ORTHOPEDIC ASSOCIATES OF LONG ISLAND

PRECISIONCARE

NO FAULT REGISTRATION

Name (Last, First, MI) _____ Sex M F

Date of Birth _____ Age _____ SS#_____ Occupation _____

Street Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Phone _____ Cell _____ E-mail _____ Marital Status _____

Primary Physician Name: _____ Primary Physician Phone: _____

Pharmacy _____ Address _____ Phone _____

Employer _____ Phone _____

Work Address _____ City _____ State _____ Zip _____

Emergency Contact Name & Phone _____

IS THIS A MANAGED CARE NO-FAULT POLICY? Yes No

Date of accident _____ Time of accident _____ Date symptoms began _____

Location of accident (include town/city, county, and state) _____

Body part(s) injured _____ Did the accident occur while working? **Yes No**

Were you disabled by this accident? **Yes No** If yes, date disability began _____

Insurance company name _____ Phone _____

File # _____ Policy # _____

Was the accident reported to your insurance company? **Yes No** Will we be contacted by an attorney? **Yes No**

PRIMARY INSURANCE (Should No-Fault be denied)

Commercial Insurance Co._____ Phone _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Member ID _____ Group # _____

Subscriber's Name (Last, First, MI) _____

Relationship to Patient _____ SS# _____ Date of Birth _____

Employer _____ Business Phone _____

Employer Address _____ City _____ State _____ Zip _____

Note: In consideration of services rendered or to be rendered to the above-named patient, I hereby authorize and assign payment directly to Dr. _____, provider of healthcare services. I authorize the provider to release all medical information necessary to substantiate a claim. In the event that the provider does not receive payment from the insurance company due to denial for any reason, I understand that I am personally responsible for payment of the provider's charges. I also understand that if I have not yet met my deductible under no-fault, I am fully responsible for payment of such deductible under my policy coverage. In the event that my account goes to collection, I understand that I will be responsible for all collection fees, including the cost of an attorney.

PATIENT SIGNATURE (if minor, parent or guardian) _____ Date_____

(For office use: Checked by: _____ Date: _____ Dr: _____)

ORTHOPEDIC ASSOCIATES OF LONG ISLAND

PRECISIONCARE

INITIAL VISIT HISTORY FORM

Name (Last, First, MI) _____ Sex M F

Date of Birth _____ Age _____ SS#_____ Phone _____

Name of your Primary Care Doctor _____ Phone _____

Referring Physician (if applicable) _____ Phone _____

Reason for today's visit (briefly state history of problem and when symptoms began) _____

_____

Problem due to (check one) _____ car accident _____ work-related injury _____ school injury _____ other

Past Medical History: have you ever had any of the following problems?

Yes / No	Yes / No	Yes / No
___ ___ Stroke	___ ___ Cancer	___ ___ Throid Disease
___ ___ Ulcers	___ ___ Hepatitis	___ ___ Rheumatoid Arthritis
___ ___ Colitis	___ ___ Diabetes	___ ___ High Blood Pressure
___ ___ Asthma	___ ___ Tuberculosis	___ ___Nervous Disorder
___ ___ Lyme Disease	___ ___ Heart Disease	___ ___Bleeding Disorder
___ ___ Arthritis	___ ___ Kidney Stones	___ ___ Endocrine Problems

Please explain any positive responses from above (and any other medical problems not listed) _____

_____

Medications (please attach additional sheet, if necessary) _____

_____

Past surgical history _____

Allergies _____

Review of Symptoms: Are you currently having problems with any of the following?

Yes / No	Yes / No	Yes / No
___ ___ Eyes	___ ___ Psychiatric Problems	___ ___ Digestion / Bowels
___ ___ Ears/Nose/Throat	___ ___ Joint Pain	___ ___ Stomach Burning
___ ___ Lungs / Breathing	___ ___ Immune System	___ ___ Cardiovascular Problems
___ ___ Recent Weight Loss	___ ___ Urinary Problems	___ ___ Bruising / Bleeding
___ ___ Weakness / Fatigue	___ ___ Chest Pain	___ ___ Neurologic Problems

Please explain any positive responses from above (and any other medical problems not listed) _____

_____

Family Medical History: List any medical problems of your relatives (ie. Diabetes, cancer…)

Grandparents _____

Mother _____ Father _____

Siblings _____ Children _____

Social History: Occupation _____ Working currently? Yes / No / Retired

Do you smoke? Yes / No / Quit Packs per day? _____ Years smoked? _____

Do you use alcohol? Never / Occasional / Daily / Heavy / History of alcoholism

History of drug use (please list) _____

Circle one: Married / Single / Divorced / Widowed Do you live alone? Yes / No

Do you exercise / play sports (describe briefly)? _____

Are you on a special diet? Why? _____

(For office use: Checked by: _____ Date: _____ Dr: _____)

ORTHOPEDIC ASSOCIATES OF LONG ISLAND

PRECISIONCARE

ACCEPTANCE OF FINANCIAL RESPONSIBILITY WORKERS COMPENSATION/NO FAULT

Patient: _____

Guarantor: _____

WC/NF Carrier: _____

Private Insurance: _____

In the event that my Workers Compensation/No Fault carrier does not authorize payment to

Dr. _____, you may bill my private insurance carrier for payment.

