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 OHIGH FOR AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Social Security Number
Patient Address	<u> </u>	
or my authorized representative, request that health infor		
n accordance with New York State Law and the Privacy R HIPAA), I understand that:		•
This authorization may include disclosure of inform REATMENT, except psychotherapy notes, and CONFI ne appropriate line in Item 9(a). In the event the health initial the line on the box in Item 9(a), I specifically author. If I am authorizing the release of HIV-related, alcohorohibited from redisclosing such information without an inderstand that I have the right to request a list of people of experience discrimination because of the release or disclef Human Rights at (212) 480-2493 or the New York Obsponsible for protecting my rights. I have the right to revoke this authorization at any time evoke this authorization except to the extent that action had a understand that signing this authorization is volunt enefits will not be conditioned upon my authorization of the Information disclosed under this authorization might edisclosure may no longer be protected by federal or state. THIS AUTHORIZATION DOES NOT AUTHORIZATION DOES	DENTIAL HIV* RELATED INFO information described below includes rize release of such information to the older of drug treatment, or mental healt my authorization unless permitted who may receive or use my HIV-related on the control of HIV-related information, I is City Commission of Human Rights are by writing to the health care provides already been taken based on this a tary. My treatment, payment, enroll this disclosure. be redisclosed by the recipient (exclaw.	DRMATION only if I place my initials of s any of these types of information, and e person(s) indicated in Item 8. the treatment information, the recipient is to do so under federal or state law, ated information without authorization. I may contact the New York State Division at (212) 306-7450. These agencies are der listed below. I understand that I may authorization. Ilment in a health plan, or eligibility forcept as noted above in Item 2), and this
ARE WITH ANYONE OTHER THAN THE ATTOR	NEY OR GOVERNMENTAL AG	ENCY SPECIFIED IN ITEM 9 (b).
. Name and address of health provider or entity to release	this information:	
. Name and address of person(s) or category of person to	whom this information will be sent:	
(a). Specific information to be released:		
☐ Medical Record from (insert date)	to (insert date)	
 Entire Medical Record, including patient histories, referrals, consults, billing records, insurance record 	office notes (except psychotherapy n	notes), test results, radiology studies, film
Other:		nealth care providers. c: (Indicate by Initialing)
		:: (<i>Indicate by Initiating)</i> Alcohol/Drug Treatment
		Attonorbrug Treatment Mental Health Information
		ITECHTAL LICARUM ANNOLUM AND
uthorization to Discuss Health Information (b) By initialing here I authorize		HIV-Related Information

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

(Attorney/Firm Name or Governmental Agency Name)

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

13. Authority to sign on behalf of patient:

X_	Lellean James	Date:	·	
! 'S	signature of patient or representative authorized by law.	,		•

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

10. Reason for release of information:

☐ At request of individual

Other:

* 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	TO ENABLE US TO DETERMINE IF YOUR ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY. IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION. 2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S). 3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.							
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 SUCH 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.

Hellean Janes	
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, DIAC	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) Lewen Jones SIGNATURE	DATE
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		, ("Assignee")
(Print patient's name) all rights privileges and remedies to payment for healt	th care services provided b	health care provider name) by assignee to which I am
entitled under Article 51 (the No-Fault statute) of the In	nsurance Law.	
The Assignee hereby certifies that they have not receive shall not pursue payment directly from the Assignor for due to the motor vehicle accident which occurred on	or services provided by sa	
to the contrary.	,	
This agreement may be revoked by the assignee wher of coverage and/or violation of a policy condition due		
ANY PERSON WHO KNOWINGLY AND WITH INTENT FILES AN APPLICATION FOR COMMERCIAL INSURAPERSONAL INSURANCE BENEFITS CONTAINING AN PURPOSE OF MISLEADING, INFORMATION CONCER IN CONNECTION WITH SUCH APPLICATION OR CISOLICITS OR CONSPIRES WITH ANOTHER TO MAKE CONVERSION OF ANY MOTOR VEHICLE TO A LAVEHICLES OR AN INSURANCE COMPANY, COMMITSHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOTHE SUBJECT MOTOR VEHICLE OR STATED CLAIM IN	ANCE OR A STATEMENT (IY MATERIALLY FALSE INI RNING ANY FACT MATERIA LAIM, KNOWINGLY MAKE E A FALSE REPORT OF TH AW ENFORCEMENT AGE IS A FRAUDULENT INSUR OT TO EXCEED FIVE THO	OF CLAIM FOR ANY COMMERCIAL OF FORMATION, OR CONCEALS FOR THE AL THERETO, AND ANY PERSON WHO IS OR KNOWINGLY ASSISTS, ABETS IN THE
(Print name of Patient)	Lecu	(Signature of Patient)
,		,
		(Date of signature)
(Address of Patient)		
	ape	udos k Jinks
(Print name of Provider)		(Signature of Provider)
		(Date of signature)
(Address of Devices		
(Address of Provider)		