Brattner

Chiropractic Group

Serving Long Island, Brooklyn & Queens

CUESTIONARIO DE SALUD

Nomber: _____ Seguro Social: _____

Fecha De Nacimiento: _____ Edad: _____

Direccion: _____ Ciudad: _____

Estado: _____ Codigo Postal: _____

Telefono: _____ Telefono De Trabajo: _____

Correo Electronico: _____

Ocupacion: _____ Referido Por: _____

Cuales son sus quejas? (Que parte de su cuerpo le duele):

_____

Cuanto tiempo ha tenido con esta condicion? _____

Ha tenido esta condicion en el pasado? Si _____ No _____

Que agrava su condicion? _____

_____

Siente que su condicion se esta empeorando? Si _____ No _____

El Dolor es: Constante _____ Viene y Va_____

Ha tenido atencion quiropractica antes? Si _____ No _____

Lista de doctores que an tratado esta condicion: _____

_____

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Lista de cirugias y años: _____

_____

Lista de Medicamentos que esta tomando: _____

_____

Edad del Colchon: _____ Incomoda: Si ____ No ____ Comoda Si ____ No ____

Esta usted usando? Talon Ascensores ___ Suelas interior ___ Refuerzo para el arco ___

Ha estado usted alguna vez en un accidente automovilistico? Si ____ No ____

Si contesto (si) favor de describir su accidente y la fecha en cuando ocurrio su accidente en el pasado: _____

_____

_____

Ha tenido otras lesiones o accidentes antes? Si _____ No _____

Si contesto (si) favor de describir y la fecha en cuando ocurrio:

_____

_____

_____

Fecha de su ultimo examen fisico: _____ Doctor de familia: _____

Ha sufrido usted de lo siguiente?

Mareo___	Dolores de Espalda___	Dolor de Cuello___
Diabetes___	Artristis___	Dolores de cabeza___
Asma___	Neuritis___	Digestivas de enfermedades___
Nerviosismo___	Problemas del Corazon___	Problemas Sinusitis___

East Hills office: 118 Crescent Lane, Roslyn Heights, NY 11577, (516) 626-1305
Queens office: 865 Cypress Avenue, Ridgewood, NY 11385, (718) 628-5300
www.easthillschiropractor.com www.chiroNYC.com

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Por favor incluya otra dolencioa o condiciones, Cualquier tratamiento o medicos que ha visto para esta condiciones: _____

_____

INFORMACION DE SEGURO MEDICO

Es su condicion debido a un accidente de carro o accidente de trabajo relacionados con la lesion por la cual esta en nuestra officina? Si ___ No ___

Nombre del seguro de **SU** carro: _____

Numero del clamo cuando **USTED** susmetio al Seguro que **USTED** tuvo un accidente de carro:

Nombre del seguro de **SU** trabajo: _____ **WCB:** _____

Numero del clamo que **SU** trabajo susmetio al seguro de ellos que usted tuvo una herida en el trabajo: _____

Nomber de SU seguro medico: _____

Numero de politica: _____

Tipo de plan: _____

HMO/PPO/Senior Plan: _____

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Entiende y acepta que las politicas de salud y accidente son un acuerdo entre una compañia de seguro y yo mismo. Ademas, tengo entendido que esta oficina de quiropractica prepara cualquier necesarioinforme y formularios para que me ayude en la toma de coleccion de la compañia de seguros y que cualquier importe autorizado a pagarse directamente a esta oficina de quiropractica sera acreditado a mi cuenta una vez recibida. Sin embargo, claramente entiende y acepta que todos los servicios prestados a me pagan directamente a mi y que estoy personalmente responsible por el pago. Tambien entiendo que si suspender o poner fin a mi atencion y tratamiento, los honorarios por servicios profesionales prestados para mi sera inmediatamente adeudadas y pagaderas.

Firma del Paciente: _____ Fecha: _____

Firma del Tutor: _____ Fecha: _____

Por la presente autoriza la liberacion de mis radiografias y registros medicos o copias de los mismos y solicitor que trasferirse a:

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Chiropractic Group

Serving Long island, Brooklyn & Queens

Formulario Medico De Derecho De Retención

Por la presente firmo un acuerdo con **Queens Chiropractic Asso., P.C.** (proveedor) para asegurar una compensación por los servicios prestados.Autorizo al PROVEEDOR a proporcionar a mi aseguradora y a mis abogados copias de los registros médicos y los resultados de las pruebas de diagnóstico, así como información relacionada con el diagnóstico, el pronóstico y el tratamiento.

