EPSTEIN
SHAKH
LLP

ATTORNEYS AT LAW

SOL ____________________
TICKLED (   )

PERSONAL INJURY INTAKE FORM

CLIENT:____ DRIVER OR PASSENGER

ADDRESS:____

PHONE: (H):__________________(M)_________________ (OTHER)_____________________

DOB:________________ DL#:________________(   ) SS#____________________________

EMPLOYER:____

ADDRESS: ____
EMPLOYER PHONE NO.:_____________________________
ANY TIME MISSED FROM WORK?_______________

ANYONE ELSE IN YOUR VEHICLE INJURED?_______

ANY WITNESSES?_____ IF SO, PLEASE LIST:____

DATE OF ACCIDENT :____________ LOCATION:__________________________________

COUNTY:_____________________INVESTIGATING AGENCY: _________________________

COPY OF ACCIDENT REPORT?__________________ (   ) **NEED TO REQUEST**

DID ANYONE RECEIVE A CITATION/TICKET?________ IF YES, WHO?______________________

DESCRIBE THE ACCIDENT: ____

____

EST. PROPERTY DAMAGE: $_______________ TYPE OF VEHICLE: _______________________
ANY PICTURES OF PROPERTY DAMAGE? ______________
IS THE PROPERTY DAMAGE CLAIM SETTLED? ______________

CLIENT'S AUTO INSURANCE: ______________________ POLICY #:___________________
COPY OF CLIENT'S POLICY? ________________ (   ) **NEED TO REQUEST**
LIMITS: _________
MEDPAY? _______________ IF YES, ARE WE HANDLING? ____________

ADJUSTER NAME & NO. :____

OWNER'S AUTO INSURANCE: ______________________ POLICY #____________________
COPY OF OWNER'S POLICY? ____________________ (   ) **NEED TO REQUEST**
LIMITS :________
MEDPAY? _____________________
ADJUSTER NAME & NO.: ____

DEFENDANT'S NAME: ____

DEFENDANT'S AUTO INSURANCE: _______________POLICY #.______________________

ANY CONTACT WITH ADJUSTER? _____ IF SO, NAME:_______________________________
ADJUSTER PHONE NO.: _______________ RECORDED STATEMENT? ______ **(   ) REQUEST**

DESCRIBE INJURIES:____

____

____

AMBULANCE:________ IF SO, NAME:____

LIST OF HOSPITALS/DOCTORS, ETC.____

____

____

X-RAYS TAKEN?_______ IF YES, WHERE:____

MEDICAL INSURANCE:____________________________ GROUP NUMBER:___________________
PHONE NUMBER: _________________________________

