Patient Registration Form (please print) **Suffolk Rehabilitation Medicine, PLLC. Mike M. Pappas, D.O.**

Last Name_____ First Name _____MI_____

Street Address_____Apt#_____City_____State_____Zip_____

Home Phone ( ) _____ Cell Phone ( ) _____

Emergency Contact_____ Relationship_____ Phone ( ) _____

Social Security# _____Date of Birth____/____/____ Sex □M □ F

Reason for initial visit_____

Name of Referring Doctor/Person_____ Address _____

City_____ State_____ Zip_____ Ref Doctor Phone # _____

Family Physician_____ Phone # _____

Name of Employer_____Address_____

City_____ _____State _____ Zip _____Phone# _____

May we contact you at work □Yes □No

Primary Insurance Name _____Phone # _____

Policy # _____Group # _____Co-pay amt$ _____ Effective date ____/____/___

Name of Insured _____ Relationship to patient □Self □Spouse □Child □other

Insured Date of Birth _____/_____/_____ Insured Social Security #_____

Secondary Insurance Name _____Phone # _____

Policy # _____Group # _____Co-pay amt$ _____ Effective date ____/____/___

Name of Insured _____ Relationship to patient □Self □Spouse □Child □other

Insured Date of Birth ____/_____/_____ Insured Social Security#_____

□Workmans Compensation □No Fault Claim # _____

Attorney Name/Address_____

Attorney Phone #_____Fax# _____ Contact Person _____

1) I authorize the release of my personal information necessary to process my insurance claim(s) to Suffolk Rehabilitation Medicine, PLLC
2) I authorize and request payment of medical benefits directly to my physician, Dr. Mike M. Pappas, Suffolk Rehabilitation Medicine, PLLC
3) I agree that a photocopy of this form may be used as the original
4) I agree to pay all charges not covered by my insurance carrier. These charges include but are not limited to deductible co-payments, co-insurance and non-covered service.

_____ _____

Patient/Authorized Signature ***Date***

MIKE M. PAPPAS, D.O. SUFFOLK REHABILITATION MEDICINE, PLLC

Name_____ Age_____ Appointment Date _____

Referring Physician_____ Primary Physician_____

Reason for visit?_____ When did it start?_____

What makes it worse?_____ Better?_____

What was the injury or cause of your pain _____

On a scale of 1-10 (10 being the worst) what is your pain level?_____

Circle any of these that describe your pain: Dull Sharp Burning Shooting Aching

Is your pain or injury associated with any of the following? Weakness Numbness Tingling

Have you had any of the following symptoms recently?

Changes in bowel/bladder habits Fevers Chills Recent Weight loss

Circle which factors make your pain/injury better

Sitting Standing Walking Bending Lying Down Driving Coughing/Sneezing

Circle which factors make your pain/injury worse

Sitting Standing Walking Bending Lying Down Driving Coughing/Sneezing

List other doctors that have treated this condition _____

List any testing you have had for this injury:

X-ray _____date_____ results_____

MRI_____date_____results_____

Nerve testing_____date_____results_____

Other_____

Circle any treatments you have had for this injury in the past:

Physical therapy Chiropractic Acupuncture Massage Injections_____

List any medications you have taken for this injury_____

Is this a work related injury? Yes No

Past Medical History

Do you have any of the following conditions?

