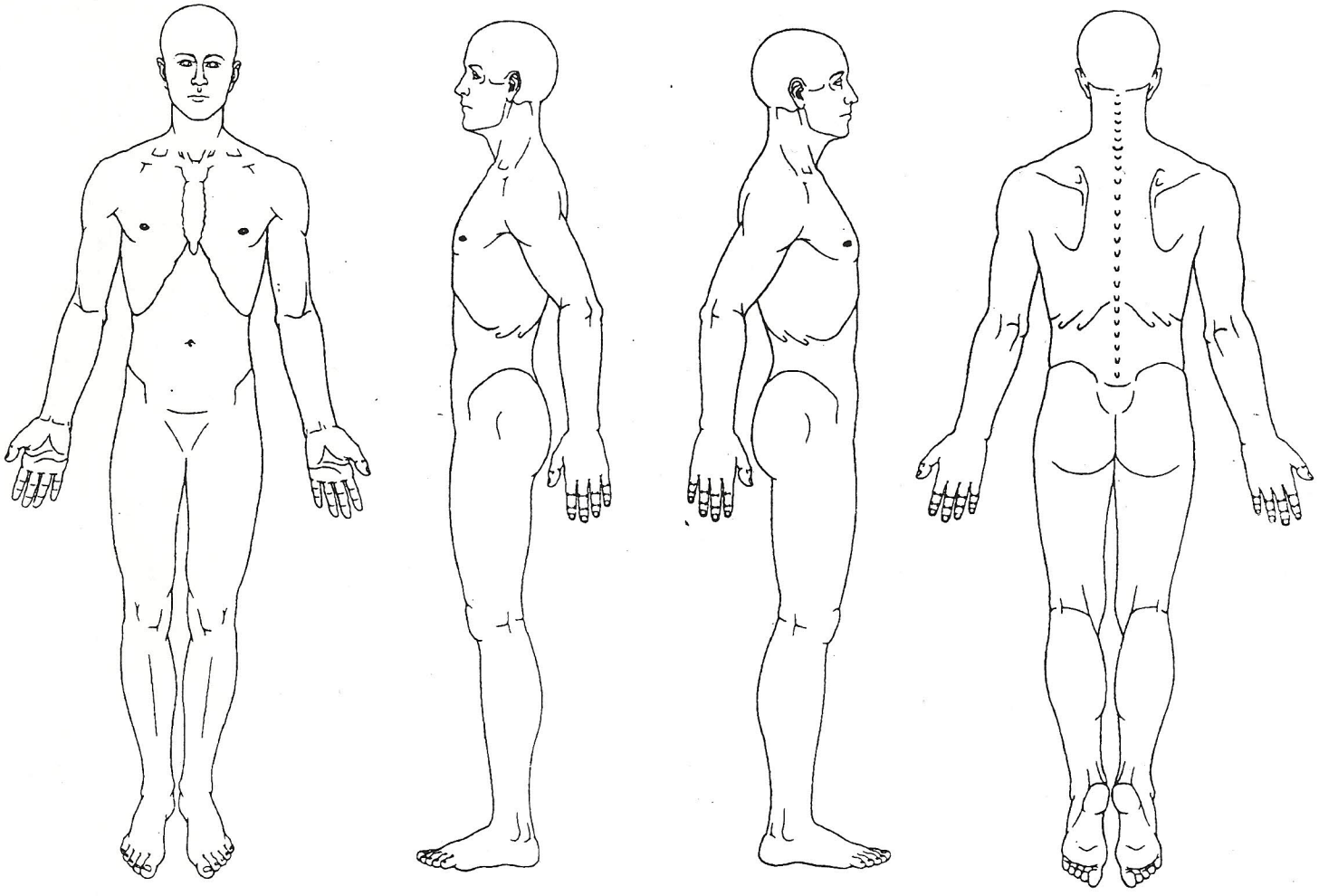
PAIN DRAWING

Name_____ Date_____

Using the following descriptive symbols, draw the location of your pain on body outlines below.
In addition, mark the level of your pain on the pain line at the bottom of the page.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
ΛΛΛΛ	========	OOOOOOOO	. . . . .	////////	XXXX
ΛΛΛ	=======	OOOOOOO	. . . . .	///////	XXX



No Pain ——————————— Worst Possible Pain

Please make a slash through this line as to the level of your pain.

