Delmar
Chiropractic
Office

NO FAULT OFFICE POLICY

To become a no fault patient in this office we will need the name, address, phone number, policy number, of your Insurance Company, and the date of accident. If you have an insurance agent we will need their name, address and phone number also.

We need to call your Insurance Company to confirm your no-fault coverage, deductible and that you have reported your injury. We will let you know if there is a deductible and the amount. The deductible amount of the policy is your responsibility. Your insurance company will send you a NF 2 form that must be completed and returned to them as soon as possible. Without that form no claims will be processed.

We are also going to need the name, address, phone number, and identification number of your major medical insurance. In the event your no-fault coverage is denied, we will then submit all charges for your no-fault accident to your major medical carrier, along with a copy of the no-fault denial.

In the event we need your help with any problems that may arise on your no-fault case we will contact you. If your no-fault insurance company denies your coverage for any reason we will contact you.

500 Kenwood Avenue • Delmar, New York 12054 • (518) 439-7644 • Fax (518) 439-0191

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)

_____ _____
(Date of signature)

_____
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

Delmar Chiropractic Office

No Fault Injury

If you are filing a no fault claim the following information is needed to process your claim through the insurance company (of the car you were in at the time of the accident.)

Name:_____

Address:_____

Please give the following information about the person who owns the car you were in:

Name_____

Address:_____

Phone#:_____

Insurance Company:

Name_____

Adress:_____

Phone #:_____

Contact Person:_____

Claim #:_____ Policy#_____

Date of Accident_____ Date Accident Reported_____

Please note: It is your responsibility to give our office all of the information needed, so that we may send your bills to the insurance company of the car you were riding in. The accident must be reported to the insurance company, for your claim to be established. If you do not report the accident to the insurance company you will be responsible for all bills incurred at this office. If your insurance company denies treatment for any bills for any reason, it will then be your responsibility to pay them.

Signature_____

204 Delaware Avenue • Delmar, New York 12054 • (518) 439-7644 • Fax (518) 439-0191

1. What was the date of the accident?_____

2. What time did the accident occur?_____

3. How many vehicles were involved in the accident?_____

4. What was the estimated damage to the vehicle you were in? _____

5. What state did the accident occur in? _____

6. What city did the accident occur in? _____

7. What street or intersection were you on when the accident occured?
_____

8. What direction were you traveling in? _____

9. What type of impact was the auto accident? _____

10. Did your vehicle hit anything after the accident? if yes, please describe
_____

11. Where were you sitting in the vehicle during the accident?
_____

12. Did you know the accident was coming?_____

13. What type of vehicle were you in? _____

14. What type of vehicle impacted yours? _____

15. At the time of the impact, how fast was your vehicle moving? _____

16. At the time of impact, how fast was the other vehicle moving? _____

17. During and after the crash what happened to your vehicle? (circle all that apply)
- kept going straight
- kept going straight hitting a car in front
- was hit by another vehicle
- spun around
- spun around and hit a stationary object
- hit a stationary object

18. Did you lose consciousness during the accident? -yes - no

19. How was your head positioned during the accident? _____

20. How was your torso positioned during the accident? _____

21. How were your hands positioned during the accident? _____

22. Did your head hit anything during the accident? -no - yes, please describe_____

23. Did your face hit anything during the accident? -no - yes, please describe_____

24. Did your shoulders hit anything during the accident? -no - yes, please describe_____

25. Did your neck hit anything during the accident? -no - yes, please describe_____

26. Did your chest hit anything during the accident? -no - yes, please describe_____

27. Did your hips hit anything during the accident? -no - yes, please describe_____

28. Did your knees hit anything during the accident? -no - yes, please describe_____

29. Did your feet hit anything during the accident? -no - yes, please describe_____

30. What kind of headrest was in your vehicle?
- movable fixed headrest
- nonmovable fixed headrest
- no headrest

31. Where was the headrest positioned on your head? _____

32. Did you have your seatbelt on during the accident? - yes -no

33. Did you slide out of your seatbelt during the accident? _____

34. What was damaged in your vehicle? (Circle all that apply)

- windshield	- rear bumper	- mirror
- steering wheel	- front bumper	- knee bolster
- dashboard	- trunk	- back right door
- seat frame	- front left door	- completely totalled
- side window	- front right door	
- rear window	- back left door	

35. Choose the items that dented inward
- floorboards - side door - dashboard

36. Choose the doors that would not open as a result of the accident
- front left - front right
- rear left - rear right

37. Did you go to the hospital? If no, why and do not answer 38-43
_____

38. How did get to the hospital? _____

39. What was the name of the hospital? _____

40. Were you hospitalized over night? _____

41. Circle what you were prescribed at the hospital
- pain medication - muscle relaxors - neck brace

42. Did you recieve any stitches for any cuts at the hospital? _____

43. Were x rays taken at the hosiptal? If yes, which area was taken?
_____