fax number is noted near the end of the letter.
Thank you both for your help in this request.
R,
S.E. Heath (281) 467-1852

Provider: , 06/21/2023

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

HEATH, Stephen DOB: 04/13/1967 (56 yo M) Acc No. 172574 DOS: 06/13/2023



Heath, Stephen

56 Y old Male, DOB: 04/13/1967

Account Number: 172574

10035 DRIFTWOOD PARK DR, HOUSTON, TX-77095-2381

Home: 281-467-1852

Guarantor: Heath, Stephen Insurance: US DEPT OF LABOR HOU

SPA

Appointment Facility: Accuhealth Houston Spa

06/13/2023

Televisit: Anum Bashwani, PA-C

Current Medications

Taking

- Meloxicam 15 MG Tablet 1 tablet Orally Once a day
- Fluticasone Propionate 50 MCG/ACT Suspension 1 spray in each nostril Nasally Once a day
- Montelukast Sodium 10 MG Tablet 1 tablet Orally Once a day
- Simethicone 80 MG Tablet Chewable 1 tablet after meals and at bedtime as needed Orally Four times a day
- Loratadine 10 MG Tablet 1 tablet Orally Once a day
- Omeprazole 20 MG Capsule Delayed Release 1 capsule 30 minutes before morning meal Orally Once a day
- Olodaterol HCl 2.5 MCG/ACT Aerosol Solution 2 puffs Inhalation Once a day
- Mometasone Furoate 370 MCG Implant as directed Nasally
- Albuterol
- Losartan Potassium 50 MG Tablet 1 tablet Orally Once a day
- Cyclobenzaprine HCl 10 MG Tablet 1 tablet at bedtime Orally 1

Review of Systems

Respiratory:

Admits Asthma. Denies Shortness of breath, denies. Denies Shortness of breath at rest. Denies Shortness of breath with exertion.

Cardiovascular:

Denies Chest pain. Denies Chest pain at rest. Denies Chest pain with exertion.

Gastrointestinal:

Denies Abdominal pain. Denies Blood in stool.

Genitourinary:

Denies Blood in urine. Admits Kidney problems.

Musculoskeletal:

Admits Trauma to knee(s). Denies Weakness.

Podiatric:

Admits Foot pain.

Psychiatric:

Reason for Appointment

1. MDFU- televisit
2. R ankle/foot

Assessments

1. Strain of right foot, initial encounter - S96.911A (Primary)
2. Strain of right ankle, initial encounter - S96.911A

Treatment

1. Strain of right foot, initial encounter

Continue Cyclobenzaprine HCl Tablet, 10 MG, 1 tablet at bedtime, Orally, Once a day, 30 days, 30 Tablet, Refills 0

2. Others

Notes:

Case is in short form closure.

TELEMEDICINE: 15 mins

1. Patient is encouraged to continue HEP and other conservative treatment measures such as heat/ice, rest, and massage. Goals of treatment are pain relief, improve function, strength, gait and improve activities of daily living.

2. Imaging: MRI right foot and ankle was ordered to evaluate extent of injury was reviewed with the patient and the diagnosis updated to reflect the findings.

3. DME: none at this time

4. Referral: none at this time

5. WORK STATUS: continue full duty

6. Follow-up in 3 months

Patient is explained course of disease, treatment options discussed, and questions were answered.

Supervising Physician: Lashondria Simpson-Camp, MD.

Follow Up

3 Months

Progress Note: Anum Bashwani, PA-C 06/13/2023

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

HEATH, Stephen DOB: 04/13/1967 (56 yo M) Acc No. 172574 DOS: 06/13/2023

Admits Anxiety. Admits Depressed mood.

History of Present Illness

DOL:

03/25/23.

Case Type:

Case Type: CA-1.

OCCUPATION:

Job Title: Correctional Officer.
FBOP.

MECHANISM OF INJURY:

Mr.Heath is a right-handed male who has been employed by FBOP for almost 2 years as a Correctional Officer. He works Tuesday-Saturday from 3pm-11pm. His daily duties consist of Computer entry, supervising the activities of inmates and performing regular headcounts, walking up and down the stairs on concrete floors, doing rounds every 30 minutes, responding quickly to de-escalate confrontational situations and conducting regular searches in inmates cells, showers and recreation areas to find unauthorized items.

On 03/25/2023 Mr. Heath was walking down the unit on large rectangle/concrete floors. He began to feel a sharp pain and achy sensation at bottom right side of his right foot and on top. He dismissed the pain because he didn't want the inmates to know he was hurting. He finished his shift and went home to try to relax. The next morning he woke up with more pain and some swelling on his right foot. He tried to stay off his feet that Sunday and Monday to get some relief, however, his foot has been hurting since then on a constant basis. He reported the incident around March 29, 2023, and a Ca1 case was filed.

Visit Codes

99213 Office Visit, Est Pt., Level 3. Modifiers: GT

Electronically signed by Anum Bashwani , PA-C on 06/13/2023 at 02:59 PM CDT

Electronically co-signed by Lashondria Simpson-Camp, MD on 06/13/2023 at 07:45 PM CDT

Sign off status: Completed

**Accuhealth Houston Spa
1725 MAIN ST
STE 2
HOUSTON, TX 77002-8142
Tel: 713-485-5200
Fax: 972-238-0456**

Progress Note: Anum Bashwani, PA-C 06/13/2023

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

HEATH, Stephen DOB: 04/13/1967 (56 yo M) Acc No. 172574 DOS: 04/28/2023

**Heath, Stephen**

56 Y old Male, DOB: 04/13/1967

Account Number: 172574

10035 DRIFTWOOD PARK DR, HOUSTON, TX-77095-2381

Home: 281-467-1852

Guarantor: Heath, Stephen Insurance: US DEPT OF LABOR HOU

SPA

Appointment Facility: Accuhealth Houston Spa

04/28/2023

Camp-Simpson, Lashondria, MD

Current Medications

Taking

- Meloxicam 15 MG Tablet 1 tablet Orally Once a day
- Fluticasone Propionate 50 MCG/ACT Suspension 1 spray in each nostril Nasally Once a day
- Montelukast Sodium 10 MG Tablet 1 tablet Orally Once a day
- Simethicone 80 MG Tablet Chewable 1 tablet after meals and at bedtime as needed Orally Four times a day
- Loratadine 10 MG Tablet 1 tablet Orally Once a day
- Omeprazole 20 MG Capsule Delayed Release 1 capsule 30 minutes before morning meal Orally Once a day
- Olodaterol HCl 2.5 MCG/ACT Aerosol Solution 2 puffs Inhalation Once a day
- Mometasone Furoate 370 MCG Implant as directed Nasally
- Albuterol
- Losartan Potassium 50 MG Tablet 1 tablet Orally Once a day

Past Medical History

Kidney stones.
Chronic sinusitis.
Hernia.

Surgical History

Hernia surgery

Family History

Mother: deceased
Father: alive 82 yrs
1 sister(s) - healthy. 1 son(s) , 1 daughter(s)
- healthy.
Mother passed from Dementia.

Social History

Tobacco Use:
Tobacco Use/Smoking
Are you a *nonsmoker*

Review of Systems

Respiratory:
Admits Asthma. Denies Shortness of

Reason for Appointment

1. ROF

Assessments

1. Strain of right foot, initial encounter - S96.911A (Primary)
2. Strain of right ankle, initial encounter - S96.911A

Treatment**1. Strain of right foot, initial encounter**

Start Cyclobenzaprine HCl Tablet, 10 MG, 1 tablet at bedtime, Orally, 1, 30 days, 30, Refills 0

2. Others

Notes: 1. Patient referred for physical assessment and treatment after treatment on another work-related claim. Physical therapy includes ROM, muscle stretching and strengthening. Goals of treatment are pain relief, improve function, improve Activities of Daily Living and and implementation of HEP.

2. Imaging: MRI right foot and ankle was ordered to evaluate extent of injury was reviewed with the patient and the diagnosis updated to reflect the findings.

3. DME: none at this time
4. Referral: none at this time
5. WORK STATUS: continue full duty
6. Follow-up in 4 weeks

Patient is explained course of disease, treatment options discussed, and questions were answered.

PMP website verified and no abuse potential found

More than 25 minutes spent with the patient and case updating current complaints, reviewing imaging, developing narrative, and discussing plan of care.

