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



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

	Date of Birth	Social Security Number
Patient Address		<del>/</del> ~
l, or my authorized representative, request that health information rega	arding my care and treatm	ent be released as set forth on this for
in accordance with New York State Law and the Privacy Rule of the H [HIPAA], I understand that:		
I. This authorization may include disclosure of information relating TREATMENT, except psychotherapy notes, and CONFIDENTIAL the appropriate line in Item 9(a). In the event the health information of initial the line on the box in Item 9(a), I specifically authorize release of the line on the box in Item 9(a), I specifically authorize release of the line on the box in Item 9(a), I specifically authorize release of the line of the release of the may recommend that I have the right to request a list of people who may recommend that I have the right to request a list of people who may recommend that I have the right to request a list of people who may recommend the release of the release or disclosure of HIV of Human Rights at (212) 480-2493 or the New York City Commit responsible for protecting my rights.  In have the right to revoke this authorization at any time by writing the evoke this authorization except to the extent that action has already be also authorization that signing this authorization is voluntary. My trepenefits will not be conditioned upon my authorization of this disclosure. Information disclosed under this authorization might be redisclosed edisclosure may no longer be protected by federal or state law.  THIS AUTHORIZATION DOES NOT AUTHORIZE YOU To	HIV* RELATED INFO described below includes of such information to the catment, or mental health ation unless permitted the cive or use my HIV-related information. In assion of Human Rights is to the health care provided the taken based on this authority, payment, enrolling, and by the recipient (exceed by the recipient (exceed by INFOLDS MY HEAL	RMATION only if I place my initials any of these types of information, an person(s) indicated in Item 8. In treatment information, the recipient of do so under federal or state law, and information without authorization, any contact the New York State Division (212) 306-7450. These agencies are listed below. I understand that I mathorization, ment in a health plan, or eligibility applies noted above in Item 2), and the THINFORMATION OR MEDICATION
CARE WITH ANYONE OTHER THAN THE ATTORNEY OR G. Name and address of health provider or entity to release this information.	OVERNMENTAL AGE	ENCY SPECIFIED IN ITEM 9 (b).
3. Name and address of person(s) or category of person to whom this in	formation will be sent:	
(a). Specific information to be released:		
a). Specific information to be released:		
☐ Medical Record from (insert date) to fi	insert date)	
☐ Medical Record from (insert date)	(except psychotherapy no	otes), test results, radiology studies, fil
☐ Medical Record from (insert date) to fi	(except psychotherapy no rds sent to you by other h	otes), test results, radiology studies, fil
☐ Medical Record from (insert date)	(except psychotherapy no rds sent to you by other h Include:	otes), test results, radiology studies, fil ealth care providers.
☐ Medical Record from (insert date)	(except psychotherapy no rds sent to you by other h Include:	otes), test results, radiology studies, fil ealth care providers. (Indicate by Initialing)
☐ Medical Record from (insert date)	(except psychotherapy no rds sent to you by other h Include:	otes), test results, radiology studies, fil ealth care providers. ( <i>Indicate by Initialing</i> ) Alcohol/Drug Treatment
☐ Medical Record from (insert date)	(except psychotherapy nords sent to you by other h	otes), test results, radiology studies, filealth care providers.  (Indicate by Initialing)  Alcohol/Drug Treatment  Mental Health Information  HIV-Related Information
☐ Medical Record from (insert date)	(except psychotherapy nords sent to you by other h Include:	otes), test results, radiology studies, filealth care providers.  (Indicate by Initialing)  Alcohol/Drug Treatment  Mental Health Information  HIV-Related Information
☐ Medical Record from (insert date)	(except psychotherapy nords sent to you by other handlessent handl	otes), test results, radiology studies, file ealth care providers. (Indicate by Initialing) Alcohol/Drug Treatment Mental Health Information HIV-Related Information
☐ Medical Record from (insert date)	(except psychotherapy nords sent to you by other handlessent to you by other handlessent to you by other handlessent handlesse	otes), test results, radiology studies, file ealth 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.

SIGNATURE	DATE
	O NOT DETACH
AUTHORIZATION FOR RELEASE	OF WORK AND OTHER LOSS INFORMATION
HAVE REGARDING MY WAGES, SALARY OR OTHER	WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY R LOSS WHILE EMPLOYED BY YOU. YOUR ARE AUTHORIZED TO WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE
OR TYPE)	SOCIAL SECURITY NO.
SIGNATURE	DATE
D	O NOT DETACH
AUTHORIZATION FOR RELEASE OF	HEALTH SERVICE OR TREATMENT INFORMATION
HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAM	WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY GNOSIS 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)

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

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

Claim Number:

	or") hereby assign to	, ("Assignee")
(Print patient's name) all rights privileges and remedies to payment	` .	r health care provider name) by assignee to which I am
entitled under Article 51 (the No-Fault statut	te) of the Insurance Law.	
The Assignee hereby certifies that they have shall not pursue payment directly from the due to the motor vehicle accident which occur	Assignor for services provided by s	
to the contrary.	(Fint accident date)	
This agreement may be revoked by the assi of coverage and/or violation of a policy con		
ANY PERSON WHO KNOWINGLY AND WIT FILES AN APPLICATION FOR COMMERCIA PERSONAL INSURANCE BENEFITS CONTAPURPOSE OF MISLEADING, INFORMATION IN CONNECTION WITH SUCH APPLICATION SOLICITS OR CONSPIRES WITH ANOTHER CONVERSION OF ANY MOTOR VEHICLE VEHICLES OR AN INSURANCE COMPANY SHALL ALSO BE SUBJECT TO A CIVIL PETHE SUBJECT MOTOR VEHICLE OR STATE	AL INSURANCE OR A STATEMENT AINING ANY MATERIALLY FALSE IN CONCERNING ANY FACT MATERION OR CLAIM, KNOWINGLY MAKE TO MAKE A FALSE REPORT OF THE TO A LAW ENFORCEMENT AGION, COMMITS A FRAUDULENT INSUENALTY NOT TO EXCEED FIVE THO	OF CLAIM FOR ANY COMMERCIAL OR IFORMATION, OR CONCEALS FOR THE AL THERETO, AND ANY PERSON WHO, ES OR KNOWINGLY ASSISTS, ABETS, HE THEFT, DESTRUCTION, DAMAGE OR ENCY, THE DEPARTMENT OF MOTOR RANCE ACT, WHICH IS A CRIME, AND
(Print name of Patient)		(Signature of Patient)
		(Date of signature)
(Address of Patient)		
	apr	ends k Jinh
(Print name of Provider)		(Signature of Provider)
		(Date of signature)
(Address of Provider)		