Por la presente autorizo y dirijo el pago al proveedor de las sumas adeudadas y adeudadas por los servicios médicos que se me prestaron tanto por razón de cualquier otra factura que se deba al proveedor como para retener las sumas de mi sentencia de conciliación o veredicto que pueda ser necesario para proteger adecuadamente al proveedor. Además, por la presente otorgo un gravamen sobre mi caso al PROVEEDOR contra todos y cada uno de los ingresos de mi acuerdo, sentencia o veredicto que pueda pagarse a mi abogado oa mí mismo como resultado de las lesiones por las que he sido tratado. Estaré disponible para aparecer o corresponder en nombre del PRESTADOR en cualquier esfuerzo de cobranza que se realice. Todas las facturas que se consideren adeudadas y pagaderas al PROVEEDOR serán cobrables según la tarifa vigente en la que se prestaron los servicios.

Entiendo completamente que soy directa y debidamente responsable ante el PROVEEDOR de todas las facturas médicas enviadas por los servicios prestados y que este acuerdo se realiza únicamente para protección adicional y en consideración de pagos pendientes. Además, entiendo que dicho pago no está sujeto a mi acuerdo, sentencia o veredicto por el cual eventualmente pueda recuperar y cobrar. Estoy de acuerdo en no devolver nunca este documento y que ningún abogado aceptará la rescisión, por la presente instruyo que en el caso de que otro abogado sea sustituido de esta manera, el nuevo abogado no desea cooperar en la protección de los intereses de los PROVEEDORES, El PROVEEDOR no esperará el pago, pero podrá declarar por escrito el saldo total adeudado y pagadero, momento en el que dicho saldo deberá pagarse dentro de los treinta días.

FIRMA DE PACIENTE _____ FECHA _____

El abajo firmante, que es el abogado del registro del paciente mencionado anteriormente, por la presente acepta cumplir con todos los términos del gravamen equitativo y acepta retener las sumas de cualquier acuerdo, sentencia o veredicto que sea necesario para proteger adecuadamente al proveedor. El abogado acepta la notificación de que una parte de la reclamación por lesiones personales de sus clientes se ha asignado al PROVEEDOR y acepta desembolsar los fondos al PROVEEDOR para satisfacer cualquier gravamen pendiente o actuar como depósito en garantía antes de desembolsar cualquier producto de la liquidación de sus clientes. El abogado además reconoce que pueden ser responsables ante los cesionarios de los clientes si pagan dinero sin tener en cuenta este gravamen. Además, el abogado acuerda que si se sustituye a otro abogado, este gravamen equitativo será remitido al abogado sustituido y el PROVEEDOR será notificado por escrito de la misma dentro de los treinta días. Alternativamente, si la acción legal del paciente se suspende o se resuelve, el PROVEEDOR será notificado por escrito de la misma dentro de los treinta días.

FIRMA DE ABOGADO/ABOGADA _____ FECHA _____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number: _____

I, _____ ("Assignor") hereby assign to Queens Chiropractic Asso. ("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)

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*	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

PROVIDER'S NAME AND ADDRESS*

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? 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

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

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 first party 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 _____ 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

*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

Motor Vehicle Accident Indemnification Corporation
110 WILLIAM STREET
NEW YORK, N.Y. 10038

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
		N/A		

TO ENABLE US TO DETERMINE IF YOU 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.

NAME AND ADDRESS OF APPLICANT

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 (GIVE U.S. 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 ACCIDENT:

OWNER'S NAME | MAKE | YEAR

THIS VEHICLE WAS:

☐ A TRUCK, OR ☐ A BUS OR SCHOOL BUS
☐ A MOTORCYCLE ☐ AN AUTOMOBILE

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

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES? ☐ YES ☐ NO

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

13. IF YOU 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 TREATMENTS(S) ☐ YES ☐ NO	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? ☐ YES ☐ NO	
17. DID YOU LOSE TIME FROM WORK? ☐ YES ☐ NO	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK? ☐ YES ☐ NO	IF YES, DATE RETURNED TO WORK:
AMOUNT OF TIME LOST FROM WORK:	18. WHAT ARE YOUR 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

(Continued on next page)

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

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS
(Page 2)