Clinical Notes: Causation/medical opinion

In my professional medical opinion, Mr. Heath's right ankle and foot conditions have occurred as a direct result of the patient's job-related incident. Mr. Heath is a 55-year-old right-handed male who has been employed by FBOP for almost 2 years as a Correctional Officer. He works Tuesday-Saturday from 3pm-11pm. His daily duties consist of Computer entry, supervising the activities of inmates and performing regular headcounts, walking up and down the stairs on concrete floors, doing

Progress Note: Camp-Simpson, Lashondria, MD 04/28/2023

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

HEATH, Stephen DOB: 04/13/1967 (56 yo M) Acc No. 172574 DOS: 04/28/2023

breath, denies. Denies Shortness of breath at rest. Denies Shortness of breath with exertion.

Cardiovascular:

Denies Chest pain. Denies Chest pain at rest. Denies Chest pain with exertion.

Gastrointestinal:

Denies Abdominal pain. Denies Blood in stool.

Genitourinary:

Denies Blood in urine. Admits Kidney problems.

Musculoskeletal:

Admits Trauma to knee(s).

Denies Weakness.

Podiatric:

Admits Foot pain.

Psychiatric:

Admits Anxiety. Admits Depressed mood.

rounds every 30 minutes, responding quickly to de-escalate confrontational situations and conducting regular searches in inmates cells, showers and recreation areas to find unauthorized items.

On 03/25/2023 Mr. Heath was walking down the unit on large rectangle/concrete floors. He began to feel a sharp pain and achy sensation at bottom right side of his right foot and on top. He dismissed the pain because he didn't want the inmates to know he was hurting. He finished his shift and went home to try to relax. The next morning he woke up with more pain and some swelling on his right foot. He tried to stay off his feet that Sunday and Monday to get some relief, however, his foot has been hurting since then on a constant basis. He reported the incident around March 29, 2023, and a Ca1 case was filed.

On exam, Mr. Heath has tenderness in the lateral foot and edema present as well. An MRI was performed which showed straining of the tendons in the right foot and ankle (S96.911A). As Mr. Heath was walking on hard concrete floors, this caused excessive force on the tendons of the right ankle and foot leading to inflammation and straining of these tendons as seen on MRI and exam. The patient would benefit from treatment to include physical therapy and other interventions to improve his overall function and to decrease the inflammation in the right foot.

Follow Up

4 Weeks

History of Present Illness

DOI:

03/25/23.

Case Type:

Case Type: CA-1.

OCCUPATION:

Job Title: Correctional Officer.

FBOP.

MECHANISM OF INJURY:

Mr.Heath is a 55-year-old right-handed male who has been employed by FBOP for almost 2 years as a Correctional Officer. He works Tuesday-Saturday from 3pm-11pm. His daily duties consist of Computer entry, supervising the activities of inmates and performing regular headcounts, walking up and down the stairs on concrete floors, doing rounds every 30 minutes, responding quickly to de-escalate confrontational situations and conducting regular searches in inmates cells, showers and recreation areas to find unauthorized items.

On 03/25/2023 Mr. Heath was walking down the unit on large rectangle/concrete floors. He began to feel a sharp pain and achy sensation at bottom right side of his right foot and on top. He dismissed the pain because he didn't want the inmates to know he was hurting. He finished his shift and went home to try to relax. The next morning he woke up with more pain and some swelling on his right foot. He tried to stay off his feet that Sunday and Monday to get some relief, however, his foot has been hurting since then on a constant basis. He reported the incident around March 29, 2023, and a Ca1 case was filed.

Vital Signs

Wt 196 lbs, BP 136/86 mm Hg, HR 76 /min, Wt-kg 88.9 kg.

HEATH, Stephen DOB: 04/13/1967 (56 yo M) Acc No. 172574 DOS: 04/28/2023

Examination

Ankle / Foot:

ANKLE:

ANKLE/FOOT (Right):

Edema present lateral right foot

Tenderness at: mild tenderness lateral right foot

ROM (degrees):

RIGHT:

Dorsiflexion 15

Plantarflexion 40

Inversion 30

Eversion 35

MUSCLE TESTING:

RIGHT

Dorsiflexion 5/5

Plantarflexion 5/5

Inversion 5/5

Eversion 5/5

Visit Codes

99214 Office Visit, Est Pt., Level 4.

**Electronically signed by Lashondria Simpson-Camp , MD on
05/05/2023 at 01:24 PM CDT**

Sign off status: Completed

**Accuhealth Houston Spa
1725 MAIN ST
STE 2
HOUSTON, TX 77002-8142
Tel: 713-485-5200
Fax: 972-238-0456**

Progress Note: Camp-Simpson, Lashondria, MD 04/28/2023

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

HEATH, Stephen DOB: 04/13/1967 (57 yo M) Acc No. 172574 DOS: 04/08/2023

**HEATH, Stephen**

55 Y old Male, DOB: 04/13/1967

Account Number: 172574

10035 DRIFTWOOD PARK DR, HOUSTON, TX-77095-2381

Home: 281-467-1852

Guarantor: Heath, Stephen Insurance: US DEPT OF LABOR HOU

SPA Payer ID: J1438

Appointment Facility: Accuhealth Houston Spa

04/08/2023

Televisit: Camp-Simpson, Lashondria, MD

Current Medications**Taking**

- Meloxicam 15 MG Tablet 1 tablet Orally Once a day
- Fluticasone Propionate 50 MCG/ACT Suspension 1 spray in each nostril Nasally Once a day
- Montelukast Sodium 10 MG Tablet 1 tablet Orally Once a day
- Simethicone 80 MG Tablet Chewable 1 tablet after meals and at bedtime as needed Orally Four times a day
- Loratadine 10 MG Tablet 1 tablet Orally Once a day
- Omeprazole 20 MG Capsule Delayed Release 1 capsule 30 minutes before morning meal Orally Once a day
- Olodaterol HCl 2.5 MCG/ACT Aerosol Solution 2 puffs Inhalation Once a day
- Mometasone Furoate 370 MCG Implant as directed Nasally
- Albuterol
- Losartan Potassium 50 MG Tablet 1 tablet Orally Once a day

Past Medical History

Kidney stones.
Chronic sinusitis.
Hernia.

Review of SystemsRespiratory:

Admits Asthma. Denies Shortness of breath, denies. Denies Shortness of breath at rest. Denies Shortness of breath with exertion.

Cardiovascular:

Denies Chest pain. Denies Chest pain at rest. Denies Chest pain with exertion.

Gastrointestinal:

Denies Abdominal pain. Denies Blood in stool.

Genitourinary:

Denies Blood in urine. Admits Kidney problems.

Musculoskeletal:

Admits Trauma to knee(s).
Denies Weakness.

Reason for Appointment

1. Right foot
2. ACCU PA-Ankle/Foot

History of Present IllnessDOI:

03/25/23.

Case Type:

Case Type: CA-1.

OCCUPATION:

Job Title: Correctional Officer.

FBOP.

MECHANISM OF INJURY:

Mr.Heath is a 55 year old right handed male. He works for FBOP and has been employed with them for 2 years.

His daily duties consist of Computer entry, lots of walking, making rounds of the units, walking up and down the stairs on concrete floors.

On 03/25/2023 Mr.Heath was walking down the unit(big rectangle/concrete floor) He began to feel a sharp pain and achy at bottom right hand side of foot and some at top.

He dismissed the pain because he didnt want inmates to know he was hurting, he finishes his shift and goes home to try to relax. The next morning he woke up with more pain and some swelling on his right foot. He tried to stay off his feet that Sunday and Monday to get some relief. His foot has been hurting since then continuously.

He logged this incident around the 29th, 2023.

(After he started working at this current employer he started feeling pain in his feet within 2 months.).

ExaminationAnkle / Foot:

ANKLE:

ANKLE/FOOT (Right):

Edema present lateral right foot

Tenderness at: mild tenderness lateral right foot

ROM (degrees):**RIGHT:**

Dorsiflexion 15

Plantarflexion 40

Progress Note: Camp-Simpson, Lashondria, MD 04/08/2023

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

HEATH, Stephen DOB: 04/13/1967 (57 yo M) Acc No. 172574 DOS: 04/08/2023

Podiatric:

Admits Foot pain.

Psychiatric:

Admits Anxiety. Admits Depressed mood.

