WELCOME

PATIENT INFORMATION

DATE: _____
SS/ID#_____
PATIENT NAME_____
LAST NAME

_____ _____
FIRST NAME MIDDLE INITIAL

ADDRESS_____
CITY_____
STATE_____ ZIP_____
EMAIL_____@_____
SEX ☐ M ☐F AGE_____
BIRTHDAY_____

☐MARRIED ☐WIDOWED ☐SINGLE ☐MINOR
☐SEPARATED ☐DIVORCED ☐PARTNERED FOR___YEARS

OCCUPATION _____
PATIENT EMPLOYER/SCHOOL _____
EMPLOYER/SCHOOL ADDRESS _____
_____
EMPLOYER/SCHOOL PHONE _(____)_____-_____
SPOUSE'S NAME _____
BIRTHDAY_____
SS#_____
SPOUSE EMPLOYER _____
WHOM MAY WE THANK REFERRING YOU? _____

INSURANCE

WHO IS RESPONSIBLE FOR THIS ACCOUNT?
_____
RELATIONSHIP TO PATIENT _____
INSURANCE CO. _____
GROUP #_____

IS PATIENT COVERED BY ADDITIONAL INSURANCE? ☐Y☐N
SUBSCRIBER'S NAME _____
BIRTHDATE_____SS#_____
RELATIONSHIP TO PATIENT _____
INSURANCE CO. _____
GROUP # _____

ASSIGNMENT AND RELEASE
I CERTIFY THAT I, AND/ OR MY DEPENDANT(S) HAVE INSURANCE COVERAGE WITH _____
NAME OF INSURANCE COMPANY

AND ASSIGN DIRECTLY TO **DR. ERIC GOLDBERG** ALL INSURANCE BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE FOR ALL INSURANCE SUBMISSIONS. THE ABOVE-NAMED DOCTOR MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE- NAMED INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENTS FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR ONE YEAR FROM THE DATE SIGNED BELOW.

_____
SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

_____
PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

_____ _____
DATE RELATIONSHIP TO PATIENT

PHONE NUMBERS

HOME PHONE (____)_____
CELL PHONE (____)_____
BEST TIME AND PLACE TO REACH YOU
_____
IN CASE OF EMERGENCY, CONTACT

NAME _____
RELATIONSHIP _____
HOME # (____)_____
WORK # (____)_____

ACCIDENT INFORMATION

IS CONDITION DUE TO AN ACCIDENT? ☐YES ☐NO
DATE_____
TYPE OF ACCIDENT ☐AUTO ☐WORK ☐HOME ☐ OTHER

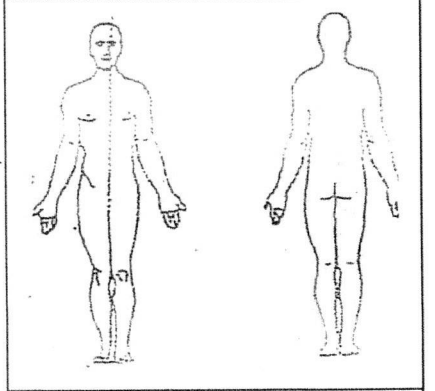
TO WHOM HAVE YOU MADE A REPORT OF YOUR ACCIDENT?
☐AUTO INSURANCE ☐EMPLOYER ☐WORKERS COMPENSATION
☐ OTHER
ATTORNEY NAME (IF APPLICABLE)

PATIENT CONDITION

REASON FOR VISIT _____ HEIGHT _____ WEIGHT_____

WHEN DID YOUR SYMPTOMS APPEAR? _____
IS CONDITION GETTING PROGRESSIVELY WORSE? ☐YES ☐NO ☐ UNKNOWN

MARK AN X ON THE PICTURE WHERE YOU CONTINUE TO HAVE PAIN, NUMBNESS, OR TINGLING.



RATE THE SEVERITY OF YOUR PAIN ON A SCALE FROM 1(LEAST PAIN) TO 10 (SEVERE PAIN). ____
TYPE OF PAIN: ☐ SHARP ☐DULL ☐ THROBBING ☐ NUMBNESS ☐ACHING ☐ SHOOTING
☐BURNING ☐ TINGLING ☐ CRAMPS ☐STIFFNESS ☐ SWELLING ☐ OTHER

HOW OFTEN DO YOU HAVE THIS PAIN? _____

IS IT CONSTANT OR DOES IT COME AND GO? _____

DOES IT INTERFERE WITH YOUR ☐ WORK ☐SLEEP ☐ DAILY ROUTINE ☐RECREATION
ACTIVITIES OR MOVEMENTS THAT ARE PAINFUL TO PERFORM ☐SITTING ☐STANDING ☐ WALKING ☐ BENDING ☐LYING DOWN

HEALTH HISTORY

WHAT TREATMENT HAVE YOU ALREADY RECEIVED FOR YOU CONDITION?

