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	,	Social Security Number
Patient Address		<u> </u>		_/~
I, or my authorized representative, request that hea				
In accordance with New York State Law and the P (HIPAA), I understand that:	rivacy Rule of the Healt	th Insurance Porta	ability and A	ecountability Act of 1996
1. This authorization may include disclosure of	information relating t	o ALCOHOL	and DRUG	ABUSE, MENTAL HEALTH
TREATMENT, except psychotherapy notes, and	CONFIDENTIAL HIV	V* RELATED II	NFORMATI	ION only if I place my initials on
the appropriate line in Item 9(a). In the event the initial the line on the box in Item 9(a), I specificall	health information desc v authorize release of si	cribed below include information t	ludes any of the nerson(these types of information, and I
2. If I am authorizing the release of HIV-related	, alcohol or drug treatn	nent, or mental I	health treatm	ent information, the recipient is
prohibited from redisclosing such information wanderstand that I have the right to request a list of	/ithout my authorizatio	on unless permit	ted to do so	under federal or state law. I
I experience discrimination because of the release	or disclosure of HIV-re	elated information	n. I may cont	tact the New York State Division
of Human Rights at (212) 480-2493 or the New responsible for protecting my rights.	York City Commission	on of Human Rig	ghts at (212)	306-7450. These agencies are
3. I have the right to revoke this authorization at	any time by writing to	the health care p	rovider listed	I below I understand that I may
revoke this authorization except to the extent that a	action has already been	taken based on th	his authorizat	tion.
4. I understand that signing this authorization is benefits will not be conditioned upon my authoriza	3 voluntary. My treatmention of this disclosure	ient, payment, ei	nrollment in	a health plan, or eligibility for
5. Information disclosed under this authorization	might be redisclosed	by the recipient	(except as n	noted above in Item 2), and this
redisclosure may no longer be protected by federal 6. THIS AUTHORIZATION DOES NOT AUT	or state law.			
CARE WITH ANYONE OTHER THAN THE A	ATTORNEY OR GOV	ERNMENTAL	AGENCYS	PECIFIED IN ITEM 9 (b).
7. Name and address of health provider or entity to	release this information	n:		
8. Name and address of person(s) or category of pe	rson to whom this infor	mation will be se	ent:	
9(a). Specific information to be released: Medical Record from (insert date)	to fina	(مرمد المرمد		
Entire Medical Record, including patient his	istories, office notes (ex	cept psychothera	iby notes), tes	— st results, radiology studies, films
referrals, consults, billing records, insurance	ce records, and records:	sent to you by otl	her health car	re providers.
Other:			•	ite by Initialing)
				hol/Drug Treatment
Authorization to Discuss Health Information		· · · · · · · · · · · · · · · · · · ·		ital Health Information '-Related Information
(b) By initialing here I authoriz	7A			•I/Graten Illioi mation
Initials		Name of individual	l health care p	rovider
to discuss my health information with my atto	orney, or a governments	al agency, listed h	nere:	

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:

	All items on this form have been completed and my question	ns about this form have been answered. In addition, I I
7	Kys In T. srow	Date:
ţ	Signature of patient or representative authorized by law.	·

10. Reason for release of information:

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

☐ 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	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 SHOLL 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.

fysher T. sear	
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
Fyshi T. Jsou	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, DIAM	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
WIT OR TYPE)	
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 ass	
(Print patient's name)	(Print hospital or health care provider name)
all rights privileges and remedies to payment for health ca entitled under Article 51 (the No-Fault statute) of the Insur	
The Assignee hereby certifies that they have not received shall not pursue payment directly from the Assignor for s	
due to the motor vehicle accident which occurred on	, not withstanding any other agreement
	rint accident date)
to the contrary.	,
This agreement may be revoked by the assignee when be of coverage and/or violation of a policy condition due to t	
FILES AN APPLICATION FOR COMMERCIAL INSURANC PERSONAL INSURANCE BENEFITS CONTAINING ANY MPURPOSE OF MISLEADING, INFORMATION CONCERNIN IN CONNECTION WITH SUCH APPLICATION OR CLAIM SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FOUNDERSION OF ANY MOTOR VEHICLE TO A LAW VEHICLES OR AN INSURANCE COMPANY, COMMITS A	DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON E OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE IG ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, M, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF REACH VIOLATION.
	Lysan T. Ison
(Print name of Patient)	(Signature of Patient)
	(Date of signature)
(Address of Patient)	
(Address of Patient)	Upenous k winks
(Print name of Provider)	(Signature of Provider)
	(Date of signature)
(Address of Provider)	