**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_ **CO-PAY:$\_\_\_\_\_\_**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SEX: Female** **Male**

**ADDRESS: ­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ APT: \_\_\_\_\_\_ CITY: \_\_\_\_\_\_\_ ST: \_\_\_\_\_\_ ZIP:** \_\_\_\_\_\_\_

**E-MAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ @ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.COM**

**HOME TEL: (\_\_\_\_)-\_\_\_\_\_-\_\_\_\_\_\_ CELL PHONE: (\_\_\_\_)-\_\_\_\_-\_\_\_\_\_\_**

**EMPLOYEED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BUS TEL: (\_\_\_\_)-\_\_\_\_\_-\_\_\_\_\_\_\_**

**DATE OF BIRTH: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ SOCIAL SECURITY#: \_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_**

**MARITIAL STATUS:** **MARRIED** **SINGLE** **WIDOWED** **DIVORCED**

**RACE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ETHNICITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMERGENCY CONTACT**

**NAME:** ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **TEL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **NON SURROGATE DECISION MAKER  SURROGATE DECISION MAKER**

 **INSURANCE INFORMATION**

**PRIMARY INS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SECONDARY INS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**POLICY#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POLICY#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**POL. HOLDER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POL. HOLDER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**POL. HOLDER’S DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POL. HOLDER’S DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**POL. HOLDER SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POL. HOLDER SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NO FAULT/LIEN**

**DATE: OF ACCIDENT: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_**

**POL. HOLDER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**POL. HOLDER’D ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_**

**INSURANCE CARRIER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TEL#: (\_\_\_\_)-\_\_\_\_\_-\_\_\_\_\_**

**CLAIM#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**POLICY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADJUSTER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADJUSTER PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **ATTORNEY INFORMATION**

**NAME: ­­­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: (\_\_\_\_\_\_)-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY: \_\_\_\_\_\_\_\_\_\_\_\_ ST: \_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_**

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**780 8th Avenue, New York, NY 10036**

**Phone: (212)-757-0222 Fax: (212)-757-02223**

**Email:Info@PPNYC.COM**

**Authorization to Leave Message with Household Members or Answering Machine**

From time to time, it is necessary for staff to leave messages for patients. The purpose of this message is to remind patients that they have an appointment or to notify the patient to call Pain Physicians NY, PLLC regarding an issue or concerns. At no time will Pain Physicians NY, PLLC discuss your medical condition without your consent. The purpose of this consent is to allow us to leave messages with members of your household or on your answering machine/voicemail. By signing this consent, you agree to allow Pin Physicians NY, PLLC and staff to leave messages on answering machine/voicemail for the purpose described above.

**You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature:**

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date: \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_

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 **780 8th Avenue Suite 201, New York, NY 10036.**

 **Phone: 212-757-0222 Fax: 212-757-0223**

 **Email:** **info@ppnyc.com**

  **Office Policy Regarding Reimbursement For Provided Services**

In order to make our payment policies clear and to avoid any misunderstanding, please read and sign this notice.

1. It is your responsibility to provide our office with:
2. **A valid copy of your insurance card (s)**
3. **A valid referral ( if required)**
4. **All other information necessary for us to secure payment from your insurance company.**

**If you do not have a valid insurance card or the required information regarding the subscriber, payment in full is expected at the time of service.**

1. After a claim is processed by your insurance company, our office will bill you for the remaining balance due to any deductibles, co-insurance and procedures not covered by your insurance. Balance must be paid within **30 days** of receiving a statement.
2. When paying with card, credit/ debit please be advised that there is a **2.75% Fee** on top of your existing co-payment or balance.
3. If we do not get a response from you after **60 days,**  your balance will be sent to collection agency. You might also be charged applicable attorney fees and any other expenses acquired in order to collect outstanding balances.
4. Please note in the event that you fail to keep an appointment or fail to notify us **24 hours prior** of cancellation, you will be charged a **$50.00 non- refundable fee.**

**Your signature below indicates:**

1. You understand and accept this policy.
2. You authorize any third party payment of medical benefits to this office on your behalf.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Patient’s Name**

**X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Signature of Patient Date**

**Pain Physician 780 8th Ave, Suite 201, New York, NY 1003**

 **Tell: (212)757-0222 Fax: (212)757-0223**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where did accident happen? Describe the accident in your own words: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What was your position in the car?

