NF

FIFTH AVENUE SURGERY CENTER

1049 FIFTH AVENUE
NEW YORK NY 10028
212-772-6667

DATE: ________________

MEDICAL RECORD #: ____________________

PATIENT INFORMATION

LAST NAME,		FIRST NAME	M. I.
ADDRESS		APT #	
CITY	STATE	ZIP	COUNTY
TELEPHONE # (H)______________ (C)______________	DATE OF BIRTH (Month, Day, Year) [ ] FEMALE [ ] MALE	SOCIAL SECURITY #	
PATIENT OCCUPATION	EMPLOYER NAME	EMPLOYER ADDRESS	TELEPHONE #
NEXT OF KIN OR EMERGENCY CONTACT'S NAME			TELEPHONE #

EN CASO DE EMERGENCIA ↑ **TELEFONO#** ↑

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON ~~FIFTH AVENUE SURGERY CENTER~~

1049 FIFTH AVE
NEW YORK, NY 10028

X 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 X ________________, not withstanding any other agreement to the contrary.
(Print accident date)

The 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 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.

X ________________________________
(Print name of Patient)

____

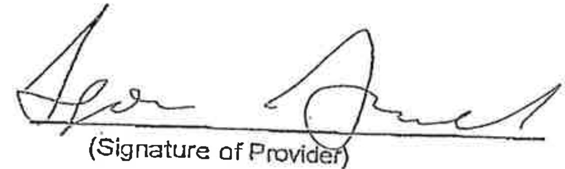
X ________________________________
(Address of Patient)

____
(Print name of Provider)

FIFTH AVENUE SURGERY CENTER
~~1049 FIFTH AVE~~
NEW YORK, NY 10028
____
(Address of Provider)

X ________________________________
(Signature of Patient)

X ________________________________
(Date of Signature)



(Signature of Provider)

____
(Date of Signature)

NYS FORM NF-AOB (Rev 1/2004)

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW

ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

X I, ______________________ (Print patient's name), ("Assignor") hereby assign to Igor Amigud Physician, PC (Print hospital or health care provider name), ("Assignee") 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 X ______________ (Print accident date), not withstanding any other agreement 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.

X ______________________ (Print name of Patient)

X ______________________ (Signature of Patient)

____

X ______________________ (Date of signature)

X ______________________ (Address of Patient)

Igor Amigud Physician, PC
(Print name of Provider)

Igor Amigud
(Signature of Provider)

____

______________________ (Date of signature)

______________________ (Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

~~(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)~~

X I, ______________________ , ("Assignor") hereby assign to United Physicians, PLLC , ("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 X______________ , not withstanding any other agreement
(Print accident date)

to the contrary.

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X______________________
(Print name of Patient)

X______________________
(Signature of Patient)

____

X______________________
(Date of signature)

X______________________
(Address of Patient)

United Physicians, PLLC
(Print name of Provider)

____
(Signature of Provider)

____

____
(Date of signature)

____
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
HOSPITAL FACILITY FORM

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIM REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM.

1. INSURANCE COMPANY | 2. ADDRESS OF INSURANCE COMPANY

3. PATIENT'S NAME AND ADDRESS | 4. DATE OF BIRTH | 5. PHONE NUMBER

6. AUTOMOBILE POLICY NUMBER | 7. NAME AND ADDRESS OF POLICYHOLDER

8. ACCIDENT DATE | 9. ADMISSION DATE | 10. DISCHARGE DATE

11. PLACE OF ACCIDENT

12. DESCRIPTION OF ACCIDENT

13. IDENTITY OF VEHICLE 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

14.	YES	NO
WAS PATIENT THE DRIVER OF THE MOTOR VEHICLE?	☐	☐
WAS PATIENT A PASSENGER IN THE MOTOR VEHICLE?	☐	☐
WAS PATIENT A PEDESTRIAN?	☐	☐
WAS PATIENT A MEMBER OF THE POLICYHOLDERS HOUSEHOLD?	☐	☐

15. ADMITTING DIAGNOSIS:

16. DISCHARGE DIAGNOSIS:

17. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?
YES ☐ NO ☐

18. WAS TREATMENT RENDERED SOLELY AS A RESULT OF INJURIES ARISING OUT OF THE ABOVE ACCIDENT?
YES ☐ NO ☐
IF NO, PLEASE EXPLAIN.

