PATIENT'S NAME:_____ **DATE:**_____

NO FAULT INFORMATION

(FILL THIS OUT IF YOU WERE INJURED IN A CAR ACCIDENT)

INSURANCE CO:_____
(VEHICLE YOU WERE IN AT TIME OF ACCIDENT)

INSURANCE CO ADDRESS:_____

_____ CITY _____ STATE _____ ZIP _____

TELEPHONE #:_____ FILE #:_____

DATE OF ACCIDENT:_____ POLICY OR CLAIM #:_____

NAME OF INSURED (IF OTHER THAN CLAIMANT):_____

ADDRESS OF INSURED:_____

_____

DATE LAST WORKED:_____

LOCATION OF ACCIDENT:_____

_____ CITY _____ STATE _____ ZIP _____

HISTORY OF ACCIDENT:_____

_____

ATTORNEY:_____ TELEPHONE #:_____

FIRM NAME:_____

FIRM ADDRESS:_____

_____ CITY _____ STATE _____ ZIP _____

IN CONSIDERATION OF SERVICES RENDERED TO THE ME, I HEREBY AUTHORIZE PAYMENT DIRECTLY TO ORTHOPAEDIC SURGEONS OF L.I., ASSOCIATES OF ANY AND ALL FIRST PARTY NO-FAULT AUTOMOBILE INSURANCE BENEFITS TO WHICH I MAY OTHERWISE BE ENTITLED FOR SERVICES RENDERED BY THE PROVIDER, BUT NOT TO EXCEED THE PROVIDER'S REGULAR CHARGES FOR SUCH SERVICES.

IN THE EVENT THE PROVIDER'S CHARGES ARE OUTSTANDING AND I FAIL TO FILE AN APPLICATION FOR BENEFITS UNDER THE NEW YORK STATE NO-FAULT INSURANCE LAW, I HEREBY AUTHORIZE THE PROVIDER TO FILE SUCH CLAIM IN MY BEHALF SO THAT THE PROVIDER MAY REALIZE PAYMENT OF ITS CHARGES. I UNDERSTAND THAT, IF THE PROVIDER DOES NOT RECEIVE PAYMENT FROM THE INSURER, I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT OF THE PROVIDER'S CHARGES.

IT IS MY RESPONSIBILITY TO INFORM ORTHOPAEDIC SURGEONS OF L.I., ASSOC. IF MY NO FAULT DEDUCTIBLE ☐ HAS or ☐ HAS NOT BEEN MET (AMOUNT:_____).

IF MY DEDUCTIBLE HAS NOT BEEN MET, I AM RESPONSIBLE FOR PAYMENT ON MY INITIAL VISIT.

I HEREBY AUTHORIZE ORTHOPAEDIC SURGEONS OF L.I., ASSOCIATES TO RELEASE MEDICAL INFORMATION ON MY INJURY TO THE NO FAULT CARRIER:_____.

DATE: _____ **SIGNED:**_____

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 ORTHOPEDIC SURGEONS OF LI ASSOCS, ("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 _____ , notwithstanding any other agreement to the contrary. (Print accident date)

This agreement may be revoked by the assignee when the 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 ANYCOMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERE TO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSIST, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRADULENT INSURANCE ACT, WHICH IS ACRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT 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)

_____ _____
(Home Address) (Date of Signature)

_____
City/Town State Zip Code

?Philip D'Ambrosio, M.D., F.A.C.S.
? Ronald Light, M.D., F. A. C. S.
? Neil Watnik, M.D., F. A. C. S.

_____
(Signature of Provider)

410 Lakeville Road Suite 303 New Hyde Park, NY 110042__ _____
(Address) (Date of Signature)

Tax ID # 11-2476144