

VKPMedical, PLLC.
920 Main Street, Niagara Falls, NY 14301
5 Limestone Drive, Williamsville, NY 14221
(P) 716.686.7816 (F) 978.495.9911

PATIENT REGISTRATION FORM (Please Print)

Today's Date: **Thank you for selecting VKPMedical, PLLC.**

PATIENT INFORMATION

| | | | | | |
|-----------------------|----------|--------------------------------------------|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| Patient's Last Name: | | First: | Middle: | Gender: | Age: |
| Patient's Birth Date: | | Marital Status: S M D W SEP | | Social Security: | Preferred Language: |
| Street Address: | | Apt # | City/Town: | State: | Zip Code: |
| Mobile Phone Number: | | Work Phone Number: | Email Address: | Preferred Method of Contact: <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Email | |
| Name of Employer: | Address: | | City/Town: | State: | Zip: |

SPOUSE INFORMATION

| | | |
|------------|--------|-----------------|
| Last Name: | First: | Contact Number: |
|------------|--------|-----------------|

EMERGENCY CONTACT

| | |
|---------------------------|-----------------------------|
| Name: | Relationship to Patient: |
| Primary Telephone Number: | Secondary Telephone Number: |

| | |
|------------------------|-------------------------------|
| REFERRAL SOURCE | Primary Care Physician |
|------------------------|-------------------------------|

| | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|
| How did you learn about us? Internet <input type="checkbox"/> Friend/Family <input type="checkbox"/> Physician <input type="checkbox"/> Attorney <input type="checkbox"/> Other <input type="checkbox"/> | Primary Care Physician Name: |
| Please list the name and number of the referral source: | Street Address: |
| | City, State, Zip: |
| | Telephone Number: |

PHARMACY INFORMATION

| | | | |
|-------------------|----------|--------------|-------|
| Name (Local): | Address: | Telephone #: | Fax#: |
| Name (Mail Away): | Address: | Telephone #: | Fax#: |

HEALTH INSURANCE INFORMATION

| | |
|---------------------------------------------------------------------------------------------------|---------------|
| Primary Insurance: Patient's Relationship to Insured: Self Spouse Child Other: | |
| Insurance Name: | Group Number: |
| | ID Number: |
| Insured's Name (if not self, spouse or parent listed above): | Birth Date: |
| Secondary Insurance: Patient's Relationship to Insured: Self Spouse Child Other: | |
| Secondary Insurance Name: | Group Number: |
| | ID Number: |
| Insured's Name (if not self, spouse or parent listed above): | Birth Date: |

SYMPTOM SPECIFICATIONS (Give only a brief description in one to two sentences)

Please list your symptoms and complaints relating to your visit today:

PATIENT REGISTRATION FORM CONTINUED (Please Print)**MEDICAL TREATMENT HISTORY**Are these symptoms related to an accident? YES NODid you go to the hospital? YES NO

If yes, list hospital name:

Were you: Out-Patient In-Patient

Any X-Rays/MRI's or testing performed?

Have you seen any doctors for this injury and/or condition:

 YES NO

If yes, what type?

Medication(s) Prescribed:

NO FAULT MOTOR VEHICLE ACCIDENT

Insurance Company Name:

Insurance Phone Number:

Policy Holder Name:

Claim Representative:

Claim #:

Policy#

Was the accident reported to the insurance company? YES NOWas the accident reported to the police? YES NO **(If yes, provider the front desk with a copy of the police report.)**Where you the: Driver Passenger Pedestrian

of people in the Vehicle:

Where was the vehicle hit? Front Rear Driver Side Passenger SideWere you working at the time of accident? YES NO**WORKERS COMPENSATION-WORK ACCIDENT**

Insurance Carrier:

Employer Name & Address (at the time of accident)

Claim/Carrier Case #:

WCB #:

Claim/Case Manager:

Telephone Number:

Was injury reported to your employer? YES NO

Name & Phone number of Supervisor Reported to:

Injury Specifications

Date of Injury:

Accident occurred in: City:

State:

Injury resulted from: Motor Vehicle Accident Work Accident Other

• If other please specify:

Do you have an attorney representing you for this injury? YES NO

Attorney Firm Name:

Telephone Number:

Did you miss any time at work as a result of the injury? YES NO

1st Date Missed:

Date of Return:

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____/_____/_____**IF GUARDIAN, PRINT RELATIONSHIP TO PATIENT:** _____



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:

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: <input type="checkbox"/> At request of individual <input type="checkbox"/> 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.