Inversion 30

Eversion 35

MUSCLE TESTING:

RIGHT

Dorsiflexion 5/5

Plantarflexion 5/5

Inversion 5/5

Eversion 5/5

Assessments

1. Strain of right foot, initial encounter - S96.911A (Primary)

Treatment

1. Others

Notes: 1. Patient referred for physical assessment and treatment. Physical therapy includes ROM, muscle stretching and strengthening. Goals of treatment are pain relief, improve function, improve Activities of Daily Living and and implementation of HEP.

2. Imaging: MRI right foot and ankle was ordered to evaluate extent of injury.

3. DME: none at this time

4. Referral: none at this time

5. WORK STATUS: continue full duty

6. Follow-up in 2 weeks to review imaging

Patient is explained course of disease, treatment options discussed, and questions were answered.

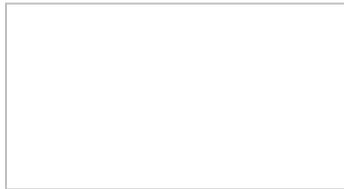
PMP website verified and no abuse potential found

Visit Codes

99215 Office Visit, Est Pt., Level 5.

Follow Up

2 Weeks (Reason: Review Imaging)



Electronically signed by Lashondria Simpson-Camp , MD on 05/13/2024 at 12:35 PM CDT

Sign off status: Pending

5/13/24, 12:36 PM

HEATH, Stephen DOB: 04/13/1967 (57 yo M) Acc No. 172574 DOS: 04/08/2023

Accuhealth Houston Spa
2000 Crawford
STE 106
HOUSTON, TX 77002-8142
Tel: 713-972-6996
Fax: 972-238-0456

Progress Note: Camp-Simpson, Lashondria, MD 04/08/2023

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



Accuhealth Houston Spa

1725 MAIN ST STE 2
HOUSTON TX 77002-8142
Ph: 713-485-5200 Fax:972-238-0456

Tobacco Control

Name: Stephen Heath

Date: 04/12/2023

Are you a

- current smoker
- former smoker
- nonsmoker
- current every day smoker
- current some day smoker
- Smoker current status unknown
- unknown if ever smoked
- light tobacco smoker
- heavy tobacco smoker
- Uses tobacco in other forms

Additional Findings: Tobacco User

- Chain smoker
- Chews fine cut tobacco
- Chews loose leaf tobacco
- Chews plug tobacco
- Chews tobacco
- Chews twist tobacco
- Heavy cigarette smoker (20-39 cigs/day)
- Light cigarette smoker ((1-9 cigs/day)
- Moderate cigarette smoker (10-19 cigs/day)
- Pipe smoker
- Rolls own cigarettes
- Snuff user
- Trivial cigarette smoker (less than one cigarette/day)

- User of moist powdered tobacco
- Very heavy cigarette smoker (40+ cigs/day)

Additional Findings: Tobacco Non-User

- Aggressive non-smoker
- Current non-smoker
- Current non-smoker, but past smoking history unknown
- Does not use moist powdered tobacco
- Ex-cigar smoker
- Ex-cigarette smoker
- Ex-cigarette smoker amount unknown
- Ex-heavy cigarette smoker (20-30/day)
- Ex-light cigarette smoker (1-9/day)
- Ex-moderate cigarette smoker (10-19/day)
- Ex-pipe smoker
- Ex-trivial cigarette smoker (<1/day)
- Ex-user of moist powdered tobacco
- Ex-very heavy cigarette smoker (40+/day)
- Intolerant ex-smoker
- Intolerant non-smoker
- Never chewed tobacco
- Never used moist powdered tobacco
- Non-smoker for medical reasons
- Non-smoker for personal reasons
- Non-smoker for religious reasons
- Tolerant ex-smoker
- Tolerant non-smoker

Document Name: VitalsInfo2024/3/13_10:51:9:.52, Scanned Date: 03/13/2024

Notes: EMR Form

Vitals

Height : **6 Feet inches**

Weight : **202 pounds**

Blood Pressure : /

Temperature : **F**

Respiratory Rate : **Breaths per minute**

Pulse Rate : **Beats per minute**

Document Name: Consent_general, Scanned Date: 03/13/2024

Notes: EMR Form

5/13/24, 12:35 PM

Patient Name : Heath, Stephen Apr 13, 1967 (57 Y, M) Acc No : 172574

Accuhealth, Inc
620 James Drive
Richardson TX, 75080
(972) 238-1976

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION

Use and Disclosure of your protected health care information will be used by Advanced Injury and Pain Solutions or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

NOTICE OF PRIVACY PRACTICES

You should review the NOTI CE OF PRIVACY PRACTICES for a more complete description of how your Protected Health Care information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

You may review the Notice prior to signing this consent. You may also request a copy of the Notice at the front desk.

REQUESTING THE RESTRICTION ON THE USE OR DISCLOSURE OF YOUR INFORMATION

Your may request a restriction on the use or disclosure of your Protected Health Information.

This office may or may not agree to restrict the use or disclosure of your Protected Health information.

If we agree to your request, the restriction will be binding with this office. Use or Disclosure of Protected Health Information in violation of the agreed upon restrictions will be a violation of federal privacy standards

REVOCAION OF CONSENT:

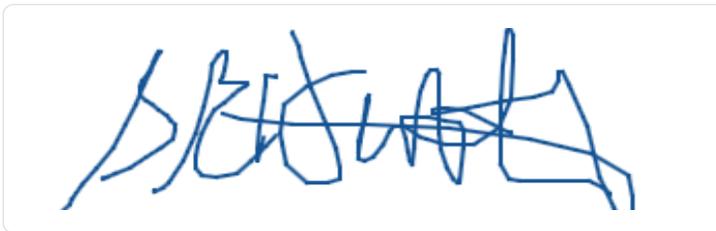
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has occurred prior to the date on which you revocation of consent is received will not be affected.

RESERVATION OF RIGHT TO CHANGE PRIVACY PRACTICE

This office reserves the right to modify the privacy practices outlined in this notice.

SIGNATURE:

I have reviewed this consent form and give my permission to this office to use and disclose my Health Information in accordance with it.



Signed By: Heath Stephen
Signed On: 2024-03-13 08:37:17 AM CDT

Document Name: TV_ConsentForm_2024/3/13_10:51:9:.77, Scanned Date: 03/13/2024

Notes: EMR Form

5/13/24, 12:35 PM

TeleVisit Consent Form

Telemedicine Consent Form

By typing my name "I agree to Terms of Use" on the Accuhealth telemedicine portal, I understand and agree that I am signing this Consent and that (i) I have reviewed, understand and accept the risks and benefits of telemedicine services as described below and wish to receive such services, and (ii) I agree to the remaining terms of this Consent.

If I am signing on behalf of a minor, incapacitated or otherwise legally dependent patient, I certify that I am a person with legal authority to act on behalf of the patient, including the authority to consent to medical services, and I accept financial responsibility for services rendered.

1. By using the Accuhealth telemedicine portal, I agree to receive telemedicine services.

Telemedicine involves the delivery of health care services, including assessment, treatment, diagnosis, and education, using interactive audio, video, and data communications. During my visit, my Accuhealth provider and I will be able to see and speak with each other from remote locations.

2. I understand and agree that:

- o I will not be in the same location or room as my medical provider.
- o My Accuhealth provider is licensed in the state in which I am receiving services. I will report my location accurately during registration.
- o Potential benefits of telemedicine (which are not guaranteed or assured) include: (i) access to medical care if I am unable to travel to my Accuhealth provider's office; (ii) more efficient medical evaluation and management; and (iii) during the COVID-19 pandemic, reduced exposure to patients, medical staff and other individuals at a physical location.
- o Potential risks of telemedicine include: (i) limited or no availability of diagnostic laboratory, x-ray, EKG, and other testing, and some prescriptions, to assist my medical provider in diagnosis and treatment; (ii) my provider's inability to conduct a hands-on physical examination of me and my condition; and (iii) delays in evaluation and treatment due to technical difficulties or interruptions, distortion of diagnostic images or specimens resulting from electronic transmission issues, unauthorized access to my information, or loss of information due to technical failures. I will not hold Accuhealth responsible for lost information due to technological failures.
- o I further understand that my Accuhealth Provider's advice, recommendations, and/or decisions may be based on factors not within his/her control, including incomplete or inaccurate data provided by me. I understand that my Accuhealth provider relies on information provided by me before and during our telemedicine encounter and that I must provide information about my medical history, condition(s), and current or previous medical care that is complete and accurate to the best of my ability.
- o I may discuss these risks and benefits with my Accuhealth provider and will be given an opportunity to ask questions about telemedicine services. I have the right to

5/13/24, 12:35 PM

withdraw this consent to telemedicine services or end the telemedicine session at any time without affecting my right to future treatment by Accuhealth.

