Attending Physician's Statement - #1 recomplete with Alice Cooper

Section A					
Plan Member/Employee I	nformat	ion and Consent TO BE COM	PLETED BY THE PA	ATIENT	
Plan Member/Employee Name (Last, First, Middle Initial):		Home Phone # (+ Area Code):	Cell Phone # (+ Are	a Code):	
Cooper, Alice			312 556-8173		
Address (Street, City, Province, Postal Code): 586 Oak Street, Chicago IL					
Employer's Name: Schools Out LLC	Group STD34	Plan Number: 56123	Employee ID Number: 337669	DOB (08/15/1990)	
Expected		Date Returned to Work or Expected Return to Work Date, if known (08/20/2024):	Please provide your: Height: 5'10" Weight: 170		
I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, for the purpose of investigating and assessing my claim (s), administering coverage (s) that I may have with Disability Company LLC and administering the group benefits plan. This consent may be revoked by me at any time by sending a written instruction. I understand that I am responsible for any fees related to the completion of this form. I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.					
Plan Member/Employee Si	gnature		Date of Consent (07/05/2024):		
Alice Cooper					
Section B			Attending Physician's Questionnaire TO BE COMPLETED BY THE DOCTOR		
I am the: Attending Physician ⊠ Consulting Specialist □ Other □ (please specify)					
Diagnosis					
Primary: General Anxiety	Disord	er			
Secondary:					
Is this condition related to: Occupational Illness/injury	□ Auto	Accident □ If so, date of even	nt: (dd/mm/yyyy):		

Date of first visit to you	u pertaining to this o	condition (06/05/2024	First date of work absen condition: (07/03/2024):	ce due to this		
Has the patient been If yes, date: (dd/mm/		ame or similar cond By whom:	lition in the past? Yes □ No) ×		
Have you completed any other disability claim forms recently for this patient? Yes ☐ No ☒ If yes, please indicate requestor: (other insurance company, Workers Compensation)						
Patient's Description	cription of Symptom	ıs				
			frequency and severity:			
Can't sleep, irritable, panic attacks, always tired, restless with constant worry due to job and manager						
Your Clinical I	Findings and Obser	vations				
Please describe how t	he condition has im	pacted the following	and to what degree:			
	No impact	Mild	Moderate	Severe		
Appearance	\boxtimes					
Memory						
Energy/Vigor						
Behavior		\boxtimes				
Decision Making						
Socialization	\boxtimes					
Concentration/Focus			П			
Speech						

	\boxtimes					
\boxtimes						
Observations or comments supporting the above: Patient is often distracted and restless. Avoids eye contact.						
Factors						
tors that may have	contributed to the cli	nical problem(s) and	I may comp	olicate the patient's		
Soc	ial/Family Issues □	l F	inancial/L	egal Problems □		
☐ Alco	ohol/Drug Abuse □	ı	/ledication	Side Effects □		
Сор	ing Skills □	F	Personality	r/Motivation □		
Other ☑ Please describe: Patient reports high stress at work and a poor relationship with his manager. He also reports he is not taking the prescribed meds and he does not like taking medication.						
Please describe the supports in place, or planned, to assist with these issues: Referred to Dr. Albert Einstein, Psychiatrist for medication management and therapy.						
Investigations						
Please attach copies of all relevant: test results/investigations (if test results are not attached, we will interpret this as tests were not performed) consultation reports Do not provide genetic test results:						
Are tests/investigations/consultations pending? Yes □ No □ Date report expected: (dd/mm/yyyy)						
: Does the patient have an appointment booked with an specialist(s) in the near future? Yes \Box No \Box						
Petty, PhD 1 2	. Psychiatrist		-	/mm/yyyy)		
	rents supporting the cted and restless. A store and restless. A store that may have so a supports in place, Einstein, Psychiatric of all relevant: test reperformed) test results: Instein appointment be supported an appointment be supported as a supported an appointment be supported as a supported an appointment be supported as a supported as	nents supporting the above: cted and restless. Avoids eye contact. Factors tors that may have contributed to the clin Social/Family Issues Alcohol/Drug Abuse Coping Skills Cribe: Patient reports high stress at work gethe prescribed meds and he does not like supports in place, or planned, to assi Einstein, Psychiatrist for medication ma of all relevant: test results/investigations performed) c test results: s/consultations pending? Yes No re an appointment booked with an special	ments supporting the above: cted and restless. Avoids eye contact. Social/Family Issues Factors	nents supporting the above: ted and restless. Avoids eye contact. Social/Family Issues Financial/L Alcohol/Drug Abuse Medication Coping Skills Personality Personality Personality Personality Personality		

