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]

| \langle | Patient Name | Date of Birth | Social Security Number |
|-----------|-----------------|---------------|------------------------|
| < | Patient Address | | |

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

- 1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
- 2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
- 3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- 4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- 5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
- 6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b)

| CARE WITH ANYONE OTHER THAN THE ATTORNEY | OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b). |
|---|--|
| 7. Name and address of health provider or entity to release this in | nformation: |
| 8. Name and address of person(s) or category of person to whom | this information will be sent: |
| 9(a). Specific information to be released: | |
| ☐ Medical Record from (insert date) | to (insert date) |
| Entire Medical Record, including patient histories, office referrals, consults, billing records, insurance records, and | to (insert date) notes (except psychotherapy notes), test results, radiology studies, films, d records sent to you by other health care providers. |
| Other: | Include: (Indicate by Initialing) |
| | Alcohol/Drug Treatment |
| | Mental Health Information |
| Authorization to Discuss Health Information | HIV-Related Information |
| (b) By initialing here I authorize | |
| Initials | Name of individual health care provider |
| to discuss my health information with my attorney, or a government | vernmental agency, listed here: |
| (Attorney/Firm Name or C | Overnmental Agency Name) |
| 10. Reason for release of information: | 11. Date or event on which this authorization will expire: |
| ☐ At request of individual | |
| Other: | |
| 12. If not the patient, name of person signing form: | 13. Authority to sign on behalf of patient: |
| All items on this form have been completed and my questions about | out this form have been answered. In addition, I have been provided a |
| 9 | \checkmark |

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

| NAME AND ADDRESS OF INSURER * | | | | 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 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.

| At . | |
|--|---|
| SIGNATURE | DATE |
| | |
| DO | 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. |
| at . | |
| SIGNATURE | DATE |
| DO | O NOT DETACH |
| AUTHORIZATION FOR RELEASE OF I | HEALTH SERVICE OR TREATMENT INFORMATION |
| HAVE REGARDING MY CONDITION WHILE UNDER Y 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) | |
| at | |
| 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:

| l, | , ("Assignor") hereby assign to | | _, ("Assignee") |
|---|--|---|--|
| (Print patient's name | • | (Print hospital or health care provi | , |
| | remedies to payment for health care set (the No-Fault statute) of the Insurance I | | nich i am |
| shall not pursue paymer | rtifies that they have not received any p nt directly from the Assignor for service accident which occurred on | s provided by said Assignee for i , not withstanding an | injuries sustained |
| to the contrary. | (Fillit acc | cident date) | |
| to the contrary. | | | |
| | revoked by the assignee when benefits tion of a policy condition due to the act | | assignor's lack |
| FILES AN APPLICATION PERSONAL INSURANCE PURPOSE OF MISLEAD IN CONNECTION WITH SOLICITS OR CONSPIRI CONVERSION OF ANY VEHICLES OR AN INSUSHALL ALSO BE SUBJI | OWINGLY AND WITH INTENT TO DEFR N FOR COMMERCIAL INSURANCE OR E BENEFITS CONTAINING ANY MATER FING, INFORMATION CONCERNING ANY SUCH APPLICATION OR CLAIM, KNO ES WITH ANOTHER TO MAKE A FALSE MOTOR VEHICLE TO A LAW ENFO JRANCE COMPANY, COMMITS A FRAI ECT TO A CIVIL PENALTY NOT TO EXC VEHICLE OR STATED CLAIM FOR EACH | A STATEMENT OF CLAIM FOR LIALLY FALSE INFORMATION, OF Y FACT MATERIAL THERETO, AN OWINGLY MAKES OR KNOWINGEREPORT OF THE THEFT, DESTIDACEMENT AGENCY, THE DEPUDULENT INSURANCE ACT, WHOEED FIVE THOUSAND DOLLAR | ANY COMMERCIAL OR R CONCEALS FOR THE ND ANY PERSON WHO, IGLY ASSISTS, ABETS, RUCTION, DAMAGE OR PARTMENT OF MOTOR HICH IS A CRIME, AND |
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| | | ghe? | |
| (Print na | me of Patient) | (Signature of P | ⁵ atient) |
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| | | | |
| | | (Date of signa | ature) |
| | | , , | , |
| | | | |
| (Addres | ss of Patient) | | |
| | | apenas k | Dink, |
| (Print nan | ne of Provider) | (Signature of Pi | rovider) |
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| | | (Date of signa | ature) |
| | | | |
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