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

Name and Address of Insurer or Self Insurer			Name, Address and Phone Number of Insurer's Claims Representative:	
Date:	Policy Holder:	Policy Number:	Date of Accident:	Claim Number:

TO ENABLE US TO DETERMINE IF YOU 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 copy of any bills you have received to date.

Name and Address of Applicant:			
1. Your Name:	2.Phone No's:	(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		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 Accident **Owner's Name** **Make** **Year** This Vehicle was o A bus or School Bus o Truck o An automobile o A Motorcycle	11. Were you a driver of the Motor Vehicle o Yes o No Were you a passenger in the Motor Vehicle o Yes o No Were you a Pedestrian? o Yes o No Were you a member of policy holder household? o Yes o No Do you or a relative with whom you reside own a Motor Vehicle? o Yes oNo

12. Were you Treated by a doctor (s) or other person (s) furnishing health services? o Yes o No
Name and address of Such doctor(s) or person (s):

13. If you were treated at a hospital (s), Were you an: o Out-Patient? o In-patient?
Date of Admission: Hospital Name and Address:

14. Amount of health Bills to date:	15. Will you have more health Treatment(s)? o yes o No	16. At the time of your accident were you in the course Of you employment? o Yes o No	
17. Did you lose time form work? **o Yes o No**	Date absence from work began:	Have you returned to work? o Yes o No	If yes, date return to work:
Amount of time lost from work?	18. What are your 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 accident? o Yes o No

20. List names and address of your employer and other employers for one year prior to accident date and give

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occupation and date of employment:

Employer and Address: To:	Occupation:	From:
Employer and Address: To:	Occupation:	From:
Employer and Address: To:	Occupation:	From:

21. As a result of you injury have you had any other expenses o Yes o No

22. Due to this accident have you received or are you eligible for payment:
New York State Disability? o Yes o No Worker's Compensation? o Yes o No

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 right of recovery provided for under the No-Fault law.

This form is subscribed and affirmed by the applicant as true under the penal ties of perjury

Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and person who, in connection with such application or claim, 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 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 of 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: _____ **Social Security No.:** _____

(Print or Type)

Signature: _____ **Date:** _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICES OR TREATMENT INFORMATION

This authorization or photocopy thereof, will authorize you to furnish all information you have regarding any condition while under your observation or treatment. Including the history obtained, X-rays and physical finding, diagnosis, prognosis, You are authorized to release information in accordance with eh New York comprehensive motor vehicle insurance reparations act (No-Fault Law)

Name: _____
(Print or Type)

Signature: _____ **Date:** _____

NYS FORM NF-2 (Rev 01/2004) (If applicant is minor, Parent or guardian shall sign and indicate capacity and relationship)

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)

Phoenix Medical Services P.C.

NEW YORK VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM
(FOR ACCIDENTS OCCURRING ON AND AFTER 03/11/2002)

I, _____ I ("Assignor") hereby assign to Phoenix Medical Services PC DBA Rockville Centre Pain Management & Rehabilitation.("Assignee) all rights, privileges and remedies to payment for healthcare 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 prior written agreement to the contrary.
(Print Accident Date)

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

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OF FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE 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 OR THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLE 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 CLAIMS FOR EACH VIOLATION.

_____ _____
(Print the Patient's Name) **(Signature of the Patient)**

_____ _____
(Patient's Address) **(Date of Signature)**

William Jones, MD
165 North Village Ave., Suite 5
Rockville Centre, NY 11570

_____
William B. Jones, MD

(Date of Signature_____

(NYS FORM NF-AOB (REV 1/2004)

PATIENT AUTHORIZATION FOR INSURANCE COMPANY TO RELEASE INSURANCE POLICY TO HEALTH CARE PROVIDER

DATE: _____

I, _____ **hereby authorize**

(Print Patient Name)

_____ **Insurance Company to**

(Insurance Company Name)

Provide a copy of the insurance policy covering me, all Independent Medical Examination reports from the IME physician and peer review reports to my healthcare provider,

_____

(Provider Name)

AT: _____

_____

_____

_____ _____ ___/___/_____

Patient's Name **Patient's Signature** **Date**

This should include all endorsements and cover pages. Thank you in advance for your professional cooperation.

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 _____ (Initials) I authorize _____ (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.**