Fresh Meadows Wellness Center

184-17 Union Turnpike
Fresh Meadows, New York 11366

Patients Name: _____

Insurance Company: _____

Address: _____

_____

Phone Number: _____ Ext: _____

Claim Number: _____ Date of Accident: _____

File Number: _____ Policy #: _____

Attorney's Name: _____

Attorney's Phone Number: _____

Has your NF2 form been submitted? YES or NO

Signature: _____ Date: _____

PLEASE COMPLETE AND SIGN ASSIGNMENT OF BENEFITS FORM.

THANK YOU

PERSONAL INJURY QUESTIONNAIRE

Name_____Date of Injury_____Phone# _____
Address_____City_____State_____Zip_____

Your Ins. Co._____Policy #_____Agent name_____

Diver/other vehicle_____ Ins. Co_____Policy #_____

ATTORNEY: Name_____Phone ( )_____
Address_____City_____State_____Zip

NATURE OF ACCIDENT:

1. Date of accident_____

2. Were you: ( ) Driver ( ) Front seat passenger ( ) Right back seat ( ) Left back seat

3. Number of people in your vehicle: _____

4. What direction was you headed? ( ) North ( ) East ( ) South ( ) West

5. Name of Street: _____

6. What direction was other vehicle headed? ( ) North ( ) East ( ) South ( ) West

7. Name of Street: _____

8. Where was your vehicle struck? ( ) Behind ( ) Front ( ) Right side ( ) Left side

9. Were you knocked unconscious? ( ) Yes ( ) No If yes for how long?_____

10. In your own words, please describe accident:

_____
_____
_____

11. Did you have any physical complaints BEFORE the ACCIDENT? ( ) Yes ( ) No If yes, please describe in detail:

_____
_____
_____

12. Please describe how you felt:

(a)Immediately after the accident:

_____
_____

(b) Later that day:

_____
_____

(c) The next day:

_____
_____

13. What are your PRESENT complaints and symptoms?

_____
_____

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)

NYS FORM NF-AOB (Rev 1/2004)