If my private carrier requires a referral and I do not have one for today's visit, I agree to be responsible for all charges. (You are urged to get a referral to cover this and other visits).

If I do not have private insurance or my private insurance denies this claim, I will be held responsible for any fees for office visits and diagnostic testing.

_____ _____

Patient/Guarantor Date

_____

Witness

ORTHOPEDIC ASSOCIATES OF LONG ISLAND

PRECISIONCARE

FINANCIAL POLICY

Thank you for choosing Orthopedic Associates of Long Island, LLP! We are committed the success of your medical treatment and care. For your convenience, we have answered a variety of commonly asked financial policy questions below. If you have any additional questions about any of these policies, please ask to speak with a Billing Specialist.

Which plans do you contract with?
Your physician/surgeon and their assistant(s) may not be an in-network provider with your health care insurance plan. Please check our website, www.oali.com, to check physician insurance participation and hospital affiliation. If you have any questions, you can contact our billing department to obtain details about your surgery or office visit including the estimated amount of money you may be responsible for paying.

When do I pay?
Payment is expected for all copays at the time of the visit. If you do not have insurance or you are covered by an insurance company with which we do not participate, all fees must be paid at the time of visit. We accept payment by cash, Check, VISA, Mastercard, American Express and Discover.

Do I need a referral?
If you have a managed care plan with which we are contracted, you may need a referral from your primary care physician. If we have not received a referral prior to your arrival at the office, there will be a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled or offered an opportunity to assume financial responsibility for the services provided that day.

What if my child needs to see the physician?
A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account. Any issues of payment resulting from separation or divorce documents must be resolved by the parents. We will hold the accompanying adult responsible for all charges unless specific arrangements have been made.

What is my financial responsibility for services?
Office Visits and Office Services
HMO & PPO plans which have a contract
If the services are covered by the plan: All applicable copays are due at the time of the office visit. We ask for immediate payment as soon as any deductible is known. If the services you receive are not covered by the plan: Payment is expected in full at the time of the visit. You will be asked to sign a statement authorizing these services.

HMO with which we are not contracted
Payment in full for office visits, x-rays, injections, and all other charges is expected at the time of the office visit. We will provide the necessary information for you to complete and file your claim directly with the insurance company.

Point of Service Plan or Out of Network PPO
Payment for the copay and non-covered services is expected at the time of visit. We will file an insurance claim on your behalf. Coinsurance and deductibles will be billed after we receive payment from your carrier. All balances due will be payable upon receipt of our statement.

Medicare (also Medicare HMO Plans)
We will file the claim on your behalf, as well as any claims to your secondary insurance. Payment for copays or any Services not covered by Medicare must be paid at the time of the visit. If you have regular Medicare as primary, and also have secondary insurance, copay will be collected depending on secondary plan. If you have regular Medicare as primary, but no secondary insurance, payment of your 20% coinsurance will be collected at the time of the visit. If Medicare is secondary, you will be billed for any patient responsibility after both insurances have processed.

ORTHOPEDIC ASSOCIATES OF LONG ISLAND

PRECISIONCARE

FINANCIAL POLICY (cont'd)

Worker's Compensation
Prior to your visit, you will need to provide the accident date, claim number, employer information and insurance carrier information. If we have verified the claim with your carrier, no payment is necessary at the time of the visit. Please remember that if the claim is denied, the responsibility for the bill will be yours and payable at our usual and customary fees.

Worker's Compensation (Out of State)
Payment in full is requested at the time of then visit. We will provide you a receipt so you can file the claim with your carrier.

Automobile No-Fault Insurance
Prior to your visit, you will need to provide the accident date, claim number and the insurance carrier information.
If the No Fault policy is not in your name, we will need full information on the policyholder.
If we have verified the claim with the carrier, no payment is necessary at the time of the visit. Please remember that if the claim is denied, the responsibility for the bill will be yours and is payable at our usual and customary fees. **If a referral is needed from your private carrier, you must obtain one in the event that your no-fault carrier denies your claim.**

Commercial Insurance: Also known as indemnity, "regular" insurance, or has a percentage coverage (eg. "80/20% coverage".) We will file a claim to your insurance company as a courtesy. In the event of a denial of any part of the claim, you will need to pay this bill and deal with your insurance carrier directly.