Signature of patient or representative authorized by law. Date: _____

* **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.**

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New Patient Medical History Form

Date: _____

Patient Name: _____

Date of Birth: _____

Chief Complaint

Where is your pain located? _____

Which is your worst pain? _____

How long have you had these symptoms? _____

What is your pain level today (on a scale of 0-10)? _____

Does your pain radiate? If so, where: _____

What word best describes the frequency of your pain: Constant Intermittent

What is the quality of your pain? *Check all the following that describe your pain?*

Aching Burning Shooting
Cramping Dull Sharp

Which of the following activities change the nature of your pain?

| | Aggravates Pain | Relieves Pain | Neither |
|-----------------------|-----------------|---------------|---------|
| Sitting | | | |
| Standing | | | |
| Walking | | | |
| Bending Forward | | | |
| Lying on your side | | | |
| Lying on your back | | | |
| Lying on your stomach | | | |
| Rising from sitting | | | |
| Coughing/sneezing | | | |
| Driving | | | |

***Now go back and CIRCLE the box to indicate the most aggravating and most relieving activities**

Medical Treatment History:

Are these symptoms related to an accident? Yes _____ No _____ Did you go to the hospital? Yes _____ No _____

Were you: Outpatient _____ In Patient _____ Name of Hospital: _____

Were any X-rays/MRI/CT scan/EMG/NCS studies?

If yes, what type(s) were done, when were they done and at what facility?

Previous Treatment(s):

Have you seen other pain management/physiatrists/surgeons for your current complaints? Yes _____ No _____

Please list in chronological order and explain what they did for you.

| |
|------------------------------|
| Name: |
| Date last seen: |
| Treatments Undergone: |
| Why you stopped seeing them: |
| |
| Name: |
| Date last seen: |
| Treatments Undergone: |
| Why you stopped seeing them: |
| |
| Name: |
| Date last seen: |
| Treatments Undergone: |
| Why you stopped seeing them: |

Put a check next to each type of treatment you have had for your pain control in the past. Then check the column that best describes the effect of the treatment:

| Treatment | Have had this | Made Pain Better | Made Pain Worse | No Change in Pain |
|---------------------------|---------------|------------------|-----------------|-------------------|
| Anti-inflammatory | | | | |
| Muscle relaxants | | | | |
| Narcotic pain medications | | | | |
| Physical therapy | | | | |
| Exercises | | | | |
| Pool therapy | | | | |
| Acupuncture | | | | |
| Chiropractic Adjustments | | | | |
| Trigger point injections | | | | |
| Epidural injections | | | | |
| Facet joint injections | | | | |
| SI joint injections | | | | |
| Spine surgery | | | | |

Functional Status:

As limited by your pain condition (please answer the following questions):

| | | | | | | | |
|---------------------------------------|----------|----------|--------|--------|--------|--------|---------|
| 1)How long can you drive? | 0-5 mins | 5-10 min | 15 min | 30 min | 45 min | 60 min | 120+min |
| 2)How long can you sit? | 0-5 mins | 5-10 min | 15 min | 30 min | 45 min | 60 min | 120+min |
| 3)How long can you stand? | 0-5 mins | 5-10 min | 15 min | 30 min | 45 min | 60 min | 120+min |
| 4)How long can you walk? | 0-5 mins | 5-10 min | 15 min | 30 min | 45 min | 60 min | 120+min |
| 5)How many hours of sleep do you get? | 1-2 | 2-4 | 3-4 | 4-5 | 5-6 | 7+ | |

