

**MEDICAL HISTORY / SUBJECTIVE INFORMATION**

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_

Was a prescription given to the front desk?      Y      N

Referring Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Condition to be treated: \_\_\_\_\_ Date Condition Began: \_\_\_\_\_

(Please check all that apply)

- |  |                                       |  |                                       |
|--|---------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes     | <input type="checkbox"/> High Blood Pressure                     | <input type="checkbox"/> Pacemaker    |
| <input type="checkbox"/> Cancer        | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Visual Impaired                         | <input type="checkbox"/> Epilepsy     |
| <input type="checkbox"/> HIV /AIDS     | <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Hearing Impaired                        | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Stroke        | <input type="checkbox"/> Asthma       | <input type="checkbox"/> Latex Allergy                           | <input type="checkbox"/> Scoliosis    |
| <input type="checkbox"/> Osteoporosis  | <input type="checkbox"/> Hepatitis    | <input type="checkbox"/> Other (if checked please explain _____) |                                       |

Therapist's comments: \_\_\_\_\_

Have you had surgery for your condition?      Y      N      If yes, date: \_\_\_\_\_

Is condition related to Auto Accident?      Y      N      If yes, date: \_\_\_\_\_

Is condition related to non-work accident?      Y      N      If yes, date: \_\_\_\_\_

Is condition related to work accident?      Y      N      If yes, date: \_\_\_\_\_

Have you had any injections for your condition? Y      N      If yes, date: \_\_\_\_\_

Please list any diagnostic tests you have had for this condition: \_\_\_\_\_

Please list any medications that you are taking: \_\_\_\_\_

What are your current symptoms? \_\_\_\_\_

How the injury or problem occurred? \_\_\_\_\_

Please rate your pain using a 0 – 10 scale (0 = no pain, 10 = the worst pain you can imagine)

Worst pain since onset: \_\_\_\_\_ Best pain since onset: \_\_\_\_\_ Today's pain: \_\_\_\_\_

Where is your pain or problem located? \_\_\_\_\_

Is your pain?      Constant      Intermittent      Dull      Sharp      Other \_\_\_\_\_

What makes your pain / problem better? \_\_\_\_\_ Worse? \_\_\_\_\_

Is there pain present at night?      Y      N      What position helps you to sleep? \_\_\_\_\_

Have you had PT for this condition?      Y      N      If Yes Where? \_\_\_\_\_

Have you had chiropractic services      Y      N      If Yes Where? \_\_\_\_\_  
for this condition?

Therapist's Comments: \_\_\_\_\_  
\_\_\_\_\_

Employment History:

Are you currently working?      Y      N      If no, how many total days of work have you missed? \_\_\_\_\_

Are your work duties?    Full    Restricted      How many hours per week do you work? \_\_\_\_\_

Who is your employer? \_\_\_\_\_

What type of work do you do? \_\_\_\_\_

What activities in your daily life or work duties have been most affected by your problem? \_\_\_\_\_  
\_\_\_\_\_

What do you hope to accomplish with therapy? \_\_\_\_\_  
\_\_\_\_\_

Are you exercising at home?      Y      N      If yes, what type? \_\_\_\_\_

Are you using heat or cold?      Y      N      If yes, what type? \_\_\_\_\_

Are you wearing a sling or brace?      Y      N      If yes, what type? \_\_\_\_\_

Do you smoke?      Y      N      If yes, how much? \_\_\_\_\_

What type of non-work activities are you involved in? \_\_\_\_\_

When are you scheduled to see your doctor again? \_\_\_\_\_ .

Therapist's comments: \_\_\_\_\_  
\_\_\_\_\_

Therapist Signature: \_\_\_\_\_

To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy services at SPEAR Physical Therapy, LLC

I have received a copy of The Patient/Client Rights and Responsibilities Information Sheet.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## AUTHORIZATIONS & ACKNOWLEDGEMENTS

**TREATMENT AUTHORIZATION:** I authorize Physical Therapy treatment of myself or my minor child by the therapists and staff at S.P.E.A.R. Physical Therapy, PLLC.

