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

Patient Name	Date of Birth	/	Social Security Number
Patient Address	<u> </u>		ρ
I, or my authorized representative, request that health informa In accordance with New York State Law and the Privacy Rule (HIPAA), I understand that: 1. This authorization may include disclosure of informatio TREATMENT, except psychotherapy notes, and CONFIDE; 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 2. If I am authorizing the release of HIV-related, alcohol or prohibited from redisclosing such information without my understand that I have the right to request a list of people who I experience discrimination because 91 the release or disclosure of Human Rights at (212) 480-2493 or the New York City 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 all 4. I understand that signing this authorization is voluntary benefits will not be conditioned upon my authorization of this	of the Health Insurance Porton relating to ALCOHOL NTIAL HIV* RELATED I mation described below increlease of such information or drug treatment, or mental authorization unless permit may receive or use my HIV re of HIV-related information. Commission of Human Rivy writing to the health care plready been taken based on the My treatment, payment, edisclosure.	ability and A and DRUG NFORMAT ludes any of to the person health treatn ited to do s '-related info n, I may con ghts at (212 provider liste his authoriza	Accountability Act of 1996 ABUSE, MENTAL HEALT TON only if I place my initials of these types of information, and also indicated in Item 8. In the information, the recipient of under federal or state law. I ormation without authorization. Itact the New York State Division of the information. These agencies and below. I understand that I material.
 Information disclosed under this authorization might be a redisclosure may no longer be protected by federal or state law THIS AUTHORIZATION DOES NOT AUTHORIZE CARE WITH ANYONE OTHER THAN THE ATTORNE Name and address of health provider or entity to release this 	: YOU TO DISCUSS MY H Y OR GOVERNMENTAL	IEALTH IN	FORMATION OR MEDICA
redisclosure may no longer be protected by federal or state law 6. THIS AUTHORIZE CARE WITH ANYONE OTHER THAN THE ATTORNE	. YOU TO DISCUSS MY H Y OR GOVERNMENTAL s information:	IEALTH IN AGENCY	FORMATION OR MEDICA
redisclosure may no longer be protected by federal or state law 6. THIS AUTHORIZATION DOES NOT AUTHORIZE CARE WITH ANYONE OTHER THAN THE ATTORNE 7. Name and address of health provider or entity to release this 8. Name and address of person(s) or category of person to who	YOU TO DISCUSS MY HAY OR GOVERNMENTAL s information: om this information will be so to (insert date) ice notes (except psychothers and records sent to you by ot	apy notes), te her health callude: (Indicate)	SPECIFIED IN ITEM 9 (b). Est results, radiology studies, filiare providers. ate by Initialing)
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* 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
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	NO NO LINE OF SHOLL 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.

Sharily	
SIGNATURE	DATE
	O NOT DETACH
	E 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
Sharing OR TYPE)	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, 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
Sharing 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)

Page 3 of 3

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 as	
(Print patient's name)	(Print hospital or health care provider name)
all rights privileges and remedies to payment for health entitled under Article 51 (the No-Fault statute) of the Insi	· · · · · · · · · · · · · · · · · · ·
(
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	services provided by said Assignee for injuries sustained , not withstanding any other agreement
	Print 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	
FILES AN APPLICATION FOR COMMERCIAL INSURAN PERSONAL INSURANCE BENEFITS CONTAINING ANY PURPOSE OF MISLEADING, INFORMATION CONCERNI IN CONNECTION WITH SUCH APPLICATION OR CLASOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A CONVERSION OF ANY MOTOR VEHICLE TO A LAW VEHICLES OR AN INSURANCE COMPANY, COMMITS	O DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON CE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE ING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, ALIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR V ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF OR EACH VIOLATION.
	Sharily
(Print name of Patient)	(Signature of Patient)
	(Date of signature)
	(= 5.0 5. 5.9.0.0.0.7)
(Address of Patient)	
	apendo & Jink
(Print name of Provider)	(Signature of Provider)
	(Date of signature)
(Address of Provider)	
(Addiess of Frovider)	