- I understand that the level of care provided by my Accuhealth provider is to be the same level of care that is available to me through an in-person medical visit. However, if my provider believes I would be better served by face-to-face services or another form of care, I will be referred to the nearest Accuhealth clinic, hospital emergency department or other appropriate health care provider.

- In case of an emergency, I will dial 911 or go directly to the nearest hospital emergency room.

Please talk to one of our office staff if you have any complaints or issues with telemedicine.

Patient Name : Heath,Stephen , DOB: 04/13/1967

I have read the consent form and the above information and I accept the conditions.

Consent Signed Date: 2024-03-13 10:51:09 CDT

Document Name: VitalsInfo2023/9/13_13:24:2:.56, Scanned Date: 09/13/2023

Notes: EMR Form

Vitals

Height : **6 Feet inches**

Weight : **202 pounds**

Blood Pressure : /

Temperature : **F**

Respiratory Rate : **Breaths per minute**

Pulse Rate : **Beats per minute**

Document Name: TV_ConsentForm_2023/9/13_13:24:3:.25, Scanned Date: 09/13/2023

Notes: EMR Form

5/13/24, 12:35 PM

TeleVisit Consent Form

Telemedicine Consent Form

By typing my name "I agree to Terms of Use" on the Accuhealth telemedicine portal, I understand and agree that I am signing this Consent and that (i) I have reviewed, understand and accept the risks and benefits of telemedicine services as described below and wish to receive such services, and (ii) I agree to the remaining terms of this Consent.

If I am signing on behalf of a minor, incapacitated or otherwise legally dependent patient, I certify that I am a person with legal authority to act on behalf of the patient, including the authority to consent to medical services, and I accept financial responsibility for services rendered.

1. By using the Accuhealth telemedicine portal, I agree to receive telemedicine services.

Telemedicine involves the delivery of health care services, including assessment, treatment, diagnosis, and education, using interactive audio, video, and data communications. During my visit, my Accuhealth provider and I will be able to see and speak with each other from remote locations.

2. I understand and agree that:

- o I will not be in the same location or room as my medical provider.
- o My Accuhealth provider is licensed in the state in which I am receiving services. I will report my location accurately during registration.
- o Potential benefits of telemedicine (which are not guaranteed or assured) include: (i) access to medical care if I am unable to travel to my Accuhealth provider's office; (ii) more efficient medical evaluation and management; and (iii) during the COVID-19 pandemic, reduced exposure to patients, medical staff and other individuals at a physical location.
- o Potential risks of telemedicine include: (i) limited or no availability of diagnostic laboratory, x-ray, EKG, and other testing, and some prescriptions, to assist my medical provider in diagnosis and treatment; (ii) my provider's inability to conduct a hands-on physical examination of me and my condition; and (iii) delays in evaluation and treatment due to technical difficulties or interruptions, distortion of diagnostic images or specimens resulting from electronic transmission issues, unauthorized access to my information, or loss of information due to technical failures. I will not hold Accuhealth responsible for lost information due to technological failures.
- o I further understand that my Accuhealth Provider's advice, recommendations, and/or decisions may be based on factors not within his/her control, including incomplete or inaccurate data provided by me. I understand that my Accuhealth provider relies on information provided by me before and during our telemedicine encounter and that I must provide information about my medical history, condition(s), and current or previous medical care that is complete and accurate to the best of my ability.
- o I may discuss these risks and benefits with my Accuhealth provider and will be given an opportunity to ask questions about telemedicine services. I have the right to

5/13/24, 12:35 PM

withdraw this consent to telemedicine services or end the telemedicine session at any time without affecting my right to future treatment by Accuhealth.

- I understand that the level of care provided by my Accuhealth provider is to be the same level of care that is available to me through an in-person medical visit. However, if my provider believes I would be better served by face-to-face services or another form of care, I will be referred to the nearest Accuhealth clinic, hospital emergency department or other appropriate health care provider.

- In case of an emergency, I will dial 911 or go directly to the nearest hospital emergency room.

Please talk to one of our office staff if you have any complaints or issues with telemedicine.

Patient Name : Heath,Stephen , DOB: 04/13/1967

I have read the consent form and the above information and I accept the conditions.

Consent Signed Date: 2023-09-13 13:24:03 CDT

Document Name: TV_ConsentForm_2023/6/21_23:7:58:.03, Scanned Date: 06/21/2023

Notes: EMR Form

5/13/24, 12:35 PM

TeleVisit Consent Form

Telemedicine Consent Form

By typing my name "I agree to Terms of Use" on the Accuhealth telemedicine portal, I understand and agree that I am signing this Consent and that (i) I have reviewed, understand and accept the risks and benefits of telemedicine services as described below and wish to receive such services, and (ii) I agree to the remaining terms of this Consent.

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5/13/24, 12:35 PM

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- In case of an emergency, I will dial 911 or go directly to the nearest hospital emergency room.

Please talk to one of our office staff if you have any complaints or issues with telemedicine.

Patient Name : Heath,Stephen , DOB: 04/13/1967

I have read the consent form and the above information and I accept the conditions.

Consent Signed Date: 2023-06-21 23:08:00 CDT

Document Name: TV_ConsentForm_2023/6/21_23:1:58:.75, Scanned Date: 06/21/2023

Notes: EMR Form

5/13/24, 12:35 PM

TeleVisit Consent Form

Telemedicine Consent Form

By typing my name "I agree to Terms of Use" on the Accuhealth telemedicine portal, I understand and agree that I am signing this Consent and that (i) I have reviewed, understand and accept the risks and benefits of telemedicine services as described below and wish to receive such services, and (ii) I agree to the remaining terms of this Consent.

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5/13/24, 12:35 PM

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- In case of an emergency, I will dial 911 or go directly to the nearest hospital emergency room.

Please talk to one of our office staff if you have any complaints or issues with telemedicine.

Patient Name : Heath,Stephen , DOB: 04/13/1967

I have read the consent form and the above information and I accept the conditions.

Consent Signed Date: 2023-06-21 23:01:59 CDT

Document Name: VitalsInfo2023/6/13_11:48:1:.24, Scanned Date: 06/13/2023

Notes: EMR Form

Vitals

Height : **6 Feet inches**

Weight : **200 pounds**

Blood Pressure : **/**

Temperature : **F**

Respiratory Rate : **Breaths per minute**

Pulse Rate : **Beats per minute**

Document Name: VitalsInfo2023/6/12_12:4:15:.52, Scanned Date: 06/12/2023

Notes: EMR Form

Vitals

Height : **6 Feet inches**

Weight : **200 pounds**

Blood Pressure : **/**

Temperature : **F**

Respiratory Rate : **Breaths per minute**

Pulse Rate : **Beats per minute**

Document Name: VitalsInfo2023/6/12_12:3:2:.44, Scanned Date: 06/12/2023

Notes: EMR Form

Vitals

Height : **6 Feet inches**

Weight : **200 pounds**

Blood Pressure : /

Temperature : **F**

Respiratory Rate : **Breaths per minute**

Pulse Rate : **Beats per minute**

Document Name: Memorial MRI Referral, Scanned Date: 05/24/2023

Notes:

STAT Appointments Available • Bi-lingual Staff • American College of Radiology Accreditation

Scheduling Direct Line: 713-554-3200
 Main Line: 713-461-3399
 Fax: 713-461-1969 or 713-904-2495
 www.memorialdiagnosis.com



STAT Doctor's Call# _____
 ROUTINE

Patient Name Heath Stephen Primary Phone 281 467-1852 Address _____	Secondary Phone _____ ICD10 Code(s) for diagnostic symptoms must be provided _____	DOB 04/13/1967 Date 04/07/2023 SS # _____
---	---	--