****Driver: if Driver were your hands on the steering wheel? ****Left ****Right ****Both

**** Passenger: If passenger, were you sitting In ****Front **** Right Rear **** Left Rear

Did your vehicle strike another vehicle****Yes****No

Was your vehicle struck by another vehicle ****Yes ****No

Angles of impact … First Collision: ****Front ****Back****Left ****Right

 If Second Collision: ****Front ****Back ****Left Right

Were you wear a seat belt? ****Yes  ****No

Did you brace for impact: ****Yes ****No… ****I braced with my hands ****I braced with my feet

Which way were facing at the time of impact… ****Straight ahead ****Left Right

Did you strike anything inside the vehicle at the time of impact? ****Yes ****No

If yes, specify what part of your body struck what: ie … head chest chin shoulder Right/Left knee

 ****Steering Wheel ****Dashboard\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ****Left side Door ****Roof\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ****Left side window ****Right Side Door\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ****Left Side Window ****Right Side Window\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ****Other­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Did the seat back bend/break? ****Yes ****No

Immediately following the accident, how did you feel? ****Dizzy/dazed ****Disoriented ****Unconscious

 ****Nervous Nauseous Upset Weak Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you go to the hospital? ****Yes ****No Were you admitted to the hospital? ****Yes ****No, If yes how long?\_\_\_\_\_\_\_\_

If you went to the hospital, when? ****At the time of accident ****Next day

How did you get to the hospital? ****Ambulance ****Police Car ****Private Transportation

Name of Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attended by Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

… what treatment was given?

****None **** place in a cervical collar **** X-rayed ****give stitches Bandaged

****Given pain medication ****Given instructions regarding concussions

****Given instructions regarding sprains and strains ****physical Therapy

****Instructed to call a Orthopedic Surgeon ****Instructed to call a private physician

****Referred to this office for treatment ****Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen any other doctor as a result of this accident? ****Yes **** No

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Doctor’s name

**CHIEF Complaints or Symptoms: Name: \_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_**

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| ** Neck pain **none ****Left shoulder ****Left arm ****Left forearm **** Left hand****Check off the areas that the pain****Runs into from the neck****Headache****Upper back pain |

****Dizziness ****Nervousness ****Fatigues **** Anxiety ****Depression ****Excessive irritability

****Fear of driving in a car **** A loss of concentration ****Nightmares ****Difficulty with sleeping at night

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| **Low Back Pain **None ****Buttocks **** Left Buttock ****Left thigh ****Left kneeSelect the areas of radiation, If any… **** Left foot ****Right buttocks ****Right thigh ****Right knee ****Right foot |

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| Hip Pain ****Left **** Right ****BilateralKnee Pain ****Left ****Right **** BilateralFoot Pain ****Left ****Right **** Bilateral  |

**Numbness:**

****Left Hand ****Left Upper Arm ****Right Hand ****Right Upper Arm

****Left Foot ****Left Leg ****Right Loot ****Right Leg

**Additional Symptoms/ Complaints:**

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Have you lost any time from work due to your injuries? ****Yes **** No

If yes please give dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had previous Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Previous Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of previous Injuries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any residual pain from the previous injury? ****Yes **** No

How much better did you feel prior to your current condition< (Example 100%, 80% etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Medical History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Surgical History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAIN PHYSICIANS NY**

**CONSENT FOR MEDICATION THERAPY**

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and your physician/health care provider complies with all state and federal regulations concerning the prescribing of controlled substances. A trail of opioid therapy can be consideration for moderate to severe pain with intent of reducing pain and increasing function. The physician’s goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risk and benefits of using opioids to treat pain.