MEDICATIONS SURGERY PHYSICAL THERAPY CHIROPRACTIC SERVICES NONE
OTHER _____

NAME AND ADDRESS OF OTHER DOCTORS WHO HAVE TREATED YOUR CONDITION _____

DATE OF LAST: PHYSICAL EXAM _____ SPINAL X-RAY _____ BLOOD TEST _____
SPINAL EXAM _____ CHEST X-RAY _____ URINE TEST _____
DENTAL X-RAY _____ MRI, CT-SCAN, BONE SCAN _____

PLACE A MARK ON "YES" OR "NO" TO INDICATE IF YOU HAVE ONE OF THE FOLLOWING:

AIDS/HIV ☐YES ☐ NO	DIABETES ☐YES ☐ NO	MIGRAINE-HEADACHES ☐YES ☐ NO	STROKE ☐YES ☐ NO
ALCOHOLISM ☐YES ☐ NO	EMPHYSEMA ☐YES ☐ NO	MISCARRIAGE ☐YES ☐ NO	SUICIDE ATTEMPT ☐YES ☐ NO
ALLERGIES SHOT ☐YES ☐ NO	EPILEPSY ☐YES ☐ NO	MONONUCLEOSIS ☐YES ☐ NO	THYROID PROBLEMS ☐YES☐ NO
ANEMIA ☐YES ☐ NO	FRACTURES ☐YES ☐ NO	MULTIPLE SCLEROSIS ☐YES ☐ NO	TONSILLITIS ☐YES☐ NO
ANOREXIA ☐YES ☐ NO	GLAUCOMA ☐YES ☐ NO	MUMPS ☐YES ☐ NO	TUBERCULOSIS ☐YES ☐ NO
APPENDICITIS ☐YES ☐ NO	GOITER ☐YES ☐ NO	OSTEOPOROSIS ☐YES ☐ NO	TUMORS GROWTH ☐YES ☐ NO
ARTHRITIS ☐YES ☐ NO	GONORRHEA ☐YES ☐ NO	PACEMAKER ☐YES ☐ NO	THYROID FEVER ☐YES ☐ NO
ASTHMA ☐YES ☐ NO	GOUT ☐YES ☐ NO	PARKINSON'S DISEASE ☐YES ☐ NO	ULCERS ☐YES ☐ NO
BLEEDING DISORDERS ☐YES ☐ NO	HEART DISEASE ☐YES ☐ NO	PINCHED NERVE ☐YES ☐ NO	VAGINAL INFECTION ☐YES ☐NO
BREAST LUMP ☐YES ☐ NO	HEPATITIS ☐YES ☐ NO	PNEUMONIA ☐YES ☐ NO	VENEREAL DISEASE ☐YES ☐NO
BRONCHITIS ☐YES ☐ NO	HERNIA ☐YES ☐ NO	POLIO ☐YES ☐ NO	WHOOPING COUGH ☐YES☐ NO
BULIMIA ☐YES ☐ NO	HERNIATED DISK ☐YES ☐ NO	PROSTATE PROBLEM ☐YES ☐ NO	OTHER _____
CANCER ☐YES ☐ NO	HERPES ☐YES ☐ NO	PROSTHESIS ☐YES ☐ NO	
CATARACTS ☐YES ☐ NO	HIGH CHOLESTEROL ☐YES ☐ NO	PSYCHIATRIC CARE ☐YES ☐ NO	
CHEMICAL ☐YES ☐ NO	KIDNEY DISEASE ☐YES ☐ NO	RHEUMATOID ARTHRITIS ☐YES ☐ NO	
DEPENDENCY ☐YES ☐ NO	LIVER DISEASE ☐YES ☐ NO	RHEUMATIC FEVER ☐YES ☐ NO	
CHICKEN POX ☐YES ☐ NO	MEASLES ☐YES ☐ NO	SCARLET FEVER ☐YES☐ NO	

EXERCISE	**WORK ACTIVITY**	**HABITS**	
☐ NONE	☐ SITTING	☐ SMOKING	PACKS A DAY _____
☐MODERATE	☐ STANDING	☐ALCOHOL	DRINKS/WEEK_____
☐DAILY	☐ LIGHT LABOR	☐COFFEE/CAFFEINE DRINKS	CUPS/DAY _____
☐HEAVY	☐ HEAVY LABOR	☐HIGH STRESS LEVEL	REASON _____

