MOTOR VEHICLE/NO-FAULT ACCIDENT INTAKE FORM

CARRIER INFORMATION

Insurance Carrier Name: ______________________ Carrier Phone #: ______________________

Address: ____

Policy #: ______________ Claim #: ______________ Date of Accident: ______________

NO-FAULT AUTHORIZATION TO PAY

I authorize payment of health benefits to LAKE SHORE CHIROPRACTIC CENTER I retain all rights, privileges and remedies to which I am entitled under Article 51 (the No-Fault provision) of the insurance law.

Date: ______________ Signature: ______________________

Date: ______________ Provider's Signature: ______________________

INJURY INFORMATION

Was accident reported to your carrier? □ yes □ no Have you filed an application for NF benefits with the carrier? □ yes □ no

Were you the driver of the vehicle or a passenger? ______________________

How did accident happen?

____

____

Have you lost time from work? □ yes □ no How much? ______________

Have you seen another physician for this condition? □ yes □ no Doctor's name: ______________________

Were x-rays taken? □ yes □ no Other tests? □ yes □ no If yes, please list test and facility where taken:

____

Do you have any previous motor vehicle related injuries? □ yes □ no If yes, please explain:

____

____

ATTORNEY INFORMATION

Attorney's name: ______________________ Phone #: ______________

Address: ____

May we contact your Attorney regarding your case? □ yes □ no

AUTHORIZATION

I, the undersigned, certify that the information given above is correct. I clearly understand and agree that all services rendered to me that are not covered, are charged directly to me, that I am personally responsible for payment in the event that my claim for No Fault benefits is denied.

Patient's Signature______________________ Date______________

Please note: In this instance, we will attempt to bill any back-up insurance you may have prior to billing you directly.

Have you had an independent medical exam for this date of injury?

Yes No

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

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

I, ______________________ (Print patient's name), ("Assignor") hereby assign to ______________________ (Print hospital or health care provider name), ("Assignee") 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 ______________ (Print accident date), not withstanding 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.

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)

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(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)