_____

Patient Signature

Christos Vasakiris, D.C.,D.A.C.A.N.
350 West Montauk Highway
Lindenhurst, N.Y , 11757

PLEASE PRINT

Patient Name _____ SS# _____

Address _____ City _____

State _____ Zip Code _____ Birth Date ____/____/_____ Age _____

Circle one: Marital Status: S/M/D/W/P
How Did you find us?_____
Your Occupation _____ Years at this job _____

Your Employer's Name &
Address_____

Cell Phone (____) _____ Work Phone (____) _____
Home Phone # (____) _____

E-Mail Address:_____

MEDICAL PHYSICIAN'S NAME _____
ADDRESS _____

EMERGENCY CONTACT
NAME:_____PHONE_____

If the patient is a minor, permission is hereby given to the doctors in this office to perform an examination and treatments. I am his/her legal guardian.

Parent Signature _____

INSURANCE INFORMATION: (choose one)

Medical Insurance company name: _____
Policy #: _____ Group #: _____
Insured person's name _____ SS#: _____

No-Fault Insurance Company: _____
Policy Number (Insurance Card) _____ Phone #: _____
Mailing Address _____

Worker's Compensation Carrier Name/Phone#_____
Claim # _____ Policy # _____ Date injured _____

NEW YORK MOTOR VEHICLE
NO-FAULT INSURANCE LAW

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

To enable us to determine if you are entitled to benefits under New York No-Fault Law, please complete this form and return it promptly.

IMPORTANT INSTRUCTIONS:

1. **To be eligible for benefits you must complete and** sign this application.
2. **You must also** sign any attached authorizations.
3. Return promptly with copies of any bills you have received to date.

,

_____ , ext _____

claim representative

Your Name (Maiden Name)	Phone Number	Home ( )	Business ( )

Parent's Name, if Minor

Your Address (Number and Street, City or Town, State, and ZIP Code) | Date of Birth / / | Social Security Number

Date and Time of Accident ☐ AM ☐ PM | Place of Accident (Street, City or Town, and State)

Brief Description of Accident

Describe Your Injury

Identity of vehicle you occupied or operated at the time of the accident:	Owner's Name	Make	Year

This vehicle was ☐ An automobile ☐ A motorcycle ☐ A truck ☐ A bus or school bus

Were you the driver of the motor vehicle? ☐ YES ☐ NO

Were you a passenger in the motor vehicle? ☐ YES ☐ NO

Were you a pedestrian? ☐ YES ☐ NO

Were you a member of our policyholder's household? ☐ YES ☐ NO

Do you or a relative with whom you reside own a motor vehicle? ☐ YES ☐ NO

Were you treated by a doctor(s) or other person(s) furnishing health services? ☐ YES ☐ NO

Name and address of such doctor(s) or person(s): _____

If you were treated at a hospital(s) were you a ☐ Out-patient ☐ In-patient

Date of admission _____

Hospital's name and address _____

Amount of health bills to date $ _____ Will you have more health treatment? ☐ YES ☐ NO

At the time of your accident were you in the course of your employment? ☐ YES ☐ NO

Did you lose time from work ? ☐ YES ☐ NO If yes, how much time? _____

Were you receiving unemployment benefits at the time of the accident ? ☐ YES ☐ NO

What are your average weekly earnings? $ _____

If you lost time from work, date absence from work began. _____ Have you returned to work? Yes No

Number of days you work per week _____ Number of hours you work per day _____

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

Employer and Address	Occupation	From	To

As a result of your injury have you had any other expenses? Yes No If yes, attach explanation and amounts of such expenses

Due to this accident, have you received or are you eligible for payments under either of the following. New York State Disability? Yes No Workers' Compensation? Yes No

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PROTECT 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 insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, 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 stated value of the claim for each such violation.

