Rutman Medical PLLC

Telephone: (631) 304 – 0781
Fax: (631) 849 – 5376

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

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 & PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

PROVIDER'S NAME AND ADDRESS

Rutman Medical PLLC
148 Natures Lane
Miller Place, NY 11764-3137

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. **PLEASE NOTE COMPLETED FORM MUST BE SUBMITTED TO INSURER NO LATER THAN 180 DAYS AFTER TREATMENT DATE.**

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. AGE	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)

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:

NOTE: COMPLETE REVERSE SIDE AND SIGN.

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE

15. REPORT OF SERVICES RENDERED

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 NUMBER	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

(OPTIONAL) 20.
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.

SIGNED _____
(PATIENT)

OR

(OPTIONAL) 21. ASSIGNMENT OF NO-FAULT BENEFITS:
I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW. THIS AGREEMENT SHALL BECOME NULL AND VOID IF AT ANY TIME IT IS DETERMINED THAT BENEFITS ARE NOT PAYABLE DUE TO THE FOLLOWING CIRCUMSTANCES: LACK OF COVERAGE, VIOLATION OF A POLICY CONDITION, OR DETERMINATION THAT THE TREATMENTS/SERVICES RENDERED ARE NOT RELATED TO SAID MOTOR VEHICLE ACCIDENT. ANY PAYMENT PURSUANT TO THIS ASSIGNMENT SHALL NOT EXCEED THE HEALTH CARE PROVIDER'S PERMISSABLE CHARGES UNDER SAID ARTICLE 51. THE PROVIDER OF HEALTH SERVICES CERTIFIES THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE INJURED PARTY AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE INJURED PARTY FOR SERVICES PROVIDED DUE TO INJURIES SUSTAINED IN RELATION TO THE AUTOMOBILE ACCIDENT.

SIGNED _____
(PATIENT)

SIGNED _____
(PROVIDER OF HEALTH CARE SERVICE)

"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."

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

I, _____ , ("Assignor") hereby assign to Dr. Matthew Rutman , ("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. If an insurer denies a claim for health service benefits because the assignor failed to appear for a medical examination or examination under oath at the insurer's request, then this assignment, unless it is made to a hospital as defined in 11 NYCRR § 52.2(m), shall be voidable by an insurer and shall not be enforceable against an insurer, and an insurer shall not be obligated to pay benefits directly to any provider of health services other than a hospital as defined in 11 NYCRR § 52.2(m).

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 2/2018)