MID ATLANTIC ORTHOPEDIC ASSOCIATES, LLP.

557 Cranbury Road Suite 10 • East Brunswick, NJ 08816
Phone (732) 238-8800 • Fax (732) 238-8246 • WWW.MAORTHOS.COM

Lewis J. Levine, M.D.
Richard A. Klein, M.D.
David Kirschenbaum, M.D.
Shawn D. Sieler, M.D.
Board Certified and Fellowship Trained

General Orthopedics
Hand and Upper Extremity
Sports Medicine
Reconstructive Surgery
Spine and Neck
Foot & Ankle

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	SS#	PATIENT DATE OF BIRTH / /	
ADDRESS	ZIP	HOME PHONE	CELL PHONE
CITY	STATE	SEX ☐ Male ☐ Female	MARITAL STATUS ☐ Single ☐ Married ☐ Other
EMPLOYER NAME	OCCUPATION:	EMPLOYER PHONE	
PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)		LENGTH OF EMPL	

PRIMARY DOCTOR/FAMILY DOCTOR:	HOW WERE YOU REFERRED TO THE OFFICE: ☐INTERNET ☐PHYSICIAN ☐FAMILY/FRIEND ☐OTHER
PHARMACY NAME AND PH. NO:	NAME:_____

IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

INSURED/RESPONSIBLE PARTY INFORMATION RELATION TO PATIENT: ☐spouse ☐parent ☐guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)		ADDRESS (if different from patient)		
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)		PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE
SECONDARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)		PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

ACCIDENT CASES – PLEASE PROVIDE ALL INFORMATION REQUESTED

☐WORKER'S COMP
☐AUTO
☐OTHER

WAS IT REPORTED
☐YES ☐NO

TREATMENT AUTHORIZED BY: ☐EMPLOYER ☐INSURANCE COMPANY		
NAME OF INSURANCE COMPANY	DATE OF ACCIDENT	ADJUSTER
INSURANCE ADDRESS		CLAIM#
INSURANCE PHONE #		

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

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Authorization to release health information to:			
Name(s)	**ADDRESS**		
CITY, STATE	**ZIP**	**HOME PHONE**	**DAYTIME PHONE**
DATES OF SERVICE **FROM:** **TO:**	**AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)** ☐ **NEVER** **DATE:**		
Release the following information: **√ All Records** **√ Chart Notes** **√ Radiology Reports** **√ Operative Reports** **√ History & Physicals**			

RELEASE OF INFORMATION

I understand that:

- once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	**DATE**	**EMAIL**
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	**SIGNATURE OF WITNESS (Optional):**	

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PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	HEIGHT	WEIGHT

Allergies:

PAST MEDICAL HISTORY

	PATIENT		FAMILY			PATIENT		FAMILY	
	YES	NO	YES	NO		YES	NO	YES	NO
ANXIETY					TUBERCULOSIS				
HYPERTENSION					PHEBITIS OR BLOOD CLOTS				
DIABETES					LIVER DISEASE				
SEIZURES OR STROKES					ULCERS				
TUMORS OR CANCER					THYROID DISEASE				
LUNG DISEASE					BLEEDING PROBLEMS/ANEMIA				
ASTHMA					HIGH CHOLESTROL				
DEPRESSION					OTHER				

SOCIAL HISTORY

☐**Yes** ☐**No** - Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic
☐**Yes** ☐**No** - Do you use tobacco? ☐ Smoke (___ packs per day) ☐ Chew

PAST History: Please list

MEDICATIONS	DOSE	SURGERY	DATE

Review of Systems: Have you ever had any of the following?		YES	NO			YES	NO
CARDIC	**CHEST PAIN**			**GI**	**NAUSEA**		
	CHEAST PRESSURE				**VOMITTING**		
	CHEST TIGHTNESS				**VOMITTING BLOOD**		
	CHEST SQUEEZING				**BLACK STOOL**		
	PALPITATIONS				**DIARRHEA**		
	ANGINA				**ABDOMINAL PAIN**		
	CHF CONGESTIVE HEART FAILURE				**WEIGHT LOSS**		
NEURO	**DIZZINESS**			**GU**	**BURNING WHILE URINATING**		
	LIGHT-HEADEDNESS				**FREQUENT URINATION**		
	FAINTING				**URINATING AT NIGHT FREQUENTLY**		
	WEAKNESS OF ARMS/LEGS				**KIDNEY PROBLEMS**		
RESPIRATORY	**SHORTNESS OF BREATH**			**OTHER**	**SWELLING OF LEGS**		
	COUGHING				**SWELLING OF JOINTS**		
	CHEST PAIN				**INFLAMMATION OF THE JOINTS**		
	FEVERS				**PAIN WHILE WALKING**		
	SHORTNESS OF BREATH WHILE LYING DOWN				**RHEUMATOID ARTHRITIS**		

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FINANCIAL RESPONSIBILITY

Mid Atlantic Orthopedics are **out-of-network providers** with your insurance company.