_____ _____

Signature* **Date**

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. 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) Social Security Number

_____

Signature* **Date**

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-ray 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)

_____

Signature* **Date**

*If the applicant is a minor, parent or guardian shall sign and indicate capacity and relationship.

Please answer all the following questions to the best of your ability.

WHAT IS YOUR MAJOR COMPLAINT? _____
_____
_____
HOW LONG HAVE YOU HAD THIS PROBLEM? _____
PLEASE DESCRIBE WHAT YOU FEEL IS THE CAUSE OF THIS COMPLAINT:
_____
_____

If Your Current Problem is from an AUTO ACCIDENT OR WORK Injury PLEASE SPECIFY:
WORK RELATED **AUTO RELATED**

This Box For Auto & Work injury Only

Please specify the date and time of your injury: Date: _____ Time: _____ Location: _____
If this was a car accident, were you (circle one): DRIVER / PASSENGER in the: FRONT/ BACK of the car or A PEDESTRIAN
How long have you been working at your current job? _____ (circle one): FULL TIME or PART TME
Are you currently working? YES or NO Last Day worked: ____/_____/_____
TO WHOM WAS THE ACCIDENT REPORTED IF IT OCCURRED AT WORK? (ex. Supervisor) _____
Did you report this accident to your insurance company? YES or NO
Please specify exactly what tasks your job involves: _____
_____

If you have been treated or seen by another Doctor or Hospital for this problem, please give us their name and address as well as what the doctor did for you and what they told you.

NAME OF DOCTOR: _____ SPECIALTY: _____
TREATMENT GIVEN: _____
SPECIAL TESTS (x-rays, etc.): _____
WHAT DID THEY SAY? _____

IS YOUR CONDITION GETTING: (circle one) WORSE BETTER SAME
WHAT HAVE YOU BEEN DOING FOR THIS INJURY AT HOME? _____
PRIOR TO THIS INJURY, HAVE YOU HAD A SIMILAR COMPLAINT? YES or NO
_____
_____
DO YOU NOTICE ANY ACTIVITY RESTRICTIONS TO YOUR DAILY ROUTINE SINCE THE INJURY?
_____
HOW HAS THE PAIN AFFECTED YOUR SLEEP HABITS? _____
_____
WHAT MAKES YOUR PAIN WORSE? _____
WHAT MAKES YOUR PAIN BETTER? _____

IS THERE ANY OTHER AREA OF YOUR BODY THAT CAUSES YOU PAIN? (circle one) YES or NO
If yes, where? _____

HAVE YOU EVER HAD A PREVIOUS MOTOR VEHICLE ACCIDENT OR JOB INJURY IN YOUR LIFE? (circle one) YES or NO If yes, when and how? _____

PREVIOUS MEDICAL HISTORY

Smoker? Yes/No Packs/Day _____ Alcohol intake weekly yes/no (circle one)
Recreational Drugs (ever) Yes/No Allergies_____

Describe all surgeries

_____
_____

Describe all fractures _____

Describe all Medical Problems (Diabetes, High Blood Pressure,Heart, Kidney, etc.)

_____
_____

Describe all Hospitalizations:

_____
_____

List all Medications or Pills You Currently are Taking:

- _____
- _____
- _____
- _____

Have you ever had any of the following tests performed? & Why!

