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** Strong Spine Chiropractic 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)	
Strong Spine Chiropractic PLLC	
(Print name of Provider)	**(Signature of Provider)**
7 Rugby Pl.	(Date of signature)
Jamestown, NY 14701	
(Address of Provider)	

NYS FORM NF-AOB (Rev 1/2004)

Motor Vehicle Accident
Chiropractic Intake Form

Name: _____ DOB _____ Date: _____

Insurance Information:
Name of Insurance Company: _____

Claims #: _____ Adjusters Name: _____

Phone # to reach Adjuster: _____ Claim open for Medical Billing: YES NO

Claims Filing Address: _____

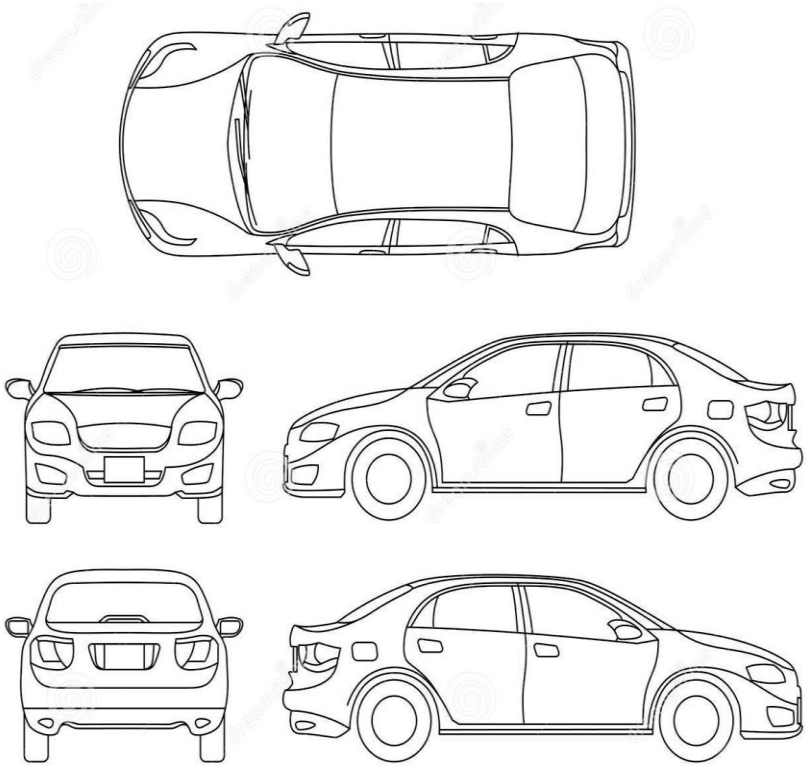
Other Party Insurance Company (If Applicable):
Name of Insurance Company: _____ Ins Phone #: _____

Secondary Claim #: _____

At Fault Party's Name: _____ Phone #: _____

ACCIDENT HISTORY:

Date of Accident: _____ Time of Accident: _____ AM or PM



State how the accident happened in your own words:

_____

_____

_____

_____

_____

_____

_____

← **Please indicate where your car was damaged to the best of your ability.**

Patient Signature: _____ Date: _____

ACCIDENT HISTORY:

Type of Vehicle: _____Year of Vehicle: _____

Were you driving the car? YES NO If NO, who was? _____

Did your vehicle strike anything else? (Tree, another car, side railing, etc.)_____

What were the weather conditions like? _____

How fast were you driving? _____

Were you driving distracted? _____

Were you wearing a seatbelt? YES NO

Did the Air Bags go off? YES NO

Did Police arrive at the accident? YES NO

Did EMS arrive at the accident? YES NO

What was the extent of damage done to your car? _____

What was the other type of vehicle involved in the accident? _____ Year_____

What was the extent of damage done to the other car? (If known) _____

INJURY HISTORY:

Did you hit any part of your body during the collision? (Head hit dashboard, chest hit steering wheel, etc.)

_____

Where are you feeling the pain now?

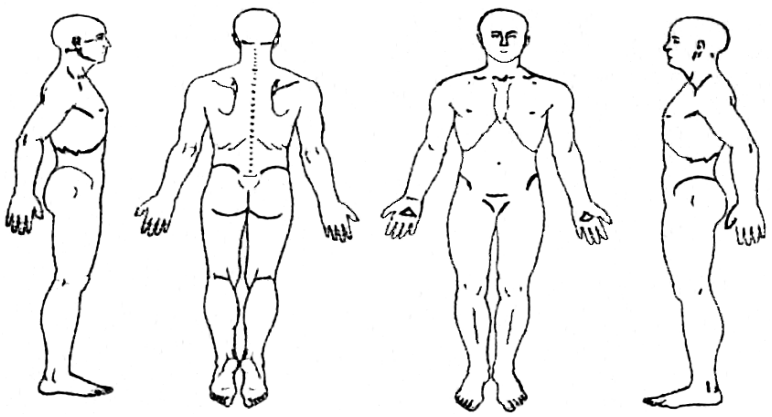
Condition #1 Main complaint: _____

Condition #2: Second complaint: _____

Condition #3: Third complaint: _____

Condition #4: Fourth complaint: _____

Please mark the image where you are feeling pain or discomfort. →



OFFICE USE ONLY
Height:
Weight:
Blood Pressure:
Pulse:

Patient Signature: _____ Date: _____