St.Charles Orthopedics

NO-FAULT REGISTRATION

Referring Physician:_____ Referring MD Phone #:_____
NAME (Last, First, MI)_____ SEX M F
Date of Birth: _____ Age:_____ SS #:_____ Occupation:_____
Street Address:_____ City:_____ State:_____ Zip:_____
Mail Address (If Different):_____ City:_____ State:_____ Zip:_____
Home #:_____ Cell #:_____ E-Mail:_____
Marital Status:_____
Present Employer:_____ Work Phone _____
Work Address:_____ City:_____ State:____ Zip:_____

IS THIS A MANAGED CARE NO-FAULT POLICY? YES_____ NO_____ Date of Injury:_____
Date Symptoms Began:_____ What body part?_____
Have you ever injured this body part before? YES_____ NO_____
Location of Accident:_____
Holder of Insurance:
Name:_____
Address:_____
Insurance Company
Name:_____
Insurance Company Address:_____
Insurance Company Phone #:_____
File #:_____ **Policy #:**_____
Was the Accident reported to your Insurance Company: YES_____ NO_____
Did injury occur while working?: YES_____ NO_____
Were you hospitalized?: YES_____ NO_____
Name of Hospital:_____
Address of Hospital:_____
Dates of Hospitalization:_____
Were you disabled by this accident?: YES_____ NO_____
Date disability began:_____
Will an Attorney be contacting us?_____
(SHOULD NO FAULT BE DENIED)
Commercial Insurance Co.: Name:_____
Commercial Insurance Address:_____
Subscriber Name:_____
Subscribers Employer:_____
Employers Address:_____
Group #_____ ID#:_____
IN CASE OF EMERGENCY CONTACT: Name:_____ Relationship_____
Cell #:_____ home # _____ work # _____

Note: In consideration of services rendered or to be rendered to the above named patient, I hereby authorize and assign payment directly to Dr._____ , provider of health services. I authorize the provider to release all medical information necessary to substantiate a claim. In the event that the provider does not receive payment from the insurance company, due to denial for any reason, I understand I am personally responsible for payment of the provider's charges. I also understand that if I have not yet met my deductible under no-fault, that I am responsible for payment of such deductible, under my policy coverage. In the event my account goes to Collection, I understand that I will be responsible for all collection fees including the cost of an attorney.

SIGNATURE_____ DATE_____
PLEASE SIGN THE ATTACHED FORM (NF3) Checked By:_____ Date:_____
Revised 5/13

St.Charles Orthopedics

INITIAL VISIT HISTORY FORM

Name:_____ Date:_____ Social Sec.# _____

Phone:_____ Age:_____ DOB:_____ Sex: M / F

Name of your Primary Care Doctor:_____

Were you referred by a physician? Y / N: Name: _____ Phone: _____

Reason for today's visit: (briefly state history of problem and when symptoms began)

_____

_____

Problem due to: (check) ____ car accident ____ work-related ____ school injury ____ other

Past Medical History: Have you ever had any of the following medical problems?

Yes	No		Yes	No		Yes	No	
—	—	Stroke	—	—	Cancer	—	—	Thyroid Disease
—	—	Ulcers	—	—	Hepatitis	—	—	Rheumatoid arthritis
—	—	Colitis	—	—	Diabetes	—	—	High Blood Pressure
—	—	Asthma	—	—	Tuberculosis	—	—	Nervous Disorder
—	—	Lyme Disease	—	—	Heart Disease	—	—	Bleeding Disorder
—	—	Arthritis	—	—	Kidney Stones	—	—	Endocrine problems

Explain any positive responses above (and other medical problems not listed): _____

_____

Past Surgical History: (list all surgeries) _____

_____

Medications (list): _____

_____

Allergies (medicines): _____

_____

Review of Systems: Are you having problems with any of the following?

Yes	No		Yes	No		Yes	No	
—	—	Eyes	—	—	Psychiatric problems	—	—	Digestion/Bowel Movement
—	—	Ears, nose, throat	—	—	Joint pain	—	—	Stomach burning
—	—	Lungs/breathing	—	—	Immune system	—	—	Cardiovascular problems
—	—	Recent weight loss	—	—	Urinary problems	—	—	Hematologic/bleeding problems
—	—	Weakness/fatigue	—	—	Chest pain	—	—	Neurologic problems

Explain positive responses: _____

_____

Family Medical History: List medical problems of your relatives (ex. Diabetes, cancer):

Grandparents:_____

Mother:_____ Father:_____

Siblings:_____

Children:_____

Social History: Occupation:_____ Working now? Yes / No / Retired

Do you smoke: Yes /No / Quit? Packs per day: ___ If Quit, years smoked: ___ yrs.

