

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

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
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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

PAGE 2

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 _____ PATIENT SIGNED _____ 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 No-Fault 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 _____ PATIENT (Assignor)	SIGNED _____ PATIENT
PRINT NAME _____ PROVIDER OF HEALTH CARE SERVICE (Assignee)	SIGNED _____ PROVIDER OF HEALTH CARE SERVICE

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

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 Steven Struhl MD, ("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)

(Date of signature)

Steven Struhl, MD
681 Lexington Avenue
5th Floor
New York, NY 10022


(Signature of Provider)

(Date of signature)

(Address of Provider)

STEVEN STRUHL, M.D., L.L.C.

**Steven Struhl, MD
681 Lexington Avenue
5th Floor
New York, NY 10022**

**ASSIGNMENT OF RECOVERY PROCEEDS AND
AUTHORIZATION TO DR. STEVEN STRUHL, M.D.**

PATIENT _____

ADDRESS _____

ATTORNEY _____

I, _____, the undersigned, do hereby assign to STEVEN STRUHL, M.D., any sums due and payable received by me or on my behalf from any source for any and all medical treatment and/or fees for services rendered to me and/or my attorney.

I authorize and direct my attorney to deduct and immediately pay STEVEN STRUHL, M.D., such fees as may be due and payable from the assigned monies that may come into my hands or my attorney's hands in any recovery resulting from any claims or lawsuit. I further direct my attorney to contact STEVEN STRUHL, M.D., to determine the exact amount owed before any money is paid to me from any recovery resulting from any claim or lawsuit. I further direct my attorney to advise STEVEN STRUHL, M.D., upon request, of the status of my lawsuit and/or any claims which may result in a monetary recovery from which the fees due and payable to STEVEN STRUHL, M.D., may be satisfied. If my attorney is replaced by another attorney, I direct that the outgoing attorney not forward my file until written acknowledgment from my new attorney is signed and forwarded to the undersigned acknowledging the terms and conditions set forth in this assignment.

STEVEN STRUHL, M.D., agrees to provide reasonable cooperation in connection with securing payment for all insurance claims to the extent required by law.

In the event of any breach of this assignment by the patient and/or the patient's attorney, it is understood that the patient shall remain responsible for all legal fees required to either obtain insurance information and/or collect any monies owed to STEVEN STRUHL, M.D., plus the

STEVEN STRUHL, M.D., L.L.C.

**Steven Struhl, MD
681 Lexington Avenue
5th Floor
New York, NY 10022**

expense of litigation and/or arbitration

It is understood that this agreement in no manner whatsoever makes the payment of the fee due and payable to STEVEN STRUHL, M.D., contingent upon securing a recovery in any lawsuit or in any insurance claim that I may have. I understand that I remain personally responsible for all fees for medical treatment as well as for services rendered on my behalf to my attorney and that I am personally liable for payment of the same. Further I acknowledge that this assignment does not, in any fashion, preclude or otherwise prevent STEVEN STRUHL, M.D., from demanding payment at any time after such services as embraced within this assignment are rendered.

(Patient or legal Guardian Signature)

(Witness)

THE TERMS AND CONDITIONS OF THE FOREGOING ASSIGNMENT ARE UNDERSTOOD AND AGREED TO.

ATTORNEY: _____

ADDRESS: _____

ATTORNEY SIGNATURE: _____

DATED: _____