I have agreed to use opioids as part of my treatment for chronic pain. I understand that these drugs can be very useful, but have a high potential for misuse and are therefore closely controlled by the local, state, and federal government. Because my physician/health care provider is prescribing such medication to help manage my pain, I agree to the following conditions:

1. I am responsible for my pain medications: I agree to take the medication only as prescribed.
2. I understand that increasing my does without the close supervision of my physician could lead to drug overdose causing severe sedation and respiratory depression and death.
3. I understand that decreasing or stopping my medication without the close supervision of my physician can lead to withdrawal. **Withdrawal symptoms** can include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, “goose fesh” abdominal cramps, and diarrhea. These symptoms can occur 24-48 hours after the last dose and can last up to 3 weeks.
4. I will not request or accept controlled substance medication from any other physician, health care provider, dentist or individual while I am receiving such medication from my physician/health care provide at the pain center.
5. There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating edema, sedation, or the possibility of impairing cognitive (mental status) and/or motor ability. Overuse of opioids can cause decreased respiration (breathing). It is my responsibility to notify my physician/health care provider for any side effects that continue or are severe (i.e., sedation, confusion). I am aso responsible for notifying my pain physician immediately if I need to visit another physician or need to visit an emergency room due to pain.
6. I understand that the opioid medication is strictly for my own use. The opioid should never be given or sold to other because it may endanger that person’s health and is **againt the law.**
7. I should inform my physician of all medication I am taking, including herbal remedies. Medications liked Valium or Ativan; sedatives such as Soma, Xanax, Fiorinal; anthistamines like Benadryl; herbal remedies, alcohol, and cough syrup containing alcohol, codeine, or hydrocodone can interact with opioids and produce serious side effects.
8. During the time that my dose is being adjusted, I will be accepted to return to the clinics as instructed y my clinic physician.
9. I understand that opioid prescriptions **will not** be mailed. If I am unable to obtain my prescriptions monthly, I will be responsible for finding a local physician who can take over the writing of the prescriptions with consultations from my pain physician.
10. Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other physicians (which includes emergency rooms). Uncontrolled dose escalation or reduction, loss of prescription, or failure to follow the agreement may result in termination of the doctor/patient relationship.
11. I will communicate fully with my physician to the best of my ability at the initial and all follow-up visits my pain level and functional activity along with any side effects of the medications. This information allows my physician to adjust your treatment plan accordingly.
12. I will not use any illicit substances, such as cocaine, heroin, etc while taking their medications. This may result in a change to your treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of the doctor/patient relationship. I will avoid use of alcohol.
13. **For female patients:**  If I plan to become pregnant or believe that I have become pregnant while taking this medication, I am aware that, should I carry the baby to delivery while taking these medications; the baby will be physically dependent upon opioids. I will immediately call my obstetricians and this office to inform them of my pregnancy. I am aware that opioids may cause birth defect, even though it is extremely rare.
14. I am responsible for my opioid prescriptions. I understand that:
15. Prescriptions can be for a maximum of one month supply and will be filled at the **same pharmacy.**

