VICTOR HEALTH ASSOCIATES 6532
ANTHONY DRIVE, SUITE A
VICTOR, NY 14564-1403
(585) 924-2100

Today's Date: ___________________________

Motor Vehicle Accident Information Form

This form as well as the Assignment of Benefits Form must be completed with all information prior to being seen for a no-fault related visit.

Patient Information

First Name: ___________________________ Last Name: ___________________________

Address: ____

Date of Birth: ________________________ Accident Date: ________________________

Brief Description of Accident (Location, circumstances):____

____

Brief Description of Injury (locations, symptoms, on-set):____

____

Have you been evaluated for the njury/symptoms previously (i.e. ER, Specialist)?: ___________________

If yes, name and location of Doctor/Facility and date of visit: ____________________________________

Employment Status: ___Employed: Full-Time ___Employed: Part-Time ___Not Currently Employed ___Other

If employed, occupation: _____________________________

Insurance Information

Company: ___________________________ Claim Number: ________________________

Address: ____

Contact Name: ____

Contact Phone: ____

I have completed this form in its entirety and the information provided is true and correct. I understand that failure to provide all required information to Victor Health Associates as well as the applicable No-fault insurance carrier, or denial of claim from no-fault carrier listed will result in my (patient/representative) responsibility for any charges.

Patient / Guardian Signature: ________________________________ Date: ___________________________

Name / Relation if not Patient: ____

Office Use:

Received By (Initials/Date): ________________

Add Insurance to chart and assign to visit.

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** VICTOR HEALTH ASSOCIATES **, ("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)**
VICTOR HEALTH ASSOCIATES 6532 ANTHONY DRIVE, SUITE A	(Date of signature)
VICTOR, NY 14564 (Address of Provider)	

NYS FORM NF-AOB (Rev 1/2004)