

PATIENT'S NAME: _____ SS#: _____ DATE: _____

NO FAULT INFORMATION - FILL THIS OUT IF YOU WERE INJURED IN A CAR ACCIDENT:

INSURANCE COMPANY: _____

(VEHICLE YOU WERE IN AT TIME OF ACCIDENT)

INSURANCE COMPANY ADDRESS: _____ TELEPHONE #: _____

_____ FILE #: _____
CITY STATE ZIP

DATE OF ACCIDENT: _____ POLICY OR CLAIM #: _____

NAME OF INSURED (IF OTHER THAN CLAIMANT): _____

ADDRESS OF INSURED: _____ DATE LAST WORKED: _____

_____ LOCATION OF ACCIDENT: _____
CITY STATE ZIP

HISTORY OF ACCIDENT: _____

ATTORNEY: _____ FIRM NAME: _____

ADDRESS: _____ TELEPHONE #: _____

_____ CITY STATE ZIP

IN CONSIDERATION OF SERVICES RENDERED TO THE ME, I HEREBY AUTHORIZE PAYMENT DIRECTLY TO ORTHOPAEDIC SURGEONS OF L.I, ASSOCIATES OF ANY AND ALL FIRST PARTY NO-FAULT AUTOMOBILE INSURANCE BENEFITS TO WHICH I MAY OTHERWISE BE ENTITLED FOR SERVICES RENDERED BY THE PROVIDER, BUT NOT TO EXCEED THE PROVIDER'S REGULAR CHARGES FOR SUCH SERVICES.

IN THE EVENT THE PROVIDER'S CHARGES ARE OUTSTANDING AND I FAIL TO FILE AN APPLICATION FOR BENEFITS UNDER THE NEW YORK STATE NO-FAULT INSURANCE LAW, I HEREBY AUTHORIZE THE PROVIDER TO FILE SUCH CLAIM IN MY BEHALF SO THAT THE PROVIDER MAY REALIZE PAYMENT OF ITS CHARGES. I UNDERSTAND THAT, IF THE PROVIDER DOES NOT RECEIVE PAYMENT FROM THE INSURER, I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT OF THE PROVIDER'S CHARGES.

I HEREBY AUTHORIZE ORTHOPAEDIC SURGEONS OF L.I, ASSOCIATES TO RELEASE MEDICAL INFORMATION ON MY INJURY TO THE NO FAULT CARRIER _____.

DATE: _____ SIGNED: _____

WORKER'S COMPENSATION INFORMATION ONLY:

EMPLOYER: _____ EMPLOYER ADDRESS: _____ PHONE: _____

WORKER'S COMPENSATION INSURANCE CARRIER: _____

ADDRESS OF CARRIER: _____ TELEPHONE #: _____

_____ CITY STATE ZIP

DATE OF INJURY: ____ / ____ / ____ LOCATION: _____

WCB CASE #: _____ POLICY OR CLAIM #: _____

HOW WERE YOU INJURED? _____

DATE LAST WORKED: _____

ATTORNEY: _____ FIRM NAME: _____

ADDRESS: _____ TELEPHONE #: _____

_____ CITY STATE ZIP

I, _____, HEREBY AGREE TO PAY ORTHOPAEDIC SURGEONS OF L.I, ASSOCIATES THEIR USUAL AND CUSTOMARY FEES FOR SERVICES RENDERED TO THE ABOVE NAMED CLAIMANT IN THE ABOVE IDENTIFIED CASE.

I HEREBY AUTHORIZE ORTHOPAEDIC SURGEONS OF L.I, ASSOCIATES TO RELEASE MEDICAL INFORMATION ON MY INJURY TO THE WORKERS COMPENSATION INSURANCE CARRIER _____.

IN THE EVENT I FAIL TO PROSECUTE THE CLAIM FOR WORKER'S COMPENSATION FOR THIS ILLNESS OR CONDITION OR THE WORKER DETERMINES IT'S COMPENSATION BOARD THAT THE ILLNESS OR CONDITION IS NOT A RESULT OF A COMPENSABLE WORKER'S COMPENSATION CASE.

DATE: _____ SIGNED: _____