**Pharmacy Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_ ST:\_\_\_\_ Zip code:\_\_\_\_\_\_\_\_\_\_ Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **It is my responsibility to schedule appointments for the next opioid refill before I leave the clinic or within 3 days of the last clinic visit.**
2. I am responsible for keeping my pain medications in a safe and secure place, such as a locked cabinet or safe. I am expected to protect my medication from loss or theft. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. I will then report the stolen medication to my physician. If my medication is lost, misplaced, or stolen my physician may choose not to replace the medication or taper and discontinue the medications. If my pain medications are stolen, I will immediately contact the police and file a police report.
3. Refills will not be made as an”emergency”, such as on Friday afternoon because I suddenly realize I will “run out tomorrow”.
4. Prescriptions can only be filled by a pharmacy in the State of New York.
5. Prescriptions for pain medicine or any other prescriptions will be done only during an office visit or during regular office hours.
6. **You must bring back all opioid medications and adjunctive medications prescribed by your physician in the original containers/bottles at every visit.**
7. **I agree to present myself, for a pill count within 24 hour notice upon the request of the doctor, with all remaining medications which have been prescribed by this practice. Failure to appear will be grounds for termination of the doctor/patient relationship.**
8. Prescriptions will not be written in advance due to vacations, meetings, or other commitments.
9. If an appointment for a prescription refill is missed, another appointment will be mad as soon as possible. *Immediate* or *emergency* appointment will not be granted.
10. I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including New York’s Board of Pharmacy, in the investigation of any possible misuse, prescription forgery, sale, or any other diversion of my pain medication; I understand that illegal substance use may be reported to the proper authorities. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
11. While physical dependence is to be accepted after long-term use of opioids, **signs of addiction, abuse, or misuse shall prompt the needs for substance dependence treatment as well as weaning and detoxification from the opioids.**
12. I will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment, and sometimes two to three days extra **if** the prescription ends on a weekend of holiday. This extra medication is **not** to be used without the explicit permission of the prescribing physician unless an emergency requires your appointment to be deferred one or two days.
13. I agree and understand that my physician reserves the right to perform random or unannounced urine drug testing. If requesting to provide a urine sample, I agree to cooperate. If I decide not to provide a urine sample, I understand that my doctor many change my treatment plan, including safe discontinuation of my opioid medication when applicable or complete termination of doctor/patient relationship. The presence of a non-prescribed drug (s) or illicit drug (s) in the urine can be grounds for termination of the doctor/patient relationship. Urine drug testing is not forensic testing, but is done for my benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substance to treat pain.
14. I agree to allow my physician/health care provide to contact any health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions if the physician feels it in necessary.
15. If I tired or mentally foggy, I will not drive, operate heavy equipment, or serve in any capacity related to public safety. I understand that this is likely to occur during dosage adjustments.
16. I agree to a family conference or a close friend or significant other if the physician feels it is necessary.
17. If I feel tired or mentally foggy, I will not drive, Operate heavy equipment, or serve in any capacity related to public safety. I understand that this is likely to occur during dosage adjustment.
18. I agree to a family conference or a conference with a close friend or significant other if the physician feels it is necessary.
19. If I have a history of alcohol or drug misuse/addiction, I must notify the physician of such history since the treatment with opioids for pain may increase the possibility of relapse. A history of addition does not disqualify one for opioids treatment of pain, but starting or continue a program for recovery **is a necessary.** I agree to participate in a detoxification program in prescribed by my physician.
20. I understand that non-compliance with the above conditions may result in a re-evaluation of my treatment plan and discontinuation of opioid therapy. I may be gradually taken off these medications or even discharge from the clinic.

I have read the above information or it has been read to me and all my questions regarding the treatment of pain with opioids have been answered to my starification, I hereby give my consent to participate in the opioid medication therapy & acknowledge receipt of this document.

**Patient’s Name X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_**

**Physician Signature X­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­ Date:** \_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

**Notice of Privacy Practices**

***This notice describes how medical information about you may be used and disclosed and how you can get access to this information so please make sure to review it carefully.***

This federal Health Insurance Portability and Accountability act of 1996 (“HIPAA”) is to provide you with a description of the types of information that we gather about you, with whom that information may be shared, the safeguard that we have in place to protect it, and your rights to access and armed your health information. Because this notice only describes your privacy protections and other rights related to your medical information under HIPAA, you may be afforded additional protections and rights under other federal laws and /or State law that are not described in this notice. If the practices described in this notice meet your expectations, there is nothing further you need to do. If you prefer that we not share certain information, you may make a written request, as described below.

**Our Pledge Regarding Your Medical Information:**  We understand that information about you and your health is personal. We are thus committed to protecting the confidentiality of your medical information. As part of our routine operations, we create records of the medical care and service you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care, weather made by your personal doctor or other personnel. Whenever we use the term “medical information” in this notice, we mean information created or received about you that concern’s your health care and payment for that health care. This notice tells you about the ways we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the used and disclosure of medical information.

***Federal law requires is to:***

* Maintain the privacy of your medical information.
* Provide you with notice of our duties and privacy practices related to your medical information.
* Notify you when there is a breach, or unlawful access, use, or disclosure of your information.
* Follow the terms of this privacy notice.

