

HANLEY PAIN & REHABILITATION CENTER, INC.

Allison W. Hanley, M.D.

Board Certified American Board of Internal Medicine
Diplomate American Academy of Pain Management
Certified Medical Review Officer

ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN AND TRANSFER ANY AND ALL RIGHTS, BENEFITS AND CAUSES OF ACTION TO THE ASSIGNEE. This is an assignment of my rights and benefits. In the event my insurance company is obligated to make payment to me upon charges made by the Assignee for it=s services, and the company fails or refuses to make timely, complete payment, I authorize Assignee to prosecute said cause of action either in my name or Assignee=s name and further I authorize Assignee to compromise, settle or otherwise resolve said cause of action as they see fit.

DIRECTION OF PAYMENT

I hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to *Hanley Pain & Rehabilitation Center, Inc.* (Assignee), such sums as may be due and owing Assignee for the services rendered to me both by reason of accident or illness, and by reason of any other bills that are due Assignee. I hereby authorize any insurance company to pay directly to Assignee the amount of this and/or any future bills for services rendered to me and to release any information requested that is pertinent to my case to my insurance company or attorney involved in this case.

LETTER OF PROTECTION IN FAVOR OF PROVIDER

I hereby authorize and direct that my lawyer, if I am represented by counsel, SHALL withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, or any other insurance benefits obligated to reimburse me, or, from any settlement, judgment or verdict on my behalf as may be necessary to reimburse Assignee for services provided to me. I HEREBY FURTHER GIVE AN IRREVOCABLE LIEN to said Assignee against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me at a result of the injuries or illness for which I have been treated by the Assignee. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to Assignee.

PIP LOG & DEC SHEET REQUEST

I HEREBY AUTHORIZE THE ASSIGNEE TO REQUEST A COPY OF THE APPLICABLE INSURANCE POLICY AND DECLARATION PAGE WHICH REFLECTS THE POLICY LIMITS AVAILABLE AT THE TIME OF THIS ACCIDENT, AND THE APPLICABLE PIP LOG TO BE PROVIDED TO THIS ASSIGNEE upon request. This request is authorized pursuant to the terms of my policy as well as Florida Statutes.. I hereby authorized this Assignee to request and receive a copy of my pip log periodically as there deem to be necessary.

RESERVATIONS OF BENEFITS

Be further advised that I AM HEREBY PLACING YOU ON NOTICE PURSUANT TO FLORIDA CASE LAW THAT SHOULD YOU (THE INSURANCE COMPANY/CARRIER) DENY, REDUCE OR FAIL TO PAY ANY PART OF, OR AN ENTIRE BILL WHICH WAS SUBMITTED ON MY BEHALF FROM THIS PROVIDER, I (THE ASSIGNOR) AS WELL AS THE ASSIGNEE ARE REQUESTING IN ADVANCE THAT YOU RESERVE, OR ASET-ASIDE,@ THE AMOUNT YOU REDUCED OR DENIED UNTIL THE DISPUTE IS RESOLVED. Should you submit a check to Assignee which is less than the correct contractual amount, and contains any language referring to payment as a Full and Final Payment,@ I have instructed Assignee to return the check to you (the carrier) and consider the bill still due and owing (i.e. a late payment as defined in F.S 627.736). Additionally SHOULD THE REMAINING AMOUNT OF MY BENEFITS APPROACH AN AMOUNT WHERE THERE WOULD BE INEFFICIENT FUNDS TO PAY THE AMOUNT YOU REDUCED, DENIED OR FAILED TO PAY, PLEASE NOTIFY ME (THE ASSIGNOR) AND THE ASSIGNEE OF THIS FACT. Should my benefits exhaust; please notify me (the assignor) and assignee promptly.

SEVERABILITY CLAUSE

If any term or provision of this Assignment, Lien and Authorization or the application thereof to any person or circumstances shall to any extent be invalid or unenforceable the remainder of this Assignment, Lien and Authorization, or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby, and each term and provision of this Assignment, Lien and Authorization shall be valid and enforced to the fullest extent of the law.