19. OPERATIONS OR PROCEDURES PERFORMED (NATURE AND DATES):

20. ATTACH REPORT OF SERVICES RENDERED AND ITEMIZED BILL | HOSPITAL CHARGES MUST BE COMPUTED IN ACCORDANCE WITH RATES PERMITTED BY SECTION 5108 OF THE NEW YORK INSURANCE LAW AND INSURANCE REGULATION NO. 83.

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.

TAKEN BY: ______ PRINT NAME ______ TITLE & PHONE NO.

______ SIGNATURE ______ DATE

|| Stay Only

DATE TAKEN FROM RECORDS: ______

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 THIS ACT. THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE PATIENT AS TRUE UNDER THE PENALTIES OF PERJURY.

X ____________________ X ____________
(SIGNATURE OF PATIENT, PARENT OR GUARDIAN) (DATE)

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer **(Authorization to Pay Benefits)** so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item A of this form.

A. ________ **(IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN ITEM B).**

AUTHORIZATION TO PAY BENEFITS:

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.

X SIGNED ____________________ SIGNED ____________________
(SIGNATURE OF PATIENT, PARENT OR GUARDIAN) (SIGNATURE OF HOSPITAL REPRESENTATIVE)

X ____________
DATE

PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider **(Assignment of Benefits)**. If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in item B or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

B. ________ **(IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #A ABOVE).**

ASSIGNMENT OF NO-FAULT BENEFITS:

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED ABOVE ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE 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, NOTWITHSTANDING ANY OTHER AGREEMENT 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.

X SIGNED ____________________ X ____________
SIGNATURE OF PATIENT, PARENT OR GUARDIAN (Assignor) DATE

____________________ SIGNED ____________________
(HOSPITAL NAME - Assignee) (HOSPITAL REPRESENTATIVE)

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED?	☐	YES	☐	NO
IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE?	☐	YES	☐	NO

NYS FORM NF-5 (Rev 6/2013)

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-RAY 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).

X ____________________ X ____________
SIGNATURE (PATIENT, PARENT OR GUARDIAN) DATE

I CERTIFY THAT PRIOR TO MY SURGERY, I HAVE BEEN GIVEN THE FOLLOWING:

Patient's Bill of Rights

Patient Responsibilities

Advanced Directives Regarding my Healthcare

Patient Notice of Privacy

New Disclosure Requirements

The following members have a financial interest in the Fifth Avenue Surgery Center.

Tony Degradi
1049 Fifth Avenue
New York, New York 10028

Lenny Tillman
1049 Fifth Avenue
New York, New York 10028

Wayne Hatami
1049 Fifth Avenue
New York, New York 10028

Feliks Kogan
1049 Fifth Avenue
New York, New York 10028

Gregg Rock, DPM
119 West 57th Street #717
New York, New York 10019

Patient Signature/Patient Representative

X ______________________________

X Date: ______________________________

FIFTH AVENUE SURGERY CENTER
RACE/ETHNICITY FORM

Facilities are required by law to provide the New York State Department of Health (NYSDOS) with information regarding the race and ethnicity of the patient population.

We want to make sure that all our patients get the best care possible. We would like you to tell us your racial/ethnic background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care.

ETHNICITY (Select One)

_____ NOT HISPANIC OR LATINO

_____ SPANISH/HISPANIC ORIGIN: Please check all that apply

__ Spaniard	__ Andalusian	__ Asturan	__ Castillian	__ Belearic Islander
__ Gallego	__ Valencian	__ Canarian	__ Mexican	__ Mexican American
__ Mexicano	__ Chicano	__ La Raza	__ Guatemalan	__ Hondurah
__ Nicaraguan	__ Panamanian	__ Salvadoran	__ Catalonian	__ South American
__ Bolivian	__ Chilean	__ Columbian	__ Peruvian	__ Ecuadorian
__ Uruguayan	__ Criollo	__ Puerto Rican	__ Cuban	__ Spanish Basque
__ Dominican	__ Venezuelan	__ South American Indian		__ Paraguayan
__ Central American Indian		__ Central American		__ Mexican Amer Indian
__ Canal Zone	__ Argentinean	__ Latin American		