Any contagious disease	Yes	No	Thyroid Disease	Yes	No
High Blood Pressure	Yes	No	Bleeding Problems	Yes	No
Diabetes	Yes	No	Suppressed Immune System	Yes	No
Heart disease	Yes	No	Cancer	Yes	No
Lung Disease (COPD/Asthma)	Yes	No	Stomach Ulcers	Yes	No
Kidney Disease	Yes	No	Seizure Disorder	Yes	No
Liver Disease	Yes	No	Rheumatoid Arthritis	Yes	No

If any of the above yes, please explain or if you have any other medical conditions please explain:

_____

_____

Previous Surgeries

_____
_____
_____
_____
_____

Medications- List all medications, dosages, and frequency

1._____ 6._____
2._____ 7._____
3._____ ___ 8. _____
4._____ 9._____
5._____ ___ 10._____

Allergies- _____

Social History

Marital Status Single Married Divorced Widowed

Occupation_____ **Currently** Full Time Part Time Retired Disabled

Tobacco Do you smoke- Yes No If yes, for how many years?_____ How many packs/day_____

Alcohol Do you drink alcohol- Yes No If so, how often? _____

Do you have any history of alcohol or drug addiction? Yes No

Review of Systems

In the past few months have you experienced any of the following symptoms or complaints?

Fever/Chills	Yes	No	Difficulty Controlling Bowels	Yes	No
Night Sweats	Yes	No	Difficulty Controlling Urine	Yes	No
Chest Pain	Yes	No	New Rashes or Blisters	Yes	No
Difficulty Breathing	Yes	No	Swelling of joints	Yes	No
Persistent Cough	Yes	No	Numbness	Yes	No
Constipation	Yes	No	Weakness	Yes	No
Diarrhea	Yes	No	Depression	Yes	No
Nausea	Yes	No	Anxiety	Yes	No
Sudden weight loss	Yes	No	Bleeding problems	Yes	No
Sudden weight gain	Yes	No	Recurrent infections	Yes	No
Visual Changes	Yes	No	Difficulty swallowing	Yes	No

Patient Signature_____ **Reviewed By _____D.O.**

Mike M. Pappas, D.O.
Suffolk Rehabilitation Medicine, PLLC
220 Fort Salonga Rd.
Northport, NY 11768

ASSIGNMENT OF BENEFITS FORM

Name of Insured (print)_____

Social Security#_____

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to the organization listed above (Suffolk Rehabilitation) for any services or equipment provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits payable to the related services or equipment to the organization, the Healthcare Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Healthcare Financing Administration, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by healthcare benefits. It is my responsibility to notify the organization of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPPA) to ensure that I have been made aware of my privacy rights.

Name of person signing below (print):

_____

Relationship to Insured:

_____

Signature of Insured or Parent/Guardian:

_____

Mike M. Pappas, D.O.
Suffolk Rehabilitation Medicine, PLLC
220 Fort Salonga Rd.
Northport, NY 11768

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name_____ Date of Birth_____

Social Security#_____

I request and authorize_____ to
Release healthcare information of the patient named above to:

Name_____

Address_____

City_____ State_____ Zip Code_____

This request and authorization applies to healthcare information relating to the following

treatment, conditions, or dates: _____

_____

All Healthcare Information:_____

Other:_____

Yes No I authorize the release of any records regarding drug, alcohol, or

mental health treatment to the person(s) listed above.

Patient Signature_____ Date Signed_____

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED

HIPPA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14th, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in this office.

What is this all about: Specifically, there are rules and restrictions on who may see of be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the US department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1) Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other health care providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, as least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to the persons other then the office staff. You agree to the normal procedure utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2) It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, us mail or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to the office policy and new technology that you might find valuable or informative.

3) The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentially rules of HIPPA.

4) You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5) You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6) Your confidential information will not be used for the purpose of marketing or advertising of products, goods, or services.

7) We agree to provide patients with access to their records in accordance with State and Federal Laws.

