VKP Medical, 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 VKP Medical, 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:	Home Phone Number:

Mobile Phone Number:	Work Phone Number:	Email Address:	Preferred Method of Contact: ☐ Home ☐ Mobile ☐ Work ☐ 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

How did you learn about us? Internet ☐ Friend/Family ☐ Physician ☐ Attorney ☐ Other ☐

Please list the name and number of the referral source:

Primary Care Physician

Primary Care Physician Name:

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 ☐ NO

Did you go to the hosptial? ☐ YES ☐ NO	If yes, list hopsital name:
Were you: ☐ Out-Patient ☐ In-Patient	Any X-Rays/MRI's or testing performed?
Have you seen any doctors for this inury 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 ☐ NO

Was 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 Side

Were 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 RELATIONISHIP TO PATIENT: _____

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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		
□ Cancer - Type_____	□ Emphysema/ COPD	□ Dialysis
□ Diabetes - Type_____	□ Pneumonia	□ Kidney infection(s)
□ HIV/ AIDS	□ Tuberculosis	□ Kidney Stones
	□ Valley Fever	□ Urinary Incontinence
Head/Eyes/Nose/Throat	**Gastrointestinal**	**Hepatic**
□ Headaches	□ Bowel Incontinence	□ Hepatitis A (active/ inactive/ unsure)
□ Migraines	□ GERD (Acid Reflux)	□ Hepatitis B (active/ inactive/ unsure)
□ Head Injury	□ Gastrointestinal Bleeding	□ Hepatitis C (active/ inactive/ unsure)
□ Hyperthyroidism	□ Constipation	
□ Hypothyroidism		
□ Glaucoma		
Cardiovascular/ Hematologic	**Musculoskeletal**	**Neuropsychological**
□ Anemia	□ Amputation	□ Alcohol Abuse
□ Bleeding Disorders	□ Bursitis	□ Alzheimer Disease
□ Heart Attack	□ Carpal Tunnel Syndrome	□ Bipolar Disorder
□ High Blood Pressure	□ Chronic Low Back Pain	□ Depression
□ High Cholesterol	□ Chronic Neck Pain	□ Epilepsy
□ Mitral Valve Prolapse	□ Chronic Joint Pain	□ Prescription Drug Abuse
□ Murmur	□ Fibromyalgia	□ Multiple Sclerosis
□ Phlebitis	□ Joint Injury	□ Paralysis
□ Poor Circulation	□ Osteoarthritis	□ Peripheral Neuropathy
□ Stroke	□ Osteoporosis	□ Schizophrenia
□ Coronary Artery Disease	□ Phantom Limb Pain	□ Seizures
□ Pacemaker/Defibrillator	□ Rheumatoid arthritis	□ Reflex Sympathetic Dystrophy/CRPS
	□ Tennis Elbow	□ Other Diagnosed Conditions
	□ Vertebral Compression Fracture	
Respiratory	**Genitourinary/Nephrology**	
□ Asthma	□ Bladder infections(s)	
□ 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 _____

Joint Surgery
□ Shoulder _____
□ Hip _____
□ Knee _____

Female Surgeries
□ Caesarean section _____
□ Hysterectomy_____
□ Laparoscopy _____

Spine I Back Surgery
□ Discectomy (levels) _____
□ Laminectomy _____
□ Spinal fusion (levels)_____

Heart Surgery
□ Valve replacement _____
□ Aneurysm repair _____
□ Stent placement _____
□ Other _____

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
□ Currently Using Illegal Drugs
Which:_____
□ Currently Using Someone Else's Prescription Medications
□ Formerly Used Illegal Drugs (not currently using) Which:_____

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	Rheuamtoid 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: □ All Negative	**Eyes: □ All Negative**	**Cardiovascular □ All Negative**
□ Denies Excessive Seating **□ Insomnia** **□ Unexplained Weight loss** **□ Fatigue** **□ Weakness**	**□ Denies Visual Changes**	**□ Denies Chest Pain** **□ Edema** **□ High Blood Pressure** **□ irregular pulse and palpitations**
Gastrointestinal: □ All Negative	**Ears/ Nose/Throat/Neck:** **□ All Negative**	**Respiratory: □ All Negative**
□ Denies abdominal pain **□ Indigestion** **□ stomach ulcers** **□ bowel incontinence**	**□ Denies difficulty swallowing** **□ Sore throat** **□ Ringing in in ears**	**□ Denies chronic cough** **□ Shortness of Breath**
Skin: □ All Negative	**Musculoskeletal: □ All Negative**	**Genitourinary: □ All Negative**
□ Denies skin, hair and nail symptoms	**□ Denies Joint pain**	**□ Denies difficulty voiding**
Neurological: □ All Negative	**Psychiatric: □ All Negative**	
□ Headaches	**□Depressed Mood** **□ Suicidal Thoughts**	

Patients Signature: _____

Date: _____

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:
VKP Medical, PLLC 5 Limestone Drive, NY 14221

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) **present**
- ❑ 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: **pertaining to injury of** _____

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: **continued medical care**	**after disclosure to my doctor**
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.**

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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, ☐ OR A MOTORCYCLE ☐ A TRUCK, ☐ AN AUTOMOBILE,

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	☐	☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	☐	☐
WERE YOU A PEDESTRIAN?	☐	☐
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	☐	☐
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	☐	☐

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 YOUR 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)?	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
$ _____	YES ☐ NO ☐	YES ☐ NO ☐

17. DID YOU LOSE TIME FROM WORK?	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK?
YES ☐ NO ☐		YES ☐ NO ☐

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
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
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:

	YES	NO
NEW YORK STATE DISABILITY?	☐	☐
WORKERS' COMPENSATION?	☐	☐

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.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
(This form is <u>not</u> 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 920 Main Street Niagara Falls ,NY 14301

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 <u>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</u>. 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?
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 [X] NO [ ] IF "NO", explain:

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

YES [ ] NO [X]

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

YES [ ] NO [ ] NOT DETERMINABLE AT THIS TIME [X]
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 2

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?
YES [X] 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
		SEE ATTACHED BILL		
			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)
Vikas K. Pilly	MD	244731			Owner

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).

Vikas K. Pilly, MD License#: 244731

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES [X] NO [ ]

19. ESTIMATED DURATION OF FUTURE TREATMENT

Unknown at this time

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 _____ (PATIENT (Assignor)) SIGNED _____ (PATIENT) DATE

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?	X	YES		NO
IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE?	X	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
		84-2536048	CPMR

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

Claim # _____

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

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

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

VKP Medical, PLLC **(Print name of Provider)**

(Signature of Provider)

920 Main Street

Vikas K. Pilly, MD, Owner

(Date of signature)

Niagara Falls, NY 14301 (Address of Provider)

TID # 84-2536048

NYS FORM NF-AOB (Rev 1/2004)