Lindenhurst Accident & Injury Center

CONFIDENTIAL PATIENT INFORMATION

Dear Patient: Please complete this questionnaire. Your answers will help us determine if physical therapy care can help you. If we do not sincerely believe your condition will respond satisfactory, we will not accept your case. THANK YOU.

Name: _____ DOB: _____

SS # _____ Age: _____

Marital Status: M S W D Home # : _____

Work #: _____ Occupation: _____

Cell Phone # : _____ Email Address: _____

Home Address: _____

_____

Who may we thank for referring you? _____

Who is your Primary Care Physician? _____

PCP Address: _____ City: _____

State: _____ Zip Code: _____ Phone #: _____

INSURANCE INFORMATION

Is this an injury due to:

☐ Work Injury ☐ Auto Injury ☐ Sports Injury ☐ Other

Do you have Major Medical Health Insurance? ☐ Yes ☐ No

Insurance Carrier: _____

Address: _____ City: _____ State: _____ Zip: _____

Insured's Name: _____ Relationship to you: _____

Insured's SS #: _____

Insured's Employer: _____

Insured's Work #: _____

Do you have a referral from your Primary Care Physician? ☐ Yes ☐ No

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Thomas Bradley, DPT will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Thomas Bradley, DPT will be credited to my account on receipt. However, I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

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

Guardian/Spouse Signature: _____ Date: ___ / ___ / ___

Information taken by: _____ Date: ___ / ___ / ___

LIEN ASSIGNMENT AGREEMENT

I hereby enter into the following agreement with _____,

Thomas Bradley, DPT, hereinafter known as "the provider" in order to guarantee payment for services rendered by "the provider" to me. I understand that I am directly and fully responsible to "the provider" for all medical bills for services rendered to me. I understand that I am directly and fully responsible to "the provider" for any remaining balance on all medical bills for services rendered to me that were submitted on my behalf to the responsible insurance carrier as applicable. This document further serves to acknowledge my responsibility to repay all remaining balances subsequent to all applicable insurance payments. I agree to make myself available to appear or correspond with "the provider" as often as may be necessary for any collections effort that is undertaken. I have been made aware of the charges for the services rendered under this lien assignment and acknowledge my responsibility for the repayment of all outstanding balances. I further direct that my attorney shall not subsequently dispute these amounts and will contact this office to arrange for full payment at the time a settlement, trial or motion proceed becomes ready for disbursement.

To the extent applicable, I agree to comply with all Insurance Company regulations including, but not limited to examinations under oath and independent medical examinations. I understand that any failure on my part to comply with any condition precedent to insurance coverage, may, at the election of the medical provider, serve to revoke any assignment of No-Fault benefits. The patient herein further acknowledges their responsibility to file a timely notice of claim to the applicable insurance carrier and that any subsequent No Fault claim denied based on the failure to provide a timely notice, at the election of the provider may result in recovery efforts in reliance of the lien.

The Provider agrees to seek compensation from the appropriate insurance carrier prior to invoking the terms of this lien based on the accuracy of the information the patient has provided and to the extent applicable. The patient shall provide all necessary insurance information, police reports, and any additional documentation or information deemed necessary by the provider for the submission of the aforementioned Insurance claim as applicable. Failure to provide accurate insurance information leading to the viable source of coverage may serve to invalidate any executed assignment of No-Fault benefits and result in the reliance on this lien for reimbursement purposes.

I hereby give and grant this lien on my case to "the provider" against any and all proceeds of any settlement, judgement, verdict, or other disposition of any litigation filed or contemplated on my behalf hat may be paid to me or my ATTORNEY as a result of the injuries for which I have been treated. I grant "the provider" the aforesaid lien against such sums of the aforesaid settlement, judgement, verdict, or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse "the provider" for services rendered to me and toward all outstanding balances. I hereby agree to provide accurate contact information for the attorney pursuing any litigation on my behalf.

I hereby direct and authorize direct payment to "the provider", such sums as may be due and owning for medical services rendered to me. I further direct my ATTORNEY to honor the aforesaid lien and to withhold such sums from any settlement, judgement, verdict or other disposition of any litigation filed or contemplated on my behalf as may ne necessary to adequately reimburse "the provider" for services rendered to me towards all outstanding balances.

