Printed on: 10/18/2017

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	-		

OCA Official Form No.: 960



OCA Official For AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name		Date of Birth	Social Security Number
Patient Address		<u> </u>	
In accordance with (HIPAA), I under: 1. This authorization of the appropriate line initial the line on the control of the authorization	New York State Law and the Privacy I stand that: ion may include disclosure of information may include disclosure of information may include disclosure of information steept psychotherapy notes, and CONFI is in Item 9(a). In the event the health me box in Item 9(a), I specifically authorizing the release of HIV-related, alcoholdisclosing such information without ave the right to request a list of people mination because of the release or disclast (212) 480-2493 or the New York lecting my rights. To revoke this authorization at any time exaction except to the extent that action hat signing this authorization is volume conditioned upon my authorization of	commation regarding my care and treatmed Rule of the Health Insurance Portability mation relating to ALCOHOL and EIDENTIAL HIV* RELATED INFORM information described below includes a prize release of such information to the solice release of such information to the my authorization unless permitted to who may receive or use my HIV-related losure of HIV-related information. I m City Commission of Human Rights a me by writing to the health care provide has already been taken based on this author. My treatment, payment, chrolling this disclosure.	PRUG ABUSE, MENTAL HEALT RMATION only if I place my initials any of these types of information, and person(s) indicated in Item 8. treatment information, the recipient o do so under federal or state law. Ed information without authorization. ay contact the New York State Division (212) 306-7450. These agencies are listed below. I understand that I methorization.
redisclosure may no 6. THIS AUTHO CARE WITH AN	o longer be protected by federal or state RIZATION DOES NOT AUTHORI	be redisclosed by the recipient (exception) IZE YOU TO DISCUSS MY HEALT RNEY OR GOVERNMENTAL AGE	TH INFORMATION OR MEDICA
6. THIS AUTHO CARE WITH AN 7. Name and address	o longer be protected by federal or state RIZATION DOES NOT AUTHORI YONE OTHER THAN THE ATTOF	be redisclosed by the recipient (exception) RICE YOU TO DISCUSS MY HEAL' RNEY OR GOVERNMENTAL AGE this information:	TH INFORMATION OR MEDICA
6. THIS AUTHO CARE WITH AN 7. Name and addres 8. Name and addres 9(a). Specific infor Medical Re Entire Med referrals, co	o longer be protected by federal or state RIZATION DOES NOT AUTHORI YONE OTHER THAN THE ATTOF ss of health provider or entity to release ss of person(s) or category of person to mation to be released: ecord from (insert date) ical Record, including patient histories.	be redisclosed by the recipient (excertaw. IZE YOU TO DISCUSS MY HEAL? RNEY OR GOVERNMENTAL AGE e this information: whom this information will be sent: to (insert date) to (insert date) rds, and records sent to you by other he Include:	I'H INFORMATION OR MEDICA NCY SPECIFIED IN ITEM 9 (b).
edisclosure may not 6. THIS AUTHO CARE WITH AN' 7. Name and address 8. Name and address 9(a). Specific infor	plonger be protected by federal or state RIZATION DOES NOT AUTHORI YONE OTHER THAN THE ATTOF se of health provider or entity to release se of person(s) or category of person to mation to be released: ecord from (insert date) ical Record, including patient histories, onsults, billing records, insurance record Discuss Health Information g here I authorize	be redisclosed by the recipient (excertaw. IZE YOU TO DISCUSS MY HEAL? RNEY OR GOVERNMENTAL AGE e this information: whom this information will be sent: to (insert date) to office notes (except psychotherapy no rds, and records sent to you by other he Include:	I'H INFORMATION OR MEDICA NCY SPECIFIED IN ITEM 9 (b). Ites), test results, radiology studies, file alth care providers. (Indicate by Initialing) _ Alcohol/Drug Treatment _ Mental Health Information _ HIV-Related Information
6. THIS AUTHO CARE WITH AN 7. Name and addres 8. Name and addres 9(a). Specific infor Medical Re Entire Med referrals, or Other: Authorization to D (b) By initialing	Pionger be protected by federal or state RIZATION DOES NOT AUTHORI YONE OTHER THAN THE ATTORS of health provider or entity to release as of person(s) or category of person to mation to be released: ecord from (insert date) ical Record, including patient histories, onsults, billing records, insurance record from the process of the provided in the pr	be redisclosed by the recipient (excertaw. IZE YOU TO DISCUSS MY HEAL' RNEY OR GOVERNMENTAL AGE e this information: to (insert date) to (insert date) do redisclosed by the recipient (except psychotherapy no reds, and records sent to you by other health. Name of individual health.	I'H INFORMATION OR MEDICANCY SPECIFIED IN ITEM 9 (b). Ites), test results, radiology studies, file alth care providers. (Indicate by Initialing) Alcohol/Drug Treatment Mental Health Information HIV-Related Information
edisclosure may not 6. THIS AUTHO CARE WITH AN' 7. Name and address 8. Name and address 9(a). Specific infor	o longer be protected by federal or state RIZATION DOES NOT AUTHORI YONE OTHER THAN THE ATTOF ss of health provider or entity to release ss of person(s) or category of person to mation to be released: ecord from (insert date) ical Record, including patient histories, onsults, billing records, insurance record Discuss Health Information g here I authorize Initials health information with my attorney, of (Attorney/Firm Na	be redisclosed by the recipient (excertaw. IZE YOU TO DISCUSS MY HEAL' RNEY OR GOVERNMENTAL AGE e this information: to (insert date) to (insert date) ords, and records sent to you by other he Include: Name of individual health or a governmental agency, listed here:	I'H INFORMATION OR MEDICA NCY SPECIFIED IN ITEM 9 (b). tes), test results, radiology studies, file alth care providers. (Indicate by Initialing) _ Alcohol/Drug Treatment _ Mental Health Information _ HIV-Related Information h care provider
edisclosure may not 6. THIS AUTHO CARE WITH AN' 7. Name and address 8. Name and address 9(a). Specific infor	o longer be protected by federal or state RIZATION DOES NOT AUTHORI YONE OTHER THAN THE ATTOF see of health provider or entity to release see of person(s) or category of person to mation to be released: ecord from (insert date) ical Record, including patient histories, onsults, billing records, insurance record Discuss Health Information g here I authorize Initials health information with my attorney, of (Attorney/Firm Na case of information:	be redisclosed by the recipient (excertaw. IZE YOU TO DISCUSS MY HEAL' RNEY OR GOVERNMENTAL AGE e this information: to (insert date) to (insert date) ords, and records sent to you by other he Include: Name of individual health or a governmental agency, listed here:	I'H INFORMATION OR MEDICA NCY SPECIFIED IN ITEM 9 (b). Ites), test results, radiology studies, file alth care providers. (Indicate by Initialing) _ Alcohol/Drug Treatment _ Mental Health Information _ HIV-Related Information