RACE (Select One)

_____ AMERICAN INDIAN OR ALASKA NATIVE

_____ ASIAN: Please check all that apply

__ Asian Indian	__ Japanese	__ Maldivian	__ Iwo Jiman	__ Korean
__ Bangladeshi	__ Nepalese	__ Indonesian	__ Bhutanese	__ Laotian
__ Singaporean	__ Burmese	__ Malaysian	__ Madagascar	__ Vietnamese
__ Hmong	__ Cambodian	__ Okinawan	__ Taiwanese	__ Thai
__ Chinese	__ Pakistani	__ Sri Lankan	__ Filipino	

_____ BLACK OR AFRICAN-AMERICAN

_____ NATIVE HAWAIIAN OR PACIFIC ISLANDER: Please check all that apply

__ Paluan	__ Polynesian	__ Samoan	__ Fijian	__ Carolinian
__ Tahitian	__ Tongan	__ Tokelauan	__ Kosraean	__ Micronesian
__ Guamanin	__ Charro	__ Pohnpeian	__ Saipanese	__ Kiribati
__ Chuukese	__ Yapese	__ Melanesian	__ Native Hawaiian	
__ Papua New Guinea		__ Salomon Islander		

_____ WHITE

Fifth Ave Surgery Center LLC

1049 5th Ave New York NY 10028
Tel.: (212) 772-6667 • Fax: (212) 988-8018
www.fifthavenuesurgerycenter.com

Notice of Facility Lien

X PATIENT : ______________________

X DATE OF ACCIDENT : ______________________

I do hereby authorize **Fifth Ave Surgery Center LLc** to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said facility such sums as may be due and owing said facility for medical service rendered to me both by reason of this accident and by reason of any other bills that are due the facility and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said facility. And, I hereby further give a lien on my case to said facility against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said facility for all medical bills submitted by said facility for services rendered to me and that this agreement is made solely for said facility's additional protection and in consideration of the facility awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said facility of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the facility. I have been advised that if my attorney does not wish to cooperate in protecting the facility's interest, the facility will not await payment but may declare the entire balance due and payable.

X Dated: __________ X ______________________

CLIENT

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said facility above-named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney's fees and costs.

Dated: __________ ______________________

ATTORNEY

Igor Amigud Physician, P.C.

1049 Fifth Avenue • New York, NY 10028
Tel.: (212) 583-9701 • Fax: (212) 583-9709

Notice of Provider Lien

PATIENT: X ______________________________

DATE OF ACCIDENT: X ______________________________

I do hereby authorize **Igor Amigud Physician, P.C.** to furnish you, my attorney, with a full report or his/her examination, diagnosis, treatment, prognosis, ets. of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said provider such sums as may be due and owing said provider for medical service rendered to me both by reason of this accident and by reason of any other bills that are due the provider and to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect and fully compensate said provider. And, I hereby further give a lien on my case to said provider against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said provider for all medical bills submitted by said provider for services rendered to me and that this agreement is made solely for said provider's additional protection and in consideration of the provider awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

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Please acknowledge this letter by signing below and returning to the provider. I have been advised that if my attorney does not wish to cooperate in protecting the provider's interest, the provider will not await payment but may declare the entire balance due and payable.

Dated: X ____________________ X ______________________________
CLIENT

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said provider above – named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney's fees and costs.

Dated: ____________________ ______________________________
ATTORNEY

United Physicians, PLLC

1049 Fifth Avenue • New York, NY 10028
Tel.: (212) 583-9701 • Fax: (212) 583-9709

Notice of Provider Lien

X PATIENT: ____

X DATE OF ACCIDENT: ____________________________________

I do hereby authorize **United Physicians, PLLC** to furnish you, my attorney, with a full report or his/her examination, diagnosis, treatment, prognosis, ets. of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said provider such sums as may be due and owing said provider for medical service rendered to me both by reason of this accident and by reason of any other bills that are due the provider and to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect and fully compensate said provider. And, I hereby further give a lien on my case to said provider against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said provider for all medical bills submitted by said provider for services rendered to me and that this agreement is made solely for said provider's additional protection and in consideration of the provider awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

I agree to promptly notify said provider of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the provider. I have been advised that if my attorney does not wish to cooperate in protecting the provider's interest, the provider will not await payment but may declare the entire balance due and payable.

X Dated: ____________________ X ______________________________________
CLIENT

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said provider above – named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney's fees and costs.

Dated: ____________________ ______________________________________
ATTORNEY

Personal Service Insurance Company

Personal Injury Protection Benefits
Conditional Assignment of Benefits

Policy Number: ______________________________
Claim Number: ______________________________
Patient Name: ______________________________
Medical Provider Name: ______________________________

I authorize and request Personal Service Insurance Company to pay directly to the above named medical provider, the amount due to me under the terms of the above referenced policy as a result of medical care rendered by that provider and all medical staff associated with the provider's office.

X______________________________ X______________________________
Patient's Signature or Parent/Legal Guardian Date

I have read the information contained in the Personal Service Insurance Company informational letter concerning the Decision Point Review Plan, including Decision Point Review and pre-certification requirements (collectively, "Plan") and, as a condition precedent to Personal Service's acceptance of this assignment, I agree for myself, and on behalf of all medical staff associated with my office, to the following:

1. I (We) have complied and will comply with all the requirements of the Plan.
2. I (We) will initiate all pre-certification review and decision point review requests as required by the Plan.
3. I (We) will submit disputes as defined in the Plan to the Internal Dispute Resolution Process set forth herein. After final determination, I (We) will submit disputes not resolved by the Internal Dispute Resolution process to the personal injury protection dispute resolution process set forth in N.J.A.C 11:3-5.
4. I (We) will submit medical records with clinically supported findings to support the diagnosis, causal relationship to the accident, and care plan.
5. In the event that I (we) fail to comply with paragraphs one (1) through four (4) above, and such failure results in the imposition of a co-payment penalty, I (we) will hold the patient harmless for such co-payment penalty insofar as I (we) will not seek payment from the patient for any unpaid portion of the medical services arising from such co-payment penalty.

I (We) agree that this assignment is the only valid assignment of benefits. I (We) agree that this assignment of benefits may require Personal Service's written consent. I (We) agree that Personal Service has the right to reject, terminate or revoke this assignment of benefits.

______________________________ ______________________________
Provider's Signature Date

______________________________ ______________________________
Provider's Name (Please Print) TIN Number

ASSIGNMENT OF BENEFITS & AUTHORIZATION

TO PURSUE APPEAL AND/OR DENIAL OF PIP BENEFITS

X ______________________ [Patient Name]

______________________ [Insurer]

______________________ [Claim #]

In consideration of the professional services rendered by **Dynamic Suppliers, LLC** ("Health Care Provider") I, hereby irrevocably direct, authorize, assign and consent to the following:

1) The assignment of my rights to bill, collect, appeal and/or arbitrate my claims for PIP insurance benefits with regard to the above-captioned claim to Health Care Provider, including but not limited to surgical facility fees, supplies, primary physician, assistant, anesthesia, and any other fees related to my claims.

2) The authorization of Health Care Provider to act as my agent-in-fact with regard to all aspects regarding the above-captioned claim and to receive any and all communications regarding the claim and any appeals or arbitration of the denial of my claim.

3) The authorization of Health Care Provider to initiate and prosecute any and all appeals and/or arbitrations or legal actions on the denial of my claim, including but not limited to internal appeals with the insurer as well as NAF PIP arbitrations.

4) The authorization of Health Care Provider to obtain and/or disclose any Private Health Information as contemplated by HIPAA limited to my claim for insurance benefits and any appeal there from. I have signed a separate HIPAA authorization in this regard.

5) The authorization of Health Care Provider to file a complaint with regard to any denial of my claim(s) with the New Jersey Department of Health and Senior Services, the New Jersey Department of Banking and Insurance, as well as any other governmental agency with jurisdiction over my claim and/or the insurer.

6) The authorization for payment of any and all PIP insurance benefits directly to Health Care Provider to which I might be entitled under the above-captioned claim.

PATIENT:

Signature: X ______________________

Date: X ______________________

WITNESS:

Signature: ______________________

Original on file

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON ...)

FIFTH AVENUE SURGERY CENTER
1049 FIFTH AVE
NEW YORK, NY 10028

X 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 X______________, not withstanding any other agreement to the contrary.
(Print accident date)

The 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.

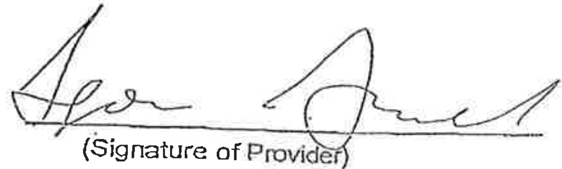
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION 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 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.

X______________
(Print name of Patient)

X______________
(Signature of Patient)

X______________
(Date of Signature)

X______________
(Address of Patient)



(Signature of Provider)

____
(Print name of Provider)

FIFTH AVENUE SURGERY CENTER
1049 FIFTH AVE
NEW YORK, NY 10028
(Address of Provider)

____
(Date of Signature)

NYS FORM NF-AOB (Rev 1/2004)

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURING ON AND AFTER 3/1/02)

I, X_________________________________ ('Assignor") hereby assign to Dynamic Suppliers, LLC, ("Assignee"),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 X_________________________, not withstanding any other agreement 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 ANS 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, KNOWLING MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITIS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO ANY 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 AVLUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIMS FOR EACH VIOLATION.

X_________________________ (Patient Signature)

X_________________________ (Date)

Dynamic Suppliers, LLC
(Name of Provider)

_________________________ (Provider's Signature)

_________________________ (Date)

612 Jericho Turnpike
New Hyde Park, NY 11040
DCA LIC # 1298816

Tel: 516-502-2900
Fax: 516-277-0069

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, X________________________ ("Assignor") hereby assign to ____ISURPLY LLC____,("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 Assignor for services provided by said Assignees for injuries sustained due to the motor vehicle accident which occurred on X________________, not withstanding any other agreement to the contrary.
(Print accident date)

This agreement may be revoked by the assignee when the benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy due to the actions or conduct of the assignors.

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 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, SOLICTS 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.

X________________________
(Print name of Patient)

X________________________
(Signature of Patient)

____
(Date of signature)

____
____
(Address of Patient)

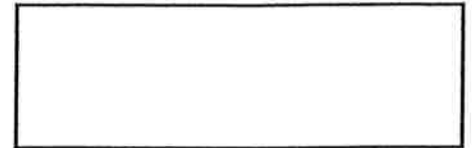
ISURPLY LLC
(Print name of Provider)

____
(Signature of Provider)

612 Jericho Turnpike , New Hyde Park, NY 11040
(Address of Provider)

____
(Date of signature)

FIFTH AVE SURGERY CENTER
1049 Fifth Ave
NY, NY 10028
212 772-6667



Center Consent

Consent for Treatment:

I, the above named and undersigned patient, give my consent for care at and by the medical, nursing, allied professional staff of the FIFTH AVE SURGERY CENTER, (**"Center"**), which may include routine diagnostic procedures and such medical treatment as my doctor or his / her designees may find are needed. I acknowledge that no promises or guarantees have been made to me about the results of any examinations, treatments or procedures I may receive while at the Center.

Release of Medical Records:

I authorize FIFTH AVE SURGERY CENTER **to** release all or any part of my medical record to **A.** hospitals or medical service companies, insurance companies, workmans' compensation carriers, welfare funds, or other organizations or agencies that may be concerned with the payment of costs related to my treatment and **B.** any other organization of agency to which the Center is permitted to release such information under applicable laws. In the event I am transferred or admitted to a hospital, post-operatively or require ER care within 72 hours postoperatively. I authorize the Center to obtain a copy of the discharge and or medical record summary.