Patient's Initials: _____ Patient's Signature: _____

I understand that this document may not be rescinded and that my ATTORNEY shall not honor any such rescission. I hereby instruct that in the event another ATTORNEY is substituted in my care, I direct the substituted attorney to provide the incoming ATTORNEY with a copy of this lien and that I direct any incoming ATTORNEY to honor this lien as inherent to the settlement, judgement, verdict, or other disposition of any litigation field or contemplated on my behalf and enforceable upon the case as if it were executed by him/her. I hereby direct and authorize my attorney, on demand, to provide the status of such litigation to "the provider" or the attorney representing the provider prior to disbursement of any funds to ascertain any outstanding balances due to the provider, herein

_____

Patient's Name: _____

Patient's Address: _____

_____

Dated: ___ / ___ / ___

Patient's Signature: _____

Patient's Attorney's Name: _____

Attorney's Address _____

_____

Attorney's Phone #: _____

Attorney Signature: _____

Dated: ___ / ___ / ___

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)	
Thomas Bradley, DPT	
(Print name of Provider)	**(Signature of Provider)**
193 N. Wellwood Ave	
Lindenhurst, N.Y. 11757	(Date of signature)
(Address of Provider)	

NYS FORM NF-AOB (Rev 1/2004)

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

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

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

TO ENABLE US TO DETERMINE IF YOUR ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

NAME AND ADDRESS OF APPLICANT*

1. YOUR NAME	2. PHONE NOS. HOME BUSINESS	
3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.
6. DATE AND TIME OF ACCIDENT A.M. P.M.	7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE	

8. BRIEF DESCRIPTION OF ACCIDENT

9. DESCRIBE YOUR INJURY

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS, ☐ A TRUCK, ☐ AN AUTOMOBILE, ☐ OR A MOTORCYCLE

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	☐	☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	☐	☐
WERE YOU A PEDESTRIAN?	☐	☐
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	☐	☐
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES ☐ NO ☐

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOUR WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT? ☐ IN-PATIENT? ☐

DATE OF ADMISSION: _____

HOSPITAL'S NAME AND ADDRESS: _____

14. AMOUNT OF HEALTH BILLS TO DATE:	15. WILL YOU HAVE MORE HEALTH TREATMENT(S)?	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
$ _____	YES ☐ NO ☐	YES ☐ NO ☐

17. DID YOU LOSE TIME FROM WORK?	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK?
YES ☐ NO ☐		YES ☐ NO ☐

IF YES, DATE RETURNED TO WORK:	AMOUNT OF TIME LOST FROM WORK:

18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?

YES ☐ NO ☐

20. LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?

YES ☐ NO ☐

IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

	YES	NO
NEW YORK STATE DISABILITY?	☐	☐
WORKERS' COMPENSATION?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE THREE

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

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.

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOUR ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____ SOCIAL SECURITY NO. _____

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____

SIGNATURE _____ DATE _____

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

NO FAULT INSURANCE INFORMATION

Patient Name: _____

Policyholder Name (if different): _____

Insurance Company: _____

Address: _____

_____

Claim #: _____

Policy #: _____

Date of Accident: ___ / ___ / ___

Were you in a company vehicle at the time of an accident? _____

Please list all prescription or non-prescription medications you are currently taking:

_____

Do you smoke? _____

Right or left hand dominant? _____

Height: _____

Weight: _____

Have you ever had any prior motor vehicle collision or injury? If so, please briefly explain:

_____

_____

Are you currently working? If so, what is your job title and what types of movements are required of you?