Patient's Name: _____

_____ (initial) I am personally responsible for all bills related to my care at the office of Mid Atlantic Orthopedics, including but not limited to my deductible and co-insurance.

_____ (initial) I authorize my insurance company to release information regarding my insurance benefits to the office of Mid Atlantic Orthopedics.

_____ (initial) I authorize Mid Atlantic Orthopedics to file insurance claims on my behalf for surgical and other services rendered to me.

_____ (initial) I irrevocably authorize Mid Atlantic Orthopedics to act on my behalf and report any suspected violations of proper claims practices to the proper regulatory Authority.

_____ (initial) I authorize Mid Atlantic Orthopedics to file appeals on my behalf, to my insurance company, should a claim not be paid correctly.

_____ (initial) I agree to be responsible for collection cost, including without limitation reasonable attorneys' fees **which can reach 50%-100% of the amount owed**, should my account become delinquent and is referred to a collection agency. I understand that an account shall be considered delinquent if (1) it is not paid in full within 90 days from the date of initial billing or (2) regardless of the amount of time that has elapsed since the initial billing if I receive payment from the insurance company and do not satisfy my bill to Mid Atlantic Orthopedics within five days thereafter

I certify that I have read and fully understand the above statements. This form supersedes any previous financial agreement.

Patient's Signature: _____ Date: _____
(Patient or parent/guardian)

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Revocable Assignment of Benefits & Authorization

I, [ ]("patient"), assign to my medical provider { Mid Atlantic Orthopedics}("the provider"), any and all of my rights and benefits under my insurance contract and/or my employer welfare benefit plan(s) as well as all of my rights and benefit under the employee Retirement Income Security Act of 1974 ("ERSIA") and any other applicable state or federal law(s);regulation(s),statue(s), or rule(s), which are in any way related to the medical services provided to me by Provider at any time.

I assign to provider any and all of my rights and benefits under my plan or policy as well as state and/or federal law(s); regulation(s), statue(s), or rule(s), to seek plan or policy documents, file appeals, seek statutory and other penalties, seek equitable relief, commence legal action, and directly receive payment of benefits insofar as they in any way relate to the treatment and/or services provided to me by Provider at any time. I assign the Provider any recovery, settlement, penalty, and/or other relief obtained.

I authorize Provider to file insurance claims on my behalf for services rendered to me at any time by Provider. I direct that all reimbursable payments for treatment and/or services rendered to me by Provider go directly to the Provider or any individual or entity they deem appropriate,

I authorize Provider to file to arbitration and/or litigation in my name and on my behalf against my PIP carrier, Healthcare carrier, Employee Welfare Benefit plan, Worker's compensation Plan, or any similar entity, which is in any way related to the treatment and/or services provided to me by Provider at any time.

I authorize Provider to retain an attorney of Provider's choice on my behalf for collections of the Provider's bill and/or file insurance claims on my behalf for services rendered to me. I authorized and consent to Provider acting on my behalf in this regard and in regard to my general health insurance coverage, and I specifically authorized Provider to pursue any administrative appeals conducted pursuant to any contract, plan, law or statute, including but not limited to ERSIA.

Provider may affirmatively disclaim any part of this assignment and authorization at any time and for any and/or reason (s) through writing. There is no reciprocal right on the Patient once this document is executed. Patient does not retain any power, right, or ability to revoke or withdraw any authorization or assignment. Should Provider disclaim any part of this assignment or authorization it shall result in the right(s) and/or benefits(s) explicitly disclaimed returning to Patient.

_____ _____

(NAME OF PATIENT) (DATE)

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Appointment Reminders/ Test Results (laboratory, X-rays, etc)

If we need to reach you regarding an appointment or test results, we will make every effort to reach you personally. If we cannot reach you personally, we will only leave a message asking you to call our office during regular business hours. Please check all item below that apply to you.