MEDICARE OR MEDICAID?______________________ I.D. NO.:________________________

ANY PREVIOUS ACCIDENTS?____

IF SO, WHEN AND WHAT TYPE OF INJURIES:____

ANY CHRONIC HEALTH PROBLEMS OTHER THAN INJURIES FROM THIS ACCIDENT? IF SO, PLEASE DESCRIBE:____

PREVIOUS MEDICAL PROVIDERS FOR THE PAST FIVE YEARS:________________________

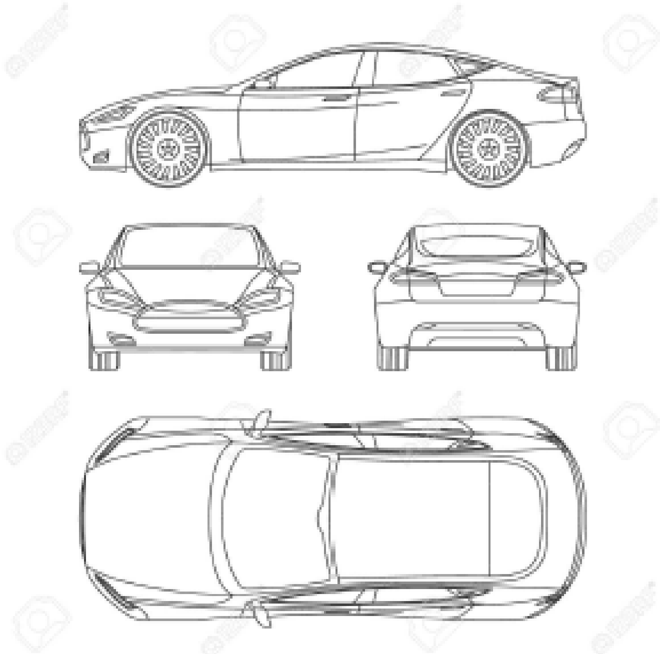
____

____

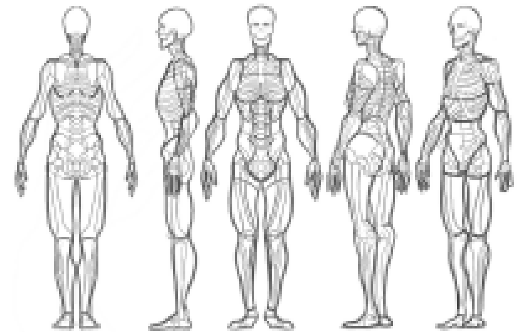
PLEASE PROVIDE A DIAGRAM OF ACCIDENT

PLEASE PROVIDE A DIAGRAM OF ACCIDENT

PLEASE IDENTIFY THE LOCATION OF PROPERTY DAMAGE



PLEASE IDENTIFY THE LOCATION OF INJURIES



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.

SIGN HERE

SIGNATURE 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).

NAME (PRINT OR TYPE) SOCIAL SECURITY NO.

SIGN HERE

SIGNATURE 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).

NAME (PRINT OR TYPE)

SIGN HERE

SIGNATURE DATE

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF
---X

Index No.:

Plaintiff(s),

- against -

PLAINTIFF'S VERIFICATION

Defendant(s),
---X

STATE OF NEW YORK)
ss.:
COUNTY OF ______________)

__________________________________, being duly sworn, deposes and says:

1. I am the plaintiff in the action;
2. I have read the foregoing ***Verified Complaint***, dated and know the contents thereof;
3. That the same is true to my own knowledge, except as to the matters therein stated to be alleged on information and belief, and as to those matters, I believe it to be true.

Dated: ________________, 202 __
Melville, New York

____
- Plaintiff

Sworn to before me this
____day of ____________, 202 __

____
Notary Public

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF
--X

Index No.:

Plaintiff(s),

- against -

PLAINTIFF'S VERIFICATION

Defendant(s),
--X

STATE OF NEW YORK)
ss.:
COUNTY OF ______________)

__________________________________, being duly sworn, deposes and says:

1. I am the plaintiff in the action;
2. I have read the foregoing ***Verified Bill of Particulars***, dated and know the contents thereof;
3. That the same is true to my own knowledge, except as to the matters therein stated to be alleged on information and belief, and as to those matters, I believe it to be true.

Dated: ________________, 202 __
Melville, New York

____
\- Plaintiff

Sworn to before me this
____day of ____________, 202 __

____
Notary Public

FOLD → ← HERE

Use only for accidents that happen in New York State

New York State Department of Motor Vehicles

REPORT OF MOTOR VEHICLE ACCIDENT

www.dmv.ny.gov

BEFORE COMPLETING THIS FORM, READ THE INSTRUCTIONS IN SECTION A ON PAGE 2

DO NOT FORGET ACCIDENT DATE

Page ________ of ________ ☐ ***RUSH*** - **DRIVER OF VEHICLE 1 - LICENSE SUSPENDED FOR FAILURE TO REPORT**

Accident Date (Month / Day / Year)	Day of Week	Time ☐ AM ☐ PM	Number of Vehicles	Number Injured	Number Killed	Did police investigate accident at scene? ☐ Yes ☐ No	If "Yes", Name of Police Agency or Precinct & Accident Number

1 DRIVER

DRIVER OF VEHICLE 1	☐ VEHICLE 2 ☐ PEDESTRIAN ☐ BICYCLIST ☐ OTHER PEDESTRIAN
Driver License ID Number / State of License	Driver License ID Number / State of License
Driver Name–exactly as printed on license (Last, First, M.I.)	Name–exactly as printed on license (Last, First, M.I.)
Address (*Include Number & Street*) / Apt. Number	Address (*Include Number & Street*) / Apt. Number
City or Town / State / Zip Code	City or Town / State / Zip Code
Date of Birth (Month / Day / Year) / Sex / Number of People in Vehicle / Public Property Damaged ☐	Date of Birth (Month / Day / Year) / Sex / Number of People in Vehicle / Public Property Damaged ☐

2 REGISTRANT

Vehicle 1	Vehicle 2
Name–exactly as printed on registration / Date of Birth (Month / Day / Year) / Sex	Name–exactly as printed on registration / Date of Birth (Month / Day / Year) / Sex
Address (*Include Number & Street*) / Apt. Number	Address (*Include Number & Street*) / Apt. Number
City or Town / State / Zip Code	City or Town / State / Zip Code
Plate Number / State of Reg. / Vehicle Year & Make / Vehicle Type / Ins. Code	**Plate Number** / State of Reg. / Vehicle Year & Make / Vehicle Type / Ins. Code