Alcohol use (circle one): Never / Occasional / Daily / Heavy / History of alcoholism

Any history of Drug use (list): _____

(circle one) Married / Single / Divorced / Widowed Live Alone? Yes / No

Are you on a special diet? _____

Do you exercise / play sports (describe briefly)? _____

Completed by: (sign)_____ Reviewed by: Dr. _____

Office Use Only ---------- H:_____ W:_____ T:_____

Revised 5/13

St.Charles Orthopedics

unparalleled skill | compassionate care

DATE_____

To Whom It May Concern:

I, _____, authorize St Charles Orthopedics to disclose to the Ombudsman for the Medical Society of the State of New York information about my medical claim(s) for health plan benefits in relation to care provided by Dr. _____ stemming from services rendered between _____ and continuing through _____. This authorization will be considered valid until the medical bills for care provided to me by Dr. _____ have been satisfactorily resolved.

Your attention and cooperation in this matter is appreciated. It is requested that the attached data be given expedited handling.

Sincerely,

_____

(Patient's Signature)

Please ONLY fill out:

1. **Date**
2. **Print your name in the blank under Date**
3. **Sign your name at the bottom**

We will fill out the rest of this form.

Thank you

St.Charles Orthopedics

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the facility and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, sexually transmitted diseases, alcohol and substance abuse treatment information, mental health information, and genetic information.

Signature of Patient or Personal Representative	Print Name of Patient or Personal Representative
Description of Personal Representative's Authority	Date
Signature of Facility Representative	Date

EXPRESS AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have been advised of my rights to obtain access to and control my Protected Health Information. I also understand that in providing treatment, submitting billing and conducting healthcare operations. St. Charles Orthopedics may need to disclose my protected health information to members of my family or certain close personal friends. By providing the requested information below, I further authorize the disclosure of my protected health information as follows:

If I am unavailable, I expressly permit St. Charles Orthopedics to disclose my protected health information for the purposes of appointment/test/procedure reminders and follow-up to the following individuals:

	(Relationship to patient)
	(Relationship to patient)

I expressly permit St. Charles Orthopedics to disclose my protected health information for the purposes of appointment / test / procedure reminder and follow-up by leaving such information in the form of a message on the following recorded media:

Home answering machine:	Tel. #
Office voicemail:	Tel. #
Other (specify):	Tel. #

Signature of Patient / Personal Representative Parent/Guardian	Date

ST. CHARLES ORTHOPEDICS
FINANCIAL POLICY

Thank you for choosing Orthopedic Associates of Long Island, LLP! We are committed the success of your medical treatment and care. For your convenience, we have answered a variety of commonly asked financial policy questions below. If you have any additional questions about any of these policies, please ask to speak with a Billing Specialist.

Which Plans Do You Contract With?

Your physician/surgeon and their assistant(s) may not be an in-network provider with your health care insurance plan. Please check our website, www.stcharlesorthopedics.com, to check physician insurance participation and hospital
affiliation. If you have any questions, you can contact our billing department to obtain details about your surgery or office visit including the estimated amount of money you may be responsible for paying.

When Do I Pay?

Payment is expected for all copays at the time of the visit. If you do not have insurance or you are covered by an insurance company with which we do not participate, all fees must be paid at the time of visit. We accept payment by cash, Check, VISA, Mastercard, American Express and Discover.

Do I Need A Referral?

If you have a managed care plan with which we are contracted, you may need a referral from your primary care physician. If we have not received a referral prior to your arrival at the office, there will be a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled or offered an opportunity to assume financial responsibility for the services provided that day.

What If My Child Needs To See The Physician?

A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account. Any issues of payment resulting from separation or divorce documents must be resolved by the parents. We will hold the accompanying adult responsible for all charges unless specific arrangements have been made.

What Is My Financial Responsibility For Services?

Your financial responsibility depends on a variety of factors, explained below.

Office Visits and Office Services
HMO & PPO plans which have a contract

If the services are covered by the plan: All applicable copays are due at the time of the office visit. We ask for immediate payment as soon as any deductible is known. If the services you receive are not covered by the plan: Payment is expected in full at the time of the visit. You will be asked to sign a statement authorizing these services.

HMO with which we are not contracted

Payment in full for office visits, x-rays, injections, and all other charges is expected at the time of the office visit. We will provide the necessary information for you to complete and file your claim directly with the insurance company.

Point of Service Plan or Out of Network PPO

Payment for the copay and non-covered services is expected at the time of visit. We will file an insurance claim on your behalf. Coinsurance and deductibles will be billed after we receive payment from your carrier. All balances due will be payable upon receipt of our statement.

