East Side Medical Radiology PLLC

170 East 77th Street – Lower Level

New York, NY 10075

Phone [redacted]

Date JAN. 18, 2018

Patient Last Name EPSTEIN First JEFFREY

Home Address 9 EAST 71ST ST. Apt #

City NEW YORK State NY Zip 10021

Country USA

Home Phone [redacted]

Date of Birth 01-20-53 SS# [redacted] Sex Male X Female

Emergency Contact Name KARYNA SHULIAK Relationship FRIEND Phone [redacted]

Name of Employer SOUTHERN TRUST COMP. (STC)

Employers Address 6100 RED HOOK QUARTER, SUITE B-3, ST. THOMAS, USVI 00802

Primary Insurance Name UNITED HEALTHCARE

Policy Holder Name JEFFREY EPSTEIN Policy Holder Date of Birth JAN 20, 1953

Policy # [redacted] Group # [redacted]

Phone Number of Insurance Company [redacted]

Secondary Insurance Name —

Policy # — Group # —

Phone # of Secondary Insurance Company —

Policy Holder Name — Policy Holder Date of Birth —

I authorized the release of any medical or other information necessary to process the claim for services rendered to me. I also request payment of government benefits or commercial insurance benefits to myself or the party who accepts the assignment below.

Name JEFFREY EPSTEIN Signature _____ Date JAN. 18, 2018

I authorize payment of medical benefits to the physician or medical practice for the services rendered.

Name _____ Signature _____ Date _____