First Name: _____ Last Name: _____

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

Complete Address: _____

Mailing Address (if different): _____

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

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

Occupation: _____ Employer (if this is an insurance case): _____

NO FAULT – VEHICLE INSURANCE INFORMATION

Insurance Company: _____ Policy Number: _____

Insurance Company Address: _____

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

Relationship to Patient: _____ Policy Holder SSN: _____

Adjuster's Name: _____ Phone: _____

Claim #: _____ Date of Accident: _____

Attorney's Name (if applicable): _____ Phone: _____

Brief Description of Accident/Injury: _____

_____

_____

EMERGENCY CONTACT

Name: _____ Phone: _____ Relationship: _____

PHARMACY INFORMATION

Name/Address: _____ Phone: _____

CHIEF COMPLAINT

Describe the reason for your visit: _____

_____

When did your symptoms begin? (select one)

_____Today _____This week _____ 3 months to 6 months

_____Within last 3 months _____ 6 months to one year _____ More than one year

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

_____ Constant _____ Occasional _____ Rare

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

_____ Worse in the morning _____ Worse at night _____ Doesn't change

Please check which issues affect you **currently**: Current pain scale (**0 being pain free, 10 worst pain imaginable**)

Part of the body you have issues with	**Pain**	**Stiffness**	**Weakness**	**Difficulty of movement**	**Numbness and/or tingling**	**Other**
Head						
Neck						
Shoulders						
Upper Arms (left or right)						
Elbow (left or right)						
Forearms (left or right)						
Hands (left or right)						
Upper Back						
Mid Back						
Lower Back						
Hips (left or right)						
Upper Legs (left or right)						
Knees (left or right)						
Lower Legs (left or right)						
Ankles (left or right)						
Feet (left or right)						
Toes- please indicate which toes (left or right)						

What helps relieve your discomfort?

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

What activities are limited by your discomfort? (check all that apply)

_____ Bending	_____ BM/Urination	_____ Walking	_____ Daily Routine
_____ Driving	_____ Getting Up	_____ Lifting	_____ Reading
_____ Pushing/Pulling	_____ Standing	_____ Working	_____ Sitting
_____ Sleeping	_____ Exercising	_____ Turning Head	_____ Other

MEDICAL HISTORY

Are you currently pregnant? ___Yes ___ No ___N/A

Are you currently taking any blood thinners? ___Yes ___ No If yes, what? _____

Please list additional medications you may be taking:

Medication: _____ Condition: _____
Medication: _____ Condition: _____
Medication: _____ Condition: _____

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

Spinal X-Ray: _____ CT Scan: _____

MRI: _____ Other Scans/X-Rays: _____

SIGNATURE: _____ DATE: _____

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

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review carefully.

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluation of your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical records to all health to all health professionals, who may provide treatment or who maybe consulted by staff members.

Payments: Your health information may be used to seek payment for your health plan, form other sources of coverage, such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of our facility. For example, information on the service you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality. We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you to provide appointment reminders or information about treat alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Individual Rights: You have certain rights under Federal Privacy Standards. These include:

- The Right to request restrictions on the use and disclosure of your protected health information.
- The Right to receive confidential communications concerning your medical condition and treatment.
- The Right to inspect and copy your protected health information.
- The Right to receive an accounting of how and to whom your reported health information has been disclosed.
- The Right to receive a printed copy of this notice.

Our Facility: By law, we are required to maintain the privacy of your protected health information and to provide you with this notice of Privacy Practice.

This notice is effective as of May 1st, 2021, and we are required to abide by the terms of the notice of Privacy Practice currently in effect. We reserve the right to change the terms of our notice of Privacy Practice and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of the revised notice of Privacy Practice from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or with Department of Health and Human Services, Office of Civil Rights about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filling a complaint.

Please contact us for more information:

Lauren Falco, Director of Operations

1717 Veterans Memorial Highway

Islandia, New York 11749

For more information about HIPPA, or to file a complaint:

US Department of Health and Human Services
Office of Civil Rights
200 Independence Ave. SW
Washington D.C., 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Patient Name Printed: _____

Patient or Guardian Signature: _____

Date: _____

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/or Jordan Sudberg MD PC and permit its employees and all other treatment providers to treat me as they deem beneficial to my condition. I consent to services, 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 multiple treatment modalities. No guarantees have been made to me about the outcome of this care.

I give permission to Spine and Sports Rehabilitation Pain Management and/or Jordan Sudberg MD PC to release information, verbal and written, contained in my medical record, 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 and/or Jordan Sudberg MD PC to obtain medical records from other medical professionals/providers as it relates to my treatment.

Initial_____

This is my authorization to allow VERBAL discussion of my condition, care, or appointment reminders to the following:

1. _____ Relationship: _____ Phone: _____
2. _____ Relationship: _____ Phone: _____

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. I have been made aware that the Notice of Privacy Practices is also posted in the lobby for my review. 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_____

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

1. _____ Relationship: _____ Phone: _____
2. _____ Relationship: _____ Phone: _____

Payment Guarantee

I agree to pay Spine and Sports Rehabilitation Pain Management and/or Jordan Sudberg MD PC for the services provided to me or any party, such as Worker's Compensation, or insurance contracts that prohibit payment for 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 a third-party payer. Verification of Benefits Form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage, I acknowledge responsibility for payment of all 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 and/or Jordan Sudberg MD PC.

Initial_____

SIGNATURE: _____ DATE: _____

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

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)	13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON:
FROM: _____ THROUGH: _____	_____ (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.

ASSIGNMENT OF BENEFITS

Dear Patients,

As a patient of Jordan Sudberg MD P.C. and/or Spine and Sports Rehabilitation Pain Management, we can accept your insurance for services performed. We will submit a claim for your treatment to your insurance company. While we are happy to provide this billing service to our patients, we do need your cooperation. By signing the assignment and release section below, you are authorizing your insurance company to send their payment directly to us instead of yourself. Should an insurance company send you a reimbursement check directly to you for services rendered here, you agree to send to us immediately after endorsing the back of the check as follows:

ENDORSEMENT: Pay to the order of:
Jordan Sudberg MD PC

Checks may be mailed to:
1717 Veterans Memorial Highway, Suite 1
Islandia, NY 11749

ASSIGNMENT and RELEASE: I hereby assign to the health care provider indicated above all rights, privilege, and remedies to payment for health care service provided by the assignee to which I am entitled under insurance law.

The assignee hereby certifies that they have not received any payment for or on behalf of the assignor (patient) and shall not pursue payment directly from the assignor (patient) for the services provided by said assignee. Notwithstanding any prior written agreement to the contrary, this agreement may be revoked by the assignee when benefits are not payable based upon the assignor's (patient) lack of coverage and / or violation of a policy condition due to the actions or conduct of the assignor (patient). I also authorize the release of any medical or other information necessary to process my claims.

Patient Name Printed: _____

Patient or Guardian Signature: _____

Date: _____

AOB

New York Motor Vehicle No-Fault Insurance Law
Assignment of Benefits Form

Claim Number:_____

I, _____,("Assignor") hereby assign to Love Galaxy Acupuncture 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 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 TFOR TEH PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSIST, 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)

Patient signature:

(address of patient)

Morgan Joaquin Sears L.Ac OMD

(print name of provider)

1717 Veterans Hwy, Islandia, NY 11749

(address of provider)

Provider Signature:

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 **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