**How We May Use and Disclose Your Medical Information:** The following describes different ways that we may use and disclose your medical information. For each category of uses or disclosures we will explain what the category means and gives examples.

**For Treatment:**  We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical student, or other facility personnel who are involved in taking care of you. For example: A doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to speak to the dietician in regards to your diabetes to determine an appropriate meal. Different departments of the facility also may share medical information about you to coordinate the different things you need, such as prescriptions, lab works, and x-rays. When necessary, we may also disclose medical information about you to people outside the facility who may be involved in your medical care. **As Required By Law:**  We will disclose medical information about you when required to do so by federal, state or local law. **Worker’s Compensation:**  We may release medical information about you to your employer’s insurance carrier, to the Worker’s Compensation Board or to similar programs.

**Special Protection for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information:** Special privacy protections apply to HIV- related information, alcohol and substance abuse treatment information, mental health information, psychotherapy notes (under federal law) and genetic information. If your care involves there special areas, please contact your health care providers or counselor for more information about these additional protections.

**Legal Proceedings:**  If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

***You’re Rights Regarding Your Medical Information***

**Right to Access and Copy:** You have the right to request access to, and obtain a copy of information that may be used to make decision about you. This information includes medical and billing records, but does not include psychotherapy notes or information pertaining to an ongoing clinical trial. You have the right to request that copies of electron records be provided in electron form. To access and copy information that may be used to make decisions about you, please submit your request in writing to the facility’s Health Information Management Department.

If you request that a copy of the information be provided to you, we may charge a fee to cover the costs of copying, preparing and mailing the request. If you are denied access to information, we will provide you with a written explanation.

**Right to a Paper Copy of this Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have obtained your notice electronically, you are still entitled to a paper copy of this Notice. You may also obtain a copy of this notice at our, [www.nyc-gov/hhc](http://www.nyc-gov/hhc). To obtain a paper copy of this notice, please request one from the front desk.

**Complaints:**

If you believe you privacy rights have been violated, or have concerns about our privacy practice, you may file a complaint with the secretary of the department of Health and Human Services. To file please call the toll- free Complaint Hotline at 1-866-HELP- HHC. You will not be penalized for filling a cpmplaint.

**Other uses and Disclosures of Medical Information:**

Other uses and disclosures of medical information that are not covered by this notice, or by applicable federal, state, and local laws, will only be made with your written permission. If you provide us with permission to use or disclose your medical information, you may revoke that permission, in writing at any time. If you revoke your permission, we no longer use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosure that we have already made with your permission and that we are required to retain in our records of the care that we provide to you.

**Acknowledgement:**

By signing and dating the form below, I acknowledge that I have received a copy of the New York City Health and Hospital Corporation’s Privacy Notice.

**Print Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_**

If executed by a patient’s personal representative, please print your name in the space below:

Personal Representative’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Representative Signature: **X** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**780 8th Avenue Suite 201, New York, NY 10036.**

**Phone: 212-757-0222 Fax: 212-757-0223**

**Email:** **info@ppnyc.com**

**Attorney Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Attorney Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **MEDICAL REPORTS AND DOCTOR’S LIEN**

 I do hereby authorize the above doctor’s office to furnish you, my attorney, with a full report of the 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 owning 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 withhold such sums from any settlements, judgment or verdict as may be necessary to adequately protect said doctor.

 And I here further give a lien on my case to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor’s additional by protection and in consideration of the doctor’s awaiting payment and in the event this case is assigned by me to another not a signatory hereto. I understand that all money due said doctor/clinic will be due and payable by me.

The execution of this lien and assignment shall not relieve the above doctor’s office of their obligation to timely submit their bills to the No Fault insurance company for payment.

The obligation of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ under the terms of this lien and assignment does not relieve the above doctor’s office from proceeding to arbitrate the denial of any No Fault benefits, prior to the enforcement of this lien. The attorney for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ shall hold in escrow, that portion of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ settlement proceeds which consists unpaid/denied No Fault benefits until such time as there is a final determination of any No Fault arbitration/lawsuit.