- MRI
- CAT SCAN
- X-RAYS
- EMG/NCV
- MYELOGRAM
- PAIN INJECTIONS

HAVE YOU EVER BEEN DIAGNOSED OR SUSPECTED OF HAVING CANCER?
_____

HAVE YOU EVER HAD A MOTOR VEHICLE ACCIDENT? WHEN?
_____

HAVE YOU EVER BEEN INJURED ON THE JOB BEFORE? WHEN?
_____

CHECK OFF ALL CONDITIONS THAT YOU MAY HAVE CURRENTLY OR HAVE HAD IN THE PAST

□ ATHRITIS	□ THYROID PROBLEMS	□ ULCERS
□ ARTERIOSCLEROSIS	□ HIGH BLOOD PRESSURE	□ PAIN UPON URINATION
□ ANEMIA	□ EPILEPSY	□ BLOOD IN STOOLS
□ ASTHMA	□ GALL BLADDER	□ DIFFICULTY SLEEPING
□ ALCOHOLISM	□ LIVER	□ VENEREAL DISEASE
□ WEAKNESS OF MUSCLES	□ INTESTINAL PROBLEMS	□ FEVER
□ HEAD TRAUMA	□ DEPRESSION	□ HEART ATTACK
□ SWELLING FEET	□ HEADACHES	□ FAINTING
□ BLOOD PROBLEMS	□ NECK PAIN	□ WEIGHT LOSS
□ DIABETES	□ NUMBNESS arms/legs	□ STROKE
DO YOU HAVE A PACEMAKER? (CIRCLE ONE)		YES or NO

AUTHORIZATION TO RELEASE INFORMATION

You are authorized to release any information you deem necessary concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof. I have received the Notice of Privacy Practices (HIPPA) and I have been offered a copy of such.

ACKNOWLEDGEMENT & UNDERSTANDING

I hereby acknowledge that I am receiving (or about to receive) health care services at **Dr. Christos Vasakiris, D.C., P.C.'s office** and that I have been advised that the doctor providing the services is willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made by insurance proceeds or out of the settlement of a liability claim. I understand that if it is determined that either:

(a) There is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor of make other provisions for the protection of the interest of the doctor, or

(b) If the liability claim exists and my attorney refuses to agree to protect the doctor, or I have not engaged the services of an attorney:

then payment for the services rendered by the doctor at **350 West Montauk Highway Lindenhurst** will be made on a current and timely basis by myself and paid in full. I agree to take full responsibility for the outstanding balance.

I hearby give consent to Dr. Christos Vasakiris to administer any/all chiropractic services allowed under the scope of practice in New York State which he deems necessary in the treatment and diagnosis of my condition.

PATIENT'S SIGNATURE _____ **DATE** _____

PATIENT AUTHORIZATION
FOR THE USE AND DISCLOSURE
OF PROTECTED HEALTH INSURANCE

1. I, _____, hereby authorize Dr.Vasakiris to use and/or disclose to my insurance company, treating physicians, and/or attorney, the following specific protected health information: complete medical record unless otherwise informed.

2. I understand that this authorization is valid until I inform Dr.Vasakiris that this authorization is no longer valid.

3. I understand that the purpose or use of the disclosure I am granting is to protect my patient privacy and personal health information.

4. I expressly acknowledge that this authorization is voluntary.

5. The following is/are other criteria or limitations that I make regarding this authorization:
   _____
   _____

6. I understand that the office will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

7. I understand that this authorization may be revoked by the authorizer, in writing, at any time in accordance with the attached authorization revocation procedure. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

8. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.

9. I understand that my health care and payment for my healthcare will not be affected if I do not sign this form.

10. I understand that I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.

11. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its consents.

12. This authorization is valid as of ___/___/_____, the date I have signed below.

_____ _____
Name of Individual (Printed) Signature of Individual Date

_____ _____
Signature of Legal Representative Relationship

PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____ hereby states that by signing this consent, I acknowledge and agree as follows.
PATIENT NAME

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosure of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out it's health care operations. The Practice has further explained to me that the Privacy Notice will be available to me in the future upon my request. The Practice has further explained to my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing the Consent.
2. The Practice reserves the right to change it's privacy practices that are described in it's Privacy Notices, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the practice a) a postcard mailed to me at the address provided by me; and b) telephoning my home, cellular device or place of employment, and leaving a message on my answering machines or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and treatment provided to me) in order for the practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct it's specific healthcare operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the practice is not required to agree to any restrictions that I have requested. If the practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven (7) years. I further understand that I have the right to revoke consent, in writing, at anytime for *all future* transaction, with the understanding that such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent.
7. I understand that <u>if I revoke consent</u> at any time, <u>the Practice has the right to refuse to treat me.</u>
8. I understand that if I do not sign this consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will have the option not to treat me.

