No fault information sheet

To be filled out at first visit for no fault injury

Date:

1. General information

Patient's name Work phone

Policy holder's name

Policy holder's street

Policy holder's state Zip

2. No fault insurance information

This section must be completed; otherwise balance will be billed to patient

Have you reported your accident to your auto insurance agent? ☐ Yes ☐ No

Auto insurance agent Phone

No fault carrier

Street address

City State Zip

Phone Policy # File/Claim #

3. Accident information

Date of accident Time

4. Authorization

I, , (print patient's name)("Assignor") hereby assign to OrthoNY ("Assignee") all rights privileges and remedies to which I am entitled under Article 51 (the No-fault provisions) 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 (print accident date), notwithstanding any prior written agreement to the contrary. This agreement shall become null and void if at anytime it is determined that benefits are not payable due to the following circumstances: lack of coverage, violations of a policy condition, or determination that the treatment/services rendered are not related to said motor vehicle accident.

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 value of the subject motor vehicle or stated claim for each violation.

Print name of patient

Address

Patient signature

Print name of provider

Address

No fault information sheet

To be filled out at first visit for no fault injury

Provider signature

FOR INTERNAL USE ONLY

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

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number: ________________

I, ______________________ **, ("Assignor") hereby assign to** ORTHOPEDICS OF NY, LLP **, ("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)

ORTHOPEDICS OF NY, LLP
(Print name of Provider)

(Signature of Provider)

121 EVERETT RD
____

______________________ (Date of signature)

ALBANY, NY 12205
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)