Financial Arrangements:

I authorize and direct my insurer/ Medicare/ or payor to pay directly to the above Center any or all benefits, up the amount of my bill, accruing to me about my treatment. I agree that, in consideration of the services that were provided to me, I individually obligate myself to pay the amount promptly in accordance with the regular rates and terms of the Center. Regulations to Medicare assignment of benefits apply. I understand, therefore, that to the extent permitted under applicable laws and contractual arrangements, I am financially responsible to the Center for any amounts not covered by my insurance. Furthermore, I understand that my insurer or payor may require myself to pay the account of the Center with respect to the services that I choose to receive notwithstanding that my health insurer or payor has refused to give pre-authorization of all or any portion of my services.

Pre-Certification:

Your insurance company will be called to pre-certify your procedure. Please make sure that we have the correct insurance information. It is important to notify us if you have different plans for physician and hospital services. I understand that my insurance plan will hold me responsible for a deducible and / or co-insurance.

Center Charge: (If you have any questions regarding the above information, please ask the administrator)

When your procedure is performed at the Center, there will be a facility fee. There is a charge for the use of the surgical OR/suite for your procedure. Fees will vary according to the type of procedures that is / are being performed. Patient responsibility is dependent upon individual insurance plans.

Collection Expenses: (Medicare/Medicaid excluded)

Should my account with the Center be referred to an attorney or outside agency for collection, I will pay all reasonable collection expenses (included attorney's fees) associated with the collection effort. I acknowledge that all delinquent accounts will bear interest at the legal rate.

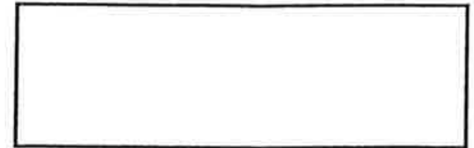
Professional Fees:

These are the fees that are billed by your Physician for his services in performing your procedure. These fees are within the range considered usual and customary for this area. Patient responsibility will vary according to each insurance plan. For questions pertaining to you Physicians' bill, please contact your Physician's office.

Anesthesia:

An Anesthesiologist or CRNA will be participating in your procedure to provide comfort and safety. I agree to give the Anesthesia provider permission to bill my insurance company.

FIFTH AVE SURGERY CENTER
1049 Fifth Ave
NY, NY 10028
212 772-6667



Center Consent

Biopsies:

If a biopsy is required during your procedure, a tissue sample (s) will be sent to a laboratory to be analyzed by a Pathologist. You may will/may receive a separate bill from the lab/Pathologist. I agree to give the lab permission to bill my insurance company.

Patient Rights & Privacy Practices

I have been offered a copy of: **A, B, C, D** yes NO

A. Patient Rights & Responsibilities. **B.** Advance Directive Policy/Info. **C.** Disclosure of Ownership **D.** HIPPA Privacy

Living Will:

__ I have an Advance Directive yes no ___ I have brought my Advance Directive with me? __ yes __no
__ Information on Advance Directives was offered to me __ yes __no

It is the policy of the Center, regardless of the contents of an Advance Directive or instructions from a healthcare surrogate or Power of Attorney that if an adverse event occurs during treatment, **"the Center personnel will initiate resuscitative or other stabilizing measures and transfer the patient to an acute care hospital for further evaluation".**

Clothing and Valuables:

I fully understand that the Center is not responsible for any personal property (clothing, eyeglasses, dentures etc.) brought in or retained in the lockers at any time. I fully understand that any valuables (money, jewelry, keys, etc.) should be given to a family member or other responsible party for safekeeping.

Driving Risks:

I have been informed by FIFTH AVE SURGERY CENTER that I should not drive for at least 24 hours after completion of my procedure. A responsible adult, upon discharge from the Center will accompany all patients who have intravenous sedation anesthesia. All patients who have had local anesthesia without sedation, and who meet the discharge criteria may be discharged unescorted.