May we call to remind you of an appointment or regarding test results? ☐YES ☐NO

If we get an answering machine/voice mail, may we leave a message? ☐YES ☐NO

If we get a family member, may we leave a message? ☐YES ☐NO

If so, can we discuss your treatment/progress/result with them? ☐YES ☐NO

☐Spouse _____

☐Parent(s)_____

☐Child(ren)_____

☐Sibling(s)_____

☐Other (s)_____

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MOTOR VEHICLE ACCIDENT FORM

DATE OF ACCIDENT _____

- You were the ☐ Driver ☐ Front Seat Passenger ☐ Rear Seat Passenger ☐Pedestrian
- Were you wearing your seat belt? ☐ **YES** ☐ **NO**
- Did the vehicle air bags deploy? ☐ **YES** ☐ **NO**
- Were you ☐ in a head-on collision ☐ hit on driver side ☐ hit on passenger side
  ☐ in a vehicle rollover ☐ unsure as to mechanism
  ☐ rear ended? If so:
  Was your vehicle stopped? ☐ **YES** ☐ **NO**
  Did you hit the vehicle in front of you? ☐ **YES** ☐ **NO**
- Was there any loss of consciousness? ☐ **YES** ☐ **NO**
- Was there any paralysis? ☐ **YES** ☐ **NO**
- Were you able to get out of the vehicle on your own? ☐ **YES** ☐ **NO**
- Estimate how much damage was done to your vehicle? ☐ Totaled ☐ $_____ Amount

- Did you go to the hospital? ☐ **YES** ☐ **NO** (If NO, skip to next question)
  On the date of the accident: ☐ **YES** ☐ **NO**

If no, what was the date of your hospital visit? _____

Name of Hospital _____

Were you brought by: ☐ Ambulance ☐ Car

Were you: ☐ Discharged from ER ☐ Admitted to hospital for ___ days

I certify that the above statements made by me are true and correct

SIGNATURE:_____ **DATE**_____

PRINT NAME:_____

Mid Atlantic Orthopedic
Effective March 1, 2005
NOTICE OF PRIVACY PRACTICES AND RIGHT TO CHAPERONE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please ask to speak to or call our Privacy Officer, Dr. Shawn Sieler at (732)238-8800.
This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability & Accountability Act (HIPAA). It describes how we may use of disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This Notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our practice except when the release is required or authorized by law or regulation.

ACKNOWLEDGMENT OR RECEIPT OF THIS NOTICE – You will be asked to provide a signed acknowledgment of receipt of this Notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information in accordance with law.

OUR DUTIES TO YOU REGARDING PROTECTED HEALTH INFORMATION – "Protected Health Information" is individually identifiable health information and includes demographic information (for example, age, address, etc), and relates to your past, present or future physical or mental health or condition and related health services. Our practice is required by law to do the following: (1) keep your protected health information private; (2) present to you this Notice of our legal duties and privacy practices related to the use and disclosure of your protected health information; (3) follow the terms of the Notice currently in effect; and (4) communicate to you any changes we may make in the Notice. We reserve the right to change this Notice. Its effective date is at the top of the first page and at the bottom of the last page. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future.

HOW WE USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMAITON – Following are examples or permitted uses and disclosures of your health information. These examples are not exhaustive.

Required Uses and Disclosures – By law, we must disclose your health information to you unless it has been determined by a health care professional that it would be harmful to you. Even in such cases, we may disclose a summary of your health information to certain of your authorized representatives specified by you or by law. We must also disclose health information to the Secretary of the US Department of Health and Human Services (HHS) for investigations or determinations of our compliance with laws on the protection of your health information.

Treatment – We will use and disclose your protected health information to provide, coordinated or manage your health case and any related services. This includes the coordination or management of your health care with a third party. For example, we may disclose your protected health information from time to time to another physician or health care provider (for example, a specialist, pharmacist or laboratory) who at the request of your physician becomes involved in your care. This includes pharmacists who may be provided information on other drugs you have been prescribed to identify potential interactions. In emergencies, we will use and disclose your protected health information to provide the treatment you require.

Payment – your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities we may need to undertake before your health care insurer approves or pays for the health care services recommended for you, such as determining eligibility or coverage for benefits. For example, obtaining approval for a surgical procedure might require that your relevant protected health information be disclosed to obtain approval to perform the procedure as a particular facility. We will continue to request your authorization to share your protected health information with your health insurer or third-party payer.

Health Care Operations – we may use or disclose, as needed, your protected health information to support our daily activities related to providing health care. These activities include billing, collection, quality assessment, licensing, and staff performance reviews. For example, we may disclose your protected health information to a billing agency in order to prepare claims for reimbursement for the services we provide to you. We may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment. For example, we will contact you at your home telephone number to remind you of your next appointment and/or mail a postcard appointment reminder to your home address. We will share your protected health information with other persons or entities who perform various activities (for example, a transcription service) for our Practices. These business associates of our practice will also be required to protect your health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that might interest you. For example, your name and address maybe used to send you a newsletter about our Practice and our services.

