

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
 VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE  
 (This form is not for verification of hospital treatment )**

NAME AND ADDRESS OF INSURER OR SELF-INSURER*
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NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*
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DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
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PROVIDER'S NAME AND ADDRESS*
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KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER THE TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM.

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS

2. DATE OF BIRTH    3. SEX    4. OCCUPATION (IF KNOWN)

5. DIAGNOSIS AND CONCURRENT CONDITIONS

6. WHEN DID SYMPTOMS FIRST APPEAR?    7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS  
 DATE: \_\_\_\_\_    CONDITION?    DATE: \_\_\_\_\_

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?

YES     NO

IF YES, state when and describe:

9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT?

YES     NO

IF "NO", explain:

10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?

YES     NO

11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?

YES     NO

NOT DETERMINABLE AT THIS TIME

IF "YES", describe:

12. PATIENT WAS DISABLED (UNABLE TO WORK)

FROM: \_\_\_\_\_    THROUGH: \_\_\_\_\_

13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON:

\_\_\_\_\_  
 (DATE)

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14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?

YES  NO

IF YES, describe your recommendation below:

**15. REPORT OF SERVICES RENDERED -- ATTACH ADDITIONAL SHEETS IF NECESSARY**

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICE RENDERED	FEE SCHEDULE TREATMENT CODE	CHARGES
TOTAL CHARGES TO DATE\$				

**16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING:**

TREATING PROVIDER'S NAME	TITLE	LICENSE OR CERTIFICATION NO.	BUSINESS RELATIONSHIP CHECK APPLICABLE BOX		
			EMPLOYEE	INDEPENDENT CONTRACTOR	OTHER (SPECIFY)

17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES  NO

19. ESTIMATED DURATION OF FUTURE TREATMENT

**PATIENT:** Your health provider may agree to accept payment for health services performed directly from your insurer (**Authorization to Pay Benefits**) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20 of this form.

20.          (IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #21)

**AUTHORIZATION TO PAY BENEFITS:**

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

PRINT NAME    SIGNED     
  PATIENT  PATIENT  DATE

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**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 \_\_\_\_\_, 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)

\_\_\_\_\_

\_\_\_\_\_  
(Date of signature)

\_\_\_\_\_  
(Address of Provider)

**True North Neurology**

Phone: 631-364-9119 Fax: 877-728-4714

Attorney: \_\_\_\_\_ RE: \_\_\_\_\_  
\_\_\_\_\_  
Insured: \_\_\_\_\_  
\_\_\_\_\_  
Claim #: \_\_\_\_\_  
\_\_\_\_\_  
Date of Injury: \_\_\_\_\_

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc., of 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 such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to without such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgement, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

Date: \_\_\_\_\_ Patients Signature: \_\_\_\_\_

The undersigned being attorney(s) of record for the above patient does hereby agree to observe all the terms of the above and agree to withhold such sums excluding attorney fees from any settlement, judgement or verdict as may be necessary to adequately protect said doctor above named.

Date: \_\_\_\_\_ Attorney's Signature: \_\_\_\_\_

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

**Attorney:** Please sign, date, and return original copy to our office. Please retain a copy for your records.

# True North Neurology

## No Fault Patient Responsibility Waiver

### 1. Individual's Financial Responsibility

- If no fault case has been closed, I understand that I am financially responsible for services rendered, either through private insurance or self-pay.
- If my private insurance requires a referral, it is my responsibility obtain one prior to my visit.
- In the event my health plan determines a service to be "not payable" I will be responsible for the complete charge and agree to pay the cost of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

### 2. Insurance Authorization for Assignment of Benefits.

- If no fault case has closed, I hereby authorize and direct payment of my medical benefits to
- True North Neurology on my behalf for any services furnished to me by the providers.

### 3. Authorization to Release Records

I hereby authorize True North Neurology to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

### 4. Medical Request for Payment

I request payment of authorized Medicare and/or private insurance benefits to me or on my behalf for any services furnished to me by or in True North Neurology. I authorize any holder of medical or other information about me to release to Medicare and/or my private insurance and its agents any information needed to determine these benefits of benefits for related services.

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Signature of Patient, Authorized Representative or Responsible Party

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Date

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Print Name of Patient, Authorized Representative or Responsible Party

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Relation to Patient