Printed on: 10/18/2017

### **Patient Information**

Personal Informati	on		
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	_		

# NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE N	NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.
CLAIMANT	NAME			ADDRESS	APT. NO.
EMPLOYER					
INSURANCE CARRIER					

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/ services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature THE	
Provider's Name and Address	

#### TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

#### **Workers' Compensation Law Section 32**

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

#### TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.





## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		
I, or my authorized representative, request that health information in accordance with New York State Law and the Privacy Rule of (HIPAA), I understand that:  1. This authorization may include disclosure of information TREATMENT, except psychotherapy notes, and CONFIDENT the appropriate line in Item 9(a). In the event the health inform initial the line on the box in Item 9(a), I specifically authorize red.  2. If I am authorizing the release of HIV-related, alcohol or diprohibited from redisclosing such information without my authorized that I have the right to request a list of people who may be a superience discrimination because of the release or disclosure	The Health Insurance Portability and relating to ALCOHOL and DRUGIAL HIV* RELATED INFORMA ation described below includes any clease of such information to the person rug treatment, or mental health treat athorization unless permitted to do nay receive or use my HIV-related information.	Accountability Act of 1996  G ABUSE, MENTAL HEALTH TION only if I place my initials on of these types of information, and I on(s) indicated in Item 8.  Imment information, the recipient is so under federal or state law. I formation without authorization. If
of Human Rights at (212) 480-2493 or the New York City C responsible for protecting my rights.  3. I have the right to revoke this authorization at any time by v revoke this authorization except to the extent that action has alre 4. I understand that signing this authorization is voluntary. I benefits will not be conditioned upon my authorization of this dis 5. Information disclosed under this authorization might be recredisclosure may no longer be protected by federal or state law.  6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOURS WITH ANYONE OTHER THAN THE ATTORNEY  7. Name and address of health provider or entity to release this in	commission of Human Rights at (21 vriting to the health care provider list ady been taken based on this authorized yet reatment, payment, enrollment sclosure.  Colorida by the recipient (except as the colorida provided by the recipient (except as the colorida provided by the recipient (except as the colorida provided by the recipient (except as the coloridate provided by the col	2) 306-7450. These agencies are ed below. I understand that I may ration. in a health plan, or eligibility for noted above in Item 2), and this <b>NFORMATION OR MEDICAL</b>
8. Name and address of person(s) or category of person to whom		
9(a). Specific information to be released:  Medical Record from (insert date)  Entire Medical Record, including patient histories, office referrals, consults, billing records, insurance records, an  Other:  Authorization to Discuss Health Information	e notes (except psychotherapy notes), d records sent to you by other health Include: (IndiAlM	test results, radiology studies, films,
(b) By initialing here Initials  to discuss my health information with my attorney, or a go		e provider
(Attorney/Firm Name or 0  10. Reason for release of information:  At request of individual  Other:	Governmental Agency Name)  11. Date or event on which this	authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of	of patient:
All items on this form have been completed and my questions ab	out this form have been answered. In	addition, I have been provided a

\* 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.

#### **WORKERS COMPENSATION INSURANCE FORM**

NAME:	SS #:	
ADDRESS:		
EMPLOYMENT INFORMATION		
EMPLOYER:	CONTACT:	
ADDRESS:		
HOW DID INJURY OCCUR?		
WORKERS COMPENSATION INSURANCE C	O.INFORMATION	
INSURANCE CO. NAME:	CONTACT:	
ADDRESS:		
LEGAL REPRESENTATIVE:		
PHONE #:		
AUTHORIZATION		
I hereby authorize <u>UK Sinha Physican</u> to release examination and treatment to my authorized worker described injury. I hereby assign payment directly to rendered. I understand that I am responsible for pay costs for collection should such action become neces for any reason. I agree that this authorization shall be a later date. A photocopy of this assignment shall be above and fully understand the terms thereof:	r's compensation insurance  DUK Sinha Physican for a  yments for all services rende  essary if worker's compensa  be valid until rescinded in wi	carrier for the above- any medical services ered and any associated ation coverage were denied riting or replaced by one of
0	TRUT	
PRINT NAME	SIGNATURE	
FRINTINAME		DATE/TIME
I hereby authorize <u>UK Sinha Physican</u> to release to my worker's compensation claim over the telephormy worker's compensation carrier.		estion information in regard
I hereby authorize <u>UK Sinha Physican</u> to release to my worker's compensation claim over the telepho		estion information in regard

I certify that the information given by me in regard to worker's compensation is correct. To the best of my knowledge, the claim is active at the time of signature. I also understand that I may be responsible for payment of coverage not covered by the worker's compensation program.

I hereby give my permission for my charges to be submitted to by private medical insurance carrier if the worker's compensation claim is denied or found to be invalid.