ARE YOU PREGNANT? ☐YES ☐ NO DUE DATE _____

INJURIES/SURGERIES YOU HAVE HAD

	DESCRIPTION	**DATE**
FALLS		
HEAD INJURIES		
BROKEN BONES		
DISLOCATIONS		
SURGERIES		

MEDICATIONS	**ALLERGIES**	**VITAMINS/HERBS/MINERALS**
PHARMACY NAME _____		
PHARMACY TEL# _____		

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

NAME _____ BIRTHDAY _____

SIGNATURE _____

DATE _____

TOTAL MEDICAL N.Y. PC
93-24 QUEENS BLVD. SUITE 1G
REGO PARK, NY, 11374
(T) 718-730-9040 (F) 718-730-9043

ASSIGNMENT AND RELEASE

I CERTIFY THAT I, AND/ OR MY DEPENDANT(S) HAVE INSURANCE COVERAGE WITH

_____
NAME OF INSURANCE COMPANY

AND ASSIGN DIRECTLY TO DR. ERIC GOLDBERG ALL INSURANCE BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE FOR ALL INSURANCE SUBMISSIONS. THE ABOVE-NAMED DOCTOR MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE- NAMED INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENTS FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR ONE YEAR FROM THE DATE SIGNED BELOW.

_____
SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

_____
PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

_____ _____
DATE RELATIONSHIP TO PATIENT

Your Information. Your Rights. Our Responsibilities.

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

Effective: February 12, 2014

LAYERED SUMMARY TEXT --

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Signature of Patient_____Print Name of Patient: _____Date: _____

Patient Summary Form

PSF-750 (Rev:2/18/2009)

Instructions
Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

*Fax number may vary by plan.

Patient Information

Patient name: Last / First / MI

○ Female ○ Male

Patient date of birth

Patient address

City / State / Zip code

Patient insurance ID#

Health plan

Group number

Referring physician (if applicable)

Date referral issued (if applicable)

Referral number (if applicable)

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form)

2. Federal tax ID (EIN) of entity in box #1

1 MD/DO 2 DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 9 Other ____

3. Name and credentials of the individual performing the service(s)

6. Phone number

4. Alternate name (if any) of entity in box #1

5. NPI of entity in box #1

7. Address of the billing provider or facility indicated in box #1

8. City

9. State

10. Zip code

Provider Completes This Section:

Date you want *THIS* submission to begin:

Cause of Current Episode

1. Traumatic
2. Unspecified
3. Repetitive
4. Post-surgical →
5. Work related
6. Motor vehicle

Date of Surgery

Type of Surgery

1. ACL Reconstruction
2. Rotator Cuff/Labral Repair
3. Tendon Repair
4. Spinal Fusion
5. Joint Replacement
6. Other ____

Diagnosis (ICD code)
Please ensure all digits are entered accurately

1° . 2° . 3° . 4° .

Patient Type

1. New to your office
2. Est'd, new injury
3. Est'd, new episode
4. Est'd, continuing care

Nature of Condition

1. Initial onset (within last 3 months)
2. Recurrent (multiple episodes of < 3 months)
3. Chronic (continuous duration > 3 months)

DC ONLY
Anticipated CMT Level

○ 98940 ○ 98942
○ 98941 ○ 98943

Current Functional Measure Score

Neck Index ____ DASH ____ (other) ____

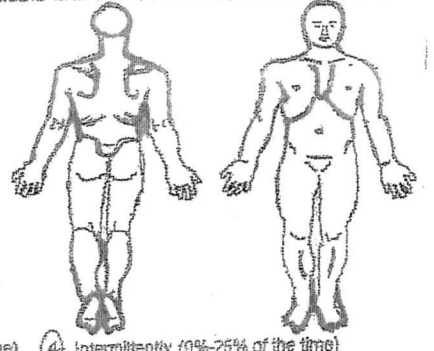
Back Index ____ LEFS ____

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

Indicate where you have pain or other symptoms:



1. **Briefly describe your symptoms:**

2. **How did your symptoms start?**

3. **Average pain intensity:**

Last 24 hours: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

Past week: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

4. **How often do you experience your symptoms?**

(1) Constantly (75%-100% of the time) (2) Frequently (51%-75% of the time) (3) Occasionally (26% – 50% of the time) (4) Intermittently (0%-25% of the time)

5. **How much have your symptoms interfered with your usual daily activities?** (including both work outside the home and housework)

(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

6. **How is your condition changing, since care began at *this* facility?**

(0) N/A – This is the initial visit (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better

7. **In general, would you say your overall health right now is...**

(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

Patient Signature: X _____ Date: _____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

TOTAL MEDICAL NY PC
ERIC GOLDBERG, MD
93-24 QUEENS BLVD #1G
REGO PARK, NY, 11374
(T) 718-730-9040 (F) 718-559-4895

DATE	POLICY HOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

IMPORTANT:
1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S)
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

