No-Fault Intake Form

☐ I require translation assistance
☐ J'ai besoin de l'aide de traduction
☐ Я нуждаюсь в помощи переводчика
☐ Requiero ayuda de la traduccion

Translator Information

Date of translation: _____
Print Name: _____
Signature: _____

Date of Accident _____

Accident State _____

INSURANCE

INSURANCE NAME			
INSURANCE ADDRESS	CITY	STATE	ZIP
POLICY NUMBER	**CLAIM NUMBER**	**POLICY HOLDER**	
CLAIM ADJUSTER NAME	INSURANCE PHONE NUMBER		

PATIENT

LAST NAME	FIRST NAME	MIDDLE NAME		
ADDRESS	SEX	DATE OF BIRTH	SOCIAL SECURITY #	
CITY	STATE	ZIP CODE	PHONE NUMBER	ALT.PHONE NUMBER
REFERRING PROVIDER	ADDRESS	PHONE NUMBER		

Description of Accident:

Date of Symptoms First Appeared: _____

Date of First Consultation: _____

Do you have a history of same or similar condition? ☐ YES ☐ NO ☐ DON'T KNOW
If YES , state when and describe:
Patient MUST initial

Is Condition Solely a Result Of This Auto Accident? ☐ YES ☐ NO ☐ DON'T KNOW
If NO , please explain:
Patient MUST initial

Is Condition Due To Injury Arising Out Of Patient's Employment? ☐ YES ☐ NO ☐ DON'T KNOW
If YES , please explain:
Patient MUST initial

Will Injury Result in Disfigurement or Disability? ☐ YES ☐ NO ☐ DON'T KNOW
If YES ,please describe:
Patient MUST initial

Did you miss any IME (Independent Medical Examination)? ☐ YES ☐ NO
If YES ,please provide date(s):
Patient MUST initial

Patient Signature _____ Date _____

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
(Print patient's name)

_____**, ("Assignee")**
(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 to the contrary.
(Date of Accident)

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)

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

PATIENT NAME:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:

PATIENT ADDRESS:

PROVIDER NAME AND ADDRESS:

I hereby authorize the Healthcare Provider indicated above to furnish copies of all information they have regarding my condition while under their observation or treatment, including the history obtained, diagnostic tests and images such as x-rays and MRIs and physical findings, diagnosis and prognosis. The Healthcare Provider indicated above is authorized to provide this information in accordance with the New York Comprehensive Motor Vehicle Insurance Reparations Act (No-Fault Law).

Patient or Guardian Signature: _____

Relationship, if patient is a minor: _____

Date: _____

MEDICAL LIEN

To Attorney: _____
_____
_____

RE: Reports and Lien for: _____
(Patient Name)
Date of Accident: _____

I do hereby authorize the above doctor/medical facility to furnish, you, my attorney, with a full report, diagnosis, treatment plan, prognosis, etc. for myself in regard to the accident in which I was involved.

I hereby authorize and direct, you, my attorney, to pay directly to said doctor/medical facility such sums as may be due and owing said doctor/medical facility for medical services rendered to me by reason of this accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor/medical facility. I further give a lien on my case to said doctor/medical facility against any proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or to myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

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

In the case of automobile accidents, where no-fault regulations govern the medical reimbursement, this lien will be effective only to the extent of those applicable no-fault regulations.

Date: _____ Patient's Signature: _____
(Guardian Signature if Patient is a Minor)

The undersigned, being the attorney of record for the above patient, does hereby agree to observe the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor/medical facility above named.

Date: _____ Attorney's Signature: _____

Authorization for Treatment of a Minor

I, _____, being the parent, legal guardian or adult authorized person persuant to § 2504 of the Public Health Law of New York, of

_____ _____ _____

Name *Relationship* *Birthdate*

give my consent for routine medical and/or diagnostic treatment of this minor at(*Practice Name)* _____. His/her condition requires treatment as per the judgment of his/her healthcare provider. As long as the medical and/or diagnostic treatment considered necessary in the situation is in accordance with generally accepted standards of medical practice for the particular type of injury or illness involved, I impose no specific limitations or prohibitions regarding treatment other than those that follow:

If there are medical/physical limitations /prohibitions, specify here:_____
_____
_____
_____
_____

I understand that this authorization is good until the minor mentioned above reaches his/her 18th birthday.

_____ _____

Signature (Parent or Guardian) *Date*

_____

Street Address

_____ _____ _____

City *State* *Zip Code*

_____ _____

Home Telephone *Work Telephone*

Witness:

_____ _____

Signature of staff receiving authorization *Date*