**INFORMED CONSENT:** The term “informed consent” means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me.

The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Physical therapy involves the use of many different types of physical evaluation and treatment. At S.P.E.A.R. Physical Therapy, PLLC, we use a variety of procedures and modalities to help us to try to improve your level of function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy. Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions. You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time before or during your treatment session. Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them. If I do not wish to participate in the therapy and/or exercise program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

**REFERRAL AUTHORIZATION:** Your insurance carrier may require a referral from your primary care physician for our services. Please be aware that it is your responsibility to obtain all necessary referrals prior to therapy. If your insurance carrier required an authorization for service, no service will be rendered until the authorization is obtained. Furthermore, we may be required to contact your doctor for a treatment order referral for services.

**CANCELLATION AND/OR NO-SHOW POLICY:** S.P.E.A.R. Physical Therapy, PLLC urges you to keep every appointment, as consistent treatment will expedite your recovery. In the event you need to cancel an appointment, we require at least 24 hours notice, excluding Saturday and Sunday. Patients who cancel without proper notice or fail to show for a scheduled appointment will be subject to a \$40.00\_\_\_\_\_ charge for each occurrence. Arrival more than 15 minutes after the time of your scheduled appointment may be considered a failed appointment.

**ASSIGNMENT OF BENEFITS:** I authorize payment of my Medicare and/or Insurance benefits to be made directly to S.P.E.A.R. Physical Therapy, PLLC on my behalf for physical therapy services rendered. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me, I will endorse such payments to S.P.E.A.R. Physical Therapy, PLLC within five (5) days of receipt of such payment.

**FINANCIAL/INSURANCE RESPONSIBILITY FOR ALL S.P.E.A.R. PHYSICAL THERAPY, PLLC SERVICES:** I understand and agree to the following policies regarding financial and insurance responsibilities. Payment is required at or before each visit. I am responsible for charges incurred for all treatment rendered. This responsibility includes co-pay, co-insurance, deductible amounts, non-covered and excluded items not paid for by my insurance carrier or other party responsible for coverage of my medical expenses. I agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary. I further understand, S.P.E.A.R. Physical Therapy LLC will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for S.P.E.A.R. Physical Therapy LLC to take action to secure payment of an outstanding balance owed.

**FURTHER NOTICES AS TO POLICIES REGARDING MEDICARE:** S.P.E.A.R. Physical Therapy LLC is a participating provider of Medicare; as such we will handle all billing to Medicare and any secondary insurance. Medicare requires you to satisfy a yearly deductible before they will begin paying benefits. Medicare will deduct the deductible amount from the first claim they receive each calendar year. Unless you have satisfied your annual deductible with another Medicare provider's office you are responsible to pay your deductible to S.P.E.A.R. Physical Therapy LLC. After your deductible is satisfied Medicare will reimburse us 80% of their standard fee for Physical Therapy services. Therefore your payment responsibility is 20% of the standard Medicare fee for Physical Therapy. Medicare has a financial allowance (\$1,880 for 2012) for Out Patient Physical Therapy Services, which will cover you for approximately 15 treatments per year there are two exceptions to this financial limit 1) you may choose to obtain your outpatient services at a hospital once you reach the \$1,880 or 2) in certain circumstances, Medicare may grant a waiver of this limit based on specific criteria which we will detail after your initial evaluation. Therefore, unless you qualify for the Medicare or have additional insurance coverage you will be responsible for payment of any treatments in excess of the Medicare allowance.

In addition, I understand that, in certain circumstances, Medicare may find that physical therapy services are not "reasonable and/or medically necessary" for the illness, injury or condition for which I am seeking treatment. I understand that Medicare bases this ruling on the diagnosis provided by my physician and their standards for that diagnosis. I understand, in this case, I will be responsible for any and all charged incurred.