Patient Name _____

Date _____

Patient Signature _____

Date _____

Physician Signature _____

Date _____

Attorney Signature _____

Date _____

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**MVA REGISTRATION
(PLEASE PRINT)**

Today's Date: _____ Who can we thank for referring you? _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____
Last Name First Name Middle Initial

SS#: _____ Sex: Male Female Marital Status: Married Single Divorced Widowed

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ Email: _____

Home Phone: _____ Work: _____ Cellular: _____

Is today's visit work related? Yes No Auto Accident? Yes No Date of Accident: _____

AUTO INSURANCE

Policy Holders Name: _____ Date of Birth: _____
Last Name First Name Middle Initial

SS#: _____ Sex: Male Female Relationship to Patient: Self Spouse Parent Other

Address: (if different from above) _____ Apt #: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Insurance Company Name: _____

Claim #: _____ Policy #: _____

Adjuster's Name: _____ Adjuster's Phone #: _____

ATTORNEY INFORMATION

Law Firm Name: _____

Attorney Name: _____ Case Manager: _____

Address: _____

Phone: _____ Fax: _____

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Patient Name: _____ Date of Birth: _____

EMERGENCY CONTACT

Full Name: _____ Relationship to Patient: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____ Phone: _____

CONSENT FOR TREATMENT:

The undersigned hereby consent to the provision of examination, treatments, medical laboratory procedures, drugs, and supplies to the patient as ordered or requested by the patients' physician and acknowledges that no guarantee or assurance has been made as to the results of such treatments, procedures or examinations.

Patient Signature: _____ Date: _____
(PHOTOCOPY AS VALID AS ORIGINAL)

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FINANCIAL DISCLOSURE POLICY

As a result of the changes to the *2003 Florida No Fault Statute*, it is a third degree felony for any provider to agree to waive a deductible or to reduce or waive your co-pay (if applicable) as a routine business practice. We therefore require payment of any balances due after all attempts by us (including litigation) to collect from the Florida No Fault coverage, whose right to collect you have assigned to us.

Two exceptions are allowed by statute involving financial inability in individual cases. Please ask to speak with our billing manager if you have any questions.

I have been notified of the changes to the No Fault Statute.

Name: _____ Birth Date: _____

Signature: _____ Date: _____

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AUTO RELATED ACCIDENT

Patient Name: _____ Date of Birth: _____

ACCIDENT INFORMATION

Accident Date: _____ Time: _____ AM PM
 Did the police come to the accident site? YES NO
 Was a police report filed? YES NO
 Was a traffic violation issued? YES NO
 If yes, to whom? _____
 Were there any witnesses? YES NO
 Make and model of the vehicle you were occupying:

 Make and model of the other vehicle:

 Name of the location or street you were traveling:

 In which direction were you traveling? N S E W
 The other vehicle was traveling? N S E W
 Was your vehicle stopped or moving? _____
 If stopped, was your foot on the brake? YES NO
 If moving, how fast were you traveling? _____MPH
 What was the speed of the other vehicle? _____MPH
 Did the impact to your vehicle come from the :
Front Rear Driver Side Passenger side
 Did your vehicle strike anything else? YES NO
 Please describe: _____
 Road Condition: DRY WET
 In your words, please describe the accident (use back if needed): _____

 Is this your first accident? YES NO If, No, how many prior accidents have you had? _____

PERSONAL INFORMATION

Were you the: Driver Front Passenger
Rear Passenger Other
 Were you wearing your seatbelt? YES NO
 During the impact, which direction was your head facing?
Forward Right Left
 Were you aware or surprised by the impact? _____
 In relation to the base of your skull, where was the headrest?
Above Below Even
 How far behind your skull was the headrest? _____
 Was your seat reclined? YES NO
 Did any part of your body strike anything inside your vehicle?
YES NO
 If yes, please describe?