* 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.

Signature of patient or representative authorized by law.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

N <i>A</i>	AME AND ADDRESS OF INSURE	R *		NAME, AD	-		NUMBER OF ENTATIVE*	INSURER'S
DATE	POLICYHOLDER	PO	LICY NUM	BER	DATE OF	ACCIDENT	CLAIM N	UMBER
PLEASE C	LE US TO DETERMINE IF YOUR ASSEMBLE THIS FORM AND RETENDED FOR TANT: 1. TO BE ELIGIBLE FOR SOME SOME SOME SOME SOME SOME SOME SOME	FURN IT PE FOR BENEF ANY ATTAG	ROMPTLY. FITS YOU N CHED AUT	MUST COM HORIZATIC	PLETE ANI DN(S).	O SIGN THI	S APPLICATIO	
NA	ME AND ADDRESS OF APPLICA	NT*						
1. YOUR N	IAME	2. PHONE	NOS.	HOME		BUSINESS	3	
3. YOUR A (NO., S	DDRESS STREET, CITY OR TOWN AND ZI	P CODE)		4. DATE O	F BIRTH	5. SOCIAL	SECURITY N	0.
6. DATE A	ND TIME OF ACCIDENT	A.M. P.M.	7. PLACE	OF ACCIDE	ENT (STRE	ET), CITY C	OR TOWN AND	STATE
8. BRIEF I	DESCRIPTION OF ACCIDENT		•					
9. DESCR	IBE YOUR INJURY							
	ITY OF VEHICLE YOU OCCUPIE 'S NAME MAKE		RATED AT	THE TIME	OF THE A	CCIDENT:		
THIS VEHI		SCHOOL I	,		A TRUCK,		AN AUTOMO	BILE,
WERE Y WERE Y	YOU THE DRIVER OF THE MOT YOU A PASSENGER IN THE MO' YOU A PEDESTRIAN? YOU A MEMBER OF OUR POLIC U OR A RELATIVE WITH WHOM	TOR VEHIC	CLE? 'S HOUSEH		EHICLE?	YES		NO