INSURANCE / WORKERS COMP. INFORMATION	
Carrier / Adjuster DOL	Policy / Claim # CA-1 Pending
Group # _____	Claims Address _____
Name of Insured _____	IPA / Authorization _____
Insurance Phone # _____	

ATTORNEY INFORMATION	
Attorney Name _____	Address _____
Phone _____	Fax _____
Date of Injury or Onset 03/25/2023	

PHYSICIAN INFORMATION (Please Print)	
Name Lashondria Camp, MD	Phone 972 238-1976 ext 5419 Fax 713 583-2321
NPI 1255596573	Dr. Signature

Claustrophobic? Yes No Metal in Body? Yes No Allergic to Iodine? Yes No Height _____ Weight _____

CPT Codes	MRI Description
BODY - MRI	
74181	Abdomen
74183	Abdomen W/ W/O contrast
72195	Pelvic
72197	Pelvic W/ W/O contrast
74185	Cholangiogram (MRCP)
74181	Liver
70543	Auditory Canal (IAC)
70553	Auditory Canal (IAC) W/ W/O contrast
70551	Brain
70553	Brain W/ W/O contrast
70551/70540	Brain and Orbits
70543/70553	Brain and Orbits W/ W/O contrast
72195	MRI Prostate
72197	MRI Prostate W/ W/O contrast
70553	Pituitary contrast mandatory
70543	Parotid W/ W/O contrast
70540	Sinus
77058	Breast Unilateral RT or LT
77059	Breast Bilateral
EXTREMITY - MRI	
73221	Shoulder RT or LT
73218	Upper Arm (Humerus) RT or LT
73221	Elbow RT or LT
73218	Forearm RT or LT
73221	Wrist RT or LT
73218	Hand RT or LT
73221	Hip RT or LT
73218	Thigh (Femur) RT or LT
73218	Tib-Fib (Leg) RT or LT
73221	Knee RT or LT
73221	Ankle RT or LT
73218	Foot RT or LT
73218	Toe RT or LT
SPINE - MRI	
72141	Cervical Spine
72142	Cervical Spine W/ Contrast
72156	Cervical Spine W/ W/O Contrast
72148	Lumbar Spine
72149	Lumbar Spine W/ Contrast
72158	Lumbar Spine W/ W/O Contrast
72146	Thoracic Spine
72147	Thoracic Spine W/ Contrast
72157	Thoracic Spine W/ W/O Contrast
72148	Sacrum - Coccyx
MRA	
70544	Head
70547	Neck
73225	LE, W/ or W/O
73225	R Run Off
71555	Thoracic Aorta
74185	Abdominal Aorta
70544	MRV
70544	Intra / Extra Canam
ECG/CARDIOGRAM	
93306	2D ECHO
93306/93015	2D ECHO WITH STRESS
EMG/NCV	
	choose: Right Left Bilateral
	Upper Lower Both
BIOPSY - Please Indicate	
	CT Biopsy:
	US Biopsy:
	Fine Needle Aspiration
MAMMOGRAPHY	
77067	Mammogram (Screening)
77066	Mammogram (Diagnostic) - Bilateral
77065	Mammogram (Diagnostic) - Unilateral
	Choose: Left Right
	Spot Compression: Left Right
77063	3D Mammogram Screening
G0279	3D Mammogram (Diagnostic)

CPT Codes	CT Description
CT	
74150	Abdomen
74170	Abdomen W/ W/O contrast
72192	Pelvis
72193	Pelvis W/ contrast
72194	Pelvis W/ W/O contrast
74176	Abdomen / Pelvis
74177	Abdomen / Pelvis W/ contrast
74178	Abdomen / Pelvis W/ W/O contrast Urogram
74176	Renal Stone Protocol
71250	Chest (High Resolution)
71250	Chest w Heart Scan
71250	Chest W/O contrast
71270	Chest W/ W/O contrast
70450	Brain
70470	Brain W/ W/O contrast
72125	Cervical
72127	Cervical W/ W/O contrast
72131	Lumbar
72133	Lumbar W/ W/O contrast
72128	Thoracic
72130	Thoracic W/ W/O contrast
70491	Soft Tissue Neck W/ contrast
70492	Soft Tissue Neck W/ W/O contrast
70480	Temporal Bones
70486	Facial Bones
70480	TMJ
70480	Orbits
70486	Sinus
	mm cuts
	Axial Coronal Both
70486/76376	Landmarx Protocol
70486/77011	Instatrak Protocol
	LDCT Low dose CT Scan for lung cancer screening
	All CTA:
	Other:
EXTREMITY - CT	
73200	Elbow Wrist Hand
73700	Foot RT or LT
73700	Knee RT or LT
73200	Shoulder RT or LT
73700	Ankle RT or LT
73700	Hip RT or LT
PREVENTATIVE SCANS / OTHERS	
71250	Heart Scan
93880	Carotid IMT Bilateral
	Full Body Scan
	ABI
	PAD
93015	Treadmill Stress Test
93000	BKG
BONE DENSITOMETRY	
77080	DXA Scan (Dual Energy Xray)
77086	Vertebral Ex Assessment (IVA)
FLUOROSCOPY	
74220	Esophagram/ Barium Swallow
74230	Upper GI W/O Swallowing Function
74240	Upper GI W/ No Air
74246	Upper GI W/ Air
74250	Small Bowel Follow Through
74270	Barium Enema W/No Kub
74280	Barium Enema W/Air W/No Glucagon
74210	Upper GI W/Esophagram
58340/74740	HSG (Hysterosalpingogram)
OTHER REQUEST	
	Patient to take films
	Need films Delivered
	Need CD Delivered
	Patient to take CD
	Patient needs Transportation

CPT Codes	ULTRASOUND Description
GENERAL US	
76700	Abdomen
76856	Pelvis
76830	Transvaginal
76805	OB
76705	Gallbladder
76770/51798	Renal
76536	Thyroid
76641	Breast Left Right
76705	Liver
78670	Scrotum / Testicular
76536	Soft Tissue
	3D/4D OB
VASCULAR US	
	Left Right Bilateral
	Upper Lower
	with ABI
93925	Arterial Doppler
93880	Carotid Doppler
93971	Venous Doppler Unilateral
93970	Venous Doppler Bilateral
PARANASAL SINUS	
	ES's x1 or x3 Level:
	Cervical Thoracic Lumbar
	Facet Blocks: Level:
	Cervical Thoracic Lumbar
	Nerve Root Injections/Hardware
	Cervical Thoracic Lumbar
	Medial Branch Block
	Cervical Thoracic Lumbar
	Myelogram
	Cervical Thoracic Lumbar
	Radiofrequency Ablation
	Cervical Thoracic Lumbar
	Discogram: Level:
	Cervical Thoracic Lumbar
	Arthrogram: Shoulder Wrist Knee
	choose: Right Left Both
	Hip Injection
	choose: Right Left Both
	Kyphoplasty
	Percutaneous Discectomy
	Consult and Treat
	Consults Only
NUCLEAR MEDICINE	
78607/A9584	DAT Scan
78014	Thyroid Scan
78012	Thyroid Scan with Uptake
79005	Thyroid Therapy / I-131 Thyroid ablation
78070	Parathyroid Nuclear Imaging
78205	Liver Spect Hemangioma
78264	Gastric Emptying
78315	3 Phase Bone Scan
78306	Whole Body Bone Scan
78478	MPI with Wall Motion
78480	MPI with Ejection Fraction
78708	Lasix Renal Scan
78708	GER Renal Scan
78708	Captopril Renal
78806	Gallium Scan Extremity Whole Body
78458/78457	Long/Upper Venogram Bilateral/Unilateral
78451	Myocardial Perfusion - Treadmill
78451	Myocardial Perfusion - Chemical Treadmill
78227	HIDA Scan
78261	Mecckel's - Gastric Mucosa
78320	Bone Spect
78710	Renal Spect Scan
78607	Brain Spect
78709	Kidney Scan
78806	Indium Scan

Memorial MRI & Diagnostic Imaging Centers
 Scheduling Direct Line: 713-554-3200
 Main Line: 713-461-3399
 Fax: 713-461-1969 or 713-904-2495
 www.memorialdiagnosis.com



X-RAYS/OTHERS PROCEDURES/SPECIAL INSTRUCTIONS	

Document Name: 2023-0428-Painscale, Scanned Date: 05/24/2023

Notes:

