

**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)

\_\_\_\_\_  
25 Harrison St.

\_\_\_\_\_

\_\_\_\_\_  
Jamestown, NY 14701

\_\_\_\_\_  
(Date of signature)

\_\_\_\_\_  
(Address of Provider)

## 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):

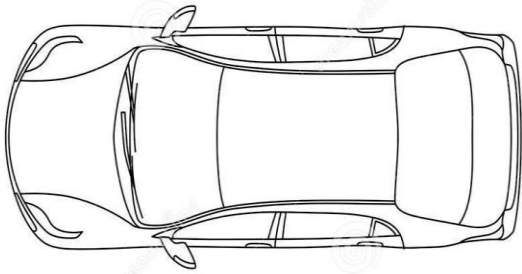
Name of Insurance Company: \_\_\_\_\_ Ins Phone #: \_\_\_\_\_

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:

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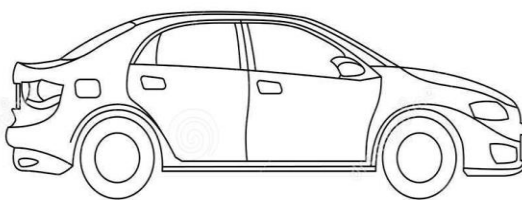
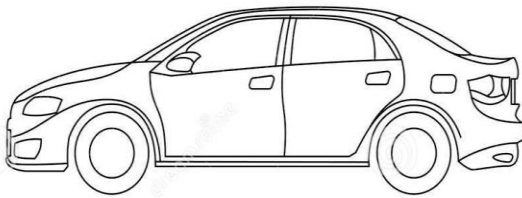
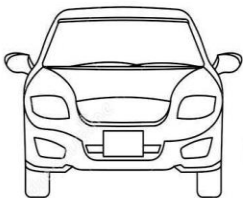
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← Please indicate where your car was damaged to the best of your ability.

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: \_\_\_\_\_

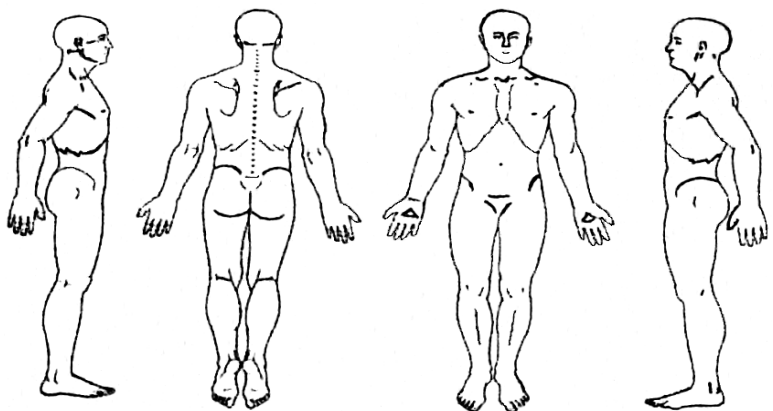
Condition #2: Second complaint: \_\_\_\_\_

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: \_\_\_\_\_