Patient Name_____ Date of Birth_____

Medicare (also Medicare HMO Plans)
We will file the claim on your behalf, as well as any claims to your secondary insurance. Payment for copays or any Services not covered by Medicare must be paid at the time of the visit. If you have regular Medicare as primary, and also have secondary insurance, copay will be collected depending on secondary plan. If you have regular Medicare as primary, but no secondary insurance, payment of your 20% coinsurance will be collected at the time of the visit. If Medicare is secondary, you will be billed for any patient responsibility after both insurances have processed.

Worker's Compensation
Prior to your visit, you will need to provide the accident date, claim number, employer information and insurance carrier information. If we have verified the claim with your carrier, no payment is necessary at the time of the visit. Please remember that if the claim is denied, the responsibility for the bill will be yours and payable at our usual and customary fees.

Worker's Compensation (Out of State)
Payment in full is requested at the time of then visit. We will provide you a receipt so you can file the claim with your carrier.

Automobile No-Fault Insurance
Prior to your visit, you will need to provide the accident date, claim number and the insurance carrier information. If the No Fault policy is not in your name, we will need full information on the policyholder.
If we have verified the claim with the carrier, no payment is necessary at the time of the visit. Please remember that if the claim is denied, the responsibility for the bill will be yours and is payable at our usual and customary fees. **If a referral is needed from your private carrier, you must obtain one in the event that your no-fault carrier denies your claim.**

Commercial Insurance: Also known as indemnity, "regular" insurance, or has a percentage coverage (eg. "80/20% coverage".)
We will file a claim to your insurance company as a courtesy. In the event of a denial of any part of the claim, you will need to pay this bill and deal with your insurance carrier directly.

School Insurance: You must submit the original form from the school's carrier. Please bring a copy of the form with you. If you do not have any other insurance, we will bill the school insurance directly. If you have other insurance, the school insurance is secondary and while we will file the claim with your school carrier, you are responsible for payment.

No Insurance (Self Pay)
Payment in full is due at the time of the visit. We will work with you to settle your account. Please ask to speak with our staff if you need assistance.

SURGERY
If your physician recommends surgery, you will have the opportunity to speak with his executive assistant. She will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it. If you have a commercial plan or are self-pay, she may request a pre-surgical deposit.

Updated 5/19/15

Patient Name_____ Date of Birth_____
Signature _____ Date_____

Catholic Health Services

Patient Authorization, Assignment of Benefits & Financial Agreement

Patient Name_____ Date of Birth_____ Effective Date: 01/01/2016

I acknowledge and understand that by signing below, I hereby authorize payment directly to ST. CHARLES ORTHOPEDICS 6 TECHNOLOGY DRIVE, SUITE 100 EAST SETAUKET, NY 11733 www.stcharlesorthopedics.com for services rendered to me, as specified more fully below.

1. **MEDICARE:**
   - I authorize my Medicare benefits to be paid to the Practice for services furnished to me by the Practice.
   - I authorize the Practice to release to the Centers for Medicare and Medicaid Services ("CMS" or "Medicare") and its agents any information needed to determine my Medicare benefits or the benefits payable for related services.
   - I authorize the release of medical information necessary to complete any insurance claim forms and to pay the claim.
   - The Practice accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for any deductible and/or coinsurance payment and payment for any non-covered services. Coinsurance and deductibles for covered services will be based upon the charge determination of the Medicare carrier.
   - I authorize the release of my information to any MediGap or other health insurance carrier I maintain and authorize payment of these secondary insurance benefits to be made on my behalf to the Practice, if possible.
   - My authorization will remain in effect unless I revoke my authorization in writing.

2. **OTHER INSURANCE PLAN PARTICIPATION:** The Practice maintains a list of its contracts with health care service plans ("Plans"), which identifies the Practice physicians who participate in each Plan. A copy of the current list is available from the Practice at the address, telephone number and/or website listed above.
   - I have been informed whether any services rendered to me by the Practice may be provided by a non-participating provider and, if so, (i) that such services by a non-participating provider may result in costs not covered by the Plan and (ii) I am individually obligated to pay the full charges for all such services.
   - I understand that the Practice has no contract, expressed or implied, with any Plan that does not appear on the list.
   - I have been informed that I am individually obligated to pay the full charges for all services rendered to me by the Practice if my Plan does not appear on the list of Plans maintained by the Practice.

3. **NON-COVERED SERVICES:** I understand that each Plan (*i.e.*, HMOs, PPOs) defines what items and services are covered and what items and services are not covered by the Plan.
   - I understand that I will receive an Advanced Beneficiary Notice ("ABN") from the Practice for services that are not or may not be covered by my Plan, and that I will be given the option to accept or decline any non-covered services.
   - I accept full financial responsibility for payment for any potentially non-covered services that I have accepted, as reflected on the ABN, if my Plan determines that such service is not covered. Examples of non-covered services include, but are not limited to, services not specified as being covered by a Plan, services not listed in the benefit summary furnished to patients by the Plan, and/or treatment or tests not authorized by the Plan.
   - I agree to cooperate with the Practice to obtain all necessary authorizations required by my Plan.

