DG PAIN MANAGEMENT

Patient Health History - Intake Form

Patient Information

Name (Last, First, Middle):			Date:
Date of Birth:	Soc. Sec. #		Home Phone:
E-mail Address:			Cell Phone:
Address:			May We Text You? ☐ Yes ☐ No
City:	State:	Zip Code:	Sex: ☐ Male ☐ Female
Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated			

MVA/Car Accident

Insurance Company:	
Claim #:	Date of Accident:
Adjuster's Name;	Adjuster's Phone Number:

Workers Compensation

Insurance Company:	WCB #:
Claim #:	Date of Accident:
Adjuster's Name:	Adjuster's Phone Number:

Attorney

Firm:	Phone Number:
Lawyer:	Address:

Employment

Currently Employed: ☐Yes ☐No ☐Retired ☐Disabled ☐Student			Occupation	
Employer:			Address:	
City:	State:	Zip Code:	Phone number:	Supervisor:

Health Insurance

Insurance Company:	Effective Date:
Insurance ID:	Group #:
PLEASE ENTER POLICY HOLDER INFORMATION BELOW, IF YOU ARE THE POLICY HOLDER CHECK OFF HERE ☐	
Policyholder's Name (Last, First, Middle):	
Relationship to Patient:	Soc. Sec. #: Date of Birth:

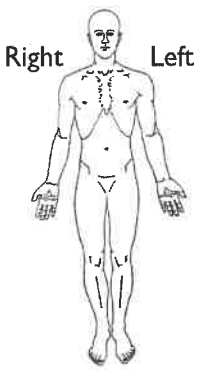
Contact

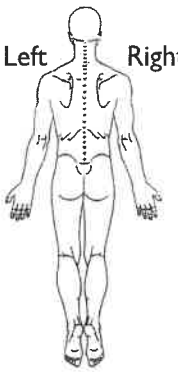
Emergency Contact:	
Relationship:	Phone:
Who referred you to Pain Management Associates?	
Primary Care Physician	Phone:

Patient Name: _____ Date: _____

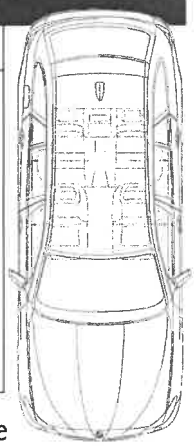
Please Draw the Location of Your Pain Using the Symbols Shown Below

D = Dull
B = Burning
N = Numb
S = Stabbing
T = Tingling
C = Cramping





L/S	*C/S*



What is your Pain Level? *No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible*

Injury / Pain Information

What caused your pain? ☐ Work Related Date: ☐ Car Accident Date:

Describe Accident:

Have you had any injuries in your area of pain prior to the accident? ☐ Yes ☐ No

Have you ever been treated for the area of injury prior to the accident? ☐ Yes ☐ No

Past Treatment

Have you tried other treatments for this condition?

Please indicate below the improvement seen with any other treatments you have received
Improvement Rating: 1= Better 2= Little to No improvement 3= No Change 4=Worse

Treatment	Start Date	Duration /# of Times	Area	Rating
Chriropractor				1 2 3 4
Physical Therapy				1 2 3 4
Pain Management Injections		☐ Yes ☐ No When _____ Type _____	Where _____ Area _____	
Back Surgery		☐ Yes ☐ No When _____	Where _____	

Diagnostic Testing	Yes	No	Where
MRI			

History

Allergies:

Any Medical Problems

Please List All Other Medicatins You are currently Taking:

Medication	Dosage	Medication	Dosage

Occupational History

Are you currently working? Yes No If No when was your last day of work?