1. YOUR NAME	2. PHONE NOS. HOME	BUSINESS
3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.
6. DATE AND TIME OF ACCIDENT A.M. P.M.	7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE	

8. BRIEF DESCRIPTION OF ACCIDENT:

9. DESCRIBE YOUR INJURY:

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS:

☐ A TRUCK, OR ☐ A BUS OR SCHOOL BUS
☐ A MOTORCYCLE ☐ AN AUTOMOBILE

11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE? ☐ YES ☐ NO

WERE YOU A PASSENGER IN THE MOTOR VEHICLE? ☐ YES ☐ NO

WERE YOU A PEDESTRIAN? ☐ YES ☐ NO

WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD? ☐ YES ☐ NO

DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE? ☐ YES ☐ NO

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES? ☐ YES ☐ NO

NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOU WERE TREATED AT A HOSPITAL(S), WERE YOU AN: OUT-PATIENT ☐ IN-PATIENT ☐

DATE OF ADMISSION: HOSPITAL'S NAME AND ADDRESS:

14. AMOUNT OF HEALTH BILLS TO DATE $	15. WILL YOU HAVE MORE HEALTH TREATMENTS(S) ☐ YES ☐ NO	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? ☐ YES ☐ NO	
17. DID YOU LOSE TIME FROM WORK? ☐ YES ☐ NO	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK? ☐ YES ☐ NO	IF YES, DATE RETURNED TO WORK:
AMOUNT OF TIME LOST FROM WORK:	18. WHAT ARE YOUR AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT? ☐ YES ☐ NO

(Continued on next page)

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

20. LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? ☐ YES ☐ NO
IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING

NEW YORK STATE DISABILITY? ☐ YES ☐ NO

WORKERS' COMPENSATION? ☐ YES ☐ NO

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE
APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, 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 STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

SIGNATURE: _____ DATE: _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____ SOCIAL SECURITY NO. _____

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____ DATE _____

SIGNATURE

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

* BRACKETED LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

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

I, _____, ("Assignor") hereby assign to Total Medical N.Y., P.C., ("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. **If an insurer denies a claim for health service benefits because the assignor failed to appear for a medical examination or examination under oath at the insurer's request, then this assignment, unless it is made to a hospital as defined in 11 NYCRR § 52.2(m), shall be voidable by an insurer and shall not be enforceable against an insurer, and an insurer shall not be obligated to pay benefits directly to any provider of health services other than a hospital as** defined in 11 NYCRR § 52.2(m).

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)	
Total Medical N.Y, P.C.	
(Print name of Provider)	
93-24 Queens Blvd. Suite 1G	
Rego Park NY, 11374	
(Address of Provider)	

NYS FORM NF-AOB (Rev 2/2018)

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_____

Patient Name_____

Date of Accident_____ Time of Accident_____ ☐ a.m. ☐ p.m.

Please describe the accident in your own words:_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle?_____

ACCIDENT SITE

Road/Street Name_____

City/State_____

Nearest intersection with road/street_____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other_____

Which direction were you headed?_____

Speed you were traveling?_____

VEHICLE

Make and model of vehicle you were in:_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain_____

Was impact from:

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE

(if applicable)

Make and model of other vehicle_____

Which direction was other vehicle headed?_____

Speed other vehicle was traveling_____

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom?_____

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?_____

Please describe how you felt immediately after the accident:

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital_____ Name of doctor_____

Diagnosis_____

Treatment received_____

X-rays taken_____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?_____

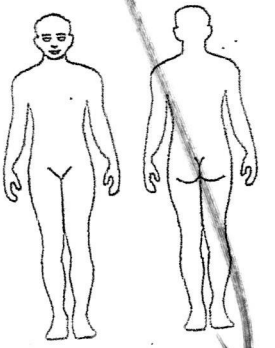
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

- ☐ Arm/shoulder pain
- ☐ Back pain
- ☐ Back stiffness
- ☐ Chest pain
- ☐ Dizziness
- ☐ Ear buzzing
- ☐ Ear ringing
- ☐ Fatigue
- ☐ Feet/toe numbness
- ☐ Hand/finger numbness
- ☑ Headaches
- ☐ Irritability
- ☐ Jaw problems
- ☐ Leg pain
- ☐ Memory loss
- ☐ Nausea
- ☐ Neck pain
- ☐ Neck stiff
- ☐ Shortness of breath
- ☐ Sleep difficulty
- ☐ Stomach upset
- ☐ Tension
- ☐ Vision blurred

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain: ☐ Sharp ☐ Aching ☐ Cramps ☐ Dull ☐ Shooting ☐ Stiffness ☐ Throbbing ☐ Burning ☐ Swelling ☐ Numbness ☐ Tingling ☐ Other_____

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Walking

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Bending ☐ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient