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, ☐ OR A MOTORCYCLE ☐ A TRUCK, ☐ AN AUTOMOBILE,

	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

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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

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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.

WORKERS COMPENSATION / NO FAULT

DATE_____

NAME_____ **DATE OF BIRTH**_____

If your condition is **work related or automobile accident related** please fill out questions #1 or #2

#1 Worker's Compensation
DATE OF INJURY: _____WCB CASE NO.:_____ Carrier Case#:_____
Time of Injury: _____ am / pm
Employer at time of injury: _____
Employer Address: _____
Employer phone #: _____
INSURANCE CARRIER: (for this case) _____
Address: _____
_____
Insurance company phone #: _____
Describe in detail exactly how injury happened and what injuries you incurred:
_____
_____
_____
Loss of time? _____ If yes, from _____to_____
Are you working now? _____ Is your work limited? _____
Are you disabled? _____

I understand that I am personally responsible for the normal office fee if the compensation carrier does not honor my claim.

Patient/Guardian Signature_____
Date_____

#2 No Fault / Automobile Accident Case
Has a written accident report been filed with your insurance company? YES / NO
DATE OF ACCIDENT_____
Name of Auto Insurance company:_____
Address: _____
_____
Phone Number of Insurance company: _____
Contact Person: _____
Policy Holder: _____
Policy #:_____ **Claim #**_____
Unable to work: FROM_____/_____/_____ TO_____/_____/_____

I understand that I am personally responsible for the normal office fee if the insurance carrier does not honor my claim.

Patient/Guardian Signature: _____
Date: _____

As an Auto Accident Case - Patient and Doctor assume certain obligations:
PATIENT: To supply correct information to the doctor on the FIRST VISIT OR AT LEAST WITHIN 48 HOURS. To sign Assignment of Benefits which authorizes insurance company to pay doctor for services rendered. Otherwise we cannot accept you as an Assignment Auto Accident Case.
DOCTOR: File necessary forms with insurance carrier. Accept fees set by the insurance commissioner as payment in full for services rendered.

PATIENT HEALTH QUESTIONNAIRE

Name_____ Date_____

Please check all answers and fill in the blanks where appropriate. In the space below, please describe the major complaint which brought you to this office for care.

1. Major Complaint Description: (include related areas)

a. Area □head □neck □upper back □mid back □low back □shoulder □arm □hand □hip □leg □knee □foot

b. Location: □front □back □right □left □both sides □other (specify)_____

c. Description: □ sharp pain □ dull pain □ache □weak □throbbing □numb □shooting □gripping □burning □ tingling

d. Frequency: □ constant (76-100%) □ frequent (51-75%) □ occasional (26-50%) □ intermittent (25% or less)

e. Intensity:

no pain 1 2 3 4 5 6 7 8 9 10 unbearable pain

2. Describe how you current episode began: □ Uneventfully □ Gradually over time □ After specific incident

a. If from a fall, how many feet did you fall?_____

Did you land on □ Right □ Left □ Head □ Shoulder □ Middle Back □ Low Back □ Other_____

b. If from lifting, how many lbs?_____ and in what position were you?

□ bent forward □ bent backward □ knees bent □ twisted

Did you lift □ once □ a few times □ many times? Additional information?_____

3. Since current episode began on _____ has it □ decreased □ not changed □increased?

date

(if you don't know the specific date approximately how many _____weeks _____months_____years?)

4. What doctors/providers have you seen for this episode? □ DC □ MD □ DO □ PT □ None □Other_____

Examinations included: □ X-Rays _____ □ MRI _____ □ Other/results_____

date date

5. Treatment for this episode has included: □ Chiropractic _____ □ Exercise therapy □ heat □ cold (ice)

□ physical therapy_____ □ electrical therapy □ spinal injection_____ □ support/brace

□ surgery: describe_____ □ prescribed medication: list _____ □ OTC meds _____

6. In the past, have you been treated for a similar problem? □ Yes □ No If Yes, when?_____

What treatment helped?_____ Type of provider seen?_____

7. What makes your problem better/worse?

□ nothing □ lying down □ walking □ standing □ sitting □ movement/exercise □inactivity

8. How would you rate your general stress level? □ little or no stress □ minimal stress □ moderate stress □ greatly stressed

9. Physical activity at work: □sitting more that 50%of the day □light manual labor □manual labor □heavy manual labor □repeated motion

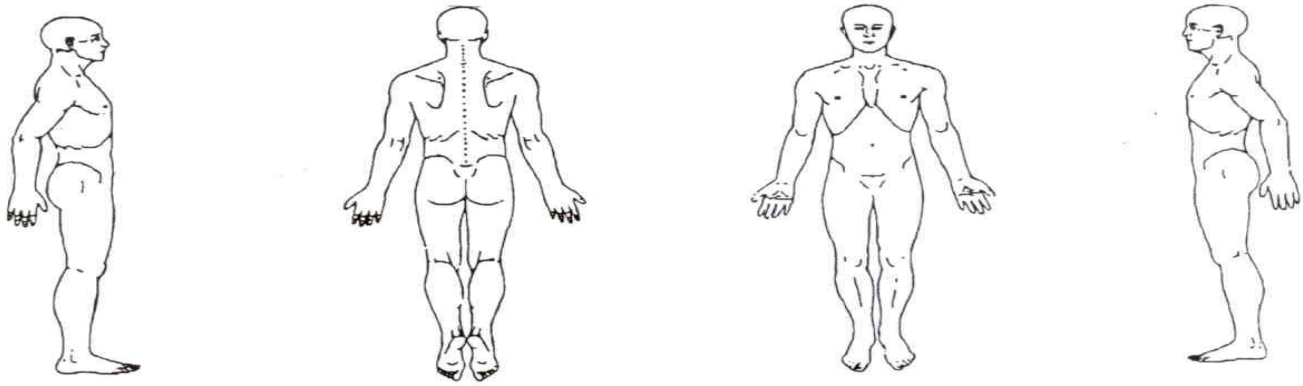
10. General physical activity:

□ no regular exercise program □ light exercise program □ moderate exercise program □ strenuous exercise program

11. Are your complaints affecting your ability to work or otherwise be active?

□ no effect
□ some physical restrictions (able to perform light duty & household tasks)
□ need limited assistance w/ common everyday tasks
□ need assistance often
□ significant inability to function w/out assistance
□ am totally disabled (impaired), and cannot care for self
□ cannot perform usual work duties
□ cannot work at all

Mark an X on the picture where you have pain or other symptoms as described in the major complaint description above.



Patient's Signature_____ **Date** _____

PERSONAL HISTORY

NAME_____ DATE_____

ADDRESS: _____

_____

HOME#: _____ CELL#:_____ WORK#:_____
EMERCENCY CONTACT NAME_____
EMERCENCY CONTACT PHONE_____
EMAIL ADDRESS: _____
DATE OF BIRTH: _____ MARITAL STATUS_____ REFERRED BY_____
PRIMARY CARE PHYSICIAN: _____

PRIMARY INSURANCE COMPANY: _____ Phone Number: _____
ID#:_____ Group#:_____

INSURED'S NAME: _____ Relationship: _____
Date of Birth of Insured: _____
Occupation & Employer: _____

SECONDARY INSURANCE: _____ Phone Number: _____
ID#: _____ Group#: _____

INSURED'S NAME: _____Relationship: _____
Date of Birth of Insured_____
Occupation & Employer_____

DO YOU TAKE ANY MEDICATIONS? ☐ yes ☐ no
If yes, please list all medications:

_____

_____

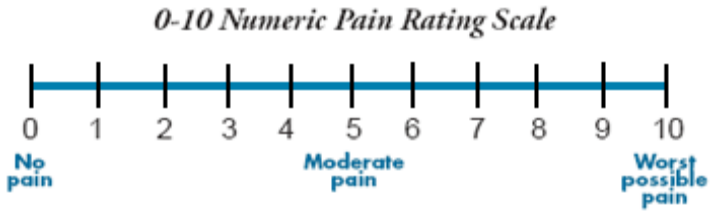
DO YOU HAVE ANY MEDICATION ALLERGIES? ☐ yes ☐ no
If yes, please describe: _____

_____

DO YOU HAVE ANY OTHER ALLERGIES? ☐ yes ☐ no
If yes, please describe:

_____

ARE YOU A SMOKER? ☐ yes ☐ no
☐ current smoker ☐ ex-smoker ☐ never smoked



HEIGHT: _____ WEIGHT: _____ BLOOD PRESSURE: _____

Signature_____ Date_____

PATIENT NAME_____ **DATE**_____

Below is a list of conditions, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can effect your overall diagnosis, treatment plan and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE OR HAVE HAD:

- ☐ Appendicitis
- ☐ Scarlet Fever
- ☐ Diphtheria
- ☐ Typhoid Fever
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Malaria
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Goiter
- ☐ Influenza
- ☐ Pleurisy
- ☐ Alcoholism
- ☐ Venereal Infection
- ☐ Auto Immune Deficient Syndrome
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Lumbago
- ☐ Eczema

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulder
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain / Stiffness
- ☐ Difficult Chewing / Clicking Jaw
- ☐ Gas / Bloating
- ☐ Heartburn
- ☐ Black / Bloody Stool
- ☐ Colitis
- ☐ Walking Problems

FEMALES ONLY

When was your last period?_____

Are you pregnant? ☐yes ☐no ☐ maybe

NERVOUS SYSTEM CODE

- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion / Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold / Tingling Extremities

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful / Excessive Urination
- ☐ Discolored Urine

GASTRO-INTESTINAL CODE

- ☐ Poor / Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Trouble
- ☐ Gall Bladder Problems
- ☐ Weight Trouble

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Heart Problems
- ☐ Irregular Heartbeat
- ☐ Lung Problems / Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling

GENERAL CODES

- ☐ Headaches
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever

MALE / FEMALE CODE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Cramping
- ☐ Breast Pains / Lumps
- ☐ Prostate / Sexual Dysfunction
- ☐ Genital Herpes

EENT CODE

- ☐ Vision Problem
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

FAMILY HISTORY- check all that apply

	Maternal		Paternal					
	Grandma	Grandpa	Grandma	Grandpa	Mother	Father	Brother	Sister
Allergies	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Cancer (type)	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Mental Disease	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Imbalance	☐	☐	☐	☐	☐	☐	☐	☐

Other_____

DR. DAVID A. WALLMAN

CERTIFIED SPORTS CHIROPRACTOR
CERTIFIED CLINICAL NUTRITIONIST
GENERAL AND FAMILY PRACTICE

SMITHTOWN CHIROPRACTIC 32 LAWRENCE AVENUE SMITHTOWN, NEW YORK 11787
PHONE (631) 265-1727 FAX (631) 265-9014

ASSIGNMENT & INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

I hereby direct and instruct the _____ insurance company to pay by check made out and mailed directly to:

Smithtown Chiropractic
32 Lawrence Avenue
Smithtown, New York 11787

If my current policy prohibits direct payment to the doctor, then I hereby also direct and instruct you to make the check payable to me and mail it as follows:

Patient Name: _____
c/o Smithtown Chiropractic
32 Lawrence Avenue
Smithtown, New York 11787

The professional or chiropractic expense benefits allowable and otherwise payable to me under my current policy as payment towards the total charges for professional services rendered are to be directed toward and made payable to Smithtown Chiropractic. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in the claim/case.

Dated at Smithtown Chiropractic this _____ day of _____ 201__

_____ _____
Signature of Policy Holder Witness

_____
Signature of Claimant, if other than policy holder

Assignment & Instruction For Direct Payment to Doctor

DR. DAVID A. WALLMAN

CERTIFIED SPORTS CHIROPRACTOR
CERTIFIED CLINICAL NUTRITIONIST
GENERAL AND FAMILY PRACTICE

SMITHTOWN CHIROPRACTIC
32 LAWRENCE AVENUE
SMITHTOWN, NEW YORK 11787
PHONE (631) 265-1727 FAX (631) 265-9014

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Smithtown Chiropractic's "Notice of Privacy Practices".

_____ _____
Signature of Patient/Legal Guardian Date

I give permission to Smithtown Chiropractic to disclose protected health information without restriction as outlined in their "Notice of Privacy Practices" to the appropriated parties, including the following indivduals:

_____

_____

_____

_____ _____
Signature of Patient/Legal Guardian Date