OM PHYSICAL THERAPY

OM PHYSICAL THERAPY - NEW PATIENT INTAKE FORM
(No-fault/Automobile Accident)

Welcome to OM Physical Therapy! We are here to support your journey to recovery and improve health. Please fill out this form to help us tailor our care to your specific needs.

PATIENT INFORMATION			
Patient's full name (last, first, middle)			
Home Address	City	State	Zip
Birth sex: ☐ Male ☐ Female	SSN	Dob (mm/dd/yyyy)	
Home phone ☐ Ok to call ☐ Ok to text	Cell phone ☐ Ok to call ☐ Ok to text	Work phone ☐ Ok to call ☐ Ok to text	
Email	How did you hear about us?		
Primary Care physician	Address	Phone	
Referring physician (if different from primary care)	Address	Phone	
Emergency contact name	Relation	Phone	
Employment Status: ☐ Full-Time ☐ Part-Time ☐ Not Working			

ACCIDENT INFORMATION Note: Please present a copy of your accident **police report**, if you have it, to the front desk during your initial visit.		
Date of Accident (mm/dd/yyyy)	Place of Accident:	Were you ☐ Driver OR ☐ Passenger?
Briefly describe how did accident happen?		
Did you lose consciousness? ☐ Yes ☐ No	If yes, for how long? _____	

OM PHYSICAL THERAPY

Were you taken to hospital? ☐ Yes ☐ No	If yes, which hospital? _____
Did they take any X-ray or Scans? ☐ Yes ☐ No	Note: Please present a copy of hospital record to the front desk during your initial visit.

INSURANCE INFORMATION

Note: Provide your vehicle insurance information (Ex: Geico, Allstate, State Farm)
Note: Please present a copy of all your insurance cards to the front desk during your initial visit.

Vehicle Insurance company	
Vehicle Insurance company address	
Phone#	Fax#
Policy#	No-Fault Claim (if known)#
Policy holder Name	Policy holder relationship to you
Insurance adjuster name (if known)	Phone#
No-fault Attorney Name (if known)	
No-fault Attorney address	

Phone#	Fax#	Email:

Certification

By signing below, I affirm that the information provided here is accurate to the best of my knowledge.

Signature: _____

Print Name: _____

Date: _____

OM PHYSICAL THERAPY

OM PHYSICAL THERAPY - COMPREHENSIVE MEDICAL HISTORY FORM

Current Condition/Major Complaints:

- **What are you/the patient being seen for?**

☐ Neck

☐ Shoulder

☐ Elbow or Upper Arm

☐ Forearm or Hand

☐ Wrist

☐ Mid Back

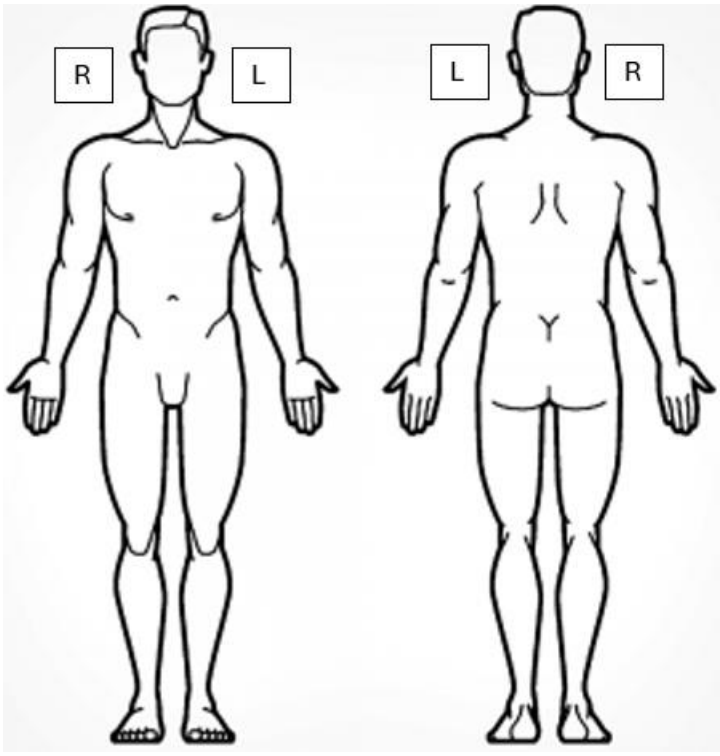
☐ Lower Back

☐ Hip

☐ Thigh

☐ Knee ☐ Lower Leg ☐ Ankle or Foot

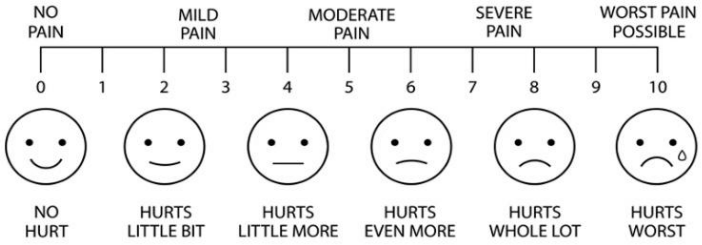
(Please circle where you feel pain/discomfort)



- **Date of condition onset/ When did your pain start: _____**
- **Is your current condition/complaint a result of,**

☐ Personal Injury ☐ Motor Vehicle Accident/No-Fault ☐ On the Job/Workers' Compensation

- **Describe pain (please circle):** Sharp Dull Aching Throbbing Cramping Burning Shooting Stabbing Constant Intermittent
- **Pain Assessment**: **Rate your pain on a scale of 0 to 10 (0 = No pain, and 10 = Unbearable pain)**



Pain at its best: ____
Pain today: ____
Pain at its worst: ____
What makes it worse? _____
What makes it better? _____
Does time of day affect pain? ☐ Yes ☐ No
Does pain wake you from sleep? ☐ Yes ☐ No
Daily activities affected by pain _____ %

OM PHYSICAL THERAPY

- **Do you have tingling, numbness, or loss of sensation?** ☐ Yes ☐ No **If so, where?**_____
- **Do you have weaknesses?** ☐ Yes ☐ No **If so, where and for how long?** _____
- **Do you have swelling?** ☐ Yes ☐ No **If so, where?** _____

Lifestyle Information

Do you use tobacco?	☐ Yes ☐ No	If yes, ___ # of packs per day
Do you consume alcohol?	☐ Yes ☐ No	If yes, ___ # of drinks per day
Do you wear glasses or contacts?	☐ Yes ☐ No	
Do you wear dentures or use a hearing aid?	☐ Yes ☐ No	
Do you have a pacemaker?	☐ Yes ☐ No	
Do you have any metal implants?	☐ Yes ☐ No	
Do you use a cane or crutches?	☐ Yes ☐ No	
Do you use a walker or wheelchair?	☐ Yes ☐ No	
Have you fallen two or more times?	☐ Yes ☐ No	
Have you sustained an injury as a result of these falls?	☐ Yes ☐ No	
For female patients only: Are you pregnant?	☐ Yes ☐ No	If yes, ___ # of weeks pregnant

Current Medications: Please list all medications including prescriptions, OTCs, herbals, and any supplements.

Medication: _____Dose: _____ Frequency: _____ Administration Route: _____
Medication: _____Dose: _____ Frequency: _____ Administration Route: _____
Medication: _____Dose: _____ Frequency: _____ Administration Route: _____
Medication: _____Dose: _____ Frequency: _____ Administration Route: _____

☐ No current medication

Surgical History List any surgeries you have had including the type and date.

Surgery Type: _____ **Date:** _____
Surgery Type: _____ **Date:** _____
Surgery Type: _____ **Date:** _____

Diagnostic and Treatment History Have you received any of the following for this condition?