Accuhealth

Injury & Wellness

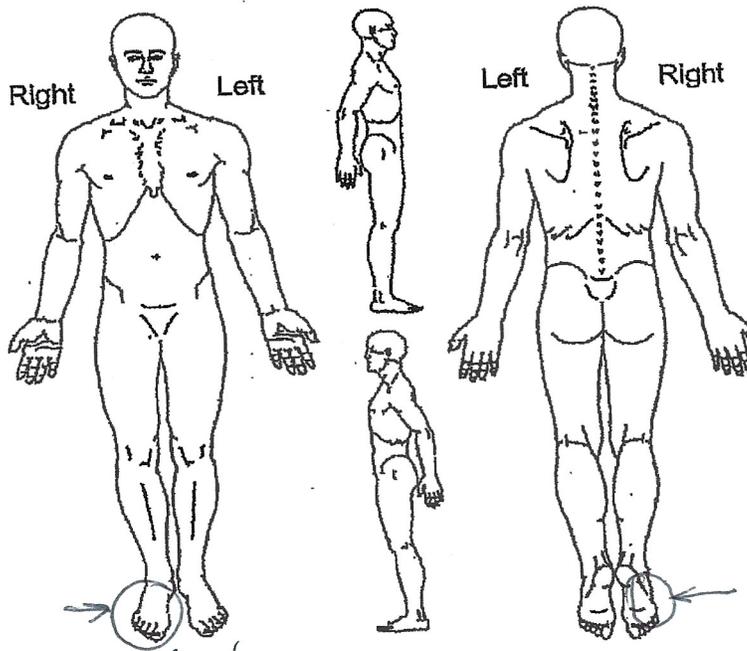
BP: 136/86 W: 196
 P: 76

Date: 28 APR 2023

Name: STEPHEN HEATH

Area:	Pain Level Today				
	No Pain	Mild	Moderate	Severe	Extreme
1. <u>RIGHT FOOT</u>	0	1 <u>(2)</u> 3	4 5 6	7 8 9	10
2. <u>(BOTTOM RIGHT; UPPER RIGHT)</u>	0	1 2 3	4 5 6	7 8 9	10
3. <u>(CROSSED OUT)</u>	0	1 2 3	4 5 6	7 8 9	10
4. <u>(CROSSED OUT)</u>	0	1 2 3	4 5 6	7 8 9	10
5. <u>(CROSSED OUT)</u>	0	1 2 3	4 5 6	7 8 9	10
6. <u>(CROSSED OUT)</u>	0	1 2 3	4 5 6	7 8 9	10

Please **circle** or use an "X" to indicate the areas that you have pain. Draw arrows to indicate radiating pain, numbness, or tingling of the arms, hands, legs, or feet.



List of current medications (medical follow up visits only).

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Signature: [Handwritten Signature]

Date: 28 APR 2023

I HEREBY STATE THAT THE ABOVE IS TRUE AND REPRESENTATIVE OF MY INJURY AND SYMPTOMS.

Document Name: 2023-0408-Painscale, Scanned Date: 05/24/2023

Notes:

Accuhealth

Injury & Wellness

Name: STEPHEN E HEATH

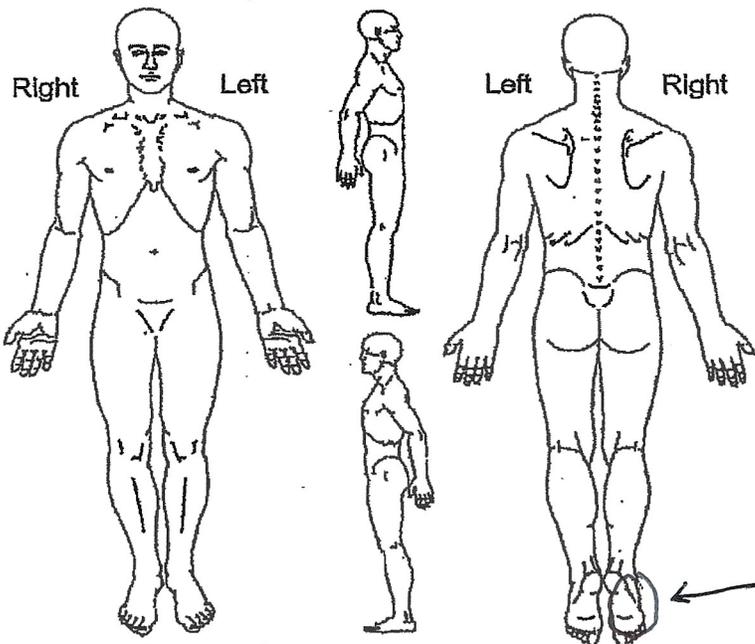
Date: 8 APR 2023

Area:

Pain Level Today

	No Pain	Mild	Moderate	Severe	Extreme
1. <u>RIGHT FOOT</u>	0	<u>1</u> 2 3	4 5 6	7 8 9	10
2. _____	0	1 2 3	4 5 6	7 8 9	10
3. _____	0	1 2 3	4 5 6	7 8 9	10
4. _____	0	1 2 3	4 5 6	7 8 9	10
5. _____	0	1 2 3	4 5 6	7 8 9	10
6. _____	0	1 2 3	4 5 6	7 8 9	10

Please **circle** or use an "X" to indicate the areas that you have pain. Draw arrows ↓ to indicate radiating pain, numbness, or tingling of the arms, legs, or feet.



List of current medications (medical follow up visits only).

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Signature: *Stephen E Heath*

Date: 8 APRIL 2023

I HEREBY STATE THAT THE ABOVE IS TRUE AND REPRESENTATIVE OF MY INJURY AND SYMPTOMS.

Document Name: 2023-0428-CA17, Scanned Date: 05/24/2023

Notes:

Duty Status Report

U.S. Department of Labor Office of Workers' Compensation Programs



This form is provided for the purpose of obtaining a duty status report for the employee named below. This request does not constitute authorization for payment of medical expense by the Department of Labor, nor does it invalidate any previous authorization issued in this case. This request for information is authorized by law (5 USC 8101 et seq.) and is required to obtain or retain a benefit. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-130. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No. 1240-0046
 Expires: 05/31/2024
 OWCP File Number
 (If known)
 550407066

SIDE A - Supervisor: Complete this side and refer to physician 1. Employee's Name (Last, first, middle) Heath Stephen 2. Date of Injury (Month, day, yr.) 3. Social Security Number 03/25/2023	SIDE B - Physician: Complete this side 8. Does the History of Injury Given to You by the Employee Correspond to that Shown in Item 5? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (If not, describe)
---	--

4. Occupation Correctional Officer 5. Describe How the Injury Occurred and State Parts of the Body Affected Right/foot/injury from walking	9. Description of Clinical Findings Strain of right foot, initial encounter 10. Diagnosis(es) Due to Injury S96.911A 11. Other Disabling Conditions
--	--

6. The Employee Works Hours Per Day 8 Days Per Week 5 7. Specify the Usual Work Requirements of the Employee. Check Whether Employee Performs These Tasks or is Exposed Continuously or Intermittently, and Give Number of Hours.	12. Employee Advised to Resume Work? <input checked="" type="checkbox"/> Yes, Date Advised 04/28/23 <input type="checkbox"/> No 13. Employee Able to Perform Regular Work Described on Side A? <input type="checkbox"/> Yes, if so <input checked="" type="checkbox"/> Full-Time or <input type="checkbox"/> Part-Time _____ Hrs Per Day <input type="checkbox"/> No, if not, complete below:
---	---

Activity	Continuous		Intermittent	Intermittent		Hrs Per Day
	#lbs.	#lbs.		#lbs.	#lbs.	
a. Lifting/Carrying: State Max Wt.						Hrs Per Day
b. Sitting	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
c. Standing	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
d. Walking	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
e. Climbing	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
f. Kneeling	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
g. Bending/Stooping	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
h. Twisting	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
i. Pulling/Pushing	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
j. Simple Grasping	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
k. Fine Manipulation (includes keyboarding)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
l. Reaching above Shoulder	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
m. Driving a Vehicle (Specify)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
n. Operating Machinery (Specify)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
o. Temp. Extremes	<input type="checkbox"/>	<input type="checkbox"/>	range in degrees F	<input type="checkbox"/>	<input type="checkbox"/>	range in degrees F
p. High Humidity	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
q. Chemicals, Solvents, etc. (Identify)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
r. Fumes/Dust (Identify)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
s. Noise (Give dBA)	<input type="checkbox"/>	<input type="checkbox"/>	dBA Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	dBA Hrs Per Day

t. Other (Describe)	14. Are Interpersonal Relations Affected Because of a Neuropsychiatric Condition? (e.g. Ability to Give or Take Supervision, Meet Deadlines, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No (Describe)
---------------------	---

