NEW YORK NO-FAULT FORM

MEDICAL RECORD # ____________________________

PATIENT NAME: _____________________________  DATE OF ACCIDENT: _______________________________

NAME OF INSURANCE COMPANY: _________________________________________________________________

INSURANCE COMPANY ADDRESS: _________________________________________________________________

CITY: ______________________________  STATE: _______________      ZIPCODE: ______________

POLICY #: _____________________________________  FILE #: ________________________________

INSURED (POLICY HOLDER): ______________________________________________________________________

AUTHORIZATION TO PAY PHYSICIAN

I, ______________________________________________, HEREBY AUTHORIZE THE _______________________

__________________________________________________________________________________________ INSURANCE COMPANY TO PAY BY CHECK MADE

OUT AND MAILED DIRECTLY TO HARTSDALE DIAGNOSTIC AND WOMENS IMAGING SERVICES

PC 141 SOUTH CENTRAL AVE HARTSDALE NY 10530 THE MEDICAL EXPENSE BENEFITS

ALLOWABLE AND OTHERWISE PAYABLE TO ME UNDER MY CURRENT INSURANCE POLICY,

AS PAYMENT TOWARD THE TOTAL CHARGES FOR PROFESSIONAL SERVICES RENDERED.

IN THE EVENT THE PROVIDER’S CHARGES ARE OUTSTANDING AND I FAIL TO FILE AN

APPLICATION FOR BENEFITS UNDER THE NEW YORK NO-FAULT INSURANCE LAW, I HEREBY

AUTHORIZE THE PROVIDER TO FILE SUCH CLAIM ON MY BEHALF SO THAT THE PROVIDER

DOES NOT REALIZE PAYMENT FROM THE INSURER, I AM PERSONALLY RESPONSIBLE TO

HARTSDALE DIAGNOSTIC AND WOMENS IMAGING SERVICES PC ‘S USUAL AND CUSTOMARY

FEES FOR SERVICES RENDERED.

PATIENTS SIGNATURE: ___________________________________________________________________

PATIENTS NAME (PLEASE PRINT): __________________________________________________________________

DATE: ___________________________________________________________________________________

RELATIONSHIP TO PATIENT: ____________________________________________________________________

(IF SIGNED BY OTHER THAN PATIENT)
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 _______________________, (Print accident date)

(notwithstanding 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)