NO-FAULT MOTOR VEHICLE INSURANCE QUESTIONAIRE

Patient Name: _____ **Date of Birth** ____/____/_____

Home Address: _____
Street City State Zip

Date of Accident: ____/____/_____

Were you the driver of the vehicle? Yes __ No __

Were you the passenger of the vehicle? Yes __ No __

Name of Vehicle Owner: _____

Insurance Carrier: _____
(For vehicle that was involved in accident)

Address: _____
Street City State Zip

Phone Number: (____) ____-_____

Policy Number: _____

Claim/File Number: _____

Policy Holders Name: _____

Describe your injury: _____

_____

_____

Were you treated by any other physician for this injury? Yes __ No __

If yes, provide names and addresses: _____

_____

_____

Did this accident occur during your hours of employment? Yes __ No __

Signature: _____
If guardian, state relationship

Date: ____/____/_____

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

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

I, _____ (Print patient's name), **("Assignor") hereby assign to** _____ (Print hospital or health care provider name), **("Assignee") all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.**

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ (Print accident date), **not withstanding any other agreement to the contrary.**

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS 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)	

NYS FORM NF-AOB (Rev 1/2004)

MIDDLETOWN MEDICAL, P.C.
IMMEDIATE MEDICAL CARE
111 MALTESE DRIVE
MIDDLETOWN, NY 10940

DOCTOR'S LEIN

I, _____, do hereby request that my attorney's, in order to adequately protect Middletown Medical, P.C., pay directly to him such sums as may be due and owning him for medical serviced rendered to me by reason of the accident which occurred on ____/____/_____ and to withhold _____ from any settlement, judgment or verdict which may be paid as the result of the injuries for which I have been treated or injuries in connection therewith.

I understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. Further understand that such payment is not contingent on any settlement, judgment or verdict which I may eventually recover.

_____ _____
Patient Signature Date

_____ _____
Witness Date