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO

12. WERE YOU TREATED BY A DOC	TOR(S) OR OTHER PERSON(S	S) FURNISHING HEALTH SEF	RVICES?	
YES	NO			
IF YES, NAME AND ADDR	RESS OF SUCH DOCTOR(S) OF	R PERSON(S):		
13. IF YOUR WERE TREATED AT A	A HOSPITAL(S), WERE YOU AN			
OUT-PATIENT?	IN-PATIENT?			
DATE OF ADMISSION:				
HOSPITAL'S NAME AND A	ADDRESS:			
14. AMOUNT OF HEALTH 15.	WILL YOU HAVE MORE HEALT	TH 16 AT THE TIME OF	YOUR ACCIDENT WERE	
	TREATMENT(S)?	YOU IN THE CO	JRSE OF YOUR	
\$	YES NO	EMPLOYMENT? YES	NO	
17. DID YOU LOSE TIME	DATE ABSENCE FROM		IED TO	
FROM WORK? YES NO	WORK BEGAN:	WORK? YES	NO	
IF YES, DATE RETURNED	O TO WORK:	MOUNT OF TIME LOST FROM	M WORK:	
18. WHAT ARE YOUR GROSS AVER			OF HOURS YOU WORK	
WEEKLY EARNINGS?	PER WEEK:	PER DAY	:	
19. WERE YOU RECEIVING UNEMP	DI OVMENT DENEEITS AT THE	TIME OF THE ACCIDENTS		
		THINE OF THE ACCIDENT!		
YES	NO			
20. LIST NAMES AND ADDRESS OF			EAR PRIOR TO	
ACCIDENT DATE AND GIVE OCC	CUPATION AND DATES OF EM	PLOYMENT:		
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO	
EMPLOYER AND ADDRESS	OCCUPATION	FROM	ТО	
EMPLOYER AND ADDRESS	OCCUPATION	FROM	ТО	
21. AS A RESULT OF YOUR INJURY		EXPENSES?		
YES	NO NO LINE OF SUCH EVI	DENICES		
IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES. 22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS				
UNDER ANY OF THE FOLLOWII	NG: YES	NO		
NEW YORK STATE DISA				
WORKERS' COMPENSAT	TION?			

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE THREE

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

> THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

E 2 1.	
SIGNATURE	DATE
DC	NOT DETACH
AUTHORIZATION FOR RELEASE	OF WORK AND OTHER LOSS INFORMATION
HAVE REGARDING MY WAGES, SALARY OR OTHER	VILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY LOSS WHILE EMPLOYED BY YOU. YOUR ARE AUTHORIZED TO WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE
OR TYPE)	SOCIAL SECURITY NO.
SIGNATURE	DATE
DC) NOT DETACH
AUTHORIZATION FOR RELEASE OF H	IEALTH SERVICE OR TREATMENT INFORMATION
HAVE REGARDING MY CONDITION WHILE UNDER Y OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAG	VILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY OUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY INOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE
NT OR TYPE) SIGNATURE	DATE

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

NYS FORM NF-2 (Rev 1/2004)

Page 3 of 3

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number:

I, , ("Assignor") hereby	
all rights privileges and remedies to payment for heal entitled under Article 51 (the No-Fault statute) of the I	
	eived any payment from or on behalf of the Assignor and for services provided by said Assignee for injuries sustained , not withstanding any other agreement (Print accident date)
to the contrary.	(
This agreement may be revoked by the assignee whe of coverage and/or violation of a policy condition due	en benefits are not payable based upon the assignor's lack e to the actions or conduct of the assignor.
FILES AN APPLICATION FOR COMMERCIAL INSURAPERSONAL INSURANCE BENEFITS CONTAINING AN PURPOSE OF MISLEADING, INFORMATION CONCERNIN CONNECTION WITH SUCH APPLICATION OR CONCINTS OR CONSPIRES WITH ANOTHER TO MAKE CONVERSION OF ANY MOTOR VEHICLE TO A LOUGHICLES OR AN INSURANCE COMPANY, COMMIT	T TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON ANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR NY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE RNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, E A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR TS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND OT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF FOR EACH VIOLATION.
(Print name of Patient)	(Signature of Patient)
	(Date of signature)
	_
(Address of Patient)	
	apendo & Jinks
(Print name of Provider)	(Signature of Provider)
	(Date of signature)
(Address of Provider)	-