Has any license held by the patient been restricted or revoked as a result of this condition? Yes □ No □ Don't know ⊠							
If yes, as of when	? (dd/m	m/yyyy)		Type of licen	ise:		
Medications (plea	ise attac	h sepa	rate list if insufficient space)				
Medication Name		Initial dosage and date started (dd/mm/yyyy)		Current dosa and date cha if applicable (dd/mm/yyyy	anged	Response	
Lexapro		15 mgs	s once a week, 6/05/2024	Same			
Hospitalization							
Is/was the patient I	hospitaliz	zed? Ye	s ⊠ No □ Is future hospitaliza	ation anticipate	ed? Ye	s □ No ⊠	
Date admitted (04/	·		Date discharged (04/19/2024)	Institution Na			
Partial hospitalizat			4/30/2024	Tulip Hill Recovery			
Tartial 1103pitalization 4/24/2024			runp rim rec	50 TO. y			
Treatment Details Hospital program		hologic	al (e.g., cognitive behavioral,	drug/alcohol	l, group	o, family, m	narital, Day
Type of Therapy	Nam provid faci	der or	Date treatment began (dd/mm/yyyy)	Frequency of visits	,	e of last visit nm/yyyy)	Response

			Wkly □ Mthly □		
			Other □ Wkly □ Mthly □ Other □		
			Wkly □ Mthly □ Other □		
			Wkly □ Mthly □ Other □		
			Wkly □ Mthly □ Other □		
			Wkly □ Mthly □ Other □		
			Wkly □ Mthly □ Other □		
Overall Respons	e to Treatment				
Please describe the response to treatment to date: Complete □ Partial □ None □ Too soon to tell ⊠					
Is the patient foll Please explain:	owing the recor	nmended treatment _l	orogram? Yes □ No		
Patient is not takir	ng prescribed me	dication.			
		augment the curren			
If so, please explain: Possible medication changes after seeing Dr. Einstein					
Prognosis and Recovery					
What return-to-work goals have been discussed with the patient? Please explain:					
The goal is to return to work by 8/20/2024					
Please provide the patient's prognosis for improvement: Patient needs to be off of work while attending outpatient therapy, adjusting to medication and after being seen by psychiatrist					
Please provide any other information that will help us understand the patient's current condition recovery goals and prognosis:					
Note to Physician					

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.					
Attending Physician (please print):	Certified Specialty:	Physician's Stamp:			
Dr. Taylor Swift MD	Family Medicine				
Address (Street, City, Province, Pos					
Telephone # (+ Area Code):	Fax # (+ Area Code):				
312 777-2233					
Email Address					
Signature: Taylor Swift, MS	Date Signed (07/02/2024):				

Attending Physician's Statement - #2

Section A						
Plan Member/Employee I	nformat	tion and Consent TO BE COM	PLETED BY THE PA	ATIENT		
Plan Member/Employee Name (Last, First, Middle Initial):		Home Phone # (+ Area Code):	Cell Phone # (+ Area Code): 615 627-6677			
Lawrence, Jennifer						
Address (Street, City, Pro	Address (Street, City, Province, Postal Code): 1852 Red Street, Nashville, TN					
Employer's Name: Schools Out LLC	Group STD34	Plan Number: 56123	Employee ID Number: 337669	DOB (08/15/1990)		
Date Last Worked (04/15/2	Date Last Worked (04/15/2024): Date Exp		Please provide your: Height: 5'8" Weight: 125			
I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, for the purpose of investigating and assessing my claim (s), administering coverage (s) that I may have with Disability Company LLC and administering the group benefits plan. This consent may be revoked by me at any time by sending a written instruction. I understand that I am responsible for any fees related to the completion of this form. I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.						
Plan Member/Employee Si	gnature	:	Date of Consent (04/16/2024):			
Jennifer Lawrence						
Section B			Attending Physician's Questionnaire TO BE COMPLETED BY THE DOCTOR			
I am the: Attending Physician ⊠ Consulting Specialist □ Other □ (please specify)						
Diagnosis						
Primary: General Anxiety Disorder						
Secondary: Major Depres	sive Di	sorder				
Is this condition related to: Occupational Illness/injury	□ Auto	o Accident □ If so. date of even	it: (dd/mm/vvvv):			