8) We may change, add delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

9) You have the right to request restrictions in the use of your protected health information and to request charge in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

_____ _____

Patient Signature Date

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
COVER LETTER

NAME, ADDRESS AND PHONE NUMBER OF INSURER, SELF-INSURER OR REPRESENTATIVE*	NAME, ADDRESS AND PHONE NUMBER OF CLAIM REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

NAME AND ADDRESS OF APPLICANT	**COMPLETE THE ATTACHED DB-450 FORM IMMEDIATELY IF YOU ARE ENTITLED TO NEW YORK STATE DISABILITY BENEFITS AND MAIL OR GIVE IT TO YOUR EMPLOYER. TO FIND OUT IF YOU ARE ELIGIBLE, TELEPHONE THE NEW YORK STATE DISABILITY BENEFITS BUREAU AT (718) 802 6964**

DEAR APPLICANT:

This will acknowledge receipt of notice that you may have sustained injuries in the above captioned accident. The New York No-Fault Law provides for the payment of benefits to victims of motor vehicle accidents to reimburse them for their basic economic loss. Briefly summarized, basic economic loss consists of up to $50,000 per person in benefits for the following:

a. all necessary doctor and hospital bills and other health service expenses, payable in accordance with fee schedules established or adopted by the New York State Insurance Department;
b. 80% of lost earnings up to a maximum monthly payment of $2,000 for up to three years following the date of the accident;
c. up to $25 per day for a period of one year from the date of the accident for other reasonable and necessary expenses the injured person may have incurred because of an injury resulting from the accident, such as the cost of hiring a housekeeper or necessary transportation expenses to and from a health service provider; and
d. a $2,000 death benefit, payable to the estate of a covered person, in addition to the $50,000 coverage for economic loss described above.

Additional benefits may be owed to you if the above policy has been endorsed to include Optional Basic Economic Loss coverage and/or Additional Personal Injury Protection coverage.

In determining the benefits payable to you under the No-Fault Law, amounts recovered or recoverable on account of the accident from Workers' Compensation, New York State Disability, and certain wage continuation plans will reduce your No-Fault benefits. Therefore, if you are entitled to any of these benefits you should make your claim for them promptly.

If you are a named insured or relative under a Mandatory Personal Injury Protection policy which includes OBEL coverage, you may be entitled to an additional $25,000 of Basic Economic Loss coverage. You should make your claim to that motor vehicle insurer promptly, but in no event later than 90 days after your $50,000 of Basic Economic Loss coverage under this policy is exhausted.

NOTE: The No-Fault Law provides that if you are injured on a bus or a school bus in New York State, No-Fault benefits must be paid by your auto insurer or if you have no auto, the auto insurer of a relative with whom you reside. The law further provides that you should only file a No-Fault claim with the insurer of the bus or school bus if there is no such auto policy in your household. If the above rule does not apply, you may file a No-Fault claim with the insurer of the bus or school bus if you are the operator, owner or employee of the owner of the bus company.

COVER LETTER -- PAGE TWO

To enable us to determine if you are entitled to any No-Fault benefits, please complete and immediately return the enclosed APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS (NYS FORM NF-2) along with copies of any bills you have received to date. This application must be sent to us within 30 days of the accident date if your original notice to us was not in writing.

You are entitled to receive health service benefits without any time limit if it is possible to determine during the first year after the accident that further health services may be required after the first year. As you receive additional medical bills or any other bills you believe to be covered, send them to us immediately. In order to be considered for payment, all bills for health care services must be submitted within **45** days of treatment. If it is not possible for you or your health care provider to submit these bills within that time period, submit a written explanation of the reason for the delay. Claims for lost earnings and other reasonable and necessary expenses must be submitted within **90** days. We will reimburse you as soon as we are able to verify that they are covered expenses under No-Fault. Please identify all communications with us with the claim number shown above. Should you have any questions concerning your claim, we will be most happy to assist you. Please feel free to call the claim representative at the phone number provided at the top of page one.