Occupation: _____ Job Title: _____

Does your pain affect your ability to perform your job duties? Yes No

History and Physical

Patient Name: _____

Age: _____ Sex: Female Male Height: _____ Weight: _____

Allergies: ☐ None ☐ Yes ☐ NKDA ☐ Latex ☐ Dye ☐ Contrast ☐ Other _____

Reaction to Allergies: _____

Medications: ☐ None ☐ Yes Please List _____

_____

_____

Are you on blood thinners: ☐ None ☐ Yes ☐ Coumadin ☐ Plavix ☐ Other _____

Patient Medical History

					Other
Endocrine	☐None	☐ Diabetes:Insulin	☐Diabetes:Non-Insulin	☐ Thyroid	
Eyes	☐None	☐ Glaucoma:Narrow Angle	☐Glaucoma:Wide Angle		
Cardio	☐None	☐ High Blood Pressure ☐ Heaert Surgery	☐Heart Attack ☐Angina	☐ Valve Problem	
Circulation	☐None	☐ Peripheral Vascular Disease	☐Chronic Edema	☐ Varicose Veins ☐ Spider Veins	
Neurological	☐None	☐ CVA/Stroke	☐Seizures		
Respiratory	☐None	☐ Emphysema	☐Asthma	☐ COPD	
Gastrointestinal	☐None	☐ Ulcers	☐Heartburn/Reflux	☐ Liver Problems	
Genitourinary	☐None	☐ Urination Problems	☐Kidney Stones	☐ Erectile Dysfunction	
Musculoskeletal	☐None	☐ Arthritis	☐Joint Replacement		
Psychiatric	☐None	☐ Depression	☐Anxiety	☐ Claustrophobia	
Hematologic	☐None	☐ Low Platelets	☐Bleeding	☐ Poor Clotting	
Venous Disease	☐None	☐ Varicose	☐Spider Veins		

Surgical History: ☐ None ☐ Yes Type: _____

If Yes- Any difficulty with Anesthesia? _____

Social History: Smoking: No Yes How Much: _____

Alcohol: No Yes How Much: _____

Drugs: No Yes

Family History: _____

Office Use Only --- Do Not Write Below

Physical Exam

	Normal	Abnormal	If Abnormal. please specify;
HEENT			
Chest/Lungs			
Heart			
Neurological			
Mental Status			

Planned Procedure:

Signature: _____

Date: _____ Time: _____

Assesment/H&P review day of srgery: _____ No Changes: _____ Updated (See additional documentation)

Date: _____ Time: _____

DG PAIN MANAGEMENT

73-24 195 STREET, FRESH MEADOWS, NY 11366

TEL: 718-690-2572 FAX: 718-886-1868

MEDICAL LIEN

To Attorney: _____

_____

_____

Re: Reports and lien for: _____

(Patient Name)

Date of Accident: _____

I do hereby authorize the above doctor/ medical facility, you, my attorney, with a full report, diagnosis, treatment plan, prognosis, etc. for myself in regard to the accident in which I was involved.

I hereby authorize and direct, you, my attorney, to pay directly to said doctor / medical facility such sums as may be due and owing said doctor / medical facility for medical services rendered to my by reason of this accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor/ medical facility. I further give a lien on my case to said doctor / medical facility against any proceeds of any settlement, judgment or verdict which may be paid to you , my attorney , or to myself, as the 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 doctor/medical facility for all medical bills submitted by said doctor/medical facility for services rendered to me ad this agreement is made solely for said doctor /medical facility 's additional protection and in consideration of said doctor/medical facility awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict from which I may eventually recover said fee.

In the case of automobile accidents, where no-fault regulations govern the medical reimbursement, this lien will be effective only to the extent of those applicable no-fault regulations.

Date: _____ Patient Signature: _____

The undersigned, being the attorney of records for the above patient, does hereby agree to observe the terms of the above and agrees to withhold such from any settlement, judgement or verdict as maybe necessary to adequately protect said doctor / medical facility above named.

Date: _____ Attorney's Signature: _____

DG Pain Management

Assignment of Benefits and LTD Power of Attorney

I hereby assign benefits and authorize payment directly to DG Pain Management and/or its staff (hereinafter collectively "You") of any insurance benefits made as payment to me (or a minor for whom I am 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 payments which are made directly to me.

I, _____ , irrevocably assign to you, DG Pain Management, my medical provider, all of my right and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically included filling arbitration /litigation in your name 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 NY 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 a 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 I fail to comply with same, in consideration for the carrier's consent to this assignment.

In the even the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid. I execute this limited/special power of 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 or in your name as a medical provider rendering services to me and designate your collection agency 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 call such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

I understand that I am responsible for all fees charged, whether they are covered by insurance or not. Also, I am aware it is my personal responsibility to monitor insurance payments and maximums. If I receive any payment in trust for _____ and I also agree to send such payment to _____ within one week after receipt of same. I also agree to pay attorney's fees equal to 33 1/3% of the outstanding balance, plus court costs, in the event the account is turned over to an attorney for collection.

Patient's Signature: _____ Date : _____

Patient's Name (printed) : _____

DG Pain Management

Acknowledgement of Patient Rights and 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 our practice listed at the beginning of this notice, and how I may obtain access to and control this information.

_____ _____

Signature (Patient) Date

_____

Print Name

DG Pain Management

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information. At this time, I am requesting the following:

_____ Complete record

_____ Records of care from _____ to _____ only

_____ Records of care concerning the following condition(s)

_____

_____ Other . Specify : _____

_____ Confer with other person orally about information in my medical record to the following person(s):

_____

Name

_____

Street

_____

City State Zip

The reasons or purposed for this release of information are :

_____

_____

_____

I understand that you will provide this information within 15 business days from receipt of request, and you may charge a fee for preparing and furnishing this information.