School Insurance: You must submit the original form from the school's carrier. Please bring a copy of the form with you. If you do not have any other insurance, we will bill the school insurance directly. If you have other insurance, the school insurance is secondary and while we will file the claim with your school carrier, you are responsible for payment.

No Insurance (Self Pay)
Payment in full is due at the time of the visit. We will work with you to settle your account. Please ask to speak with our staff if you need assistance.

SURGERY
If your physician recommends surgery, you will have the opportunity to speak with his executive assistant. She will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it. If you have a commercial plan or are self-pay, she may request a pre-surgical deposit.

Updated 8/1/19

Patient Name_____ Date of Birth_____

Signature _____ Date_____

(8/1/19)

ORTHOPEDIC ASSOCIATES OF LONG ISLAND

Patient Authorization, Assignment of Benefits & Financial Agreement

Patient Name_____ Date of Birth_____ Effective Date: 08/01/2019

I acknowledge and understand that by signing below, I hereby authorize payment directly to ORTHOPEDIC ASSOCIATES OF LONG ISLAND/PRECISIONCARE, 6 TECHNOLOGY DRIVE, SUITE 100 EAST SETAUKET, NY 11733 www.OALI.com for services rendered to me, as specified more fully below.

1. MEDICARE:

- I authorize my Medicare benefits to be paid to the Practice for services furnished to me by the Practice.
- I authorize the Practice to release to the Centers for Medicare and Medicaid Services ("CMS" or "Medicare") and its agents any information needed to determine my Medicare benefits or the benefits payable for related services.
- I authorize the release of medical information necessary to complete any insurance claim forms and to pay the claim.
- The Practice accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for any deductible and/or coinsurance payment and payment for any non-covered services. Coinsurance and deductibles for covered services will be based upon the charge determination of the Medicare carrier.
- I authorize the release of my information to any MediGap or other health insurance carrier I maintain and authorize payment of these secondary insurance benefits to be made on my behalf to the Practice, if possible.
- My authorization will remain in effect unless I revoke my authorization in writing.

2. OTHER INSURANCE PLAN PARTICIPATION: The Practice maintains a list of its contracts with health care service plans ("Plans"), which identifies the Practice physicians who participate in each Plan. A copy of the current list is available from the Practice at the address, telephone number and/or website listed above.

- I have been informed whether any services rendered to me by the Practice may be provided by a non-participating provider and, if so, (i) that such services by a non-participating provider may result in costs not covered by the Plan and (ii) I am individually obligated to pay the full charges for all such services.
- I understand that the Practice has no contract, expressed or implied, with any Plan that does not appear on the list.
- I have been informed that I am individually obligated to pay the full charges for all services rendered to me by the Practice if my Plan does not appear on the list of Plans maintained by the Practice.

3. **NON-COVERED SERVICES**: I understand that each Plan (*i.e.*, HMOs, PPOs) defines what items and services are covered and what items and services are not covered by the Plan.

- I understand that I will receive an Advanced Beneficiary Notice ("ABN") from the Practice for services that are not or may not be covered by my Plan, and that I will be given the option to accept or decline any non-covered services.
- I accept full financial responsibility for payment for any potentially non-covered services that I have accepted, as reflected on the ABN, if my Plan determines that such service is not covered. Examples of non-covered services include, but are not limited to, services not specified as being covered by a Plan, services not listed in the benefit summary furnished to patients by the Plan, and/or treatment or tests not authorized by the Plan.
- I agree to cooperate with the Practice to obtain all necessary authorizations required by my Plan.

4. **RELEASE OF INFORMATION**:

- I understand that the Practice may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, (1) to any person or corporation that is or may be liable or under contract to the Practice for reimbursement for services rendered, and/or (2) to any health care provider for continued patient care.
- I understand that the Practice may also disclose on an anonymous basis any information concerning my care that is necessary or appropriate for the advancement of medical science, medical education, medical research, and/or for the collection of statistical data or pursuant to State or Federal law.

5. FINANCIAL AGREEMENT:

- In return for the services provided to me by the Practice, I will pay my account at the time service is rendered to me or will make financial arrangements satisfactory to the Practice for payment.
- If my account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action.
- If my account is delinquent, I may be charged interest at the legal rate. I assign to the Practice any benefits of any type under any policy of insurance that insures me or any other party liable to me.
- If my insurance company or Plan designates copayments and/or deductibles, I will pay such copayment and/or deductible amounts to the Practice.
- ***I agree to be primarily responsible for the payment of the Practice's bill.***

_____ _____

Beneficiary Signature or Authorized Party Date

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
(This form is not 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 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. 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)

FROM: _____ THROUGH: _____

13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON:

_____
(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
			C-PMR-PM

*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)