PLEASE NOTE THAT THE TIME ALLOWED FOR PROVIDING NOTICE AND PROOF OF CLAIM TO YOUR INSURER HAS BEEN REDUCED. FAILURE TO RETURN A COMPLETED APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS FORM (NF-2) TO YOUR INSURER TIMELY CAN RESULT IN LOSS OF ALL BENEFITS. FAILURE TO SUBMIT BILLS FOR HEALTH CARE SERVICES WITHIN 45 DAYS OF TREATMENT OR MAKE CLAIM FOR LOST EARNINGS OR OTHER REASONABLE AND NECESSARY EXPENSES WITHIN 90 DAYS OF OCCURRENCE CAN RESULT IN THOSE BENEFITS BEING DENIED. **If your insurer denies coverage for failure to make a timely submission you can provide them with a written reply stating why you could not reasonably meet the time frames and your insurer must consider it.**

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.

Very truly yours,

IMPORTANT REMINDERS

PLEASE ANSWER ALL QUESTIONS ON THE APPLICATION FORM AND SIGN BOTH AUTHORIZATIONS SO THAT WE MAY GIVE PROMPT ATTENTION TO YOUR CLAIM

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

TO ENABLE US TO DETERMINE IF YOUR ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

1. YOUR NAME	2. PHONE NOS. HOME	BUSINESS

3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.

6. DATE AND TIME OF ACCIDENT A.M. ○ P.M. ○	7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE

8. BRIEF DESCRIPTION OF ACCIDENT

9. DESCRIBE YOUR INJURY

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS, ☐ A TRUCK, ☐ AN AUTOMOBILE, ☐ OR A MOTORCYCLE

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	☐	☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	☐	☐
WERE YOU A PEDESTRIAN?	☐	☐
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	☐	☐
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES ☐ NO ☐

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOUR WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT? ☐ IN-PATIENT? ☐

DATE OF ADMISSION: _____

HOSPITAL'S NAME AND ADDRESS: _____

14. AMOUNT OF HEALTH BILLS TO DATE:	15. WILL YOU HAVE MORE HEALTH TREATMENT(S)?	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
$ _____	YES ☐ NO ☐	YES ☐ NO ☐

17. DID YOU LOSE TIME FROM WORK?	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK?
YES ☐ NO ☐		YES ☐ NO ☐

IF YES, DATE RETURNED TO WORK: _____ AMOUNT OF TIME LOST FROM WORK: _____

18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?

YES ☐ NO ☐

20. LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?

YES ☐ NO ☐

IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

	YES	NO
NEW YORK STATE DISABILITY?	☐	☐
WORKERS' COMPENSATION?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE THREE

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

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.

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOUR ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____ SOCIAL SECURITY NO. _____

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____

SIGNATURE _____ DATE _____

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

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

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

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 <u>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</u>. 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 Female | 4. OCCUPATION (IF KNOWN)

5. DIAGNOSIS AND CONCURRENT CONDITIONS

6. WHEN DID SYMPTOMS FIRST APPEAR?
DATE: _____

7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS 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)

CONTINUE ON PAGE 2

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
PAGE 2

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
		See Attached		
			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

CONTINUE ON PAGE 3

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
PAGE 3

PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (**Assignment of Benefits**). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in # 21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

21. _____ (IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)

ASSIGNMENT OF NO-FAULT BENEFITS:

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE 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, 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

PRINT NAME _____ SIGNED _____
PATIENT (Assignor) PATIENT DATE

PRINT NAME Mike Pappas, D.O. SIGNED _____
PROVIDER OF HEALTH CARE SERVICE (Assignee) PROVIDER OF HEALTH CARE SERVICE DATE

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED? ☐ YES ☐ NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? ☐ YES ☐ NO

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.

DATE	PROVIDER'S SIGNATURE	IRS/TIN IDENTIFICATION NO.	WCB RATING CODE IF NONE, SPECIALTY
		204209624	OPCPMR

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

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** Suffolk Rehabilitation Medicine PLLC **, ("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)	
Suffolk Rehabilitation Medicine, PLLC	
(Print name of Provider)	**(Signature of Provider)**
P.O. Box 1795	(Date of signature)
Huntington NY 11743	
(Address of Provider)	

NYS FORM NF-AOB (Rev 1/2004)