 **I UNDERSTAND THIS IS AN IRREVOCABLE LIEN AND ASSIGNMENT**

**PATIENT’S NAME: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT SIGNATURE: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

 The undersigned, being attorney of record for the above patient, does herby to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said clinic within 10 (ten) days in the patient (my client) assigned to other counsel.

**DATE\_\_\_/\_\_\_/\_\_\_\_ ATTORNEY’S SIGNATURE X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ATTORNEY’S NAME AND ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TO THE ATTORNEY:** Please date and return one copy to the above stated doctor/clinic at once; treatment can continue on the herein contained lien basis.

**NEW YORK MOTOR VEHICLE NO – FAULTINSURANCE LAW**

 **ASSIGNMENT OF BENEFITS FORM**

(FOR ACCIDENT ACCORDING ON AND AFTER 03/01/02)

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (“Assignor”)** hereby assign to PAIN PHYSICIANS NY PLLC, **(Assignee”)**

 **(Patient’s name) (Print hospital or health care provider name)**

All rights privileges and remedies to payment to health care services provided y 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 form or on behalf of the assigner 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 agreements.

 **(Print accident date)**

To the contrary,

The 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 COMMERCAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERICAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE OMFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO CONNECTION WITH SUCH APPLICATION CLAIM KNOWINLGY ASSISTS, ABETS, SOLICITS, OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VECHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, EHICH IS A CRIME, AND SHALL ALSO BE SUBJUECT TO A CIVIL PEENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(Print name of Patient) (Signature of Patient)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Date of Signature)**

 **(Address of Patient)**

 **TAMER ELBAZ MD.\_\_\_\_\_\_\_\_\_\_\_**

 **(Print name of Provide) X**

 **708 8TH Avenue, Suite 201\_\_\_\_\_\_\_\_\_\_**

 **(Address of Provider)**

 **\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_**

**NYS FORM NF-AOB (Rev 05/2015) (Date of Signature)**

**NEW YORK MOTOR VEHICLE NO – FAULTINSURANCE LAW**

 **ASSIGNMENT OF BENEFITS FORM**

(FOR ACCIDENT ACCORDING ON AND AFTER 03/01/02)

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (“Assignor”)** hereby assign to NY ANESTHESIA , **(Assignee”)**

 **(Patient’s name) (Print hospital or health care provider name)**

All rights privileges and remedies to payment to health care services provided y assignee to which I am entitled under article 51 ( the No- Fault statute) of the Insurance **Law**.

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 **(Print accident date)**

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(Print name of Patient) (Signature of Patient)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (**Date of Signature)

 **(Address of Patient)**

 **TAMER ELBAZ MD.\_\_\_\_\_\_\_\_\_\_\_**

 **(Print name of Provide) X **

 **708 8TH Avenue, Suite 201\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(Date of Signature)**

 **New York, N.Y 10036\_\_\_\_**

 **(Address of Provider)**

**NYS FORM NF-AOB (Rev 05/2015)**

**NEW YORK MOTOR VEHICLE NO – FAULTINSURANCE LAW**

 **ASSIGNMENT OF BENEFITS FORM**

(FOR ACCIDENT ACCORDING ON AND AFTER 03/01/02)

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (“Assignor”)** hereby assign to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, **(Assignee”)**

 **(Patient’s name) (Print pharmacy name)**

All rights privileges and remedies to payment to health care services provided y assignee to which I am entitled under article 51 ( the No- Fault statute) of the Insurance **Law**.

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 **(Print accident date)**

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(Print name of Patient) (Signature of Patient)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (**Date of Signature)

 **(Address of Patient)**

 **TAMER ELBAZ MD.\_\_\_\_\_\_\_\_\_\_\_**

 **(Print name of Provide) X **

 **708 8TH Avenue, Suite 201\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(Date of Signature)**

 **New York, N.Y 10036\_\_\_\_**

 **(Address of Provider)**

**NYS FORM NF-AOB (Rev 05/2015)**

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