 Did you Loose Consciousness Feel Dazed
 Did you have any pain or symptoms immediately after the accident?
YES NO
 Please explain: _____

 Did paramedics come to the accident site? YES NO
 Did the paramedics examine you? YES NO
 Did you go to the hospital? YES NO
 Which one? _____
 From the accident site? YES NO
 How did you get to the hospital?
Ambulance Self Other
 At the hospital, what was performed?
X-rays CT Scan MRI Other
 Were you prescribed medication? YES NO
 If yes, list medications: _____
 If given work excuse at hospital, what date does it state you may return to work? _____

WORK INFORMATION

What do you do for work? _____
 Please indicate your daily job duties:
Standing Sitting Walking Lifting Driving Twisting Crawling Bending Operate Equipment
Work with arms above head Typing Stooping Other: _____
 Have you missed any work due to the accident? YES NO If yes, how many days? _____
 While in recovery, is there any light duty work you can request? YES NO If yes, describe: _____

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PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

Name: _____ Birth Date: _____

Signature: _____ Date: _____

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MEDICAL HISTORY

Date: _____

Patient Name: _____ Date of Birth: _____ Gender: Male Female

SOCIAL HISTORY

Marital Status Single Married Divorced Widowed Separated

With whom do you live? _____

Use of Alcohol:	<input type="checkbox"/> Never	<input type="checkbox"/> <1 per week	<input type="checkbox"/> 1-5 per week	<input type="checkbox"/> Other: _____
Use of Recreational Drugs:	<input type="checkbox"/> Never	<input type="checkbox"/> <1 per week	<input type="checkbox"/> 1-5 per week	<input type="checkbox"/> Other: _____
Use of Tobacco:	<input type="checkbox"/> Never	<input type="checkbox"/> <1 per day	<input type="checkbox"/> 1-5 per day	<input type="checkbox"/> Other: _____
Coffee:	<input type="checkbox"/> Never	<input type="checkbox"/> <1 per day	<input type="checkbox"/> 1-5 per day	<input type="checkbox"/> Other: _____
Tea:	<input type="checkbox"/> Never	<input type="checkbox"/> <1 per day	<input type="checkbox"/> 1-5 per day	<input type="checkbox"/> Other: _____

Current Medications: _____

Please List any allergies: _____

Employment: Full Time Part Time Job Position: _____

Are you exposed to fumes, dusts or solvents? _____

HISTORY OF ILLNESS

(Please check only those which you have had a personal history)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Endocarditis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Gastritis | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Cancer – Type: _____ | <input type="checkbox"/> Genital Disease | <input type="checkbox"/> Malaria | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Measles | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Congenital Abnormalities | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Migraine | |
| | <input type="checkbox"/> HIV | <input type="checkbox"/> Mumps | |
| | <input type="checkbox"/> Hives | <input type="checkbox"/> Osteomyelitis | |

PLEASE LIST YOUR HOSPITALIZATIONS/ADMISSIONS (Not Including pregnancies):

YEAR	ILLNESS/SURGERY	LOCATION(Hospital/City/State)

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<u>VACCINES</u>	<u>YEAR OF LAST</u>	<u>TEST/EXAM</u>	<u>YEAR OF LAST</u>
Tetanus	_____	Rectal/Stool	_____
Influenza	_____	Cholesterol	_____
Pneumonia	_____	Eye	_____
Hepatitis	_____	Stress Test	_____
Tuberculosis(TB)	_____	Colonoscopy	_____

FAMILY HISTORY: (If any of your blood relatives have suffered any of the following, please check the box and write his/her relationship to you)

- | | |
|---|---|
| <input type="checkbox"/> Alcoholism: _____ | <input type="checkbox"/> High Blood Pressure: _____ |
| <input type="checkbox"/> Anemia: _____ | <input type="checkbox"/> Hypertension: _____ |
| <input type="checkbox"/> Arthritis: _____ | <input type="checkbox"/> Lipid Disorder: _____ |
| <input type="checkbox"/> Asthma: _____ | <input type="checkbox"/> Mental Illness: _____ |
| <input type="checkbox"/> Bleeds easily _____ | <input type="checkbox"/> Migraine: _____ |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Osteoporosis: _____ |
| <input type="checkbox"/> Diabetes: _____ | <input type="checkbox"/> Sickle Cell: _____ |
| <input type="checkbox"/> Epilepsy: _____ | <input type="checkbox"/> Stroke: _____ |
| <input type="checkbox"/> Glaucoma: _____ | <input type="checkbox"/> Suicide: _____ |
| <input type="checkbox"/> Gout: _____ | <input type="checkbox"/> Thyroid Disease: _____ |
| <input type="checkbox"/> Hay Fever: _____ | <input type="checkbox"/> Tuberculosis: _____ |
| <input type="checkbox"/> Heart Disease: _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hepatitis: _____ | <input type="checkbox"/> Other: _____ |

INJURIES:

Have you ever been seriously injured in a motor vehicle accident? If yes, When and what Injuries? Yes No

Have you ever had any head injuries or concussions? If yes, when and describe incident? Yes No

Have you ever been knocked unconscious? If yes, when and describe incident? _____

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Patient Name: _____ Date of Birth: _____

REVIEW OF SYSTEMS: (Please check any of the following you have experienced or are currently experiencing)

- Agitation
- Allergies
- Back Pain: Recurrent
- Bloody or Tarry Stools
- Bronchitis
- Bruise Easily
- Chest Pain
- Chronic Abdominal Pain
- Jaundice
- Chronic Cough
- Cold/Numb Feet
- Concentration Difficulties
- Constipation
- Decreased Hearing
- Depression
- Diarrhea
- Difficulty Swallowing
- Dizzy Spells
- Double or Blurred Vision
- Ear Infections: Frequent
- Eczema
- Eye Pain
- Failing Vision
- Fainting Spells
- Fatigue
- Feelings of Worthlessness
- Foot Pain
- Gout
- Hair Loss: Progressive Recent
- Hay Fever
- Headaches: Frequent
- Heartburn
- Hemorrhoids
- Hernia
- Hives
- Hoarseness: Prolonged
- Irregular Pulse
- Leg Pain: When Walking
- Loss of Appetite
- Memory Loss
- Moodiness
- Nervousness
- Nose Bleeds
- Numbness/Tingling Sensations
- Palpitations
- Persistent Nausea/Vomiting
- Phobias
- Psoriasis
- Rashes
- Ringing In Ear
- Shortness of Breath: On Exertion
- Lying Flat
- Sinus Trouble
- Sleeping Difficulties
- Sore Throats: Frequent
- Stress
- Suicidal Thoughts
- Swollen Ankles
- Tremors
- Urination Problems
 - Overactive Bladder
 - More Than 8 times/day
 - Urgency to Urinate
 - With Leakage
 - Decrease in Flow/Force
 - Painful
- Urine Infections: Frequent
- Blood in Urine
- Varicose Veins/Phlebitis
- Weight Gain
- Weight Loss
- Wheezing
- Other: _____
- Other: _____

FEMALES (Please Complete)

Menstrual Flow: Regular Irregular Pain/Abnormal Cramps

Date of first day of your last period: _____ Pain or Bleeding During or After Sex

Date of last Mammogram: _____ Normal Abnormal Where Complete: _____

Number of Pregnancies: _____ No. of Miscarriages: _____ No. of Live Births: _____ No. of Abortions: _____

Birth Control Method: _____

Date of last PAP: Normal Abnormal

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____

SSN: _____ (optional)

I authorize: (Organization Name) _____

(Address) _____

(Phone & Fax) _____

(A): to release ALL information contained in my medical record concerning treatment provided between the dates of _____ to _____.

