SPINE & SPORTS
REHABILITATION
PAIN MANAGEMENT

First Name: _____ M.I. _____ Last Name: _____

DOB: ___/___/___ SSN: _____ Marital Status: _____ Gender:_____

Home Address and Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Email Address: _____ How did you hear about our office? _____

Insurance Information

Insurance Company: _____

Adjuster's Name and Phone Number: _____

Insurance Company's Address: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Claim #: _____ Policy #: _____ DOA: _____

Attorney's Name and Phone Number: _____

Brief Description of Accident: _____

_____

_____

Other Information

Emergency Contact: _____ Phone #: _____ Relationship: _____

Pharmacy Name/Address: _____ Pharmacy Phone: _____

Do you have Advanced Directives? ("Living Will", etc.,) Yes___ No___ I have no idea what that means ___

SPINE & SPORTS REHABILITATION
PAIN MANAGEMENT

Chief Complaint

Describe the reason for your visit: _____
_____
_____

When did your symptoms begin? (select one)

_____Today
_____This week
_____Within last 3 months
_____ 3 months to 6 months
_____ 6 months to one year
_____ More than one year

For Women Only: Most recent menstrual cycle: _____

Are you pregnant? Y N

Which word describes the frequency of your discomfort? (select one)

_____ Constant
_____ Occasional
_____ Intermittent
_____ Rare

Which phrases best describe changes in your discomfort during the day?

_____ It is worse in the morning
_____ It is worse in the afternoon
_____ It is worse at night
_____ changes with weather
_____ doesn't change

What helps relieve your discomfort?

_____ Ice _____ Heat _____ Medication
_____ Other (please describe): _____

What activities are limited by your discomfort?

_____Bending _____ BM _____ Coughing _____ Daily Routine
_____ Driving _____ Getting Up _____Lifting _____ Lying Down
_____ Pulling _____ Pushing _____ Reading _____ Sitting
_____ Sleeping _____ Sneezing _____ Standing _____ Turning head
_____ Urination _____ Walking _____Working _____ Other

Where applicable, specify the approximate date of your most recent:

Physical Exam: _____ Dental X-Rays: _____
Spinal X-Ray: _____ CT Scan: _____
MRI: _____ Other Scans/X-Rays: _____

SPINE & SPORTS REHABILITATION
PAIN MANAGEMENT

Patient Name: _____ Date: _____

Health Questionnaire

Do you have an Advance Directive? Y N
Are you a victim of violence or abuse? Y N
Had a flu shot this year? Y N
Had a pneumonia shot? Y N
Name of Primary Care Provider:_____
Have you or members of your family recently been hospitalized for any reason? Y N
PLEASE INDICATE BELOW, ARE YOU CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS:

General
Good general health: Y N
Recent weight change: Y N
Fever: Y N
Fatigue: Y N

Eyes and Vision
Eye disease or injury: Y N
Wear glasses/contacts: Y N
Blurred/Double vision: Y N
Glaucoma: Y N

Ears, Nose, Throat
Hearing Loss: Y N
Ringing in ears: Y N
Earaches or drainage: Y N
Sinus problems: Y N
Nose bleeds: Y N
Mouth sores: Y N
Bleeding gums: Y N
Bad breath/taste: Y N
Sore throat/ voice change: Y N
Swollen Glands: Y N

Heart and Cardiovascular
Heart trouble: Y N
Chest pains: Y N
Sudden heartbeat changes: Y N
Swelling of extremities: Y N

Respiratory
Frequent coughing: Y N
Spitting up blood: Y N
Shortness of breath: Y N
Asthma or wheezing: Y N

Gastrointestinal
Loss of appetite: Y N
Change in BM's: Y N
Nausea or vomiting: Y N
Frequent diarrhea: Y N
Painful BM's or constipation: Y N
Blood in stool: Y N
Stomach pain: Y N

Genitourinary
Frequent urination: Y N
Burning or painful urination: Y N
Blood in urine: Y N
Change in force/strain: Y N
Incontinence or dribbling: Y N
Kidney stones: Y N
Sexual difficulty: Y N
Painful/irregular periods: Y N

Musculoskeletal
Joint pain: Y N
Joint stiffness/swelling: Y N
Weakness of muscles/joints: Y N
Back pain: Y N
Cold extremities: Y N
Difficulty walking: Y N

Skin and Breasts
Rash or itching: Y N
Change in skin color: Y N
Change in hair or nails: Y N
Varicose veins: Y N
Breast pain: Y N
Breast lump: Y N
Breast discharge: Y N

Neurological
Frequent/recurrent headaches: Y N
Light headed or dizzy: Y N
Convulsions or seizures: Y N
Numbness or tingling: Y N
Tremors: Y N
Paralysis: Y N
Stroke: Y N
Head Injury: Y N

Psychiatric
Memory loss or confusion: Y N
Nervousness: Y N
Depression: Y N
Sleep problems: Y N

Endocrine
Glandular: Y N
Thyroid disease: Y N
Diabetes: Y N
Excessive thirst/urination: Y N
Heat or cold intolerance: Y N
Dry skin: Y N
Change in hat or glove size: Y N

Hematologic/Lymphatic
Slow to heal after cuts: Y N
Easily bruise or bleed: Y N
Anemia: Y N
Phlebitis: Y N
Transfusion: Y N
Swollen glands: Y N

Last menstrual period: _____

Patient Signature: _____

SPINE & SPORTS
REHABILITATION
PAIN MANAGEMENT

HIPAA CONSENT FORM

This is my authorization to allow VERBAL discussion of my condition, care, reminders of appointment times, test results, or other medical information regarding the following patient:

- Me
- My child or ward, name: _____
- Other: _____

The following are **AUTHORIZED** to receive the patient's protected health information:

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____
4. _____ Relationship: _____

I have received today, or at a previous visit, a copy of the HIPAA "Notice of Privacy Practice": Y___ N___

Printed Name: _____ Date: _____

Patient/ Parent/ Legal Guardian Signature: _____

(This form can be updated at any time by request of patient. Our office will ask you to update this form on a yearly basis.)