17. Specialty General Surgeon	16. Date of Next Appointment 6/11/23 18. Tax Identification Number 824827893
19. Physician's Signature 	20. Date 04/28/23 CA-17 (Rev. 08-14)

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodations and/or modifications, please contact OWCP. See form instructions for Requests for Accommodations or Auxiliary Aids and Services

Document Name: 2023-0408-CA17, Scanned Date: 05/24/2023

Notes:

Duty Status Report

U.S. Department of Labor Office of Workers' Compensation Programs



This form is provided for the purpose of obtaining a duty status report for the employee named below. This request does not constitute authorization for payment of medical expense by the Department of Labor, nor does it invalidate any previous authorization issued in this case. This request for information is authorized by law (5 USC 8101 et seq.) and is required to obtain or retain a benefit. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-130. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No. 1240-0046
 Expires: 05/31/2024
 OWCP File Number
 (If known)

SIDE A - Supervisor: Complete this side and refer to physician

SIDE B - Physician: Complete this side

1. Employee's Name (Last, first, middle)
Heath Stephen

2. Date of Injury (Month, day, yr.)
03/25/2023

3. Social Security Number
XXX-XX-4590

4. Occupation
Correctional Officer

5. Describe How the Injury Occurred and State Parts of the Body Affected
Mr. Heath was walking down the unit (big rectangle/concrete floor) He began to feel a sharp pain and achy at the bottom right hand side of the foot and some at top

6. The Employee Works
 Hours Per Day _____ Days Per Week _____

7. Specify the Usual Work Requirements of the Employee. Check Whether Employee Performs These Tasks or is Exposed Continuously or Intermittently, and Give Number of Hours.

8. Does the History of Injury Given to You by the Employee Correspond to that Shown in Item 5? Yes No (If not, describe)

9. Description of Clinical Findings
Strain of right foot, initial encounter

10. Diagnosis(es) Due to Injury
S96.911A

11. Other Disabling Conditions

12. Employee Advised to Resume Work?
 Yes, Date Advised **04/08/23** No

13. Employee Able to Perform Regular Work Described on Side A?
 Yes, If so Full-Time or Part-Time _____ Hrs Per Day
 No, If not, complete below:

Activity	Continuous			Intermittent		
	#lbs.	#lbs.	Hrs Per Day	#lbs.	#lbs.	Hrs Per Day
a. Lifting/Carrying: State Max Wt.						
b. Sitting	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
c. Standing	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
d. Walking	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
e. Climbing	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
f. Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
g. Bending/Stooping	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
h. Twisting	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
i. Pulling/Pushing	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
j. Simple Grasping	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
k. Fine Manipulation (includes keyboarding)	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
l. Reaching above Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
m. Driving a Vehicle (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
n. Operating Machinery (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
o. Temp. Extremes	<input type="checkbox"/>	<input type="checkbox"/>	_____ range in degrees F	<input type="checkbox"/>	<input type="checkbox"/>	_____ range in degrees F
p. High Humidity	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
q. Chemicals, Solvents, etc. (Identify)	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
r. Fumes/Dust (identify)	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
s. Noise (Give dBA)	<input type="checkbox"/>	<input type="checkbox"/>	dBA Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	dBA Hrs Per Day
t. Other (Describe)						

14. Are Interpersonal Relations Affected Because of a Neuropsychiatric Condition? (e.g. Ability to Give or Take Supervision, Meet Deadlines, etc.)
 Yes No (Describe)

15. Date of Examination **04/08/23** 16. Date of Next Appointment **04/21/23**

17. Specialty
General Surgeon

18. Tax Identification Number
824827893

19. Physician's Signature

20. Date **04/08/23** CA-17 (Rev. 08-14)

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodations and/or modifications, please contact OWCP. See form instructions for Requests for Accommodations or Auxiliary Aids and Services

Document Name: BLANK CA17, Scanned Date: 04/28/2023

Notes:

Duty Status Report

U.S. Department of Labor Office of Workers' Compensation Programs



This form is provided for the purpose of obtaining a duty status report for the employee named below. This request does not constitute authorization for payment of medical expense by the Department of Labor, nor does it invalidate any previous authorization issued in this case. This request for information is authorized by law (5 USC 8101 et seq.) and is required to obtain or retain a benefit. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-130. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No. 1240-0046
 Expires: 05/31/2024
 OWCP File Number
 (If known)
 550407066

SIDE A - Supervisor: Complete this side and refer to physician

SIDE B - Physician: Complete this side

1. Employee's Name (Last, first, middle)
 Heath Stephen

2. Date of Injury (Month, day, yr.) 03/25/2023

3. Social Security Number

4. Occupation Correctional Officer

5. Describe How the Injury Occurred and State Parts of the Body Affected
 Right/foot/injury from walking

6. The Employee Works
 Hours Per Day 8 Days Per Week 5

7. Specify the Usual Work Requirements of the Employee. Check Whether Employee Performs These Tasks or is Exposed Continuously or Intermittently, and Give Number of Hours.

8. Does the History of Injury Given to You by the Employee Correspond to that Shown in Item 5? Yes No (If not, describe)

9. Description of Clinical Findings

10. Diagnosis(es) Due to Injury

11. Other Disabling Conditions

12. Employee Advised to Resume Work?
 Yes, Date Advised No

13. Employee Able to Perform Regular Work Described on Side A?
 Yes, If so Full-Time or Part-Time ____ Hrs Per Day
 No, If not, complete below:

Activity	Continuous		Intermittent	Continuous		Intermittent
	#lbs.	#lbs.		#lbs.	#lbs.	
a. Lifting/Carrying: State Max Wt.			Hrs Per Day			Hrs Per Day
b. Sitting	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
c. Standing	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
d. Walking	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
e. Climbing	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
f. Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
g. Bending/Stooping	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
h. Twisting	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
i. Pulling/Pushing	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
j. Simple Grasping	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
k. Fine Manipulation (includes keyboarding)	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
l. Reaching above Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
m. Driving a Vehicle (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
n. Operating Machinery (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
o. Temp. Extremes	<input type="checkbox"/>	<input type="checkbox"/>	____ range in degrees F	<input type="checkbox"/>	<input type="checkbox"/>	____ range in degrees F
p. High Humidity	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
q. Chemicals, Solvents, etc. (Identify)	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
r. Fumes/Dust (Identify)	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	Hrs Per Day
s. Noise (Give dBA)	<input type="checkbox"/>	<input type="checkbox"/>	dBA Hrs Per Day	<input type="checkbox"/>	<input type="checkbox"/>	dBA Hrs Per Day

t. Other (Describe)

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodations and/or modifications, please contact OWCP. See form instructions for Requests for Accommodations or Auxiliary Aids and Services

14. Are Interpersonal Relations Affected Because of a Neuropsychiatric Condition? (e.g. Ability to Give or Take Supervision, Meet Deadlines, etc.)
 Yes No (Describe)

15. Date of Examination

16. Date of Next Appointment

17. Specialty

18. Tax Identification Number

19. Physician's Signature

20. Date

Document Name: 2023-0405, Scanned Date: 04/28/2023

Notes:

File Number: 550407066
CCL-SFC-O-OT

U.S. DEPARTMENT OF LABOR

DFELHWC-FECA, PO Box 8311
LONDON, KY 40742-8311
Phone: (202) 513-6860

Want Faster Service?
Upload a document at ecomp.dol.gov

April 5, 2023

Date of Injury: 03/25/2023
Employee: STEPHEN E HEATH

STEPHEN E HEATH
10035 DRIFTWOOD PARK DR
HOUSTON, TX 77095

Dear STEPHEN E HEATH:

We have received your claim, and it has been assigned the case number noted above.

