

Workers' Compensation/No Fault Disability Questionnaire: Please answer all questions completely. The information is used for your Workers' Compensation or No Fault Claim Forms. Any incomplete or incorrect information may lead to a delay in your claim.

Patient's Name: _____ Today's Date: _____

Insurance Company: _____ Date of Injury: _____ Claim #: _____

Have you had a recent IME (Exam from Insurance Company Physician)? YES NO Date: _____

Have there been any changes to your case since your last visit? YES NO

If YES, please specify: _____

Are you currently employed? YES NO Are you currently working? YES NO

If YES, are you working? ___ Full Time ___ Part Time ___ Full Duty ___ Light Duty

If YES, do you have any of the following restrictions?

- Bending/Twisting
- Climbing Stairs/ Ladders
- Environmental Conditions
- Kneeling
- Lifting
- Operating Heavy Equipment
- Other: _____
- Operation of Motor Vehicle
- Personal Protective Equipment
- Sitting
- Standing
- Use of Public Transportation
- Use of Upper Extremities

If NO, when did you stop working? _____ Did you stop working as a result of the injury? YES NO

When do you plan to return to work? _____

I hereby certify the statements hereon and attached are completed and accurate and I authorize any person or institute rendering care or any person or organization in possession of insurance or other benefit information concerning me to furnish or disclose all known facts concerning this disability. A copy of this authorization shall be valid as the original.

Patient's Signature _____

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

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

I, _____, ("Assignor") hereby assign to _____, ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am
entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and
shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained
due to the motor vehicle accident which occurred on _____, not withstanding any other agreement
(Print accident date)
to the contrary.

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

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON
FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR
PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE
PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO,
IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS,
SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR
CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR
VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND
SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF
THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

(Print name of Patient)

(Signature of Patient)

(Date of signature)

(Address of Patient)

(Print name of Provider)

(Signature of Provider)

(Date of signature)

(Address of Provider)