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

NEW YORK STATE DISABILITY? ☐ YES ☐ NO

WORKERS COMPENSATION? ☐ YES ☐ NO

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 INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, 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 STATED VALUE OF THE CLAIM FOR EACH SUCH 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. 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) _____ 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)

- BRACKETED LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER

QUEENS CHIROPRACTIC ASSOCIATES P.C.
865 CYPRESS AVENUE
RIDGEWOOD, NY 11385
PHONE: 718-628-5300
FAX: 718-628-6297

LIEN FORM

I do hereby enter into an agreement with, QUEENS CHIROPRACTIC ASSOCIATES P.C. (provider) in order to assure compensation for service rendered. I authorize the PROVIDER to furnish my insurance carrier and or attorney with copies of medical records and diagnostic test results as well as information regarding diagnosis, prognosis, and treatment.

I hereby authorize and direct payment to the PROVIDER such sums as may be due and owing for medical services rendered me both by reason of my accident and by reason of my accident and by reason of any other bills that are due to the PROVIDER and to withhold such sums from my settlement judgment, or verdict as may be necessary to adequately protect the PROVIDER. Furthermore, I hereby give a lien on my case to the PROVIDER against any and all proceeds of my settlement, judgment, or verdict which may be paid to my attorney or to myself as a result of the injuries for which I have been treated. I will make myself available to appear or correspond on behalf of the PROVIDER in any collection effort that is undertaken. All bills deemed owing and payable to the PROVIDER shall be collectible at the prevailing fee schedule at the time services were rendered.

I fully understand that I am directly and fully responsible to the PROVIDER for all medical bills submitted for services rendered and that this agreement is made solely for additional protection and in consideration of pending payment. I further understand that such payment is not contingent on my settlement, judgment, or verdict by which I may eventual ly recover and fee.

I agree never to rescind this document and that a rescission will not be honored by any attorney, I hereby instruct that in the event another attorney is substituted in this manner, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as it were executed by him/her. I have been advised that if my attorney does not wish to cooperate in protecting the PROVIDERA interest, the PROVIDER will not await payment but May in writing declare the entire balance due and payable at which time said balance is to be paid within thirty days.

(Patient's signature) DATE

The undersigned being the attorney of record for the above name patient does hereby agree to observe all the terms of the equitable lien and agrees to withhold such sums from my settlement, judgment, r verdict as may be necessary to adequately protect the PROVIDER. The attorney accepts notice that a portion of their client's personal injury claim has been assigned to the PROVIDER and agrees to disburse the funds to the PROVIDER in order to satisfy any outstanding lien or to act as an escrow prior to disbursing any proceeds from their client's settlement. The attorney further acknowledges that they may be liable to client's assignees if they pay out money in disregard of this lien. Furthermore, the attorney agrees that if another attorney is substituted, this equitable lien will be forwarded to the substituted attorney and the PROVIDER will be notified in writing of the same within thirty days. Alternatively, if the patient's legal action is discontinued or resolved, the PROVIDER will be notified in writing of the same within thirty days.

DATE

Signature of Attorney/Representative

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURING 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 to the contrary.
(Print accident date)

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 INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, 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 STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

_____ _____
(Print name of Patient) (Signature of Patient)

_____
(Date of signature)

_____
_____
(Address)

OCA Official Form No.: 960

AUTHORIZATION FOR RE' ÁSE OF HEALTH INFORMATION RSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

Queens Chiropractic Associates, P.C.

Dr. Jason S. Brattner Dr. Dominic J. Rubino Dr. Frank J. Mandarino
865 Cypress Avenue
Ridgewood, NY 11385
Tel: 718-628-5300 Fax: 718-628-6297

I do hereby enter into an agreement with Queens Chiropractic Associates, P.C. in order to ensure reimbursement for cab services provided to me during my treatment.

I fully understand that I am responsible for providing Queens Chiropractic Associates, P.C. with any payments made to me for transportation by the insurance carrier pertaining to this matter.

Yo por este medio llego a un acuerdo con Queens Chiropractic Associates, P.C. a fin de garantizar el reembolso de los servicios de transportacion prestados durante mi tratamiento.

Entiendo perfectamente que soy responsable de proporcionar Queens Chiropractic Associates, P.C. con cualquier pago hecho a mi para el transporte por la compania de seguros relacionados con este asunto.

Patient Signature

Date