Authorization for Treatment, Release of information, Assignment of Benefits & Acknowledgement of Receipt of Notice of Privacy Practices, Financial Policy and/or Medicare Financial Responsibility Disclosure Release of Information & Consent for Treatment

PATIENT NAME:_____ DATE OF BIRTH:_____

Release of Information & Consent for Treatment

All information provided herein is true and correct. I am aware of my diagnosis and wish to receive treatment from **Spine and Sports Rehabilitation Pain Management** and permit its employees and all other persons caring for me to treatment they judge are beneficial to me. I consent to services and I understand, acknowledge and affirm that services may involve bodily contact and/or direct contact of a sensitive nature. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to **Spine and Sports Rehabilitation Pain Management** to release information, verbal and written, contained in my medical record, and other released information, to my insurance company, rehab curse, case manager, attorney, employer, school, related health care provider, assignees and/or beneficiaries, and all other relented person's as it relates to my treatment and/or payment for services provided. I authorize **Spine and Sports Rehabilitation Pain Management** to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment the signature below certifies that I have read and understand the above information.

Initial_____

Assignment of Benefits

I authorize payment directly to **Spine and Sports Rehabilitation Pain Management** for services and to bill and release payment directly to **Spine and Sports Rehabilitation Pain Management** for any services provided, this is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Initial_____

Notice of Privacy Practices (HIPAA Acknowledgment/Consent)

I hereby acknowledge that I have been given the opportunity to receive and/or review the office Notice of Privacy Practices. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and healthcare operations.

Initial_____

Payment Guarantee

I agree to pay **Spine and Sports Rehabilitation Pain Management** for the services provided to me or the party named above, if any law, such as Worker's Compensation, or insurance contract prohibits payment for these services, I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer, where the law or insurance contract does not prohibit payment by me, I acknowledge responsibility for all account balances. The Intake Verification of Benefits Form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage, I will be responsible for payment of services. I understand that my good faith payment may not be inclusive of all payments for which I am responsible, and I may be billed for any remaining balance. I further understand that this agreement is binding regardless of any legal transaction currently progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of **Spine and Sports Rehabilitation Pain Management**.

Initial_____

Financial Policy and/or Medicare Financial Responsibility Disclosure (Acknowledgment)

I hereby acknowledge that I have received a copy of the Financial Policy and/or Medicare Financial Responsibility.

Initial_____

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 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

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

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 OCCURING AFTER 3/1/02)

I,_____ ("Assignor") hereby assign to **Aubrey Wilson Massage Therapist, P.C.** ("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 _____, 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 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 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, KNOWING MAKES OR KNOWING ASSISTS, ABETS SOLICITES 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 BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

_____ _____ _____

(Patient's Name) (Signature of Patient) (Date)

_____

_____

(Patient's Address)

Aubrey Wilson Massage Therapist, P.C.

(Name of Provider)

_____ _____

(Signature of Provider) (Date)

1717 Veterans Memorial Highway Suite 1
Islandia, NY 11749

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS-FORM
(FOR ACCIDENTS OCCURING AFTER 3/1/02)

I,_____ ("Assignor") hereby assign to **Jordan Sudberg MD, PC** ("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 _____, 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 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 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, KNOWING MAKES OR KNOWING ASSISTS, ABETS SOLICITES 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 BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

_____ _____ _____

(Patient's Name) (Signature of Patient) (Date)

_____

_____

(Patient's Address)

Jordan Sudberg MD, PC
(Name of Provider)

_____ _____

(Signature of Provider) (Date)

1717 Veterans Memorial Highway Suite 1
Islandia, NY 11749

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS-FORM
(FOR ACCIDENTS OCCURING AFTER 3/1/02)

I,_____ ("Assignor") hereby assign to **Forget Me Not Acupuncture, P.C.** ("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 _____, 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 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 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, KNOWING MAKES OR KNOWING ASSISTS, ABETS SOLICITES 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 BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

_____ _____ _____

(Patient's Name) (Signature of Patient) (Date)

_____

_____

(Patient's Address)

Forget Me Not Acupuncture, P.C.
(Name of Provider)

_____ _____

(Signature of Provider) (Date)

1717 Veterans Memorial Highway Suite 1
Islandia, NY 11749

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS-FORM
(FOR ACCIDENTS OCCURING AFTER 3/1/02)

I,_____ ("Assignor") hereby assign to **David L. Shapiro, DC** ("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 _____, 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 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 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, KNOWING MAKES OR KNOWING ASSISTS, ABETS SOLICITES 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 BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

_____ _____ _____

(Patient's Name) (Signature of Patient) (Date)

_____

_____

(Patient's Address)

David L. Shapiro, DC

_____ _____

(Signature of Provider) (Date)

1717 Veterans Memorial Highway Suite 1
Islandia, NY 11749