_____

_____

Please state your current health conditions and history of health: _____

_____

_____

Have you received care from another health care provider/facility for your injury? _____

_____

_____

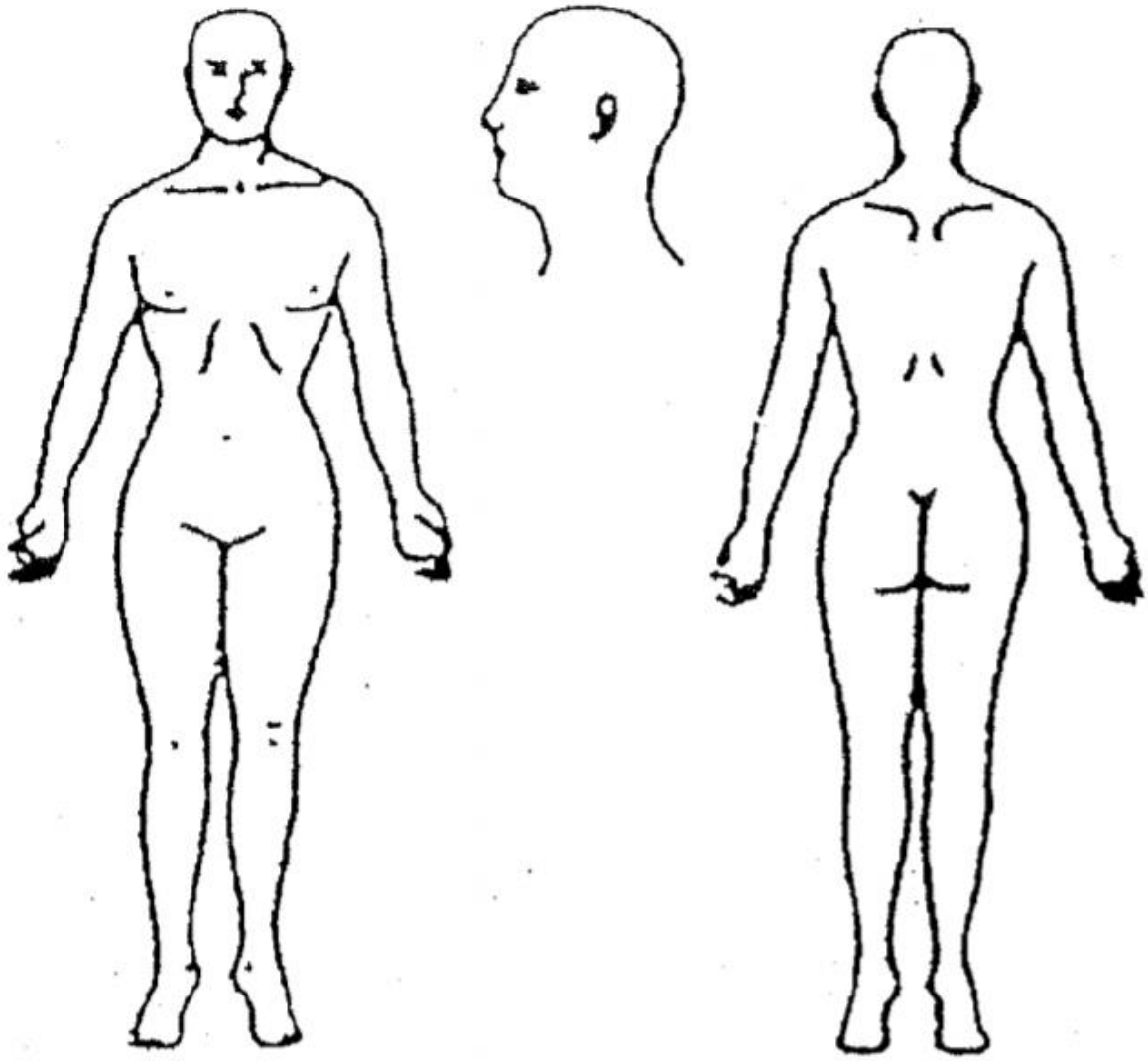
SYMPTOM DIAGRAM

Patients Name: _____ Number: _____ Date: _____

Please be sure to full this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

ACHES = ^^^^ PINS/NEEDLES = · · · · STABBING = /////

NUMBNESS = °°°° BURNING = XXXX



Physical Therapy Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of massage therapy physiotherapy and diagnostic procedures, including various modes of massage therapy, physiotherapy and diagnostic X-rays and diagnostic testing, on me (or on the patient names below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic name below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-names procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature _____ Date ____/____/____

Witness Signature _____ Date ____/____/_