| Past Medical History: | | |
|-------------------------------------------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------------------|
| Mark the following conditions/diseases that you have been treated for in the past? | | |
| General Medical | <input type="checkbox"/> Emphysema/ COPD | <input type="checkbox"/> Dialysis |
| <input type="checkbox"/> Cancer - Type _____ | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Kidney infection(s) |
| <input type="checkbox"/> Diabetes - Type _____ | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Valley Fever | <input type="checkbox"/> Urinary Incontinence |
| Head/Eyes/Nose/Throat | Gastrointestinal | Hepatic |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Bowel Incontinence | <input type="checkbox"/> Hepatitis A (active/ inactive/ unsure) |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> GERD (Acid Reflux) | <input type="checkbox"/> Hepatitis B (active/ inactive/ unsure) |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Gastrointestinal Bleeding | <input type="checkbox"/> Hepatitis C (active/ inactive/ unsure) |
| <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Constipation | |
| <input type="checkbox"/> Hypothyroidism | | |
| <input type="checkbox"/> Glaucoma | | |
| Cardiovascular/ Hematologic | Musculoskeletal | Neuropsychological |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Amputation | <input type="checkbox"/> Alcohol Abuse |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Alzheimer Disease |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chronic Low Back Pain | <input type="checkbox"/> Depression |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Chronic Neck Pain | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Chronic Joint Pain | <input type="checkbox"/> Prescription Drug Abuse |
| <input type="checkbox"/> Murmur | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Joint Injury | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Peripheral Neuropathy |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Phantom Limb Pain | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Reflex Sympathetic Dystrophy/CRPS |
| | <input type="checkbox"/> Tennis Elbow | <input type="checkbox"/> Other Diagnosed Conditions |
| | <input type="checkbox"/> Vertebral Compression Fracture | |
| Respiratory | Genitourinary/Nephrology | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bladder infections(s) | |
| <input type="checkbox"/> Bronchitis | | |

Past Surgical History:

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

Abdominal Surgery

- Gallbladder removal _____
- Appendectomy _____
- Other _____

Female Surgeries

- Caesarean section _____
- Hysterectomy _____
- Laparoscopy _____

Heart Surgery

- Valve replacement _____
- Aneurysm repair _____
- Stent placement _____
- Other _____

Joint Surgery

- Shoulder _____
- Hip _____
- Knee _____

Spine I Back Surgery

- Discectomy (levels) _____
- Laminectomy _____
- Spinal fusion (levels) _____

Other Common Surgeries

- Hemorrhoid surgery _____
- Hernia repair _____
- Thyroidectomy _____
- Tonsillectomy _____
- Vascular surgery _____

Please list any other surgeries and dates (attach an additional sheet if necessary)

- I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE.

Social History

Are you capable of becoming pregnant? Yes No

Work Status: Working Full Time Part Time Disabled Unemployed

Marital Status: Married Single Divorced Widowed

Alcohol Use: Daily Limited Use History of Alcoholism Current Alcoholism Never Drinks Alcohol Drinks Alcohol Socially

Tobacco Use: Current Tobacco User Packs per day _____ How many years smoker _____ Former Tobacco User Has Never used Tobacco

Illegal Drug Use: Denies Any Illegal Drug Use Currently uses Marijuana Formerly Used Illegal Drugs (not currently using) Which: _____

Currently Using Illegal Drugs Which: _____ Currently Using Someone Else's Prescription Medications

Have you ever abused alcohol, narcotic or prescription medications? Yes No

If yes which one? _____

Have you ever completed a detoxification program for either opioid or alcohol abuse? Yes No

If yes, where and when: _____

Family History

Mark all appropriate diagnoses as they pertain to your biological MOTHER AND FATHER only.

| | | | | | | | | | | | | | |
|--------|-----------|--------|----------|-----------|---------------|---------------------|------------------|-----------------|----------------|--------------|----------------------|----------|--------|
| | Arthritis | Cancer | Diabetes | Headaches | Heart Disease | High Blood Pressure | High Cholesterol | Kidney Problems | Liver Problems | Osteoporosis | Rheumatoid Arthritis | Seizures | Stroke |
| Mother | | | | | | | | | | | | | |
| Father | | | | | | | | | | | | | |

Other medical problems: _____

- I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY I AM ADOPTED (No Medical History Available).

Allergies

Do you have any known drug allergies? Yes No
 If so, please list all medications you are allergic to.

| Medication Name | Allergic Reaction Type |
|-----------------|------------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Topical Allergies: Iodine Latex Tape Are you allergic to shellfish? Yes No

Current Medications

Please indicate which (if any) of the following blood-thinners you are taking:

- Aggrenox Coumadin / Warfarin Efferent Lovenox Plavix Pletal Pradaxa
 Prasugrel Ticlid Other _____

Please list all medications you are currently taking. Attach an additional sheet, if required.