Required by Law – We may use or disclose your protected health information if law or regulations requires the use or disclosure.

Public Health – We may disclose your protected health information to a public health authority who is permitted by law to collect or receive the information. For example, the disclosure may be necessary to prevent a control disease, injury or disability; report births and deaths; or report reactions to medications or problems with products.

Communicable Diseases – We may disclose your protected health information, if authorized by law, to a person who might otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight – We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. These health oversight agencies might include government agencies that averse the health care system, government benefit programs, other regulatory programs, or civil rights laws.

Food and Drug Administration – We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events: track products, enable product recalls; make repairs or replacements; or conduct post-marketing review, as required.

Legal Proceedings – We may disclose your protected health information during any judicial or administrative proceeding in response to a court order or administrative tribunal (if such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

Legal Enforcement – We may disclose protected health information for law enforcement purposes, including responses to legal proceedings; information requests for identification and location; and circumstances pertaining to victims of a crime.

Coroners, Funeral Directors, and Organ Donations – We may disclose protected health information to coroners or medical examiners for identification to determine the cause of death or for the performance of other duties authorized by law. We may also disclose protected health information

to funeral directors as authorized by law. Protected health information may be used and disclosed for cadaver organ; eye or tissue donations.

Research – We may disclose protected health information to researchers when authorized by law, for example, if their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Threat to Health or Safety – Under applicable Federal and State Laws, we may disclose your protected health information to law enforcement or another health care professional if we believe in good faith that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identity or apprehend an individual.

Military Activity and National Security – When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel for activities believed necessary by appropriate military command authorities to ensure the proper execution of the military mission, including determination of fitness for duty; or to a foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information, under specified conditions to authorized Federal officials for conducting national security and intelligence activities including protective services to the President or others.

Worker's Compensation – We may disclose your protected health information to comply with workers' compensation laws and other similar legally established programs.

Inmates – We may use or disclose your protected health information, under certain circumstances, if you are an inmate of a correctional facility.

Parental Access – State laws concerning minors permit or require certain disclosure of protected health information to parents, guardians, and persons acting in a similar legal status. We will act consistently with the laws of this State (or, if you are treated by us in another state, the laws of that state) and will make disclosures following such laws.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR PERMISSION – In some circumstances, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. Following are examples in which your agreement or objection is required.

Individuals Involved in Your Health Care – Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may also give information to someone who helps pay for your care. Additionally, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person who is responsible for your care, or your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and coordinate uses and disclosures to family or other individuals involved in your health care.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMAITON – You may exercise the following rights by submitting a written request to our privacy Officer. Our Privacy Officer can guide you in pursuing these options. Please be aware that our Practice may deny your request; however, I most cases you may seek a review of the denial.

Right to Inspect and Copy – You may inspect and/or obtain a copy of your protected health information that is contained in a "designated record set" for as long as we maintain the protected health information. A designated records set contains medical and billing records and any other records that our Practice used for making decisions about you. This right does not include

Signature of Patient OR Authorized Representative.

inspection and copying of the following records: psychotherapy notes; information compiled in reasonable anticipation of or use in a civil criminal or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. You will be charged a fee for a copy of your record and we will advise you of the exact fee at the time you make your request. We may offer to provide a summary of your information and, if you agree to receive a summary, we will advise you of the fee at the time of your request.

Right to Request Restrictions – you may ask us not to use or disclose any part of your protected health information for treatment, payment or health care operations. Your request must be made in writing to our Privacy Officer. In your request, you must tell us: (1) what information you want restricted; (2) whether you want to restrict our use or disclosure, or both; (3) to whom you want the restriction to apply, for example, disclosures to your spouse; and (4) an expiration date. If we believe that the restriction is not in the best interests of either party, or that we cannot reasonably accommodate the request, we are not required to agree to your request. If the restriction is mutually agreed upon, we will not use or disclose your protected health information in violation of that restriction, unless it is needed to provide emergency treatment. You may revoke a previously agreed upon restriction, at any time, in writing.

Right to Request Alternative Confidential Communications – You may request that we communicate with you using alternative means or at an alternative location. We will not ask you the reason for your request. We will accommodate reasonable requests, when possible.