3 VEHICLE DAMAGE

Estimated Cost of Property Damage - Vehicle 1: ☐ $1,001-$1,500 ☐ $1,501-$2,500 ☐ Over $2,500

Estimated Cost of Property Damage - Vehicle 2: ☐ $1,001-$1,500 ☐ $1,501-$2,500 ☐ Over $2,500

Describe damage to vehicle 1

ACCIDENT DIAGRAM: Circle one of the 9 diagrams (numbered 0-8) if it describes the accident, or draw your own diagram below in space #9. Number the vehicles. Your vehicle is # 1

0. Left Turn	1. Rear End	2. Sideswipe (same direction)
3. Left Turn	4. Right Angle	5. Right Turn
6. Right Turn	7. Head On	8. Sideswipe (opposite direction)

9.

Describe damage to vehicle 2

4 ACCIDENT LOCATION

Place Where Accident Occurred in New York State:

County ____________ ☐ City ☐ Village ☐ Town of ____________. Permanent Landmark____________

Road on which accident occurred ____________ (Route Number or Street Name)

at ☐ 1) intersecting street____________ (Route Number or Street Name)

or 2) ________ Feet ________ Miles ☐ N ☐ S ☐ E ☐ W of ____________ (Milepost, Nearest intersecting Route Number or Street Name)

How did the accident happen?

5 ALL INVOLVED

Names of All Persons Involved	8. Which Veh. Occupied	9. Position in/on Vehicle	10. Safety Equip.Used	12. Age	13. Sex	16. Injury A	B	C	Describe Injuries	If Deceased, Enter Date of Death

6 INSURANCE

Identify Damaged Property Other Than Vehicle(s)	VIN
Name of Insurance Company That Issued Policy For Vehicle 1	Policy Number
Name and Address of Policy Holder	Policy Period From To
If Vehicle was Operated Under Permit (ICC, USDOT or NYSDOT), give No.	Name and Address of Permit Holder
If Self-Insured, give Certificate No.	and State

Date	SIGN HERE Print Name of Driver (*or Representative**) of Vehicle 1	Signature of Driver (*or Representative**) of Vehicle 1

* A representative may sign for the driver if the driver is unable to sign because of injury or death. If you are signing as the driver's representative, check the box that describes why the driver cannot sign. ☐ Injury ☐ Death

An accident report is not considered complete and filed unless it is signed, and if not signed may result in the suspension of your driver's license.

1 2 3 4 5 6 7 23 24 25 26 27 28 29 30

CLIENT AFFIRMATION AND DECLARATION

I, ______________________________, affirm and declare as follows:

1. That at the time of the accident, which occurred on the _____ day of 20_____, I was present in the motor vehicle involved.

2. That as a result of the said accident, I feel pain and I believe that I have sustained injuries.

3. That no one has solicited, coerced, or convinced me to seek medical treatment or pursue legal action/insurance claim.

4. That prior to the accident, I had no knowledge of or a relationship with the driver and/or passengers of the other vehicle(s) involved in the subject accident.

5. That at the time of the accident, I was not working or performing any tasks for my employer.

6. That I have been advised by the law firm of EPSTEIN SHAKH, LLP, that the bringing a fraudulent claim is a crime punishable by imprisonment and/or a fine, and that the law offices of EPSTEIN SHAKH, LLP, reserves the right to withdraw from representation of any party participating/involved in fraudulent claim.

7. That I declare and affirm that the above-referenced claim is not fraudulent in any manner.

8. That I understand that should it be determined that my claim is fraudulent, or should the law firm become aware of any material misrepresentations, the law firm of EPSTEIN SHAKH, LLP, reserves the right to immediately withdraw from representing me in the instant claim/litigation.

I have read the foregoing and understand same, and declare under the penalty of perjury that the foregoing is true and accurate.

Dated: 202__
Melville, New York

SIGN HERE

____
Signature

____
Print Name

AFFIDAVIT OF NO SOCIAL SECURITY NUMBER

I, ______________________________, hereby certify under the penalties of perjury that I have never been issued or assigned a Social Security Number by the Social Security Administration, or any other agency of the Federal Government of the United States of America.

I have read the foregoing and understand same, and declare under the penalty of perjury that the foregoing is true and accurate.