The fee is waived because the records re to be used for supporting an application for disability or other benefits or assistance under Aid to Families with Dependent Children, Medicare, Supplemental Security Income, and Federal Old-Age and Survivors Insurance. I have attached a statement which confirms that such an application or appeal has been filed or is pending.

Signed : _____ Date : _____

(Patient or person legally authorized to consent on patient's behalf)

DG Pain Management

Controlled Substance Agreement Contract

I understand there are risks involved with chronic controlled substance (narcotics, pain killers, sleeping pills, nerve pills) administration including, but not limited to dependence; addiction, sleep and appetite changes; constipation and even bowel obstruction ; and changed in sexual desire and performance. I understand that the inappropriate use of medications such as mixing with another substance can cause death.

Please initial Each item and Sign Below

_____ I understand that the reason I am being I am being prescribed controlled substances is to improve my ability to function and reduce my pain. Alternative forms of treatment have been offered t me, and I have chosen to be treated with controlled substances for pain control. If I find these medications hinder my ability to function in my job or interpersonal relationships, I will inform Dr. Gamburg so he can address these issues and make appropriate changes. I agree to comply with Dr. Gamburg's treatment plan including, if appropriate, weight loss, smoking cessation and alcohol cessation, I will use care when driving or operating machinery. I understand that only through following a healthier lifestyle can I have the most successful outcome to my treatment.

_____ I have never been involved in the illegal sale, possession, diversion or transport of controlled substances.

_____ I am not currently abusing illicit nonprescription drugs, and I am not undergoing treatment for substance dependence or abuse.

_____ I understand that stopping these medications suddenly can lead to rebound pain and withdrawal symptoms, and I have been informed not to stop my controlled substances suddenly. Controlled substances can react with certain medications; the most important of which is alcohol. I have been informed of the risks of mixing alcohol with controlled substances and will inform Dr. Gamburg of my alcohol consumption. I will also inform Dr. Gamburg of all over the counter and prescription medications am taking.

_____ I understand to minimize the risks involved with controlled substances and assure adequate supervision, I agree to report any change in my mental status or drug reactions. I agree to have any lab test he advises, including blood and urine drug screens. I also agree to go for any consultation he deems necessary.

_____I agree not to obtain any controlled substances from any other physicians unless Dr. Gamburg 's office is notified.

_____ I agree that I may not discard any medication given by this office unless witnessed by our staff.

_____ I will not use any other narcotic medication or sedatives or street drugs such as heroin or cocaine or other substances; since the use of these can result in serious injury or death.

_____I agree to take the medication at the dosage and frequency prescribed. If I feel I must stop my medication or change the dose, I will call dr. Gamburg during office hours before making changes. Any change in the dose or frequency will be at the direction of Dr. Gamburg.

_____ I understand controlled substance medications are my responsibility and I will protect their safety, Should they be lost, destroyed or used up for any reason, I will not receive a new prescription until my next regular refill, no matter the circumstance, I agree to report any stolen medications to the police, and produce, such documentation, at which time Dr. Gamburg will make a decision regarding the replacement of the stole medications, I will not give any medications to another person.

_____ I will give 5 business days' notice of my need for refill, if my medication is scheduled to run out before my next scheduled appointment. I will not request a refill at any other time other than office hours (including evenings, holidays and weekends). I will be required to pick up my prescription at the office during office hours as no prescriptions are called in or mailed. I agree to obtaqin controlled substances from only the pharmacy, and will inform the office if I change pharmacies.

____ I have red this contact and dr. Gamburg and or his staff has explained it to me. All my questions and concerns about treatment have been adequately answered.

_____ I understand that if I do not follow this contract, Dr . Gamburg may taper and stop my controlled substances and refer me elsewhere for care. A copy of this document has been given to me.

____ I give permission for DG Pain Management to search electronically for my medical history, including but not limited to Prescriptions and Radiology reports.

Please indicate your pharmacy name _____ and telephone # _____

_____ _____ _____

Patient Signature Staff Signature Date

CRP – Controlled Substaance

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

CLAIM#_____

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

I, _____ (Print patient's name), **("Assignor") hereby assign to** _____ (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 _____ (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.