I have read and understand the forgoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) **Signature of Individual** **Date**

_____ _____
Signature of Legal Representative **Relationship**

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
(This form is <u>not</u> for verification of hospital treatment)

NAME AND ADDRESS OF INSURER OR SELF-INSURER*	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

PROVIDER'S NAME AND ADDRESS*

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. **PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE <u>BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER THE TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT</u>. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM**.

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS

2. DATE OF BIRTH	3. SEX	4. OCCUPATION (IF KNOWN)

5. DIAGNOSIS AND CONCURRENT CONDITIONS

6. WHEN DID SYMPTOMS FIRST APPEAR? DATE: _____	7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE: _____

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?

YES ☐ NO ☐ IF YES, state when and describe:

9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT?

YES ☐ NO ☐ IF "NO", explain:

10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?

YES ☐ NO ☐

11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?

YES ☐ NO ☐ NOT DETERMINABLE AT THIS TIME ☐
IF "YES", describe:

12. PATIENT WAS DISABLED (UNABLE TO WORK)	13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON:
FROM: _____ THROUGH: _____	_____ (DATE)

CONTINUE ON PAGE 2

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
PAGE 2

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?
YES ☐ NO ☐ IF YES, describe your recommendation below:

15. REPORT OF SERVICES RENDERED -- ATTACH ADDITIONAL SHEETS IF NECESSARY

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICE RENDERED	FEE SCHEDULE TREATMENT CODE	CHARGES
			TOTAL CHARGES TO DATE$	

16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING:

TREATING PROVIDER'S NAME	TITLE	LICENSE OR CERTIFICATION NO.	BUSINESS RELATIONSHIP CHECK APPLICABLE BOX		
			EMPLOYEE	INDEPENDENT CONTRACTOR	OTHER (SPECIFY)

17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES ☐ NO ☐

19. ESTIMATED DURATION OF FUTURE TREATMENT

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (**Authorization to Pay Benefits**) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20 of this form.

20. _____ (IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #21)

AUTHORIZATION TO PAY BENEFITS:

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

PRINT NAME _____ SIGNED _____
PATIENT PATIENT DATE

CONTINUE ON PAGE 3

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
PAGE 3

PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (**Assignment of Benefits**). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in # 21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

21. _____ (IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)

ASSIGNMENT OF NO-FAULT BENEFITS:

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE ASSIGNEE TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT STATUTE) OF THE INSURANCE LAW. THE ASSIGNEE HEREBY CERTIFIES THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE ASSIGNOR AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE ASSIGNOR FOR SERVICES PROVIDED BY SAID ASSIGNEE FOR INJURIES SUSTAINED DUE TO THE MOTOR VEHICLE ACCIDENT, NOTWITHSTANDING ANY OTHER AGREEMENT TO THE CONTRARY. THIS AGREEMENT MAY BE REVOKED BY THE ASSIGNEE WHEN BENEFITS ARE NOT PAYABLE BASED UPON THE ASSIGNOR'S LACK OF COVERAGE AND/OR VIOLATION OF A POLICY CONDITION DUE TO THE ACTIONS OR CONDUCT OF THE ASSIGNOR

PRINT NAME _____ SIGNED _____
PATIENT (Assignor) PATIENT DATE

PRINT NAME _____ SIGNED _____
PROVIDER OF HEALTH CARE SERVICE (Assignee) PROVIDER OF HEALTH CARE SERVICE DATE

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED? ☐ YES ☐ NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? ☐ YES ☐ NO

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.

DATE	PROVIDER'S SIGNATURE	IRS/TIN IDENTIFICATION NO.	WCB RATING CODE IF NONE, SPECIALTY

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____ **, ("Assignor") hereby assign to** _____ **, ("Assignee")**
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ **, not withstanding any other agreement**
(Print accident date)
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

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.

(Print name of Patient)	**(Signature of Patient)**
	(Date of signature)
(Address of Patient)	
(Print name of Provider)	**(Signature of Provider)**
	(Date of signature)
(Address of Provider)	

NYS FORM NF-AOB (Rev 1/2004)