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]

Patient Name

Date of Birth

Patient Address

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 ir	formation:			
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)			
<ul> <li>Entire Medical Record, including patient histories, office referrals, consults, billing records, insurance records, and</li> </ul>	to (insert date)			
☐ 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 gov	remmental agency, listed here:			
(Attorney/Firm Name or G	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 abo	but 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.

### 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
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	NO NO LINE OF SUCH EVI	DENICES		
IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.  22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS				
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.

Carlon	
SIGNATURE	DATE
DO NOT [	DETACH
AUTHORIZATION FOR RELEASE OF WO	ORK AND OTHER LOSS INFORMATION
THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AL HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS PROVIDE THIS INFORMATION IN ACCORDANCE WITH INSURANCE REPARATIONS ACT (NO-FAULT LAW).	WHILE EMPLOYED BY YOU. YOUR ARE AUTHORIZED TO
OR TYPE)	SOCIAL SECURITY NO.
Carl Me	
SIGNATURE	DATE
DO NOT [	DETACH
AUTHORIZATION FOR RELEASE OF HEALTH	SERVICE OR TREATMENT INFORMATION
THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AL HAVE REGARDING MY CONDITION WHILE UNDER YOUR O OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS THIS INFORMATION IN ACCORDANCE WITH THE NEW REPARATIONS ACT (NO-FAULT LAW).	BSERVATION OR TREATMENT, INCLUDING THE HISTORY AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE
NT OR TYPE)	
Can P Mu	
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 li	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 when 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 LIVEHICLES OR AN INSURANCE COMPANY, COMMITSHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOTHE SUBJECT MOTOR VEHICLE OR STATED CLAIM	ANCE OR A STATEMENT OF ANCE OR A STATEMENT OF ANY FACT MATERIAL LAIM, KNOWINGLY MAKED A FALSE REPORT OF THE AW ENFORCEMENT AGETS A FRAUDULENT INSUFFIT TO EXCEED FIVE THOU	OF CLAIM FOR ANY COMMERCIAL OF FORMATION, OR CONCEALS FOR THE ALTHERETO, AND ANY PERSON WHO ES OR KNOWINGLY ASSISTS, ABETS IE THEFT, DESTRUCTION, DAMAGE OF INCY, THE DEPARTMENT OF MOTOR RANCE ACT, WHICH IS A CRIME, AND
(Print name of Patient)	. Carl	(Signature of Patient)
		(Date of signature)
(Address of Patient)		
	ape	now k winks
(Print name of Provider)		(Signature of Provider)
		(Date of signature)
(Address of Provider)	•	