Rights to Request Amendment – If you believe that the information, we have about you in incorrect or incomplete, you may request an amendment to your protected health information as long as we maintain this information. While we will accept requests for amendment, we are not required to agree to the amendment.

Right to an Accounting of Disclosure – You may request that we provide you with an accounting of the disclosures we have made of your protected health information. This right applies to disclosures made for purposes other than treatment, payment or health care operations as described in this Notice and excludes disclosures made directly to you, to others pursuant to an authorization form you, to family members or friends involved in your care, or for notification purposes. The accounting will only include disclosures made on or after April 14, 2003 and no more than 6 years prior to the date of your request. The right to receive this information is subject to additional exceptions, restrictions, and limitations as described earlier in this Notice.

Right to Obtain a Copy of this Notice – You may obtain a paper copy of this Notice from us by requesting one.

Special Protections – This Notice is provided to you as a requirement of HIPAA. There are several other privacy laws that also apply to HIV-related information, mental health information, and substance abuse information. These laws have not been suspended and have been taken into consideration in developing our policies and this Notice.

Complaints – If you believe these privacy rights have been violated, you may file a written complaint with our Privacy Officer or wit the US Department of Health and Human Services Office of Civil Rights. We will provide their address upon request. No retaliation will occur against you for filing a complaint.

CONTACT INFORMATION – Our Privacy Officer is Dr. Shawn Sieler and he may be contacted at this office or by calling (732) 238-8800. You may contact our Privacy Officer for further information about our complaint process or for further explanation of this Notice of Privacy Practices.

_____ Date: ____/____/____

Signature

New Jersey Application for Benefits
Personal Injury Protection

Name
Address 1
Address 2
Address 3

Important:
1. To enable us to determine if you are entitled to benefits under the Personal Injury Protection Law you must complete and sign this form.
2. You must also sign the authorizations, Affidavit and Notice attached.
3. Return promptly with any medical bills you have received to date.

Date	Type of Claim	Date of Accident	Claim Number

Your Name	Gender M / F	Phone Nos.: Home Business

Your Address (No. & Street, City/Town, State & Zip Code	Date of Birth	Social Security No. (If none, enter "none

Your Previous Address

Date of Accident	Time of Accident	Place of Accident (Street, City/Town & State)
	☐ AM ☐ PM	

Brief Description of Accident

Do you or any member of your household own a vehicle? Yes ☐ No ☐
Name of Insurance Company _____

Do you have health insurance? Yes ☐ No ☐
Name of Insurance Company _____

	Yes	No
Were you the driver of the vehicle?	☐	☐
Were you a passenger in the vehicle?	☐	☐
Were you a pedestrian?	☐	☐
Were you a member of vehicle owner's household?	☐	☐

As a result of this accident were you injured? Yes ☐ No ☐ If your answer is "Yes", complete the remainder of this form.
If "No", sign here and return this form to us.

Signature: _____ Date: _____

Describe your injury:

Were you treated by a doctor? Yes ☐ No ☐	Doctor's Name and Address
If you were treated in a hospital, were you an In-patient? ☐ Out-patient? ☐	Hospital's Name and Address

Amount of Medical Bills to Date: $_____	Will you have more medical expenses? Yes ☐ No ☐	At the time of your accident, were you in the course of your employment? Yes ☐ No ☐	Did you lose wages or salary as a result of your injury? Yes ☐ No ☐ If yes, amount loss to date: $_____	What is your average weekly wage or salary? $_____

Your lost wages: Date disability from work began: Date you returned to work:

Have you received or are you eligible for benefits under:	Yes	No
(1) Any Workers' Compensation Law?	☐	☐
(2) Employees' Temporary Disability Benefit Statute?	☐	☐
(3) Medicare?	☐	☐

If yes, amount: $_____ Per week ☐ Per month ☐

If you are a Medicare beneficiary, enter your Health Insurance Claim Number (HICN) _____

List names and addresses of your employer and other employers for one year prior to accident date and give occupation and dates of employment:

Employer & Address	Occupation	Dates: From - To

As a result of your injury, have you had any other expenses? Yes ☐ No ☐ If your answer is "Yes", explain on reverse side.

Signature: _____ Date: _____

Do Not Detach

Authorization for Medical Information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, X-ray and physical findings, diagnosis and prognosis. You are authorized to provide this information in accordance with the Personal Injury Protection Benefits Law.

Signature: _____ Date: _____

Do Not Detach

Authorization for Wage Information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wage or salary while employed by you. You are authorized to provide this information in accordance with the Personal Injury Protection Benefits Law.

Signature: _____ Date: _____
Social Security No.: _____

"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."