_____
(Print name of Patient)

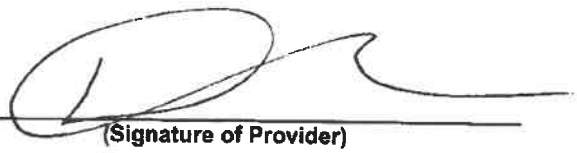
_____
(Signature of Patient)

_____

_____
(Date of signature)

_____
(Address of Patient)

David Gamburg, M.D.
(Print name of Provider)


(Signature of Provider)

73-24 195 Street

_____
(Date of signature)

Fresh Meadows, NY 11366
(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)

Claim Number: _____

I, _____ **, ("Assignor") hereby assign to** FULTON CARE PHARMACY **, ("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)

FULTON CARE PHARMACY
_____ _____
(Print name of Provider) **(Signature of Provider)**

557 EAST 169TH STREET

_____ _____
(Date of signature)

BRONX, NY 10456

_____
(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)

Claim Number: _____

I, _____ (Print patient's name), **("Assignor") hereby assign to** JONGWHAN CHA, L.Ac. (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 _____ (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.

_____ (Print name of Patient)

_____ (Signature of Patient)

_____ (Date of signature)

_____ (Address of Patient)

JONGWHAN CHA, L.Ac. (Print name of Provider)

(Signature of Provider)

156 DOLSON AVE SUITE 11

_____ (Date of signature)

MIDDLETOWN, NY 10940 (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)

Claim Number: _____

I, _____ (Print patient's name), **("Assignor") hereby assign to** BLUMENTHAL CHIROPRACTIC (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 _____ (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.

_____ (Print name of Patient)

_____ (Signature of Patient)

_____ (Date of signature)

_____ (Address of Patient)

BLUMENTHAL CHIROPRACTIC (Print name of Provider)

(Signature of Provider)

156 DOLSON AVE SUITE 11

_____ (Date of signature)

MIDDLETOWN, NY 10940 (Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

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

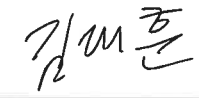
(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____ **, ("Assignor") hereby assign to** MOVE FIT Physical Therapy. P.C **, ("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)	
MOVE FIT PHYSICAL THERPAY P.C.	
(Print name of Provider)	**(Signature of Provider)**
156 Dolson Avenue STE11	_____
	(Date of signature)
Middletown, NY. 10940	
(Address of Provider)	

NYS FORM NF-AOB (Rev 1/2004)

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 **DAE HOON KIM P.T.**		SIGNED 김대훈		
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
	김대훈	88-3850445	PT

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

MOVE FIT PHYSICAL THERAPY PC
Service Address: 156 Dolson Ave Ste 11, Middletown, NY, 10940-6560
Mailing Address: 156 Dolson Ave Ste 11, Middletown, NY, 10940-6560

Medical Lien Agreement

Attorney:_____

_____

Patient records and doctor's lien

I do hereby authorize the above doctor any settlement to furnish you, my attorney/insurance carrier, with a full report of his case history, examination, diagnosis, treatment and prognosis of myself in regard to my accident/illness which occurred/began on (Date).

I hereby give alien to said doctor on any settlement, claim, judgement, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor, such sums as may be due and owing him for service rendered me and to withhold such sums from such settlement, judgement, or verdict as may be necessary to protect said doctor adequately.

I fully understand that I am directly and fully responsible to said doctor for all physical therapy bills submitted by him for service rendered me and that this agreement is made solely for said doctor's addition protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, claim judgment, or verdict by which I may eventually recover said fee.

Patient Name: _____

Patient's Signature: _____ Date: _____

The undersigned, being attorney or record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said named doctor.

Attorney's Signature: _____ Date: _____

Notes: Please date sign and return to doctor's office. Keep one copy for you records.

JongWhan Cha, L.Ac.
156 Dolson Ave STE 11
Middletown, NY, 10940
Ph: 845-360-2500
Fax: 845-345-8201

Patient: _____

Date of Accident: _____

NOTICE OF DOCTOR'S LIEN

I do hereby authorize _____ to furnish you, my attorney, with a full report of his 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 doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this Lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his 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.

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

Dated: _____ _____

Patient's Signature

The undersigned being attorney 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 said doctor above-named. Attorney further agrees that in the event the Lien is litigated, that the prevailing party will be awarded attorney fees and costs.

Dated: _____ _____

Attorney's Signature

Blumenthal Chiropractic, P.C.
156 Dolson Ave STE 11
Middletown, NY, 10940
Ph: 845-360-2500
Fax: 845-345-8201

Patient: _____

Date of Accident: _____

NOTICE OF DOCTOR'S LIEN

I do hereby authorize _____ to furnish you, my attorney, with a full report of his 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 doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the Injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this Lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and In consideration of his 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.

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

Dated: _____ _____

Patient's Signature

The undersigned being attorney 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 said doctor above-named. Attorney further agrees that in the event the Lien is litigated, that the prevailing party will be awarded attorney fees and costs.

Dated: _____ _____

Attorney's 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
Patient Address		

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:
CROSS RIVER MEDICAL, 156 DOLSON AVE STE 11, MIDDLETOWN, NY, 10940

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:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☐ Other:	
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.**