4. **RELEASE OF INFORMATION:**
   - I understand that the Practice may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, (1) to any person or corporation that is or may be liable or under contract to the Practice for reimbursement for services rendered, and/or (2) to any health care provider for continued patient care.
   - I understand that the Practice may also disclose on an anonymous basis any information concerning my care that is necessary or appropriate for the advancement of medical science, medical education, medical research, and/or for the collection of statistical data or pursuant to State or Federal law.

5. **FINANCIAL AGREEMENT:**
   - In return for the services provided to me by the Practice, I will pay my account at the time service is rendered to me or will make financial arrangements satisfactory to the Practice for payment.
   - If my account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action.
   - If my account is delinquent, I may be charged interest at the legal rate. I assign to the Practice any benefits of any type under any policy of insurance that insures me or any other party liable to me.
   - If my insurance company or Plan designates copayments and/or deductibles, I will pay such copayment and/or deductible amounts to the Practice.
   - ***I agree to be primarily responsible for the payment of the Practice's bill.***

_____ _____

Beneficiary Signature or Authorized Party Date

St.Charles Orthopedics

unparalleled skill compassionate care

ACCEPTANCE OF FINANCIAL RESPONSIBILITY WORKERS COMPENSATION/NO FAULT

Patient: _____

Guarantor: _____

NF/WC Carrier: _____

Private Insurance: _____

In the event that my Workers Compensation/No Fault carrier does not authorize payment to Dr. _____, you may bill my private insurance carrier for payment.

If my private carrier requires a referral and I do not have one for today's visit, I agree to be responsible for all charges. (You are urged to get a referral to cover this and other visits).

If I do not have private insurance or my private insurance denies this claim, I will be held responsible for any fees for office visits and diagnostic testing.

Signed: _____ Date: _____

Patient/Guarantor

Witness: _____

ATTENTION!

For the following NF-3 forms (3 pages)

Please fill out sections with an * only

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
(This form is not for verification of hospital treatment)

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

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

PROVIDER'S NAME AND ADDRESS*

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 THE 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 CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM.**

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS

2. DATE OF BIRTH	3. SEX	4. OCCUPATION (IF KNOWN)

5. DIAGNOSIS AND CONCURRENT CONDITIONS

6. WHEN DID SYMPTOMS FIRST APPEAR?
DATE: _____

7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE: _____

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?

YES ☐ NO ☐ IF YES, state when and describe:

9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT?

YES ☐ NO ☐ IF "NO", explain:

10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?

YES ☐ NO ☐

11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?

YES ☐ NO ☐ NOT DETERMINABLE AT THIS TIME ☐
IF "YES", describe:

12. PATIENT WAS DISABLED (UNABLE TO WORK)

FROM: _____ THROUGH: _____

13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON:

_____
(DATE)

CONTINUE ON PAGE 2

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?

YES ☐ NO ☐ IF YES, describe your recommendation below:

15. REPORT OF SERVICES RENDERED -- ATTACH ADDITIONAL SHEETS IF NECESSARY

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICE RENDERED	FEE SCHEDULE TREATMENT CODE	CHARGES
			TOTAL CHARGES TO DATE$	

16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING.

TREATING PROVIDER'S NAME	TITLE	LICENSE OR CERTIFICATION NO.	BUSINESS RELATIONSHIP CHECK APPLICABLE BOX		
			EMPLOYEE	INDEPENDENT CONTRACTOR	OTHER (SPECIFY)

17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES ☐ NO ☐

19. ESTIMATED DURATION OF FUTURE TREATMENT

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 20 of this form.

20. _____ **(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 #21)**

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.

PRINT NAME _____ SIGNED _____

PATIENT PATIENT DATE

CONTINUE ON PAGE 3

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
PAGE 3

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 # 21 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.

21. _____ **(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 #20 ABOVE)**

ASSIGNMENT OF NO-FAULT BENEFITS:

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW 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

PRINT NAME _____ SIGNED _____
PATIENT (Assignor) PATIENT DATE

PRINT NAME _____ SIGNED _____
PROVIDER OF HEALTH CARE SERVICE (Assignee) PROVIDER OF HEALTH CARE SERVICE DATE

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED? ☐ YES ☐ NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? ☐ YES ☐ NO

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.

DATE	PROVIDER'S SIGNATURE	IRS/TIN IDENTIFICATION NO.	WCB RATING CODE IF NONE, SPECIALTY

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