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	_		

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	B	_Date
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 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 CONFIDEN the appropriate line in Item 9(a). In the event the health information initial the line on the box in Item 9(a), I specifically authorize recomplished from redisclosing such information without my an understand that I have the right to request a list of people whom I experience discrimination because of the release or disclosure of Human Rights at (212) 480-2493 or the New York City of responsible for protecting my rights. 3. I have the right to revoke this authorization at any time by revoke this authorization except to the extent that action has already authorization disclosed under this authorization of this defended in the sum of the redisclosure may no longer be protected by federal or state law. 6. THIS AUTHORIZATION DOES NOT AUTHORIZE YEARE WITH ANYONE OTHER THAN THE ATTORNEY.	relating to ALCOHOL and DR TIAL HIV* RELATED INFORM nation described below includes any elease of such information to the per drug treatment, or mental health treather inthorization unless permitted to draw receive or use my HIV-related of HIV-related information, I may Commission of Human Rights at (writing to the health care provider leady been taken based on this author My treatment, payment, enrollment is closure.	UG ABUSE, MENTAL HEALTH IATION only if I place my initials on y of these types of information, and I rson(s) indicated in Item 8. eatment information, the recipient is to so under federal or state law. I information without authorization. If contact the New York State Division (212) 306-7450. These agencies are listed below. I understand that I may orization. In the in a health plan, or eligibility for as noted above in Item 2), and this HINFORMATION OR MEDICAL
7. Name and address of health provider or entity to release this		
8. Name and address of person(s) or category of person to whom	n this information will be sent:	
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, as ☐ Other:	te notes (except psychotherapy notes and records sent to you by other heal Include: (In	s), test results, radiology studies, films,
Authorization to Discuss Health Information		HIV-Related Information
(b) By initialing here I authorize Initials to discuss my health information with my attorney, or a g	Name of individual health of overnmental agency, listed here:	are provider
	Governmental Agency Name)	
10. Reason for release of information:☐ At request of individual☐ Other:	11. Date or event on which th	is authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on beha	f of patient:
All items on this form have been completed and my questions a copy of the form	bout 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 INSURAN	CE CO. INFORMATION	
INSURANCE CO. NAME:		
ADDRESS:		
LEGAL REPRESENTATIVE:		
PHONE #:		
AUTHORIZATION		
I hereby authorize <u>UK Sinha Physican</u> to reexamination and treatment to my authorized described injury. I hereby assign payment directed rendered. I understand that I am responsible costs for collection should such action become for any reason. I agree that this authorization a later date. A photocopy of this assignment is above and fully understand the terms thereof:	worker's compensation insurance ca ectly to <u>uk sinha Physican</u> for any for payments for all services rendere he necessary if worker's compensation shall be valid until rescinded in writing shall be considered as valid as the o	rrier for the above- medical services and any associated on coverage were denied ng or replaced by one of
	Ling	
PRINT NAME	SIGNATURE	DATE/TIME
I hereby authorize <u>UK Sinha Physican</u> to re to my worker's compensation claim over the t	elease information to anyone request	ion information in regard
PRINT NAME I hereby authorize <u>UK Sinha Physican</u> to re to my worker's compensation claim over the to my worker's compensation carrier.	elease information to anyone request	ion 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.