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



Patient Name		Date of Birth	1	Social Security Number
Patient Address		<i>U</i>		Α
, or my authorized representative, request that	health information rega	arding my care and	treatment be	released as set forth on this form
n accordance with New York State Law and the [HIPAA], I understand that:	e Privacy Rule of the H	calth Insurance Por	tability and A	Accountability Act of 1996
This authorization may include disclosure TREATMENT, except psychotherapy notes, a he appropriate line in Item 9(a). In the event nitial the line on the box in Item 9(a), I specific. If I am authorizing the release of HIV-relation behalf from redisclosing such information anderstand that I have the right to request a list experience discrimination because of the release of Human Rights at (212) 480-2493 or the Nesponsible for protecting my rights. I have the right to revoke this authorization evoke this authorization except to the extent the	and CONFIDENTIAL the health information cally authorize release of ted, alcohol or drug tr a without my authorize of people who may receive or disclosure of HIV lew York City Commit at any time by writing at action has already be	HIV* RELATED I described below inc of such information eatment, or mental ration unless permi recive or use my HIV V-related information ssion of Human Recipion to the health care permitted in the health care permitted.	NFORMAT cludes any of to the person health treatmented to do so related info in, I may confights at (212 provider lister this authoriza	TON only if I place my initials these types of information, and a (s) indicated in Item 8, ment information, the recipient of under federal or state law, the mation without authorization, and the New York State Division of the New York State Divisi
 I understand that signing this authorization penefits will not be conditioned upon my autho 	n is voluntary. My tre rization of this disclosu	atment, payment, e re.	enrollment in	n a health plan, or eligibility f
 Information disclosed under this authorizated edisclosure may no longer be protected by federal 	ral or state law.			
5. THIS AUTHORIZATION DOES NOT A CARE WITH ANYONE OTHER THAN TH	UTHORIZE YOU TO E ATTORNEY OR G	O DISCUSS MY I	HEALTH IN	FORMATION OR MEDICA
7. Name and address of health provider or entit	y to release this inform	ation:		
3. Name and address of person(s) or category o	person to whom this in	nformation will be s	ent:	
P(a). Specific information to be released:				
☐ Medical Record from (insert date)	to (insert date)		
□ Entire Medical Record, including paties	t histories, office notes	(except psychother	apy notes), te	est results, radiology studies, file
referrals, consults, billing records, insu				•
Other:		, In	clude: (<i>Indic</i> a	ate by Initialing)
		•		ohol/Drug Treatment
		_	Mer	ntal Health Information
Authorization to Discuss Health Information			ніл	V-Related Information
(b) By initialing here I auth	orize			
(b) ☐ By initialing here I auth Initials to discuss my health information with my	attorney, or a governm	Name of individuental agency, listed	al health care p here:	provider
(Attors	ey/Firm Name or Govern	mental Agency Name		
O. Reason for release of information: At request of individual Other:				uthorization will expire:

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

13. Authority to sign on behalf of patient:

		•
× 20	Date:	
Signature of patient or representative authorized by law	,	

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

* 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
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 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.

SIGNATURE	DATE
	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.
SIGNATURE	DATE
Di	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, 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)	
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	
(Print patient's name) all rights privileges and remedies to payment for healt entitled under Article 51 (the No-Fault statute) of the Ir	
	ved any payment from or on behalf of the Assignor and or services provided by said Assignee for injuries sustained , not withstanding any other agreement
to the contrary.	
This agreement may be revoked by the assignee wher of coverage and/or violation of a policy condition due	n benefits are not payable based upon the assignor's lack to the actions or conduct of the assignor.
FILES AN APPLICATION FOR COMMERCIAL INSURA PERSONAL INSURANCE BENEFITS CONTAINING AN PURPOSE OF MISLEADING, INFORMATION CONCER IN CONNECTION WITH SUCH APPLICATION OR CI SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE CONVERSION OF ANY MOTOR VEHICLE TO A LA VEHICLES OR AN INSURANCE COMPANY, COMMIT	TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON ANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR IT MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE NING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, LAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, E A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR AW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR IS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF FOR EACH VIOLATION.
(Print name of Patient)	(Signature of Patient)
	(Date of signature)
(Address of Patient)	
(Address of Fatient)	apendo k winks
(Print name of Provider)	(Signature of Provider)
	(Date of signature)
(Address of Provider)	