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?

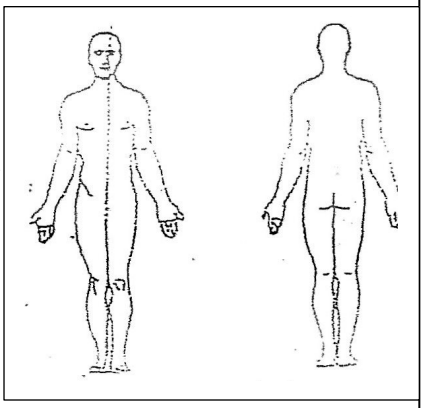
☐AUTO INSURANCE ☐EMPLOYER ☐WORKERS COMPENSATION

☐ 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: January 1, 2024

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 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, an email to OCRComplaint@hhs.gov, or visiting **https://www.hhs.gov/hipaa/filing-a-complaint/what-to-expect/index.html**
- 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.

To treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for on 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:
https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situation 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

For 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.

Address workers' compensation, law enforcement and other government requests

We can use or share health information about you:

- For workers' compensation claim
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

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 website.

Signature of Patient:_____

Print Name of Patient:_____ 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
(T) 718-730-9040 (F) 718-559-4895

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

TO ENABLE US TO DETERMINE IF YOUR 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.

NAME AND ADDRESS OF APPLICANT*

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 THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS, ☐ A TRUCK, ☐ AN AUTOMOBILE, ☐ OR A MOTORCYCLE

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	☐	☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	☐	☐
WERE YOU A PEDESTRIAN?	☐	☐
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	☐	☐
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES ☐ NO ☐

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

13. IF YOUR 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 TREATMENT(S)?	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
$ _____	YES ☐ NO ☐	YES ☐ NO ☐

17. DID YOU LOSE TIME FROM WORK?	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK?
YES ☐ NO ☐		YES ☐ NO ☐

IF YES, DATE RETURNED TO WORK: _____ AMOUNT OF TIME LOST FROM WORK: _____

18. WHAT ARE YOUR GROSS 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 ☐

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
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
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:

	YES	NO
NEW YORK STATE DISABILITY?	☐	☐
WORKERS' COMPENSATION?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE THREE

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 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.

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. YOUR 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) _____

SIGNATURE _____ DATE _____

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

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

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** 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.

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) **(Signature of Provider)**

93-24 Queens Blvd., Suite 1G _____
(Date of signature)

Rego Park, NY 11374
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

MOTOR VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Patient Name _____ Date _____

Date of Accident _____ Time of Accident _____ ☐ A.M. ☐ P.M.

Please describe the accident in you own words: _____

_____

_____

_____

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

How many people were in the accident vehicle? _____

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 after the accident: _____

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 or more days 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 _____

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 of health.

_____ _____ _____

Signature of Patient, Parent, Guardian or Personal Representative Print Date

Relationship to Patient _____