

## Patient Information

Personal Information			
First Name	EMILY	Middle Name	-
Last Name	EDWARDS	D.O.B	01/24/2003
Gender	Female	Address	423 SOUTH FULLTON AVE APT3
City	MOUNT VERNON	State	NEW YORK
Cell Phone #	347-206-6391	Home Phone	718-881-5845
Work	-	Zip	10553
Email	-	Extn.	-
Attorney	DOMINICK LAVELLE	Case Type	No-Fault
Attorney Address	100 HERRICKS ROAD SUITE 201	Attorney Phone	800-745-4878
Case Status	OPEN	SSN	-

Insurance Information			
Policy Holder	-	Name	LIBERTY MUTUAL INS.
Address	P.O. Box# 1052	City	Montgomeryville
State	PENNSYLVANIA	Zip	18936-1052
Phone	800 245-1700	Fax	-
Contact Person	-	Claim File #	034381648
Policy #	AOS228001979405		

Accident Information			
Accident Date	09/14/2016	Plate Number	-
Report Number	-	Address	-
City	-	State	-
Hospital Name	-	Hospital Address	-
Date of Admission	-	Additional Patient	-
Describe Injury	-	Patient Type	Passenger

Employer Information			
Name	-	Address	-
City	-	State	-
Zip	-	Phone	-
Date of First Treatment	-	Chart #	-

Adjuster Information			
Name	-	Phone	-
Extension	-	Fax	-
Email	-		

# ANJANI SINHA MEDICAL P.C.

## ORTHOPEDIC SURGERY

164-10 Northern Boulevard Flushing, NY 11358

Tel: 917-300-5003 Fax: 929-333-7950

anjanisinhamedicalpc@GMAIL.COM

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### DISCLOSURE OF PHYSICIAN OWNERSHIP

This notice is provided to you pursuant to the New York Public Health Law § 238-d. Practitioner disclosure requirements, and any other state and/or federal laws and regulations which may apply. New York state passed a law due to concerns that there may be a conflict of interest where a health practitioner makes a referral to a health care provider for the furnishing of any health related items or services where such practitioner (or immediate family member of such practitioner) has a financial relationship with or a financial interest in the health care provider. With certain exceptions, such referrals may be prohibited. The financial relationship must be disclosed to the patient as a condition to the referral. The patient must also be advised of his/her right to utilize a specifically identified alternative health care provider IF any such alternative is reasonably available.

I acknowledge that I have been placed on specific notice that **Dr. Anjani Sinha** has no financial and ownership in the **North Queens Surgery Center**. I have been informed that I have a right to be treated at a different facility of my own choosing if I so desire. After being fully informed of the above rights, my own volition, I expressly elect to have the procedure performed at the above-listed center. Any questions I may have had regarding this notice have been fully answered.

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PRINTED PATIENT NAME

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PATIENT SIGNATURE

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DATE

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To ATTORNEY(S): \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

TO WHOM IT MAY CONCERN:

I HEREBY AUTHORIZE AND DIRECT YOU, MY INSURANCE, AND/OR MY ATTORNEY TO PAY. DIRECTLY TO **ANJANI. SINHA, MEDICAL P.C.** THE SUMS AS MAYBE DUE AND OWING THIS OFFICE FOR SERVICES RENDERED ME BOTH BY REASON OF THIS ACCIDENT OR COMPENSATION BENEFITS, PERSONAL INJURY, NO-FAULT OR ANY OTHER INSURANCE BENEFITS OBLIGATED TO REIMBURSE ME OR FROM ANY SETTLEMENT, JUDGEMENT OR VERDICT ON MY BEHALF AS MAY BE NECESSARY TO ADEQUATELY PROTECT SAID OFFICE. I HEREBY FURTHER GIVE LIEN TO SAID OFFICE AGAINST ANY AND ALL INSURANCE BENEFITS NAMED HEREIN, AND ANY PROCEEDS OF ANY SETTLEMENT, JUDGEMENT OR VERDICT WHICH MADE BE PAID TO ME AS A RESULT OF THE INJURIES OR ILLNESS FOR WHICH I HAVE BEEN TREATED BY SAID OFFICE THIS IS TO ACT AS ASSIGNMENT OF MY RIGHTS AND BENEFITS TO THE EXTENT OF THE OFFICE'S SERVICES PROVIDED. IN THE EVENT MY INSURANCE COMPANY AND AUTHORIZE THIS OFFICE'S NAME AND FURTHER, I AUTHORIZE THIS OFFICE TO COMPROMISE, SETTLE, OR OTHERWISE RESOLVE SAID CLAIMS OR CAUSE OF ACTION AS THEY SEE FIT.

I UNDERSTAND THAT I REMAIN PERSONALLY RESPONSIBLE FOR THE TOTAL AMOUNTS DUE TO THE FACILITY FOR THEIR SERVICES, I FURTHER UNDERSTAND AND AGREE THAT THIS ASSIGNMENT, LIEN AND AUTHORIZATION DOES NOT CONSTITUTE AND CONDERATION FOR THE FACILITY TO AWAITE PAYMENT AND THEY MAY DEMAND PAYMENTS FROM ME IMMEDIATELY UPON RENDERING SERVICES AT THEIR OPTION. I AUTHORIZE THE FACILITY TO RELEASE ANY INFORMATION PERTINENT TO MY CASE TO ANY INSURANCE COMPANY, ADJUSTER OR ATTORNEY TO ENDORSE/SIGN MY NAME ON ALL CHECKS FOR PAYMENT OF MY MEDICAL BILL.

I FURTHER UNDERSTAND AND AGREE THAT THIS OFFICE MUST TAKE ANY ACTION TO COLLECT AN OUTSTANDING BALANCE ON MY ACCOUNT, I WILL BE RESPONSIBLE FOR PAYMENT OF AND WILL REIMBURSE THIS OFFICE FOR ALL COSTS OF SUCH COLLECTION EFFORTS, INCLUDING BUT NOT LIMITED TO ALL COURT COSTS AND ALL ATTORNEY FEES.

PATIENT \_\_\_\_\_ DATE \_\_\_\_\_

WITNESS: \_\_\_\_\_

ATTORNEY SIGNATURE OR STAMP: \_\_\_\_\_



Workers'  
Compensation  
Board

## CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

(Pursuant to Workers' Compensation Law Section 110-a)

PO Box 5205, Binghamton, NY 13902-5205 • www.wcb.ny.gov

**CLAIMANTS ARE PROHIBITED FROM AUTHORIZING RELEASE OF WORKERS' COMPENSATION INFORMATION TO PROSPECTIVE EMPLOYERS OR IN CONNECTION WITH ASSESSING FITNESS OR CAPABILITY OF EMPLOYMENT.**

**PLEASE COMPLETE ALL ITEMS. AN INCOMPLETE FORM WILL DELAY THE PROCESSING OF YOUR REQUEST.**

Claimant's Name	Claimant's Social Security or Tax Identification Number	Case Number <input type="checkbox"/> WCB <input type="checkbox"/> DB <input type="checkbox"/> Discrimination <input type="checkbox"/> PFL and/or Date of Accident
IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILE(S), IDENTIFY BELOW BY WCB/DB/DC/PFL CASE NUMBER AND/OR DATE OF ACCIDENT(S)		

### INSTRUCTIONS:

Submit original to the Workers' Compensation Board and retain a copy for your records. *Authorization for disclosure of records for certain purposes is not valid under the law. See excerpt of WCL Section 110-a on the reverse of this form.* This authorization is effective until it is revoked by the claimant. Claimant may revoke this authorization at any time upon written notice to the Workers' Compensation Board.

THIS AUTHORIZATION DOES NOT PERMIT YOU TO OPEN AN INDIVIDUAL eCASE ACCOUNT  
OR TO VIEW CASES VIA eCASE OUTSIDE OF A BOARD LOCATION.

Pursuant to Section 110-a of the Workers' Compensation Law, I, \_\_\_\_\_,  
(CLAIMANT'S NAME)

represent that I am a person who is/was the subject of the workers' compensation cases(s) indicated above, and I authorize the Workers' Compensation Board to discuss the above-referenced Workers' Compensation Board records with and/or release a copy of the above-referenced records to \_\_\_\_\_,

(NAME OF A SPECIFIC PERSON, CORPORATION, ASSOCIATION OR PUBLIC OR PRIVATE ENTITY)

at \_\_\_\_\_,  
(ADDRESS)

I understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records by the Workers' Compensation Board.

Claimant's Signature (ink only - use blue ink if possible)

Date

Failure to provide the information requested on this form will not result in the denial of your authorization, but may delay the processing of your request. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your request.



**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA****[This form has been approved by the New York State Department of Health]**

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV\* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) \_\_\_\_\_ to (insert date) \_\_\_\_\_
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: \_\_\_\_\_ Include: *(Indicate by Initialing)*

\_\_\_\_\_ **Alcohol/Drug Treatment**  
\_\_\_\_\_ **Mental Health Information**  
\_\_\_\_\_ **HIV-Related Information**

**Authorization to Discuss Health Information**

- (b) ☐ By initialing here \_\_\_\_\_ I authorize \_\_\_\_\_  
Initials Name of individual health care provider  
to discuss my health information with my attorney, or a governmental agency, listed here:  
\_\_\_\_\_  
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:

- ☐ At request of individual  
☐ Other:

11. Date or event on which this authorization will expire:

12. If not the patient, name of person signing form:

13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

\_\_\_\_\_  
Signature of patient or representative authorized by law.

Date: \_\_\_\_\_

\* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**