| Medication Name | Dose | Frequency |
|-----------------|------|-----------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| Review of Systems: Mark the following symptoms that you currently suffer from. | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Constitutional: <input type="checkbox"/> All Negative | Eyes: <input type="checkbox"/> All Negative | Cardiovascular <input type="checkbox"/> All Negative |
| <input type="checkbox"/> Denies Excessive Seating <input type="checkbox"/> Insomnia <input type="checkbox"/> Unexplained Weight loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Weakness | <input type="checkbox"/> Denies Visual Changes | <input type="checkbox"/> Denies Chest Pain <input type="checkbox"/> Edema <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> irregular pulse and palpitations |
| Gastrointestinal: <input type="checkbox"/> All Negative | Ears/ Nose/Throat/Neck: <input type="checkbox"/> All Negative | Respiratory: <input type="checkbox"/> All Negative |
| <input type="checkbox"/> Denies abdominal pain <input type="checkbox"/> Indigestion <input type="checkbox"/> stomach ulcers <input type="checkbox"/> bowel incontinence | <input type="checkbox"/> Denies difficulty swallowing <input type="checkbox"/> Sore throat <input type="checkbox"/> Ringing in in ears | <input type="checkbox"/> Denies chronic cough <input type="checkbox"/> Shortness of Breath |
| Skin: <input type="checkbox"/> All Negative | Musculoskeletal: <input type="checkbox"/> All Negative | Genitourinary: <input type="checkbox"/> All Negative |
| <input type="checkbox"/> Denies skin, hair and nail symptoms | <input type="checkbox"/> Denies Joint pain | <input type="checkbox"/> Denies difficulty voiding |
| Neurological: <input type="checkbox"/> All Negative | | Psychiatric: <input type="checkbox"/> All Negative |
| <input type="checkbox"/> Headaches | | <input type="checkbox"/> Depressed Mood <input type="checkbox"/> Suicidal Thoughts |

Patients Signature: _____

Date: _____

VKP Medical, PLLC.
920 Main Street, Niagara Falls, NY 14301
5 Limestone Drive, Williamsville, NY 14221
(P) 716.686.7816 (F) 978.495.9911

AUTHORIZATION TO RELEASE INFORMATION

I authorize and instruct my insurance carrier, _____, to provide all information requested by **VKP Medical, PLLC.** including but not limited to state of origin of policy, deductible/co payment information and/or policy maximum information and to verify benefit eligibility, pre-certify procedures, and predetermine benefits as necessary under this policy.

Patient Name (printed): _____

Patient Signature: _____

Date: _____

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS**

| |
|-------------------------------|
| NAME AND ADDRESS OF INSURER * |
|-------------------------------|

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

| | | | | |
|------|--------------|---------------|------------------|--------------|
| DATE | POLICYHOLDER | POLICY NUMBER | DATE OF ACCIDENT | CLAIM NUMBER |
|------|--------------|---------------|------------------|--------------|

TO ENABLE US TO DETERMINE IF YOUR ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW,
PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

- IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

| |
|--------------------------------|
| NAME AND ADDRESS OF APPLICANT* |
|--------------------------------|

| | | | |
|--------------|---------------|------|----------|
| 1. YOUR NAME | 2. PHONE NOS. | HOME | BUSINESS |
|--------------|---------------|------|----------|

| | | |
|-------------------------------------------------------------|------------------|------------------------|
| 3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE) | 4. DATE OF BIRTH | 5. SOCIAL SECURITY NO. |
|-------------------------------------------------------------|------------------|------------------------|

| | |
|----------------------------------------------|-------------------------------------------------------|
| 6. DATE AND TIME OF ACCIDENT A.M. P.M. | 7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE |
|----------------------------------------------|-------------------------------------------------------|

8. BRIEF DESCRIPTION OF ACCIDENT

9. DESCRIBE YOUR INJURY

10. IDENTITY OF VEHICLE YOU 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

| | | |
|----------------------------------------------------------------|--------------------------|--------------------------|
| | YES | NO |
| 11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE? | <input type="checkbox"/> | <input type="checkbox"/> |
| WERE YOU A PASSENGER IN THE MOTOR VEHICLE? | <input type="checkbox"/> | <input type="checkbox"/> |
| WERE YOU A PEDESTRIAN? | <input type="checkbox"/> | <input type="checkbox"/> |
| WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD? | <input type="checkbox"/> | <input type="checkbox"/> |
| DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE? | <input type="checkbox"/> | <input type="checkbox"/> |

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES NO

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOU WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT? IN-PATIENT?