Date of first visit to you	u pertaining to this o	condition (02/20/2024	First date of work absence condition: (04/16/2024):	First date of work absence due to this condition: (04/16/2024):		
Has the patient been If yes, date: (dd/mm/		ame or similar condi By whom:	ition in the past? Yes □ No			
Have you completed any other disability claim forms recently for this patient? Yes ☐ No ☒ If yes, please indicate requestor: (other insurance company, Workers Compensation)						
Patient's Desc	cription of Symptom	ıs				
			frequency and severity:			
Can't sleep, irritable, panic attacks, always tired, restless with constant worry due to job and manager						
Your Clinical I	indings and Obser	vations				
Please describe how t	he condition has im	pacted the following	and to what degree:			
	No impact	Mild	Moderate	Severe		
Appearance	\boxtimes					
Memory	\boxtimes					
Energy/Vigor						
Behavior						
Decision Making						
	\boxtimes					
Socialization						
Socialization Concentration/Focus						
	\boxtimes					

\boxtimes						
Observations or comments supporting the above: Patient is often distracted and restless. Avoids eye contact						
Factors						
tors that may have	contributed to the cli	nical problem(s) an	d may comp	olicate the patient's		
Soc	ial/Family Issues □]	Financial/Lo	egal Problems 🗆		
Alco	ohol/Drug Abuse □		Medication	Side Effects □		
Сор	ing Skills □		Personality	r/Motivation □		
Other ⊠ Please describe: Patient started having symptoms in February due to high stress at work and a poor relationship with her manager. She is also continuing to deal with the death of her mother 6 months ago						
Please describe the supports in place, or planned, to assist with these issues: Referred to Dr. Richard Petty, Psychiatrist for medication and therapy.						
Investigations						
Please attach copies of all relevant: test results/investigations (if test results are not attached, we will interpret this as tests were not performed) consultation reports Do not provide genetic test results:						
Are tests/investigations/consultations pending? Yes □ No □ Date report expected: (dd/mm/yyyy)						
: Does the patient have an appointment booked with an specialist(s) in the near future? Yes \Box No \Box						
Petty, PhD 1 2	. Psychiatrist			/mm/yyyy)		
	Factors Soc Cop Cribe: Patient started anager. She is also supports in place, and Petty, Psychiatris of all relevant: test reperformed) c test results: as/consultations pender an appointment by the property of the performed by the property of the performance of the performa	nents supporting the above: cted and restless. Avoids eye contact Factors tors that may have contributed to the cli Social/Family Issues Alcohol/Drug Abuse Coping Skills Cribe: Patient started having symptoms in hanager. She is also continuing to deal we have a supports in place, or planned, to assign a support of all relevant: test results/investigations performed) of all relevant: test results/investigations performed) c test results: Ins/consultations pending? Yes No Specialty	ments supporting the above: cted and restless. Avoids eye contact Factors tors that may have contributed to the clinical problem(s) and Social/Family Issues Coping Skills Cribe: Patient started having symptoms in February due to himanager. She is also continuing to deal with the death of her supports in place, or planned, to assist with these issued and Petty, Psychiatrist for medication and therapy. of all relevant: test results/investigations (if test results are reperformed) ce test results: ss/consultations pending? Yes No Date report expective an appointment booked with an specialist(s) in the near form of the properties of the pro	nents supporting the above: ted and restless. Avoids eye contact Social/Family Issues Financial/L Alcohol/Drug Abuse Medication Coping Skills Personality Personality Personality Personality Cribe: Patient started having symptoms in February due to high stress at banager. She is also continuing to deal with the death of her mother 6 modes		

Has any license h Yes □ No □ Do	_		ent been restricted or revoked	d as a result o	of this o	condition?	
If yes, as of when	n? (dd/mi	m/yyyy))	Type of licer	ise:		
Medications (plea	ase attac	h sepai	rate list if insufficient space)				
Medication Name		Initial dosage and date started (dd/mm/yyyy) a		Current dosa and date cha if applicable (dd/mm/yyyy	anged	Response	
Lexapro		10 mgs	s once a week, 4/16/2024	Same			
Hospitalization							
Is/was the patient	hospitaliz	ed? Ye	s ⊠ No □ Is future hospitaliza	ation anticipat	ed? Ye	s □ No ⊠	
Date admitted (04/	·		Date discharged (04/19/2024)				
Partial hospitalizat			4/30/2024	Tulip Hill Recovery			
Tartial 1103pitalization 4/24/2024			Tanp Tim Tto	<u> </u>			
Treatment Details Hospital program		nologic	al (e.g., cognitive behavioral,	drug/alcoho	l, group	o, family, m	narital, Day
Type of Therapy	Namo provid facil	ler or	Date treatment began (dd/mm/yyyy)	Frequency of visits	,	e of last visit nm/yyyy)	Response

