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	Α
In accordance with New York State Law and the Prival (HIPAA), I understand that: 1. This authorization may include disclosure of interpretation of the ITREATMENT, except psychotherapy notes, and CO the appropriate line in Item 9(a). In the event the heat initial the line on the box in Item 9(a), I specifically at 2. If I am authorizing the release of HIV-related, alternative from redisclosing such information without the Item 1 have the right to request a list of peof experience discrimination because of the release or of Human Rights at (212) 480-2493 or the New Yoresponsible for protecting my rights. 3. I have the right to revoke this authorization at any revoke this authorization except to the extent that actions.	formation regarding my care and treatment be released as set forth on this for Rule of the Health Insurance Portability and Accountability Act of 1996 mation relating to ALCOHOL and DRUG ABUSE, MENTAL HEALT FIDENTIAL HIV* RELATED INFORMATION only if I place my initials a information described below includes any of these types of information, an norize release of such information to the person(s) indicated in Item 8. The hol or drug treatment, or mental health treatment information, the recipient to my authorization unless permitted to do so under federal or state law. It was who may receive or use my HIV-related information without authorization. It is closure of HIV-related information, I may contact the New York State Division of City Commission of Human Rights at (212) 306-7450. These agencies are the household of the health care provider listed below. I understand that I may have already been taken based on this authorization.
penefits will not be conditioned upon my authorization 5. Information disclosed under this authorization miredisclosure may no longer be protected by federal or s 5. THIS AUTHORIZATION DOES NOT AUTHO	f this disclosure. It be redisclosed by the recipient (except as noted above in Item 2), and the law. RIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICATION OF MEDICATIO
penefits will not be conditioned upon my authorization 5. Information disclosed under this authorization miredisclosure may no longer be protected by federal or s 5. THIS AUTHORIZATION DOES NOT AUTHOCARE WITH ANYONE OTHER THAN THE ATT	f this disclosure. It be redisclosed by the recipient (except as noted above in Item 2), and the law. RIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICADRNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b). Is this information:
5. Information disclosed under this authorization miredisclosure may no longer be protected by federal or s 5. THIS AUTHORIZATION DOES NOT AUTHOCARE WITH ANYONE OTHER THAN THE AT 7. Name and address of health provider or entity to rel 8. Name and address of person(s) or category of person (a). Specific information to be released: Medical Record from (insert date) Entire Medical Record, including patient historeferrals, consults, billing records, insurance related.	f this disclosure. It be redisclosed by the recipient (except as noted above in Item 2), and the law. RIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICADRNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b). Is this information:
Senefits will not be conditioned upon my authorization of the conditioned upon my authorization miredisclosure may no longer be protected by federal or so the condition of the	f this disclosure. In the redisclosed by the recipient (except as noted above in Item 2), and the law. RIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICA RINEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b). Is this information: To whom this information will be sent: To (insert date) To, office notes (except psychotherapy notes), test results, radiology studies, fillords, and records sent to you by other health care providers. Include: (Indicate by Initialing) Alcohol/Drug Treatment
Denefits will not be conditioned upon my authorization of the conditioned upon my authorization miredisclosure may no longer be protected by federal or so the condition of the	f this disclosure. In the redisclosed by the recipient (except as noted above in Item 2), and the law. RIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICADENEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b). Is this information: To whom this information will be sent: To (insert date) It (insert
Denefits will not be conditioned upon my authorization of the conditioned upon my authorization miredisclosure may no longer be protected by federal or so the condition of the	f this disclosure. In the redisclosed by the recipient (except as noted above in Item 2), and the law. RIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICADENEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b). Is this information: I to (insert date) I to (insert date) Is, office notes (except psychotherapy notes), test results, radiology studies, fillords, and records sent to you by other health care providers. Include: (Indicate by Initialing) Alcohol/Drug Treatment Mental Health Information HIV-Related Information Name of individual health care provider or a governmental agency, listed here:
Denefits will not be conditioned upon my authorization of the conditioned upon my authorization miredisclosure may no longer be protected by federal or so the condition of the	f this disclosure. In the redisclosed by the recipient (except as noted above in Item 2), and the law. RIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICADENEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b). Is this information: To whom this information will be sent: To (insert date) It (insert

* 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 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.

Instruct Pages	
SIGNATURE	DATE
D	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) Induct Paper	
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:

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	n benefits are not payable based upon the assignor's lack 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	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.
	Induct Pagen
(Print name of Patient)	(Signature of Patient)
	(Date of signature)
(Address of Patient)	-
	apenas & Jink
(Print name of Provider)	(Signature of Provider)
	(Date of signature)
(Address of Provider)	-