Dated: 202 __
Melville, New York

SIGN HERE
____
Signature

____
Print Name

STATE OF NEW YORK)
} ss.:
COUNTY OF SUFFOLK)

____
NOTARY PUBLIC

On the ______ day of___________, in the year_____, before me, the undersigned, personally appeared_________________

____

personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s) or the person upon behalf of which the individual(s) acted, executed the instrument, and that such individual made such appearance before the undersigned in the

____

FIRE DEPARTMENT – CITY OF NEW YORK
Public Records Unit / Fire Records Section
9 MetroTech Center
Brooklyn, New York 11201-3857
(718) 999-2681 or 2682

Fire Incident Report Request Form

SECTION A — CUSTOMER INFORMATION

Please print the required information below.

____
Name

____
Address

____
State Zip Code

________________ ______________________________
Telephone Number Patient Signature

OFFICE USE ONLY

____
Cashier / Search No.

PRU Staff
Accepted By/Initials:____________

Searched By:________________

Total Amount:________________

Note: Please make sure you complete this form and attach all required documents. Enclose a check or money order made payable to the NYC Fire Department **and a stamped self-addressed envelope (with postage).** Mail checks or money orders directly to the address and unit listed above. DO NOT MAIL CASH.

SECTION B — REQUEST FIRE INCIDENT REPORT FEE $1.00 / PER REPORT

Please print the required information below.

______________________________ ________ ______ ______ _____
House No Street Name Floor(s) Apt(s) Borough Box #

(Note: If you are requesting Section C, do not fill out the remaining section below)

INCIDENT DATE ____/____/____ INCIDENT REPORT NO. (If available) ____________________

Please check the incident type below (choose only one box):

☐ **Building**

☐ **Transportation - Type:** _______________ **Make:** ____________________ **Plate:** ______________

☐ **Outdoors (provide description) -** ____

☐ **Non-Fire Emergency (provide description) -** ________________________________

SECTION C

REQUEST PROPERTY REPORT FEE $10.00 / PER REPORT (ONE YEAR)

Please indicate the period to be searched:

From: ____/____/____ **To:** ____/____/____

We will only provide a listing of the incident dates found for the time period requested.

Note: Requests will be responded to within 10 business days.

MEDICARE AUTHORIZATION FORM

****ALL SECTIONS REQUIRED****

SECTION A: BENEFICIARY INFORMATION

Enter beneficiary name as it appears on Medicare card.

First Name:	Middle Name:	Last Name:
Date of Birth *(mm/dd/yyyy)*	Medicare Identification Number:	
Address:		
City:	State:	Zip code:

SECTION B: RECORD DETAILS DEFINITION

Medicare will only disclose the claim information identified below for the individual in Section A.

Select **one** option:
- Release **all** records to date
- Release records in timeframe from start date ____________________ to end date: ____________________

NY residents only:
- Include all records
- Exclude information about alcohol and drug abuse, mental health treatment, and HIV

Indicate whether authorization release is for a one-time disclosure, or Identify a future date or event when the authorization will expire.

Select **one** option:
- One-time disclosure
- Expiration upon specified date ______________________________
- Expiration upon specified event ____

SECTION C: RELEASE INFORMATION TO

Identify the name, address and contact information of the person and/or organization to whom you want Medicare to disclose the claim records. Medicare will only release claim records to those listed.

Release claim records to beneficiary at mailing address above.

Organization/Individual 1 Name	Recipient 1 Email Address
Recipient 1 Mailing Address:	

SECTION D: PURPOSE FOR REQUEST

This section helps Medicare understand the reason or intent for use for this record request.

At the request of the individual	Litigation

SECTION E: AUTHORIZATION AGREEMENT

I authorize Medicare to disclose claim records to the person(s) or organization(s) documented in Section C. I understand that these claim records may be re-disclosed by the recipient and may no longer be protected by law.

I understand I have the right to revoke this authorization at any time, in writing, except to the extent that Medicare has already acted based on my permission.

I understand that signing this authorization is voluntary. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on my authorization of this disclosure.

SIGN HERE Signature of Beneficiary or Representative Authorized by Law:	Date Signed:
Legal Role of Representative (Requires Additional Documentation):	

MODEL LANGUAGE

Proof of Representation

The language below should be used when you, the Medicare beneficiary, want to inform the Centers for Medicare & Medicaid Services (CMS) that you have given another individual the authority to represent you and act on your behalf with respect to your claim for liability insurance, no-fault insurance, or workers' compensation, including releasing identifiable health information or resolving any potential recovery claim that Medicare may have if there is a settlement, judgment, award, or other payment. You are not required to use this model language, but proof of representation must include the information provided in this model language. Your representative must also sign that he/she has agreed to represent you. This model language also makes provisions for the information your representative must provide.

