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 Fort AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

		nent of Heal	ari
Patient Name	Date of Birth	/	Social Security Number
Patient Address	<u> </u>	······································	
l, or my authorized representative, request that health information	regarding my care and trea	itment be rele	ased as set forth on this for
In accordance with New York State Law and the Privacy Rule of (HIPAA), I understand that:	the Health Insurance Portab	ility and Acco	ountability Act of 1996
1. This authorization may include disclosure of information of TREATMENT, except psychotherapy notes, and CONFIDENT the appropriate line in Item 9(a). In the event the health information initial the line on the box in Item 9(a), I specifically authorize release of HIV-related, alcohol or draprohibited from redisclosing such information without my authorizated from redisclosing such information without my authorizated that I have the right to request a list of people who may be a superience discrimination because of the release or disclosure of Human Rights at (212) 480-2493 or the New York City Corresponsible for protecting my rights. 3. I have the right to revoke this authorization at any time by we revoke this authorization except to the extent that action has alreaded. I understand that signing this authorization is voluntary. More benefits will not be conditioned upon my authorization of this disclosed under this authorization might be redisclosure may no longer be protected by federal or state law. 6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOR.	IAL HIV* RELATED INF tion described below includes ease of such information to to ug treatment, or mental her horization unless permitted by receive or use my HIV-re if HIV-related information, immission of Human Right riting to the health care pro- dy been taken based on this by treatment, payment, enre- closure.	formation les any of the the person(s) alth treatmen if to do so uselated information I may contact is at (212) 30 wider listed be authorization authorization authorization authorization	N only if I place my initials se types of information, an indicated in Item 8. It information, the recipient nder federal or state law. It information authorization. It the New York State Division of the New York Stat
<u>CARE WITH ANYONE OTHER THAN THE ATTORNEY (</u>	OR GOVERNMENTAL A	GENCY SPI	CIFIED IN ITEM 9 (b).
7. Name and address of health provider or entity to release this in	formation:		
8. Name and address of person(s) or category of person to whom (his information will be sent	:	
9(a). Specific information to be released:			
☐ Medical Record from (insert date) ☐ Entire Medical Record, including patient histories, office	to (insert date)	mutaa\ tast =	ander and the large of the first
referrals, consults, billing records, insurance records, and	records sent to you by other	r health care i	esuns, radiology studies, in providers.
Other:		de: (<i>Indicate</i>	
- Onici.	inciu		by Inilialing)
C Onici.			•
- One.		Alcoho	/Drug Treatment
		Alcoho Mental	/Drug Treatment Health Information
Authorization to Discuss Health Information		Alcoho Mental	/Drug Treatment
Authorization to Discuss Health Information (b) By initialing here I authorize		Alcoho Mental HIV-R	/Drug Treatment Health Information elated Information
Authorization to Discuss Health Information	Name of individual h	Alcoho Mental HIV-R	/Drug Treatment Health Information elated Information
Authorization to Discuss Health Information (b) By initialing here I authorize Initials to discuss my health information with my attorney, or a gov (Attorney/Firm Name or G	Name of individual hermmental agency, listed her	Alcoho Mental HIV-R	/Drug Treatment Health Information elated Information
Authorization to Discuss Health Information (b) By initialing here I authorize Initials to discuss my health information with my attorney, or a gov (Attorney/Firm Name or Government on the context of the context o	Name of individual h	Alcoho Mental HIV-R calth care prov	/Drug Treatment Health Information elated Information ider
Authorization to Discuss Health Information (b) By initialing here I authorize Initials to discuss my health information with my attorney, or a gov (Attorney/Firm Name or Gillo. Reason for release of information: At request of individual Other:	Name of individual hermental agency, listed her	Alcoho Mental HIV-R calth care prove:	/Drug Treatment Health Information elated Information ider rization will expire:
Authorization to Discuss Health Information (b) By initialing here I authorize Initials to discuss my health information with my attorney, or a gov (Attorney/Firm Name or Government of the content o	Name of individual hernmental agency, listed her overnmental Agency Name) 11. Date or event on where the state of the sta	Alcoho Mental HIV-R calth care prove:	/Drug Treatment Health Information elated Information ider rization will expire:
Authorization to Discuss Health Information (b) By initialing here I authorize Initials to discuss my health information with my attorney, or a gov (Attorney/Firm Name or Government of the content o	Name of individual hernmental agency, listed her overnmental Agency Name) 11. Date or event on where the state of the sta	Alcoho Mental HIV-R calth care prove:	/Drug Treatment Health Information elated Information ider rization will expire:
Authorization to Discuss Health Information (b) By initialing here I authorize Initials to discuss my health information with my attorney, or a gov (Attorney/Firm Name or Gillon Reason for release of information: At request of individual	Name of individual hermental agency, listed her overnmental Agency Name) 11. Date or event on wh 13. Authority to sign on ut this form have been answ	Alcoho Mental HIV-R calth care prove:	/Drug Treatment Health Information elated Information ider rization will expire:

* 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.

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 IF YES, ATTACH EXPLANATION	NO NO LINE OF SHOLL EVI	DENICES	
22. DUE TO THIS ACCIDENT HAVE	YOU RECEIVED OR ARE YOU		
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.

Tund	
SIGNATURE	DATE
DO NOT	DETACH
AUTHORIZATION FOR RELEASE OF W	ORK AND OTHER LOSS INFORMATION
HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS	UTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY WHILE EMPLOYED BY YOU. YOUR ARE AUTHORIZED TO THE NEW YORK COMPREHENSIVE MOTOR VEHICLE
OR TYPE) SIGNATURE	SOCIAL SECURITY NO. DATE
DO NOT	DETACH
AUTHORIZATION FOR RELEASE OF HEALT	H SERVICE OR TREATMENT INFORMATION
HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSI	UTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY OBSERVATION OR TREATMENT, INCLUDING THE HISTORY S AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE 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 as	ssign to, ("Assignee")
(Print patient's name) all rights privileges and remedies to payment for health entitled under Article 51 (the No-Fault statute) of the Inst	
due to the motor vehicle accident which occurred on	ed any payment from or on behalf of the Assignor and 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 when b of coverage and/or violation of a policy condition due to	
FILES AN APPLICATION FOR COMMERCIAL INSURANCE PERSONAL INSURANCE BENEFITS CONTAINING ANY PURPOSE OF MISLEADING, INFORMATION CONCERNI IN CONNECTION WITH SUCH APPLICATION OR CLA SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A CONVERSION OF ANY MOTOR VEHICLE TO A LAW VEHICLES OR AN INSURANCE COMPANY, COMMITS	O DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON CE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE NG ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR WENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF OR EACH VIOLATION.
	[hand]
(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)	