Current Status	Based on the circumstances regarding your claim, we are suspending its adjudication and administratively closing your case. While in an administrative closure status: <ul style="list-style-type: none"> • Medical bills related to the work injury are payable up to \$1500.00. You should have received an Optum/FECA pharmacy card by mail or through the link provided by e-mail after filing your claim via ECOMP. You MUST use the provided pharmacy card for injury related prescriptions. No other pharmacy card will be recognized for your claim. The card will expire within 180 days from the date of your injury or when benefits paid surpass \$1500.00 – whichever comes first. • You remain eligible for continuation of pay (COP) pursuant to 20 CFR 10.205 - 224, if an appropriate form was timely filed.
For Information About Your Case	View your case and compensation claim status, the documents contained within your case file, billing updates (including reimbursements) and other information provided to injured workers in the Employees' Compensation Operations and Management Portal (ECOMP) accessed at https://www.ecomp.dol.gov/ . For help registering for an ECOMP account, click the "HELP" option found at the top right hand corner of the ECOMP website. Then click on the "FECA Claimant" option and choose the "Account Registration" user guide. To access information about your FECA claim(s), you must verify your identity in ECOMP after you register for an account. The "Identity Verification" user guide can be accessed from the FECA Claimant User Guide Landing page by clicking "More Topics". Electronic communications are faster than paper communications, so we encourage you to verify your identity in ECOMP.
To Submit Documentation to Us	The fastest way to submit evidence is by uploading it through ECOMP at https://www.ecomp.dol.gov . We will have it within minutes of the upload. You can also mail the information to the address at the top of this letter.
If You Think Your Medical Bills Will Exceed \$1,500	Should your medical bills or anticipated treatment costs exceed \$1500.00 and/or should you be disabled for an extended period, your claim will be reopened and formally adjudicated. <u>If this occurs</u> , you will need to submit a report from a medical doctor containing 1) a description of your work injury, 2) a medical diagnosis, and 3) an explanation of how your medical condition was caused by the claimed work event(s). Other information may also be required, as determined by the Claims Examiner.

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodation(s) and/or modification(s), please contact OWCP.

Document Name: 2023-0419-RT Foot, Scanned Date: 04/27/2023

Notes:



Phone: (713) 461-3399
Fax: (713) 461-1969

Patient ID: MMD1512028000 **Exam Date:** 19-Apr-2023 12:18 PM
Patient Name: Stephen, Heath **Accession #:** 4719754
DOB: 13-Apr-1967 **Referred By:** Lashondria Renee Camp
Modality: MR **Location:** M3T_155

MRI Foot Right without Contrast (MR082)

HISTORY: Foot pain

TECHNIQUE: Multiplanar multiecho sequences were obtained.

FINDINGS:

Tarsal bones are maintained.

Reactive marrow edema in the head of the second metatarsal compatible with mild degenerative change. Small joint effusion and in the second MTP joints with multiple small loose bodies.

Mild tenosynovitis of the flexor tendons to the second digit.

Muscle signal intensity is maintained.

The plantar fascia is intact.

No fluid collection or mass identified.

IMPRESSION:

1. Second MTP joint degenerative changes with a joint effusion and multiple small loose bodies and minimal reactive marrow edema in the head of the second metatarsal.
2. Mild flexor tendon tenosynovitis to the second digit.

Electronically Signed by: Robert Loeb, MD, Board Certified Radiologist, on 20-Apr-2023 8:14 AM

Thank you for the opportunity to assist in your patient's care.

Document Name: 2023-0419- RT-Ankle, Scanned Date: 04/27/2023

Notes:



Phone: (713) 461-3399
Fax: (713) 461-1969

Patient ID: MMD1512028000 **Exam Date:** 19-Apr-2023 12:49 PM
Patient Name: Stephen, Heath **Accession #:** 4719753
DOB: 13-Apr-1967 **Referred By:** Lashondria Renee Camp
Modality: MR **Location:** M3T_155

MRI Ankle Right without Contrast (MR027)

HISTORY: Ankle pain

TECHNIQUE: Multiplanar multiecho sequences were obtained.

FINDINGS:

LIGAMENTS: The anterior talofibular, the posterior talofibular, the calcaneofibular, and the syndesmotoc ligaments are intact. The deltoid ligament is unremarkable.

TENDONS: There is mild tenosynovitis of all the flexor tendons and otherwise the posterior tibial, the flexor digitorum longus, and the flexor hallucis longus tendons are intact. Peroneus longus tendinosis. Intact extensor tendons. Intact Achilles tendon.

BONES/CARTILAGE: Intact distal tibia and fibula. No fracture or significant osseous abnormality. No cartilage lesions of the talar dome. The subtalar joint and the sinus tarsus are unremarkable.

GENERAL: Small ankle joint effusion. The tarsal tunnel and the plantar fascia are normal.

IMPRESSION:

1. Peroneus longus tendinosis and mild tenosynovitis of the flexor tendons.

Electronically Signed by: Robert Loeb, MD, Board Certified Radiologist, on 20-Apr-2023 8:12 AM

Thank you for the opportunity to assist in your patient's care.

Document Name: VitalsInfo2023/4/8_13:0:3:.64, Scanned Date: 04/08/2023

Notes: EMR Form

Vitals

Height : **6 Feet 0 inches**

Weight : **195 pounds**

Blood Pressure : /

Temperature : **97.8 F**

Respiratory Rate : **Breaths per minute**

Pulse Rate : **Beats per minute**

Document Name: PracConsentForm2023/4/8_12:51:3:.72, Scanned Date: 04/08/2023

Notes: EMR Form

5/13/24, 12:36 PM

Telemedicine Consent Form By typing my name “I agree to Terms of Use” on the Accuhealth telemedicine portal, I understand and agree that I am signing this Consent and that (i) I have reviewed, understand and accept the risks and benefits of telemedicine services as described below and wish to receive such services, and (ii) I agree to the remaining terms of this Consent. If I am signing on behalf of a minor, incapacitated or otherwise legally dependent patient, I certify that I am a person with legal authority to act on behalf of the patient, including the authority to consent to medical services, and I accept financial responsibility for services rendered. 1. By using the Accuhealth telemedicine portal, I agree to receive telemedicine services. Telemedicine involves the delivery of health care services, including assessment, treatment, diagnosis, and education, using interactive audio, video, and data communications. During my visit, my Accuhealth provider and I will be able to see and speak with each other from remote locations. 2. I understand and agree that: I will not be in the same location or room as my medical provider. My Accuhealth provider is licensed in the state in which I am receiving services. I will report my location accurately during registration. Potential benefits of telemedicine (which are not guaranteed or assured) include: (i) access to medical care if I am unable to travel to my Accuhealth provider’s office; (ii) more efficient medical evaluation and management; and (iii) during the COVID-19 pandemic, reduced exposure to patients, medical staff and other individuals at a physical location. Potential risks of telemedicine include: (i) limited or no availability of diagnostic laboratory, x-ray, EKG, and other testing, and some prescriptions, to assist my medical provider in diagnosis and treatment; (ii) my provider’s inability to conduct a hands-on physical examination of me and my condition; and (iii) delays in evaluation and treatment due to technical difficulties or interruptions, distortion of diagnostic images or specimens resulting from electronic transmission issues, unauthorized access to my information, or loss of information due to technical failures. I will not hold Accuhealth responsible for lost information due to technological failures. I further understand that my Accuhealth Provider’s advice, recommendations, and/or decisions may be based on factors not within his/her control, including incomplete or inaccurate data provided by me. I understand that my Accuhealth provider relies on information provided by me before and during our telemedicine encounter and that I must provide information about my medical history, condition(s), and current or previous medical care that is complete and accurate to the best of my ability. I may discuss these risks and benefits with my Accuhealth provider and will be given an opportunity to ask questions about telemedicine services. I have the right to withdraw this consent to telemedicine services or end the telemedicine session at any time without affecting my right to future treatment by Accuhealth. I understand that the level of care provided by my Accuhealth provider is to be the same level of care that is available to me through an in-person medical visit. However, if my provider believes I would be better served by face-to-face services or another form of care, I will be referred to the nearest Accuhealth clinic, hospital emergency department or other appropriate health care provider. In case of an emergency, I will dial 911 or go directly to the nearest hospital emergency room. Please talk to one of our office staff if you have any complaints or issues with telemedicine.

_____ Signature of patient (or guardian)

_____ Printed name

_____ Date

I have read the consent form and the above information and I accept the conditions.

Consent Date: Sat Apr 08 13:50:17 EDT 2023