Inpatient	НСА	4/16/2024	Wkly □ Mthly □ Other ⊠	4/19/2024	Daily inpatient Therapy
Out patient	Tulip Hill	4/24/2024	Wkly □ Mthly □ Other ⊠	4/30/2024	Daily – Mon - Fri
			Wkly □ Mthly ⊠ Other □		
			Wkly □ Mthly □ Other □		
			Wkly □ Mthly □ Other □		
			Wkly □ Mthly □ Other □		
			Wkly □ Mthly □ Other □		
Overall Respons	e to Treatment				
		treatment to date: Too soon to tell ⊠			
Is the patient foll Please explain:	owing the recor	mmended treatment program?	? Yes ⊠ No		
Are there any pla	nns to change o	r augment the current treatme	ent program?	Yes 🗆 No 🗆	
If so, please expl	ain: Possible m	edication changes after seein	ng Dr. Petty		
Prognosis and R	ecovery				
What return-to-work goals have been discussed with the patient? Please explain:					
The goal is to return to work by 7/1/2024					
Please provide the patient's prognosis for improvement: Patient needs to be off of work while attending outpatient therapy, adjusting to medication and after being seen by psychiatrist					
Please provide any other information that will help us understand the patient's current condition recovery goals and prognosis:					
Note to Physicia	n				

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.				
Attending Physician (please print):	Certified Specialty:	Physician's Stamp:		
Dr. Jessica Biel MD	Family Medicine			
Address (Street, City, Province, Pos				
Telephone # (+ Area Code):	Fax # (+ Area Code):			
615 555-6723				
Email Address				
Signature: Jessica Biel	Date Signed (04/25/2024):			

Attending Physician's Statement - #3

Section A					
Plan Member/Employee Information and Consent TO BE COMPLETED BY THE PATIENT					
Plan Member/Employee Name (Last, First, Middle Initial):		Home Phone # (+ Area Code): Cell Phone # (+ Area Code): 212 636-5798		a Code):	
Blunt, Emily					
Address (Street, City, Province, Postal Code): 4223 42 nd Ave, New York, NY					
Employer's Name: Red Sparrow Inc.			Employee ID Number: 993452	DOB (08/15/1990)	
Date Last Worked (04/12/2024):		Date Returned to Work or Expected Return to Work Date, if known (08/12/2024):	Please provide your: Height: 5'7" Weight: 125		
I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, for the purpose of investigating and assessing my claim (s), administering coverage (s) that I may have with Disability Company LLC and administering the group benefits plan. This consent may be revoked by me at any time by sending a written instruction. I understand that I am responsible for any fees related to the completion of this form. I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.					
Plan Member/Employee Signature:			Date of Consent (04/11/2024):		
Emily Blunt					
Section B			Attending Physician's Questionnaire TO BE COMPLETED BY THE DOCTOR		
I am the: Attending Physician ⊠ Consulting Specialist □ Other □ (please specify)					
Diagnosis					
Primary: General Anxiety Disorder					
Secondary: Major Depressive Disorder					
Is this condition related to: Occupational Illness/injury □ Auto Accident □ If so, date of event: (dd/mm/yyyy):					

Date of first visit to you	u pertaining to this o	,	First date of work absence due to this condition: (04/16/2024):			
-	Has the patient been treated for this same or similar condition in the past? Yes ⊠ No □ If yes, date: (02/07/2023) By whom: Dr. Dave Grohl PhD					
Have you completed any other disability claim forms recently for this patient? Yes □ No ⊠ If yes, please indicate requestor: (other insurance company, Workers Compensation)						
Define the Dec						
	cription of Symptom					
Please describe the	patient's current s	ymptoms including	g frequency and severity:			
Panic attacks, can't sleep, won't leave the house, always tired, restless, withdrawn, unable to focus						
Your Clinical Findings and Observations						
Please describe how t			and to what degree:			
	No impact	Mild	Moderate	Severe		
Appearance		\boxtimes				
Memory	\boxtimes					
Energy/Vigor						
Behavior						
Decision Making			\boxtimes			
Socialization						
Concentration/Focus						
Speech	_					