Note: If you have an attorney, your attorney may be able to use his/her retainer agreement instead of this language. (If the beneficiary is incapacitated, his/her guardian, conservator, power of attorney etc. will need to submit documentation other than this model language.) Please visit https://go.cms.gov/cobro for further instructions.

Type of Medicare Beneficiary Representative (Check one below and then print the requested information):

- ☐ Individual other than an Attorney: ______________________
- ☐ Attorney
- ☐ Guardian
- ☐ Conservator
- ☐ Power of Attorney

Name: ______________________

Relationship to the Beneficiary: ______________________

Firm or Company Name: ______________________

Address: ______________________

Address Line 2: ______________________

City/State/ZIP: ______________________

Telephone: ______________________

Medicare Beneficiary Information and Signature/Date:

Beneficiary's Name: ______________________
(please print exactly as shown on your Medicare card)

Beneficiary's Medicare ID (number on your Medicare card): ______________________

Date of Illness/Injury for which the beneficiary has filed a
liability insurance, no-fault insurance, or Workers' Compensation claim: ______________________

Beneficiary's Signature: ______________________ Date signed: ______________

Representative Signature/Date:

Representative's Signature: ______________________ Date signed: ______________

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Authorization to Release Protected Medicaid Member Information to a Third Party

Medicaid Member Name (required): ______________________________

Date of Birth (required): ____ / ____ / ______

At least one of the following identification numbers is required, preferably both.

Client Identification Number (CIN): ______________

Social Security Number (SSN): ____ – ____ – ______

Persons/organizations authorized to receive or use the information:

Name: ______________________________

Address: ______________________________

____

City: ____________________ State: __________ Zip Code: __________

Phone Number: (______) ______ – ______

Dates Authorized: ☐ All OR From: ____ / ____ / ____ To: ____ / ____ / ____ OR ☐ To Present

Purpose of the use/disclosure: ______________________________

1. I understand that my health care and the payments for my health care will not be affected if I do not sign this form except in some situations when information is needed for the health plan's eligibility or enrollment determinations relating to the individual.
2. I understand, with few exceptions, that I may see and copy the information described on this form if I ask for it, and that I may get a copy of this form after I sign it.
3. I may revoke this authorization at any time by notifying the Department of Health in writing at the address below, but, if I do, it will not have any effect on actions that the Department took before they received the revocation. If not previously revoked, this authorization will expire upon completion of this request or one year from the date this form is signed, whichever comes first.
4. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan, health care provider or clearinghouse, the released information may no longer be protected by federal privacy regulations, and therefore the recipient of the confidential data may re disclose the confidential data.

By signing this form, I understand that I am allowing the New York State Department of Health to use or disclose all of the payment information for the Medicaid Member as indicated above, including data on certain conditions such as HIV/AIDS, Mental Health and Alcohol and Substance Abuse. I specifically authorize release of such information to the person(s) indicated above as the recipient.

SIGN HERE

______________________________ ______________
Signature of Medicaid Member or Agent — Date

______________________________ ______________________________
If not member, name of person signing for member — Authority to sign on behalf of member

______________________________ ______________________________
Witness Signature — Witness Name

Please return to: Medicaid Data Warehouse – CDRs
NYSDOH – MISCNY
ESP P1-11S Dock J
Albany NY 12237

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF
---X Index No.:

Plaintiffs,

- against -

Defendant(s),
---X

S I R S:

IT IS HEREBY CONSENTED THAT:
EPSTEIN SHAKH, LLP
150 Broadhollow Road, Suite PH - 4
Melville, New York 11747
T. (516) 447-6688
F. (516) 447-6689
E. info@eslawny.com

be substituted as attorneys of record for the undersigned parties in the above-entitled action in place and stead of the undersigned attorneys as of the date hereof.

DATED: __________ , 20 ____
Melville, New York

____
By:
EPSTEIN SHAKH, LLP
Incoming Counsel

____
By:

Outgoing Counsel

____
By:
Client

STATE OF NEW YORK)
: ss
COUNTY OF SUFFOLK)

On this ______ day of __________________, 20 ___ before me personally came ____, to me known and known to me to be the same person described herein and who executed the foregoing Consent and acknowledged to me that he executed the same.

____
Notary Public