NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW

ASSIGNMENT OF BENEFITS FORM

I, _____("Assignor") here by assign to Marc D. Price, D.O., ("Assignee") all rights and 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 any 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.

This assignment 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 KNOWLINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR 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 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 MAKEA FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OFF 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 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

_____
Patient's Address

_____
Signature of Provider

Family Medicine of Malta
2299 Route 9
Mechanicville NY 12118

_____
Date of Signature

NYS FORM NO-AOB (REV 1/2004)

NO-FAULT INSURANCE IN-TAKE FORM

*INJURED PATIENT'S NAME _____ D.O.B. _____/_____/_____

*INSURED PARTY'S NAME: _____

* INSURANCE COMPANY'S NAME: _____

*CLAIMS ADDRESS OF INSURANCE COMPANY: _____

_____

*CLAIM NUMBER: _____

*INSURANCE AGENT'S NAME & PHONE NUMBER: _____

*DATE/TIME OF ACCIDENT: _____

WERE YOU TREATED IN A HOSPITAL OR URGENT CARE SETTING?

☐NO ☐YES, WHERE AND DATE? _____

*PLACE OF THE ACCIDENT (STREET), CITY OR TOWN AND STATE

_____

*BRIEF DESCRIPTION OF ACCIDENT: _____

_____

*DESCRIBE YOUR INJURY: _____

_____

HAVE YOU EVER HAD SAME OR SIMILAR CONDITION: ☐ YES☐ NO

IF YES, STATE WHEN AND DESCRIBE: _____

_____

WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	☐YES	☐NO
WERE YOU THE PASSENGER IN THE MOTOR VEHICLE?	☐YES	☐NO
WERE YOU A PEDESTRIAN?	☐YES	☐NO