DATE OF ADMISSION: _____

HOSPITAL'S NAME AND ADDRESS: _____

| | | |
|-------------------------------------------------|---------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| 14. AMOUNT OF HEALTH BILLS TO DATE: \$ _____ | 15. WILL YOU HAVE MORE HEALTH TREATMENT(S)? YES <input type="checkbox"/> NO <input type="checkbox"/> | 16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> |
|-------------------------------------------------|---------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|

| | | |
|----------------------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------------------------------------|
| 17. DID YOU LOSE TIME FROM WORK? YES <input type="checkbox"/> NO <input type="checkbox"/> | DATE ABSENCE FROM WORK BEGAN: _____ | HAVE YOU RETURNED TO WORK? YES <input type="checkbox"/> NO <input type="checkbox"/> |
|----------------------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------------------------------------|

IF YES, DATE RETURNED TO WORK: _____ AMOUNT OF TIME LOST FROM WORK: _____

| | | |
|-----------------------------------------------------------|--------------------------------------------|--------------------------------------------|
| 18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS? _____ | NUMBER OF DAYS YOU WORK PER WEEK: _____ | NUMBER OF HOURS YOU WORK PER DAY: _____ |
|-----------------------------------------------------------|--------------------------------------------|--------------------------------------------|

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?

YES NO

20. LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

| EMPLOYER AND ADDRESS | OCCUPATION | FROM | TO |
|----------------------|------------|------|----|
| | | | |
| | | | |
| | | | |

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?

YES NO

IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

| | | | |
|----------------------------|--------------------------|--------------------------|--------------------------|
| NEW YORK STATE DISABILITY? | YES | NO | <input type="checkbox"/> |
| WORKERS' COMPENSATION? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE THREE

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 THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

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.

SIGNATURE

DATE

.....
DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOUR ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE)

SOCIAL SECURITY NO.

SIGNATURE

DATE

.....
DO NOT DETACH

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-RAYS 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).

NAME (PRINT OR TYPE)

SIGNATURE

DATE

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

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

NYS FORM NF-2 (Rev 1/2004)

Page 3 of 3

**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* |
|------------------------------|

VKP Medical, PLLC
 5 Limestone Drive
 Williamsville, NY 14221

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

See Attached Report

6. WHEN DID SYMPTOMS FIRST APPEAR? 7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS
 DATE: _____ 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
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 _____ PATIENT (Assignor) | SIGNED _____ PATIENT |
| PRINT NAME _____ VKP Medical, PLLC PROVIDER OF HEALTH CARE SERVICE (Assignee) | SIGNED _____ 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. 84-2536048 | WCB RATING CODE IF NONE, SPECIALTY CPMR |
|------|----------------------|----------------------------------------------|---------------------------------------------------|

**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 VKP Medical, 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 _____, not withstanding any other 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.

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)

VKP Medical, PLLC

(Print name of Provider)

(Signature of Provider)

5 Limestone Drive

Vikas K. Pilly, MD, Owner

Williamsville, NY 14221

(Address of Provider)

(Date of signature)

TID # 84-2536048

Notice of Intention to Make Claim

This form must be subscribed and sworn to. Fax or e-mail notification is not acceptable.

To: MOTOR VEHICLE ACCIDENT INDEMNIFICATION CORPORATION
100 WILLIAM ST, 14th Floor
NEW YORK, N.Y. 10038 phone: 646-205-7800

State of New York -
County of _____ -ss.

Pursuant to Article 52 and/or pertinent sections of Article 18 of the Insurance Law of the State of New York, this affidavit is presented to the Motor Vehicle Accident Indemnification Corporation for the purpose of giving my Notice of Intention to Make Claim against said Motor Vehicle Accident Corp. for injuries sustained by me. I have been duly sworn and state:

My name is _____; my date of birth is _____

I reside at _____;
Street Address /Apt City - State - Zipcode

My Social Security # is: _____ My email is: _____
My telephone number is: _____

I am employed by: _____ [] Unemployed

I was involved in an automobile accident on: _____
Month Day Year time (am/pm)

Place of Accident: _____
Street or highway City State

I was driver [] a passenger [] of vehicle #1 [] a pedestrian []
vehicle #2 [] a bicyclist []

Vehicle #1 _____ Vehicle #2 _____
Year/Make/Model/Color Year/Make/Model/Color

License Plate #: _____ State _____ License Plate #: _____ State _____

Owner: _____ Owner: _____
Address: _____ Address: _____

Driver: _____ Driver: _____
Address: _____ Address: _____

Insured by: _____ Insured by: _____
Policy #: _____ Policy #: _____
Effective Date: _____ Expiration date: _____ Effective Date: _____ Expiration date: _____

The accident was reported to the Police on _____, in _____
Date Precinct - City - State