I acknowledge that I have read this form (or that it has been read to me). I understand the contents and significance as they have been explained to me. I have been given an opportunity to ask questions, which have been answered to my satisfaction.

Date: ______________________________

Signature of Patient / guardian	Print Name
Witness	Print Name

Metropolitan Surgical Services, LLC
P.O. Box 28758
New York, NY 10087-8758
888-324-7980
973-695-1047 (Fax)

NF

PLEASE READ THIS FORM, SIGN AT THE BOTTOM AND HAVE YOUR ATTORNEY SIGN.
IF THE ILLNESS OR INJURY HAS OCCURRED TO A MINOR, ALL REFERENCES TO EXPENSES, SETTLEMENT AND JUDGEMENT REFERED TO THOSE OF THE MINOR, THE MINOR'S GUARDIAN MUST SIGN THIS FORM.

LIEN AGREEMENT

I hereby authorize and direct you, my attorney, or Insurance Company to pay directly to Metropolitan Surgical Services, LLC such sums as may be due and owing for Surgical Assistance rendered to me both by reason of this accident and by reason of any other bills that are due to this company and withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said company.

I hereby further give Lien on my case to Metropolitan Surgical Services, LLC against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith. I fully understand that I am directly and fully responsible to said provider for all medical bills for services rendered to me and that this agreement is made solely for said provider's additional protection and in consideration of the awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I also fully understand that if payment is not made as agreed upon I shall be responsible for any and all interest (**at 1.75% per month or 21% per annum**), all reasonable attorney fees, cost of collection and court cost incurred in efforts to enforce this agreement. I hereby authorize my attorney to release *ultimate settlement figures, final disbursement and/or copy of settlement check regarding my accident/injuries* to Metropolitan Surgical Services, LLC.
I understand and agree that if I fail to refuse to sign this LIEN, Metropolitan Surgical Services, LLC may bring a court action against me to obtain reimbursement.

I agree to promptly notify said provider on any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this Lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below. I have been advised that if my attorney doesn't wish to cooperate in protecting above provider's interest, the provider will not await payment but may declare the entire balance due payable.

X I ______________________________, benefit in this matter agree that I will attempt the independent medical exams that are
Print Patient's name
scheduled by the insurance carrier as required by the terms of the insurance contract, in order to preserve the provider's ability to collect the medical billing. I understand that if I do not attend the independent medical exams or violate policy contract I will be responsible for all medical bills that are outstanding as a result of said failure. Said responsibility is in the form of billing to myself and for a lien.

______________________________ X ________________
Patient's/injured party's Signature Date Signed

I ______________________________, attorney for the above named agree that I have received this
Print Attorney's Name
notice of lien and that I will comply with its terms and I will not disburse funds to above named client until I have paid from said process the lien amount to Metropolitan Surgical Services, LLC.

______________________________ ________________
Attorney's Signature Date Signed

ASSIGNMENT OF BENEFITS & LTD POWER OF ATTORNEY

I hereby assign benefits and authorize payment directly to Metropolitan Surgical Services, LLC and/or its staff (hereinafter collectively "You") of any insurance benefits made as payment to me (or a minor for whom I am the guardian) as reimbursement for services provided to me (or a minor for whom I am the guardian) for their services. I agree to immediately forward to this office any insurance payment, which are made directly to me.

X I, ____, irrevocably assign to you,
Patient Name

Metropolitan Surgical Services, LLC, my medical provider, all of my rights and benefits under my insurance contract for payment for service rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and its specially includes filing arbitration/litigation on your name on my behalf against the PIP carrier/ health are carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize you to act on my behalf. I consent to your acting on my behalf in this regard and in regard to my general health Insurance coverage pursuant to the "benefit denial appeals process" set forth in the NJ Administrative Code. I request that the insurance carrier consent to my assignment of benefits within 10 days of receipt otherwise it is deemed consented to.

As medical provider I agree to attempt to reasonably comply with the PIP carrier's decision point review/pre-certification plan and to hold the patient harmless if fail to comply with same, in consideration for the carrier's consent to this assignment.

