Printed on : 06/20/2022

# Patient Information

## Personal Information

| | | | |
|---|---|---|---|
| **First Name** | Adina | **Middle Name** | |
| **Last Name** | Rose | **D.O.B** | 01/01/1966 |
| **Gender** | Ms. | **Address** | P.O Box 685 |
| **City** | Brooklyn | **State** | NY |
| **Cell Phone #** | | **Home Phone** | |
| **Work** | | **Zip** | |
| **Email** | | **Extn.** | |
| **Attorney** | karine bogoraz | **Case Type** | |
| **Attorney Address** | | **Attorney Phone** | 646-809-1616 |
| **Case Status** | | **SSN** | |

## Insurance Information

| | | | |
|---|---|---|---|
| **Policy Holder** | | **Name** | Geico Indemnity Co |
| **Address** | | **City** | |
| **State** | | **Zip** | |
| **Phone** | | **Fax** | |
| **Contact Person** | | **Claim File #** | |
| **Policy #** | 4531-02-99-75 | | |

## Accident Information

| | | | |
|---|---|---|---|
| **Accident Date** | | **Plate Number** | |
| **Report Number** | | **Address** | |
| **City** | | **State** | |
| **Hospital Name** | | **Hospital Address** | |
| **Date of Admission** | | **Additional Patient** | |
| **Describe Injury** | | **Patient Type** | |

## Employer Information

| | | | |
|---|---|---|---|
| **Name** | | **Address** | |
| **City** | | **State** | |
| **Zip** | | **Phone** | |
| **Date of First Treatment** | | **Chart #** | |

## Adjuster Information

| | | | |
|---|---|---|---|
| **Name** | Zaria Scarlett~~ | **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 |
|---|---|---|
| Adina Rose | 1 / 1 / 1966 | |
| **Patient Address** P.O Box 685 , Brooklyn, NY - 11233 | | |

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).**

7. Name and address of health provider or entity to release this information:

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 notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

**Authorization to Discuss Health Information**

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

| 10. Reason for release of information: ☐ At request of individual ☐ Other: | 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 patient: |

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a

_____ Signature of patient or representative authorized by law.

Date: 05-26-2022

* 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**

| NAME AND ADDRESS OF INSURER * | NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE* |
|---|---|
| | |

| DATE | POLICYHOLDER | POLICY NUMBER | DATE OF ACCIDENT | CLAIM NUMBER |
|---|---|---|---|---|
| | | 4531-02-99-75 | 01/24/2022 | 0621 6272 6010 1030 |

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.

NAME AND ADDRESS OF APPLICANT*

| 1. YOUR NAME | 2. PHONE NOS. HOME | BUSINESS |
|---|---|---|
| Adina Rose | | |

| 3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE) | 4. DATE OF BIRTH | 5. SOCIAL SECURITY NO. |
|---|---|---|
| P.O Box 685 , Brooklyn, NY - 11233 | 01/01/1966 | |

| 6. DATE AND TIME OF ACCIDENT | 7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE |
|---|---|
| 01/24/2022 A.M. P.M. | |

8. BRIEF DESCRIPTION OF ACCIDENT

9. DESCRIBE YOUR INJURY

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS, ☐ OR A MOTORCYCLE ☐ A TRUCK, ☐ AN AUTOMOBILE,

| | YES | NO |
|---|---|---|
| 11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE? | ☐ | ☐ |
| WERE YOU A PASSENGER IN THE MOTOR VEHICLE? | ☐ | ☐ |
| WERE YOU A PEDESTRIAN? | ☐ | ☐ |
| WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD? | ☐ | ☐ |
| DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE? | ☐ | ☐ |

CONTINUATION ON NEXT PAGE

**APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO**

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES ☐ NO ☐

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOUR WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT? ☐ IN-PATIENT? ☐

DATE OF ADMISSION: _____

HOSPITAL'S NAME AND ADDRESS: _____

| 14. AMOUNT OF HEALTH BILLS TO DATE: | 15. WILL YOU HAVE MORE HEALTH TREATMENT(S)? | 16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? |
|---|---|---|
| $ _____ | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 17. DID YOU LOSE TIME FROM WORK? | DATE ABSENCE FROM WORK BEGAN: | HAVE YOU RETURNED TO WORK? |
|---|---|---|
| YES ☐ NO ☐ | | YES ☐ NO ☐ |

IF YES, DATE RETURNED TO WORK: _____ AMOUNT OF TIME LOST FROM WORK: _____

| 18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS? | NUMBER OF DAYS YOU WORK PER WEEK: | NUMBER OF HOURS YOU WORK PER DAY: |
|---|---|---|
| | | |

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?

YES ☐ NO ☐

20. LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

| EMPLOYER AND ADDRESS | OCCUPATION | FROM | TO |
|---|---|---|---|
| EMPLOYER AND ADDRESS | OCCUPATION | FROM | TO |
| EMPLOYER AND ADDRESS | OCCUPATION | FROM | TO |

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?

YES ☐ NO ☐

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 FOLLOWING:

| | YES | NO |
|---|---|---|
| NEW YORK STATE DISABILITY? | ☐ | ☐ |
| WORKERS' COMPENSATION? | ☐ | ☐ |

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.**

SIGNATURE

05-26-2022

DATE

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOUR ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

Adina Rose

OR TYPE)

SOCIAL SECURITY NO.

SIGNATURE

05-26-2022

DATE

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

Adina Rose

NT OR TYPE)

SIGNATURE

05-26-2022

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.

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW**
**ASSIGNMENT OF BENEFITS FORM**

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number: 0621 6272 6010 1030

**I,** Adina Rose **, ("Assignor") hereby assign to** UK Sinha Physician, PC **, ("Assignee")**
(Print patient's name) (Print hospital or health care provider name)

**all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.**

**The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on** 01/24/2022 **, not withstanding any other agreement**
(Print accident date)

**to the contrary.**

**This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.**

**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.**

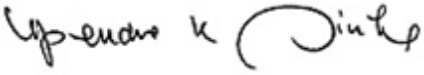
Adina Rose
**(Print name of Patient)**


**(Signature of Patient)**

05-26-2022
(Date of signature)

P.O Box 685 , Brooklyn, NY - 11233
(Address of Patient)

UK Sinha Physician, PC
**(Print name of Provider)**


**(Signature of Provider)**

05-26-2022
(Date of signature)

102-31 Jamaica Ave., Richmond Hill, NY 11418
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)