☐ Chiropractic Care
☐ CT Scan
☐ General Practitioner
☐ MRI
☐ EMG/NCV Tests
☐ Myelogram
☐ Massage Therapy
☐ Neurological Consult
☐ Occupational Therapy
☐ Orthopedic Care
☐ Physical Therapy
☐ Podiatry Services
☐ Emergency Room Services
☐ X-rays

OM PHYSICAL THERAPY

Past Medical History Check any conditions you currently have or have had in the past.

High Blood Pressure	☐ Y ☐ N	Parkinson's Disease	☐ Y ☐ N
High Cholesterol	☐ Y ☐ N	COPD/Asthma	☐ Y ☐ N
Bowel/Bladder Dysfunction	☐ Y ☐ N	Emphysema	☐ Y ☐ N
Acid Reflux/Ulcers	☐ Y ☐ N	Lupus	☐ Y ☐ N
Thyroid Disorder	☐ Y ☐ N	Kidney Disease	☐ Y ☐ N
Bleeding Disorder	☐ Y ☐ N	Stroke	☐ Y ☐ N
HIV/AIDS	☐ Y ☐ N	Osteoarthritis	☐ Y ☐ N
Seizures/Epilepsy	☐ Y ☐ N	Rheumatoid Arthritis	☐ Y ☐ N
Lyme Disease	☐ Y ☐ N	Osteoporosis/Osteopenia	☐ Y ☐ N
Congestive Heart Failure	☐ Y ☐ N	Scoliosis	☐ Y ☐ N
Diabetes	☐ Y ☐ N	Headaches/Migraines	☐ Y ☐ N
Heart Attack	☐ Y ☐ N	Dizziness/Fainting	☐ Y ☐ N
Cardiac Bypass	☐ Y ☐ N	Dementia/Alzheimer's	☐ Y ☐ N
Cardiac Stent	☐ Y ☐ N	Recent Infection	☐ Y ☐ N
Chest Pain	☐ Y ☐ N	Multiple Sclerosis	☐ Y ☐ N
Hepatitis	☐ Y ☐ N	Fibromyalgia	☐ Y ☐ N
Mental Disorder	☐ Y ☐ N	Cancer	☐ Y ☐ N
If yes, what type:_____		If yes, what type:_____	
Allergies	☐ Y ☐ N	Please list allergies:_____	

Other not listed:_____

Certification: By signing below, I affirm that the information provided here is accurate to the best of my knowledge.

Signature: _____

Print Name: _____

Date: _____

OM PHYSICAL THERAPY

OM PHYSICAL THERAPY- NOTICE OF PRIVACY PRACTICES AND CONSENT (HIPPA)

Understanding Your Rights: Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, you have specific rights concerning the privacy of your protected health information. This information will be used in the following ways:

- **For Treatment:** To coordinate, manage, and administer your medical treatment and services among healthcare providers involved in your care.
- **For Payment:** To secure payment for health care services provided, from insurers and other third-party payers.
- **For Healthcare Operations:** To support essential healthcare operations such as quality reviews and physician evaluations.

Comprehensive Privacy Notice: I acknowledge that I have read and understood the detailed notice of privacy practices, which provides more extensive information on how my health information may be used and disclosed. I am aware that the organization may modify its privacy practices and that I can obtain the most recent version of this notice upon request.

Restriction Requests: I understand that I have the right to request restrictions on how my health information is used or disclosed for treatment purposes, although the organization is not obligated to comply with such requests.

Consent Revocation: I reserve the right to withdraw my consent at any time in writing, except to the extent that actions have already been taken based on this consent.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

*** 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.**

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

OM PHYSICAL THERAPY

MEDICAL LIEN

I, _____**,** hereby authorize and direct _____ my attorney, or attorney's to pay from the proceeds of my case to **OM Physical Therapy PLLC** the amount of **$**_____ and any other amount that may come for professional services in the treatment or injuries sustained by me and/or my wife/ or my child or children, as may be, in an accident which occurred on _____.