Insight/Judgment		\boxtimes				
Self-Criticism		\boxtimes				
Observations or comments supporting the above: Patient is often distracted and restless. Appears overwhelmed by simple questions. Appearance – dis-shelved. Avoids eye contact						
Complicating I	Factors					
Please indicate all fact recovery period:	tors that may have	contributed to the cl	inical _l	problem(s) and may comp	olicate the patient's	
Workplace Issues □	Soc	cial/Family Issues		Financial/L	Financial/Legal Problems □	
Physical Condition [Alc	ohol/Drug Abuse □]	Medication	Side Effects □	
Pain Perception □	Cop	oing Skills ⊠		Personality	/Motivation ⊠	
Other Please describe: Patient describes having depression on and off since her teenage years but the last two the symptoms have worsened to the point she is afraid to leave her house. She is divorced and lives alone finding it hard to care for her daily needs. She has lost 15 lbs in the last 6 months and says she does not have the energy to make meals. She recently accepted taking medication as she would not take it in the past.						
Please describe the supports in place, or planned, to assist with these issues: Started in patient therapy and treatment at Manhattan Psychiatric Center on July 15, 2024						
Investigations						
Please attach copies of all relevant: test results/investigations (if test results are not attached, we will interpret this as tests were not performed) consultation reports Do not provide genetic test results:						
Are tests/investigations/consultations pending? Yes ⊠ No □ Date report expected: (dd/mm/yyyy)						
: Does the patient have an appointment booked with an specialist(s) in the near future? Yes \boxtimes No \square						
Name of Specialist	Spec	ialty		Date of Appointment: (dd	/mm/yyyy)	
1. Dr. Dave Gro PhD 2.	hl, MD,	. Psychiatrist		1. 08/01/2024		
Reason for requesting the consultation:						

Has any license held by the patient been restricted or revoked as a result of this condition? Yes □ No ☒ Don't know □					
If yes, as of when? (dd/mm/yyyy)			Type of license:		
Medications (please attach separate list if insufficient space)					
Medication Name		Initial dosage and date started (dd/mm/yyyy)		age Response anged	9
Celexa	20 mg	ıs daily, 4/16/2024	Same		
Savella	40 mg	40 mgs daily, 6/6/2024			
Hospitalization					
Is/was the patient hospitalized? Yes □ No ☒ Is future hospitalization anticipated? Yes ☒ No □]
Date admitted (07/15/2024) Date discharged 08/02/2024)			Manhattan Psychiatric Center		
,			Manhattan Psychiatric Center		
Out-patient program (08/05/2024)		LSt, 0/30/2024	Iviaililattaii F	Sychiatric Center	
Treatment Details – Psychological (e.g., cognitive behavioral, drug/alcohol, group, family, marital, Day Hospital program)					
Type of Therapy	Name of provider or facility	Date treatment began (dd/mm/yyyy)	Frequency of visits	Date of last visit (dd/mm/yyyy)	Response

Inpatient	Manhattan Psychiatric Center	7/15/2024	Wkly □ Mthly □ Other ⊠	Onging	Daily inpatient Therapy
Out patient	Manhattan Psychiatric Center	8/05/2024	Wkly ⊠ Mthly □ Other ⊠	Until 8/30/24	3 days a week
			Wkly □ Mthly ⊠ Other □		
			Wkly □ Mthly □ Other □		
			Wkly □ Mthly □ Other □		
			Wkly □ Mthly □ Other □		
			Wkly □ Mthly □ Other □		
Overall Respons	e to Treatment				
Please describe the response to treatment to date: Complete □ Partial ⊠ None □ Too soon to tell □					
Is the patient following the recommended treatment program? Yes ⊠ No □ Please explain:					
Are there any plans to change or augment the current treatment program? Yes ☐ No ☒					
If so, please explain: Possible medication changes after inpatient treatment					
Prognosis and Recovery					
What return-to-work goals have been discussed with the patient? Please explain:					
The goal is to return to work by 9/2/2024					
Please provide the patient's prognosis for improvement: Patient needs to be off of work while attending inpatient and then outpatient therapy. She will be re-evaluated at the end of outpatient therapy					
Please provide any other information that will help us understand the patient's current condition recovery goals and prognosis:					
Note to Physician					

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.					
Attending Physician (please print):	Certified Specialty:	Physician's Stamp:			
Dr. David Grohl, MD, PhD	Psychiatry				
Address (Street, City, Province, Po					
Telephone # (+ Area Code):	Fax # (+ Area Code):				
212 454-6349					
Email Address					
Signature: David Grohl, M.D., Ph.D	Date Signed (08/05/2024):				