**NO GUARANTEES:** I recognize that the practice of physical therapy is as much an art as a science, and therefore acknowledge that no guaranties have been or can be made regarding the likelihood of success or outcome of any therapy rendered at S.P.E.A.R. Physical Therapy, PLLC

**REVOCATION OF AUTHORIZATIONS:** These authorizations may be revoked by me, in writing, at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

**PATIENT ACKNOWLEDGMENT:** I certify that the information I provide to my doctors, therapists and insurance company is correct. I certify that I am here to receive medical care and for no other purpose. I do not represent any third party.

By signing and dating this form I acknowledge I have discussed, or have had the opportunity to discuss, with my therapist the nature and purpose of Physical Therapy treatment in general and my treatment in particular (including my Individualized Plan of Care) as well as the contents of these Acknowledgements and Authorizations.

I consent to the Physical Therapy treatments offered or recommended to me by my Doctor and/or Physical Therapist. I intend this consent to apply to all my present and future Physical Therapy care.

Patient's Signature	Date
Print Name	



# **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

My signature below indicates that I have been given the Notice of Privacy Practices for SPEAR Physical Therapy, LLC. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to SPEAR Physical Therapy, LLC to release any of my protected healthcare information.

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Patient's or Authorized Representative's Printed Name & Date

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Patient's or Authorized Representative's Signature



## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE FEEL FREE TO SPEAK TO YOUR THERAPIST, HIS/HER DESIGNEE OR THE HIPAA PRIVACY OFFICER.

S.P.E.A.R. Physical Therapy, PLLC is committed to maintaining and protecting the confidentiality of your personal information. This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It will inform you about the ways in which we may use and disclose your health information, and the safeguards we have put into place to protect it. It also describes your rights and certain obligations we have regarding the use and disclosure of your health information.

### OUR DUTIES TO YOU REGARDING YOUR PROTECTED HEALTH INFORMATION

“Protected Health Information” is individually identifiable health information expressed in the form of oral, written or electronic communications. This information includes demographic information such as your age, address, email address, and other information that relates to your past, present or future health condition and related healthcare services. S.P.E.A.R. Physical Therapy, PLLC is required by law to:

- Make sure your health information is kept private.
- Give you this notice of our legal duties and privacy practices related to the use and disclosure of your protected health information.
- Follow the terms of the notice currently in effect.
- Communicate any changes in this notice to you.

### GOVERNMENTAL PRIVACY LAWS AND REGULATIONS

There are several other federal, state and city privacy laws that provide stronger restrictions about the use and disclosure of health information. The stricter laws have been taken into consideration in developing our policies and this notice of how we will use and disclose your protected health information.

### HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

The following categories describe different ways that we use and disclose your health information. We will not use your confidential information or disclose it to others without your authorization, except for the following purposes:

**Treatment.** We may use and/or disclose your confidential health information to provide you with treatment and/or services. This includes your therapist’s recommendation(s), and those of other professionals/paraprofessionals including clerical, coordination and management staff.

**Payment.** Your protected health information will be used, as needed, to bill and collect payment for treatment and services provided to you. We may share information about a treatment and/or service you may receive to your health insurer to receive approval for payment.

**Health Care Operations.** We may use and disclose health information about you for regular health care operations. The medical staff in this practice will use your health information to assess the care you received and the outcome of your case compared to others like it. Your information may be reviewed for risk management or quality assessment/improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

We will share your protected health information with third-party “business associates” who perform various activities for the practice. The business associates will also be required to protect your health information.

We may remove information that identifies you from this set of health information so others may use it to study health care and health care delivery without learning your identity.

**Appointment Reminders.** We may use and disclose health information to contact you as a reminder that you have an appointment for treatment or care in our Practice. These reminders will not identify the purpose of your visit.

**Required by Law.** We will disclose health information about you when required to do so by federal, state or local laws.

**Public Health Activities.** We may disclose your confidential health information for the following public health activities and purposes:

- To report health information to public health authorities that are authorized by law to receive such information for the purpose of preventing or controlling disease, injury or disability;
- To report child abuse or neglect to a government authority that is authorized by law to receive such reports;
- To report information about a product or activity that is regulated by the US Food and Drug Administration (FDA) to a person responsible for the quality, safety or effectiveness of the product or activity;
- To conduct post-marketing surveillance, as required; and
- To alert a person who may have been exposed to a communicable disease, if we are authorized by law to give this notice.

