Grand Island
PHYSICAL THERAPY PC

I _____ request Grand Island Physical Therapy to bill my Physical Therapy treatments under my Workman's Compensation/No-Fault Insurance. I understand and agree that if for any reason my Workers' Compensation/No-fault Claims are denied that I am fully responsible for all charges that I have incurred.

I agree to provide Grand Island Physical Therapy with my private insurance information upon my first appointment. If I fail to give Grand Island Physical Therapy all of my necessary insurance information so that they can obtain authorization for treatment, I will be fully responsible for all charges I have incurred.

I also understand that Grand Island Physical Therapy will bill my private insurance only upon denial of payment from my Workers' Compensation/No-Fault Insurance and that I will be responsible for all of my co-pay charges I incur from my private insurance.

Signed _____

Date _____

Witness _____

Grand Island Office
1801 Grand Island Blvd. Grand Island, NY 14072
(P) 716.773.4323 · (F) 716.773.9418

Kenmore Office
1491 Sheridan Dr., Ste 300 Kenmore, NY 14217
(P) 716.871.1100 · (F) 716.871.1102

grandislandphysicaltherapy.com

Grand Island
PHYSICAL THERAPY PC

Workers' Compensation Information

Date: _____

Patient Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Date of Birth: _____ Soc. Sec. #: _____

Employer Name and Address: _____

_____

_____

_____

Contact Person in W/C Dept: _____

Date of Accident: _____

Are you seeing a Chiropractor? Yes No

Insurance Carrier Name: _____

Address: _____

_____

_____

Phone: _____

Case Number: _____ WCB Number (W/C only): _____

Referring Doctor: _____

Diagnosis: _____

Length of Treatment (Per Prescription): _____

Date of Prescription: _____

Date called insurance carrier: _____

Spoke with: _____

Treatment authorized thru: _____ Number of approved visits: _____

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

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

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

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

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

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

(Print name of Patient)	**(Signature of Patient)**
	(Date of signature)
(Address of Patient)	
(Print name of Provider)	**(Signature of Provider)**
	(Date of signature)
(Address of Provider)	

NYS FORM NF-AOB (Rev 1/2004)