NO-FAULT PATIENT INFORMATION
***** PLEASE COMPLETE ALL INFORMATION REQUESTED FOR OUR RECORDS *****

Date: _____

Last Name: _____ **MI**: _____ **First Name**: _____

DOB : _____ **SEX** : _____**SS #** : _____

Address: _____

City: _____**State** _____ **Zip Code:** _____

Phone (Home): _____ **Phone (Cell):** _____

Phone (Work): _____ **Email**: _____

Emergency Contact: _____ **Telephone #:** _____

Ref. Doctor: _____ **Telephone #:** _____

Primary Doctor: _____ **Telephone #:** _____

Pharmacy Info (name, address, phone/fax #) _____

Additional Information (as requested by Insurance Carrier):

Marital Status: ☐ Single ☐ Married ☐ Other **Student Status**: ☐ Full time ☐ Part time

1) **Ethnicity**: ☐ Hispanic or Latino ☐ Not-Hispanic/Latino ☐ Unknown

2) **Race:** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ Other Race ☐ White

3) **Primary Language**: ☐ Chinese ☐ English ☐ French ☐ German ☐ Italian ☐ Japanese ☐ Portuguese ☐ Russian ☐ Spanish

4) **Preferred Method of Communication:** **Phone**: ☐ Home ☐ Cell ☐ Work **Email**: ☐ (provide e-mail address above)

Was an "Application for Benefits" form from your Insurance Carrier filled? ☐ **Yes** ☐ **No**

INSURANCE INFORMATION

(If the above has not been done, your medical expenses will not be recognized for payment. Satisfaction of your account would then become your direct responsibility.)

Policyholder Name: _____

Policyholder Address: _____

Policy Number: _____ **Insurance Claim File #**: _____

Date of Accident/Injury: _____ **State How Accident/Injury Occurred**: _____

_____

_____

Insurance Carrier Name: _____

Address: _____

Are You Working? ☐ **Yes** ☐ **No** **Date Last Worked** _____ **Date Returned** _____

Claim Representative: _____ **Insurance Phone #** _____

Attorney: _____ **Phone #** _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS

I hereby authorize the release of any information pertinent to my case to myself, family members, physicians, hospitals, insurance company, adjuster and/or attorney involved in my case. I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance company, regardless of my insurance status. A photocopy of this release shall be considered as effective and valid as the original.

_____ _____
Patient (or authorized signature) Date Signed

Long Island Neurology Consultants--New Patient Medical History Form

Last Name: _____ First: _____ M.I. _____ Date: _____

Phone #: _____ DOB: _____ Age: _____ Sex: _____

- **PLEASE GIVE ALL RECORDS, STUDIES AND LABS TO CHECK-IN STAFF WHEN YOU ARRIVE**

For Insurance Purposes: Please Check if the patient resides in a nursing home ☐

WHICH HAND DO YOU WRITE WITH? Right Left

PLEASE TELL US YOUR REASON FOR TODAY'S VISIT. PLEASE INCLUDE A DESCRIPTION OF YOUR SYMPTOMS, WHEN THEY BEGAN, AND IF YOU HAVE HAD THEM PREVIOUSLY.

_____

_____

_____

_____

_____

_____

_____

PAST MEDICAL AND SURGICAL HISTORY: (Check all that apply)—include medical diagnoses, operations, hospitalizations

☐ Stroke _____
☐ Seizures _____
☐ Brain Surgery _____
☐ Neck/Back Surgery _____
☐ Other Neurologic Conditions _____
_____

☐ Diabetes ☐ Heart Disease ☐ Peptic Ulcer ☐ **Any metal in your body?**
☐ High Blood Pressure ☐ Pacemaker/Defibrillator ☐ Cancer/Tumor _____
☐ High Cholesterol ☐ Atrial Fibrillation ☐ Depression/Anxiety _____

Other: _____
_____
_____

MEDICATIONS: (please list all prescription and over-the-counter medication, including Aspirin)

1. _____ 5. _____ 9. _____
2. _____ 6. _____ 10. _____.
3. _____ 7. _____ 11. _____.
4. _____ 8. _____ 12. _____.

ALLERGIES TO MEDICATIONS?

_____

_____

Can you tolerate Aspirin? ☐ **Yes** ☐ **No**

FAMILY MEDICAL HISTORY: list any illnesses (especially neurological problems) that your blood relatives have had.

_____

_____

_____

PLEASE COMPLETE OTHER SIDE

PLEASE COMPLETE OTHER SIDE

Long Island Neurology Consultants

Name: _____ Date: _____

SOCIAL HISTORY

Occupation: _____ Disabled? _____

Tobacco: _____ Other recreational drugs: _____

Alcohol: _____

Marital Status: _____Who do you live with? _____
How many children do you have? _____Ages: _____

REVIEW OF SYSTEMS:

Please list any symptoms or problems and explain in the space provided.