In the event the insurance carrier responsible for making medical payments in the matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this limited/special power to attorney and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case in my name including filing an arbitration demand or lawsuit. I specially authorize that attorney to file directly against that carrier in my name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me.

I authorize you and your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray/MRI reports, and any other report or information regarding my physical condition.

X Dated: ______________ X ______________________________
PRINT

Patient's Name Printed

X ______________________________
Patient Signature

Metropolitan Surgical Services, LLC
P.O. Box 28758
New York, NY 10087-8758
888-324-7980
973-695-1047 (FAX)

ASSIGNMENT OF INSURANCE BENEFITS FORM

Authorization, Assignment and Fee Agreement

Metropolitan Surgical Services, LLC (providers) is authorized to furnish information to providers of health insurance or benefits of their representatives. In return for me and my dependants receiving medical services without immediate payment,

X I, ______________________________, assign now and forever, to providers any money due to me from any source

Print patient name

(except workers compensation payments and benefits) for these medical services, plus my right to ~~sue those responsible for payment if they do not pay what they owe. If I have a do not prosecute a~~ Worker's Compensation or No-Fault claim or if payment under these types of claims is denied for any reason other than provider's fee not meeting applicable schedule, I agree to pay the usual customary fees for treatment rendered. I understand that I am responsible for any amount not covered by insurance or benefits, and all reasonable legal fees spent by providers to collect the amount I owe. I understand that bills provided by request only. I am responsible to provide insurance information and referrals, if needed to provider. Providers can submit any dispute that may be under this authorization, assignment and fee agreement under the American Association New York Office.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I understand that I am financially responsible for all charges, whether or not paid by the insurance.

X Patient signature/Date ______________________________

Medicare Patients

I request that payment of authorized Medicare benefits be made on my behalf to service furnished to me by the provider. I authorize any holder of medical information about me to release any information needed to determine these benefits.

In Medicare assigned cases, Metropolitan Surgical Services, LLC, agrees to accept the charge ~~determination of the Medicare carrier as the full charge, and the patient is responsible only for the~~ deductible, co-insurance and non-covered services. C-insurance and deductible are based upon the ~~chare determination of the Medicare carrier.~~

X Patient signature/Date ______________________________

Metropolitan Surgical Services, LLC
P.O. Box 28758
New York, NY 10087-8758
888-324-7980
973-695-1047 (Fax)
First Assistant Services

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW ASSIGNMENT OF BENEFITS FORM
(FOR ACCIDENTS ON OR AFTER 3/1/02)

X *I.* ________________________ *("assignor") hereby assign to* **Metropolitan Surgical Services, LLC**
(Print Patient's Name)
("Assignee") 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 for services provided to said Assignee for injuries sustained due to motor vehicle accident which occurred on*X__________ *not withstanding any prior written agreement to the contrary.*
(Print Accident Date)

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 or upon determination that the treatment/ services rendered are not related to said motor vehicle accident.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR 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, 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 ANY 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.

X________________________
(PRINT PATIENT NAME)

X________________________
(SIGNATURE OF PATIENT)

____

X________________________
(DATE OF SIGNATURE)

X________________________
(ADDRESS OF PATIENT)

Metropolitan Surgical Services, LLC
(PRINT NAME OF THE PROVIDER)

____
(SIGNATURE OF THE PROVIDER)

PO BOX 28758
NEW YORK, NY 10087-8758
(ADDRESS)

____
(DATE OF SIGNATURE)

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
X	X	X
Patient Address X		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
METROPOLITAN SURGICAL SERVICES, LLC/ PO BOX 28758, NEW YORK, NY 10087

9(a). Specific information to be released:

☐ Medical Record from (insert date) ____________ to (insert date) ____________

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: ______________________

Include: (*Indicate by Initialing*)

________ Alcohol/Drug Treatment

________ Mental Health Information

________ HIV-Related Information

Authorization to Discuss Health Information

(b) ☐ By initialing here ____________ I authorize ______________________________

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

METROPOLITAN SURGICAL SERVICES, LLC

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

______________________________ Date: ______________

Signature of patient or representative authorized by law.

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.