NEW YORK SPORTS MEDICINE INSTITUTE

Orthopedic Surgery | Physical Therapy | Concussion Care

NO FAULT INFORMATION

NAME: _____

ADDRESS: _____

Home Phone: _____ Social Security: _____

Employer Name: _____

Address: _____

Contact Person: _____ Phone: _____

Date of Injury / Accident: _____

Address of where injury/accident occurred: _____

Name of Insurance Carrier: _____

Address: _____

_____

Phone: _____ Contact Person: _____

Policy #: _____ Carrier Case#: _____

Described how injury occurred: _____

_____

Have you lost time from work? No _____ Yes _____ How Long? _____

Are you working now? Yes _____ No _____ Last date worked: _____

Have you seen another doctor for this injury? No _____ Yes _____

If yes – please provide his name and phone number

Name: _____Phone _____

PLEASE NOTE: Should the insurance company refuse to accept this claims as a No Fault case, I do understand that I am fully responsible for my medical bill at the physician's normal fee.

Patient/Guardian Signature: _____ _____Date:_____

New York Sports Medicine Institute | Orthopedic Surgery

Neil S Roth MD *Gregory Galano MD* *Lisa Nason MD* *Major Angela Gagliardi MD*

Lenox Hill Hospital, 130 East 77th Street, 8th Floor - Black Hall Phone: 212-861-2300 Fax: 212-861-2442

222 N. Westchester Avenue, Suite 308, White Plains, NY 10604 Phone: 914-290-4370 Fax: 914-290-4372

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ACCIDENT REPORT FORM

Patient Name: _____ Accident Date: _____

Were you hurt on the job? _____ Yes _____No

Were you in a car accident? _____ Yes _____ No

Insurance Company Name: _____

Address:_____City:_____State: _____Zip:_____

Accident Description: Please describe the accident, place of occurrence – including city and state, whether or not you went to the hospital. Also describe your injuries.

Please list the names of doctors who have treated you for this injury. List their names, specialty, date first consulted, the treatment provided.

The information completed above is true to the best of my recollection. I understand that this information may be requested by the insurance carrier and authorize such release.

Signature of Patient/Parent/Guardian _____

Date completed: _____

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

I, _____ (Assignor) hereby assign to _____
(Print patient's name) (Print provider's 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 _____, notwithstanding any other agreement to the contrary.
(Print accident date)

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 ASSITS, ABETS, SOLICTIS 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

_____
SIGNATURE OF PROVIDER

_____
DATE OF SIGNATURE

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