If applicable:

Last Menstrual Period _____ **Height _____**

Please indicate if you might be pregnant □ Yes □ No **Weight _____**

1. General ☐ **None**	**7. Urinary** ☐ **None**
2. Head/Ear/Nose/Throat ☐ **None**	**8. Integumentary (Skin/Breast)** ☐ **None**
3. Eyes ☐ **None**	**9. Endocrine** ☐ **None**
4. Cardiac ☐ **None**	**10. Allergy/Immunologic** ☐ **None**
5. Respiratory ☐ **None**	**11. Neurological/Musculoskeletal** ☐ **None**
6. GI ☐ **None**	**12. Psychological/Psychiatric/Recent Stress** ☐ **None** **13. Symptoms or Disease not listed?**

SIGNATURE _____ **DATE SIGNED:** _____

****PLEASE COMPLETE OTHER SIDE*****

LONG ISLAND NEUROLOGY CONSULTANTS

OFFICE POLICIES

YOUR UNDERSTANDING OF OUR POLICIES IS AN ESSENTIAL ELEMENT OF YOUR CARE AND TREATMENT. IF YOU HAVE ANY QUESTIONS, PLEASE DISCUSS THEM WITH OUR FRONT OFFICE STAFF.

Our telephone lines are open from 8:00 AM to 4:00 PM Monday through Friday. Doctor's visits are by appointment only.

If you have an urgent health concern outside of business hours, please call our office and our service will assist you to page the physician on call. Please remember this is for emergency issues which cannot wait until the office re-opens. Please remove the caller ID block to allow us to reach you. If you are experiencing a medical emergency, call 911 or go directly to your nearest emergency department. Our office is affiliated with South Nassau Communities Hospital if you require in–patient care.

It is our policy to confirm all appointments three days ahead of time. We have an automated system in place which makes the initial confirmation call. It is necessary for you to use this system to confirm or cancel your appointment. This will avoid further calls to your home. If we do not hear back from you after the 3rd call, your appointment may be cancelled. If you need to speak with a person regarding your appointment, our office telephone number is 516-887-3516. Press option #2 or leave us a message on extension 702 and we will return your call. Upon cancelling or rescheduling an appointment, our office requires the courtesy of a forty eight (48) hour notice; otherwise you will be charged a $50.00 cancellation fee. A $50.00 fee will be charged to those patients with repeated no shows.

We require a copy of your insurance card and your license or photo identification at the time of service to protect you from insurance fraud.

You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor directly. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to contact you for assistance.

Co-pays are due at the time of your appointment. Unless other arrangements have been made in advance by you or your health insurance carrier, payments for any deductibles or co-insurance are due at the time of service. For your convenience, we accept cash, checks, and most major credit cards. If a co-pay is not paid at the time of your visit, a $25.00 surcharge will be applied. There is a service fee of $30.00 for all returned checks. There will be no exceptions to this policy.

For services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees, and court fees shall be your responsibility in addition to the balance due to this office.

In keeping with meaningful use requirements regarding EHR/EMR, electronic access to your chart can be obtained via the internet. In addition, electronic copies of patient health information, patient summary records, and clinical summaries can be provided electronically. Moreover, patient specific clinical reminders may also be sent electronically based on certain clinical criteria. Please inform our office if you wish to obtain access to our patient portal.

In an effort to encourage overall health, our electronic medical record recognizes concerns about weight and elevated blood pressure. Your Body Mass Index (BMI) calculates your weight based on your height. Normal BMI parameters are: for ages 18-64, BMI ≥ 18.5 and < 25 and for ages 65 and older, ≥ 23 and <30. If your BMI is outside of this range, our system will place a comment on your office visit note to your primary care provider. We encourage our patients to use several on-line resources

such as those from the American Heart Association (AHA) for education about weight monitoring, diet, and activity/exercise. Elevated blood pressure is an important modifiable risk factor for your vascular health. Guidelines from the American Heart Association/American Stroke Association define elevated blood pressure (hypertension) for anyone with readings ≥ 130/80. If your blood pressure is elevated, our system will place a comment on your office visit note and we encourage you to follow up with your primary care provider for this important concern. You may also consider several on-line resources from the American Heart Association/American Stroke Association to learn more about this topic.

As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office. To verify whether your insurance requires a referral, you can contact your primary care physician or your insurance company. Your referral needs to be in place at the time of your scheduled appointment. If you are unable to obtain a referral in a timely manner, your appointment will be rescheduled to a future date. Please contact your primary care physician at least 48 hours in advance to request a referral for your visit. Health plans are not the same and do not cover the same services. In the event your health plan determines a service is "not covered" or we are not able to obtain an authorization, you will be responsible for the complete charge. Patients are encouraged to contact their insurance plan(s) for clarification of benefits prior to services rendered.