**Legal Proceedings.** We may release protected health information about you in response to a court or administrative order if you are involved in a lawsuit or dispute. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request.

**Law Enforcement.** We may release health information if asked to do so by law enforcement officials:

- In response to a court order, subpoena, warrant, summons or similar process.
- To identify or locate a suspect, fugitive, material witness or missing person.
- About the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement.
- About the death we believe may be the result of criminal conduct.
- About criminal conduct at the Practice.
- In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

**Research.** Under certain circumstances, we may use and disclose your confidential information for research purposes without an authorization. An authorization would not be necessary if your identifying information was removed.

**Workers' Compensation.** We may release your health information to comply with Workers' Compensation Laws and other similar legally established programs. The programs provide benefits for work-related illness or injury.

**Promotional Gifts.** We may use your confidential health information so that we may provide you with nominal gifts. We will not disclose your confidential information to other companies for their marketing purposes.

**Health Related Benefits and Services.** We may use and disclose health information to inform you about health-related benefits or services that may be of interest to you. You may be contacted by the Practice regarding general health-related products and services and/or health-related products and services targeted to your specific health status or condition, but only where we believe those products or services may benefit you. If the communication is targeted to you, it must explain why you were targeted and how the product or service relates to your health. Any communication you receive must identify the Practice as the source of the communication, inform you if we received any payment for making the communication,

and contain instructions about how you may request that we not contact you further about such health-related products and services.

**Criminal Activity.** Under certain Federal and state laws, we may disclose your protected health information if we believe that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose your health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Government Functions.** We may disclose your health information to the U.S. Military or to authorized federal or state officials for purposes specified by federal law.

**Coroners, Funeral Directors, and Organ Donation.** We may disclose your health information to a coroner or medical examiner. This may be necessary to identify a deceased person or to determine the cause of death. We may also disclose protected health information to funeral directors as authorized by law to assist them in carrying out their duties. Protected health information may also be used and disclosed for organ eye and tissue donations if you have previously agreed to organ donation.

**Parental Access.** Various New York State laws determine what protected health information can be disclosed to parents, guardians, and persons acting in a similar legal status. We will act consistently with the law and will make disclosures only when necessary.

**Individuals Involved in Your Care.** Unless you object, we may use or disclose your health information to notify or assist in the notification of a family member or personal representative of your location, your general condition, or death. If you are present, you will have the opportunity to object to this type of use or disclosure. If you are unable to decide or if it is an emergency, we may disclose information that is directly relevant to the person's involvement in your healthcare, if we determine that it is in your best interest to do so.

## **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

Although your health record is the physical property of S.P.E.A.R. Physical Therapy, PLLC, the information belongs to you. You have the following rights regarding your protected health information. You may make any of the following requests by completing a "HIPAA Patient Rights Request Form" or by submitting a written request to our office.

**Right to Inspect and Copy.** You have the right to both inspect and obtain a copy of your protected health information that is contained in a "designated record set" for as long as we maintain your health information. This information is used to make health-related decisions about your care and typically includes professional treatment/progress notes, supplement programs, laboratory reports, prescriptions, and billing/financial records. This request does not include inspection and copying of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to laws that prohibit access. If you request copies, we may charge you copying and mailing costs.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. While we consider all requests for restrictions carefully, we are not required to agree to your request.

**Right To Request Amendment.** If you believe the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have a right to request an amendment for as long as the information is kept by or for S.P.E.A.R. Physical Therapy, PLLC, if we determine the record is inaccurate.

We may deny your request if it is not in the appropriate form or does not include a reason to support the request. In addition we may deny your request if you ask us to amend information that:



- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the information kept by or for S.P.E.A.R. Physical Therapy, PLLC
- Is not part of the information which you would be permitted to inspect or copy
- Is accurate and complete

**Right to Request Confidential Communications.** You may request that we communicate with you using alternative means or at an alternative location. You may also ask that we mail information to you in a sealed envelope rather than a postcard. While we will consider this request carefully, we are not required to agree to all requests.

