Rutman Medical PLLC

Telephone: 631-886-1500
Fax: 631-886-1831

MOTOR VEHICLE/NO FAULT INTAKE FORM

Name (PLEASE PRINT):_____Date of Birth: _____/_____/_____

Carrier Information

Insurance Carrier Name:_____ Carrier Phone No.( )_____

Address:_____

Policy No:_____ Claim No._____ Date of Accident:_____

Injury Information

Was the accident reported to your carrier? ◯ Yes ◯ No

Have you filed an application for no-fault benefits with the carrier? ◯ Yes ◯ No

Were you the driver of the vehicle or a passenger? _____

How did the accident happen? _____

Have you lost time from work? ◯ Yes ◯ No If yes, how much?_____

Have you seen another physician for this condition? Yes No Doctor's

Name:_____

Were x-rays taken? ◯ Yes ◯ No Other tests? ◯ Yes ◯ No If yes, please list test and facility where taken:_____

Attorney Information

Attorney's Name:_____ Phone No._____

Address:_____

May we contact your attorney regarding your case? ◯ Yes ◯ No

Authorization

I, the undersigned, certify that the information given above is correct. I clearly understand and agree that all services rendered to me that are not covered, are charged directly to me, and that I am personally responsible for payment in the event that my claim for No-Fault benefits are denied.

Patient's Signature:_____ Date: ___/___/___

Please note: In this instance, we will attempt to bill any back-up insurance you may have prior to billing you directly.

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

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

I, _____ (Print patient's name), **("Assignor") hereby assign to** RUTMAN MEDICAL PLLC (Print hospital or health care provider name), **("Assignee") 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 _____ (Print accident date), **not withstanding 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.

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)	
RUTMAN MEDICAL PLLC **(Print name of Provider)**	**(Signature of Provider)**
148 NATURES LANE	(Date of signature)
MILLER PLACE, NY 11764 (Address of Provider)	

NYS FORM NF-AOB (Rev 1/2004)