I make this authorization upon the understanding that the said doctor will render such further treatment as may be or become necessary without seeking any payment for any such services until the end of the case, at which time said doctor will send to me or counsel his total bills for all services render, which I agree to pay.

It is further understood that, by entering into this agreement, the said doctor is not making the collection of his charges contingent upon my recovering in the case but is merely to defer collection of his charges until the termination thereof.

It is further understood that in the event a dispute arises to reasonableness of the doctor's charges (other than the above stated amount) my attorney or attorney's agree (and I direct counsel so to do) to withhold the amount of said charges from the disbursement of the proceeds of the case to me and deposit the same in said counsel's special amount and that the matter of reasonableness of said charges shall then be submitted to Grievance Committee of the New York Medical Society for determination of the fair and reasonable amount due said doctor, under the circumstances, and that both I and the doctor hereby agree to this procedure and further agree that the decision of such Committee, in event of such controversy, counsel shall then to pay the doctor the amount fixed by said Committee and remit to me the balance of the sum withheld, if there is a balance.

It is further understood and agree that in the event the relationship of attorney and client between myself and the above counsel be terminated for any reason before final disposition of the case, said counsel shall relieved of the obligations hereinabove set forth as to him but said agreement shall remain in full force and effect as between myself, the doctor and such other attorney or attorney's as I may employ to represent me.

Date: _____ _____

Patient Signature

_____

Attorney's Signature

OM PHYSICAL THERAPY- ADDITIONAL FORMS
(FOR NO-FAULT PATIENT)

If your injury is related to a motor vehicle accident please fill out attached,

- **NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS (NF2)**
    - **Purpose**: The NF-2 form, also known as the "No-Fault Application" or "Motor Vehicle No-Fault Insurance Law - Application for Motor Vehicle No-Fault Benefits," is the official document that individuals must complete to apply for no-fault benefits. It should ideally be filed within 30 days of the accident in New York State. Under New York's no-fault insurance law, failing to file the NF-2 form within 30 days can potentially jeopardize the claimant's ability to receive no-fault benefits. The insurance company may have grounds to deny benefits if the form is filed late, unless there is a reasonable justification for the delay.
- **NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW ASSIGNMENT OF BENEFITS FORM**
    - **Purpose**: An Assignment of Benefits form allows healthcare providers to bill an insurance company directly for services provided to the insured patient. In the context of no-fault insurance, it permits medical providers to receive payment directly from the auto insurance company for treating an accident victim.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

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

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

TO ENABLE US TO DETERMINE IF YOUR ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

NAME AND ADDRESS OF APPLICANT*

1. YOUR NAME	2. PHONE NOS. HOME	BUSINESS

3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.

6. DATE AND TIME OF ACCIDENT A.M. P.M.	7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE

8. BRIEF DESCRIPTION OF ACCIDENT

9. DESCRIBE YOUR INJURY

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS, ☐ OR A MOTORCYCLE ☐ A TRUCK, ☐ AN AUTOMOBILE,

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	☐	☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	☐	☐
WERE YOU A PEDESTRIAN?	☐	☐
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	☐	☐
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES ☐ NO ☐

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOUR WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT? ☐ IN-PATIENT? ☐

DATE OF ADMISSION: _____

HOSPITAL'S NAME AND ADDRESS: _____

14. AMOUNT OF HEALTH BILLS TO DATE:	15. WILL YOU HAVE MORE HEALTH TREATMENT(S)?	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
$ _____	YES ☐ NO ☐	YES ☐ NO ☐

17. DID YOU LOSE TIME FROM WORK?	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK?
YES ☐ NO ☐		YES ☐ NO ☐

IF YES, DATE RETURNED TO WORK: _____ AMOUNT OF TIME LOST FROM WORK: _____

18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?

YES ☐ NO ☐

20. LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?

YES ☐ NO ☐

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 FOLLOWING:

	YES	NO
NEW YORK STATE DISABILITY?	☐	☐
WORKERS' COMPENSATION?	☐	☐

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.

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. _____

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) _____

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.

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)