These records are also to include: *(initial all that apply)*

_____ Psychiatric History/Mental Illness

_____ History of drug and/or alcohol abuse

_____ HIV and/or Aids testing

(B): to release ONLY the records listed below:

_____ These records are also to include: *(initial all that apply)*

_____ Psychiatric History/Mental Illness

_____ History of drug and/or alcohol abuse

_____ HIV and/or Aids testing

I understand that this is a required consent and I voluntarily and knowingly sign this authorization for release of information to:

Hanley Pain and Rehabilitation Center, Inc.

5979 Vineland Rd., Ste. 209

Orlando, FL 32819

Phone: 407-352-1030 Fax: 407-352-2884

Patient Signature: _____

Date: _____

Information released is confidential and protected by federal laws that prohibit re-disclosure of patient information without the prior consent of the patient. This consent is valid for up to one year from the date of its authorization and is revocable upon written notice except in the extent that action has already been taken.

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____

SSN: _____ (optional)

I authorize: Hanley Pain and Rehabilitation Center, Inc.
5979 Vineland Rd., Ste. 209
Orlando, FL 32819
Phone: 407-352-1030 Fax: 407-352-2884

(A): to release ALL information contained in my medical record concerning treatment provided between the dates of _____ to _____.

These records are also to include: *(initial all that apply)*

- _____ Psychiatric History/Mental Illness
- _____ History of drug and/or alcohol abuse
- _____ HIV and/or Aids testing

(B): to release ONLY the records listed below:

These records are also to include: *(initial all that apply)*

- _____ Psychiatric History/Mental Illness
- _____ History of drug and/or alcohol abuse
- _____ HIV and/or Aids testing

I understand that this is a required consent and I voluntarily and knowingly sign this authorization for release of information to:

(Organization Name) _____

(Address) _____

(Phone & Fax) _____

I release Hanley Pain & Rehabilitation Center, Inc, from any liability arising from the release of information to the individual or agency stated above.

Patient Signature: _____ Date: _____

Information released is confidential and protected by federal laws that prohibit re-disclosure of patient information without the prior consent of the patient. This consent is valid for up to one year from the date of its authorization and is revocable upon written notice except in the extent that action has already been taken.

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Dear Patient:

Listed below are some of our most commonly used office policies and fees. We appreciate your cooperation and understanding of these guidelines.

Policies:

Our pain and rehabilitation services are separate from our Internal Medicine practice. We are not contracted with any group health insurances and may only bill your auto insurance or letter of protection given by your attorney.

We will only be able to provide you with care related to your auto accident. If you need to establish with a primary care physician, we will gladly refer you to one.

Once you have reached a point of maximum medical improvement, you will be released from medical care. If you wish to return for treatments due to ongoing symptoms, your care will be strictly considered pain management and will require you to follow the self-pay pain management program. We will no longer be able to bill your auto insurance or letter of protection.

Self-pay patients: All payments for services rendered are required in full at time of service.

It is mandatory that all patient appointments have a 24-hour cancellation notice. All no-shows will result in a \$25.00 fee.

Please allow 48-hours for all prescription refills. Be aware that not all refills will be honored without an office visit.

Special Request Fees:

Completion of medically-necessary letters and forms (e.g. FMLA): \$25.00

Copy of medical records/billing records: \$25.00 for the first 25 pages, 0.25 per additional page.
(1 week notice is required. An additional fee will be charged if requested sooner)

I have read and understand the above policies.

Patient Name: _____

Patient Signature: _____

Date: _____

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PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- Home Telephone _____
 - O.K. to leave message with detailed information
 - Leave message with call-back number only

- Written Communication
 - O.K. to mail to my home address
 - O.K. to mail to my work/office address
 - O.K. to fax to this number

- Work Telephone _____
 - O.K. to leave message with detailed information
 - Leave message with call-back number only

- Cell Phone _____
 - O.K. to leave message with detailed information
 - Leave message with call-back number only

Patient Signature

Date

Print Name

Birth Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note: Uses and disclosures for Treatment Records, Payment Information, and Healthcare Operations (TPO) may be permitted without prior consent in an emergency.

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