As of March 27, 2016 NY State law requires all prescriptions, including controlled substances, to be transmitted electronically. If you need a refill on your medication, please contact your pharmacy. Your pharmacy will make the request to our office via internet. Please allow 24 to 48 hours before you check with your pharmacy if the prescription has been filled. You may also use our **patient portal** at https://lincneuro.com to request a prescription refill. Please include the following information in your message request: Patient name, name of the medication, dosage, and pharmacy's name and number. If you have further questions please contact our prescription liaison at 516-887-3516 select Option #5 or ext. 118. You must also be able to provide an unblocked telephone number where we can reach you in case of any questions or problems. Allow 24 hours for phoned in refill requests to be processed.

We will make every attempt to notify you of all test results when they become available. HIPAA compliance allows us to leave this information on your voicemail (unless you specify otherwise).

When you have a form that needs to be filled out by the doctor, we will require two weeks notice for processing. You must drop the form off at our office and be sure to complete all the sections that need to be filled out by you. You will be contacted when it is ready to be picked up. Likewise, if you need a letter on your behalf from the doctor, it will require the same time to process. Please call the office and advise the staff of the specific details that need to be included. Forms and letters cannot be processed at the time of your appointment. In many cases, there may be an additional charge to complete forms.

APPOINTMENT TIMES ARE EXTREMELY VALUABLE TO OUR PATIENTS

I have read and understand the office policy of Long Island Neurology Consultants. It is my responsibility to abide by the rules and regulations and agree to the above policies.

Signature of Patient/Responsible Party: _____ Date: _____

Printed Name of Patient/Responsible Party: _____ Date: _____

Long Island Neurology Consultants

777 Sunrise Highway • Suite 200 • Lynbrook, New York 11563-2950
227 Franklin Avenue • Hewlett, New York 11557-1902
(516) 887-3516 • Fax (516) 887-0331

Lewis A. Levy, M.D.
Mark A. Nelson, D.O.
Eric J. Hanauer, M.D.
Stephen J. Roth, M.D.
Kristin M. Waldron, M.D.
Diplomates in Neurology

Patient ACCT#_____

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I was provided with a copy of Long Island Neurology Consultants Notice of Privacy Practices.

_____ _____ _____

Print Patient Name **Patient Signature/Legal Representative** **Date**

PLEASE LIST PERSON(S) **WE CAN DISCLOSE** YOUR PERSONAL HEALTH INFORMATION TO:

_____
_____
_____
_____

PLEASE LIST PERSON(S) **WHOM YOU DO NOT** WISH US TO DISCLOSE YOUR PERSONAL HEALTH INFORMATION TO:

_____
_____
_____
_____

CAN WE LEAVE TEST RESULTS

ON YOUR ANSWERING DEVICE: YES_____NO_____

FOR LONG ISLAND NEUROLOGY CONSULTANTS ONLY

Complete this section if this form is not signed and dated by the patient or patient's personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Long Island Neurology Notice of Privacy Practices but was unable to for the following reason:

- **Patient declined to sign**
- **Patient unable to sign**
- **Other _____**

_____ _____
Employee Name Date

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PATIENT – ATTORNEY

MEDICAL LIEN AGREEMENT

I, _____do hereby authorize_____to furnish you,_____ my attorney, with prepaid copies of medical records relevant to my injury or accident for which he/she is representing me.

I further authorize and direct my attorney to pay directly to _____, such sums of monies as may be due and owing to them, (a) for medical services rendered to me for the injury and/or, (b) for any other services, supplies, or reports, and/or (c) legal medical (i.e. impairment rating reports, attorney-physician conferences, and depositions) and to withhold such sums from any settlement or judgment as may be necessary to adequately protect and pay for my treatment. I hereby grant_____ a lien on my claim against any and all proceeds of any settlement or judgment which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated for/or other related services.

I fully understand that I am directly and fully responsible to the above health care provider for all medical bills submitted by them for services rendered to me and that this agreement is made solely for their additional protection and in consideration of the services provided. I further understand that such payment is not contingent on any insurance company's determination, with the exception of a recognized workers compensation case, as to the appropriateness of services rendered and/or fees charged. Alternate third party payment, if accepted, is done as a courtesy provided by_____ .

By my signature below, I hereby waive and/or relinquish my right to contest and/or otherwise make any legal objections as to the appropriateness of this agreement and that my attorney has advised me of same. I understand that this agreement shall be governed by the laws of the State of _____ .

Patient: _____

Print/Type: _____

Home Address, City, State, Zip_____

ATTORNEY AGREEMENT AND ACCEPTANCE

The undersigned being the attorney for the above client (patient), does hereby agree to observe all the terms of the above agreement to withhold such sums from any settlement or judgment as may be necessary to adequately protect the above listed health care providers and to promptly pay such sums to them upon receipt of payment of any settlement or judgment without demand.

Date:

_____

Attorney's Signature

Print/Type_____

State Bar No._____

Address_____

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

NAME AND ADDRESS OF INSURER *	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*

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

	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** _____ **, ("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)