**Right to Request an Accounting of Disclosures.** You have the right to an accounting of disclosures. This is a list of where we have sent your protected health information that does not include disclosures made for treatment, payment, or healthcare operations as described in this notice. Your request must state a time period beginning on or after April 14, 2003, and no more than 6 years from the date of request.

**Right To Obtain a Copy of this Notice.** You have the right to a paper copy of this notice. You may request a copy of this notice at any time. To obtain a copy of this, please contact the Practice Administrator or his/her designee.

## **CHANGES TO THIS NOTICE**

We reserve the right to change our privacy practices and this notice. We reserve the right to make changed notice effective for health information we already have about you as well as any information we receive in the future. If we change the notice, we will provide each active patient with a new notice. You may also obtain a new notice by calling our office.

## **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with S.P.E.A.R. Physical Therapy, PLLC's Privacy Officer or his/her designee at the address below. No retaliation will occur against you for filing a complaint. All complaints must be submitted in writing. You may also file written complaints with the Secretary of the US Department of Health and Human Services. Please call our office to obtain the correct address for the Secretary.

S.P.E.A.R. Physical Therapy, PLLC  
HIPAA Privacy Officer  
120 East 56<sup>th</sup> Street, Suite 1010  
New York, NY 10022

## **OTHER USES OF YOUR HEALTH INFORMATION**

Other uses and disclosures of your health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose your health information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your health information for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your permission and we are required to maintain in our records of the care that we provided to you.

This notice was published on January 5, 2009 and all provisions become effective by Federal Law on April 14, 2003. Our Notice of Privacy Practices remain in effect until modified by S.P.E.A.R. Physical Therapy, PLLC.



**AUTO OR NON-WORK RELATED ACCIDENT  
Patient & Payor Information Form**

**(4) Medical Insurance Information** (please provide a copy of Insurance card or complete this section in the event that your Auto or Non-Work Accident claim is denied)

Ins. Co. Name: \_\_\_\_\_ Ins. Co. Phone #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured is \_\_\_ Patient \_\_\_ Spouse \_\_\_ Parent

Legal Gender: \_\_\_\_\_ Date of Birth (MM/DD/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient ID #: \_\_\_\_\_ Group. # \_\_\_\_\_ Policy/Plan #: \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Employer Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**(5) Credit Card Payment Authorization** Would you like an e-mail receipt with each transaction? Yes  No

I hereby authorize S.P.E.A.R. Physical Therapy, PLLC to charge my credit card for services rendered and/or products supplied until this authorization is revoked by me. It is my responsibility to notify S.P.E.A.R. Physical Therapy, PLLC any changes regarding this credit card authorization.

Name on Card		Signature/Date	
Credit Card Type <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa <input type="checkbox"/> American Express <input type="checkbox"/> Discover		Credit Card Number	
Expiration Date	Security Code	Billing Zip Code	

**(6) Payment Authorization: (Initials required for all 3 statements)**

**Guarantee of Payment**  
\_\_\_\_\_  
Initials I understand that all payments designated as "the patient's responsibility" such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by the billing statement due date.

**Health Insurance Option (Copy of Insurance Card Required)**  
\_\_\_\_\_  
Initials I agree to SPEAR Physical Therapy, LLC to file my Health Insurance within the required claims filing period should my Personal Auto or the other party's insurance deny the claim, exhaust the benefits or fail in any way to pay per the agreed upon terms.

**Certification of Information**  
\_\_\_\_\_  
Initials I certify that the information I have provided SPEAR Physical Therapy, LLC for payment including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.

**(7) Signature/ Date:**  
*I attest, to the best of my knowledge, the above information is accurate and true.*

\_\_\_\_\_  
**Patient or Legal Representative's Signature** \_\_\_\_\_  
**Today's Date**

**All Patients or Patients' Legal Representative Please Sign Section 7 on Page 2**

**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)