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

(FOR ACCIDENTS OCCURING IN AND AFTER 3/1/02)

New York Spine Institute

I, _____ **("Assignor")** hereby assign Dr. Alexandre B. de Moura, Dr. Adam Landskowsky, Dr. Orlando Ortiz, Dr. Debra Mottahedeh, Dr. Benjamin Hirsch, Dr. Peter Passias, Dr. Angel Macagno, Melissa Pulice, DPT, Dr. David Khanan **("Assignees")**

(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 (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 purse payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle which occurred on _____, notwithstanding any other agreement to the contrary.

(Print accident date)

The 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 conducts 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 COMMERICAL 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 FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY 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)**

_____ _____

(Address of Patient) **(Date of Signature)**

_____

(Address of Patient)

NEW YORK SPINE INSTITUTE
Dr. Alexandre B. de Moura, Dr. Peter Passias,
Dr. Angel Macagno, Dr. Orlando Ortiz, Dr. David Khanan
Dr. Benjamin Hirsch, Melissa Pulice, DPT,
Dr. Debra Mottahedeh, Dr. Adam Landskowsky

(Print name of Provider)

_____

(Signature of Provider)

761 MERRICK AVENUE

_____

(Date of Signature)

WESTBURY, NEW YORK 11590

(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

NEW YORK SPINE INSTITUTE
Medical solutions for spine disorders

NO FAULT HISTORY

CHECK OFF IF POSITIVE:

PATIENT NAME:_____

DATE OF THE ACCIDENT: _____/_____/_____

CHIEF COMPLAINT_____

WHERE IS PAIN WORST? ( ) NECK ( ) BACK ( ) OTHER_____

1. YOU WERE THE: ( ) DRIVER ( ) PEDESTRIAN
   ( ) PASSENGER SITTING IN THE: (R) REAR or (L) REAR or (R) FRONT

2. ( ) WEARING A SEAT BELT ( ) LOST CONSCIOUSNESS

3. ( ) THE CAR WAS STOPPED ( ) THE CAR WAS MOVING

4. TYPE OF VEHICLE YOU WERE IN:
   ( ) CAR
   ( ) TRUCK
   ( ) VAN
   ( ) BUS
   ( ) MOTORCYCLE
   ( ) TAXI

5. TYPE OF VEHICLE YOU WERE STRUCK BY:
   ( ) CAR
   ( ) TRUCK
   ( ) VAN
   ( ) BUS
   ( ) MOTORCYCLE
   ( ) TAXI

6. ANY PRIOR MOTOR VEHICLE ACCIDENTS?
   ( ) YES
   ( ) NO

7. PRIOR HISTORY OF NECK OR BACK PAIN?
   ( ) YES
   ( ) NO

8. TREATMENTS YOU HAVE RECEIVED TO DATE:
   ( ) PHYSICAL THERAPY
   ( ) CHIROPRACTIC CARE
   ( ) ACCUPUNCTURE
   ( ) EPIDURAL INJECTIONS
   ( ) TRIGGER POINT INJECTION
   ( ) DIAGNOSTIC IMAGING

9. ARE YOU CURRENTLY WORKING? ( ) YES ( ) NO

10. ARE YOU DOING

( ) BETTER
( ) WORSE
( ) SAME

ANY OTHER MEDICAL PROBLEMS? _____

_____

OCCUPATION & EMPLOYER NAME: _____

_____

SOCIAL HISTORY: SMOKE? ( ) NO ( ) YES, HOW MUCH? _____

DRINK? ( ) NO ( ) YES, HOW MUCH? _____

LIST ANY OPERATIONS AND/OR HOSPITALIZATIONS (WITH DATES) _____

_____

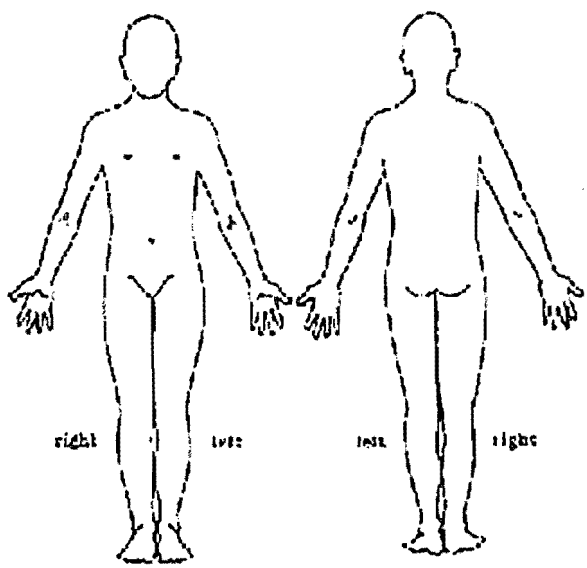
_____

ANY RADIOLOGY TESTING? _____

_____

ANY KNOWN ALLERGIES? _____

PAIN DRAWING & SCALE REVIEW



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), lunderstand 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 Jaw. 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 lexperience discrimination because of the release or disclosure of HIV-related information, lmay 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. lunderstand that lmay 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 O'I.'HER TIIAN TID: ATTORNEY OR GOVERNMENTAL AGENCY SPECIFJEI) IN ITEM 9 (II}.

7: Name and address ofliealth provider or entity to release this information:

8. Name and address ofperson(s) or category of person to whom this Information will be sent:

9(a). Specific information to be released:

O Medical Record from (insert date) to (insert date)

O Entire Medical Record, including patient histories, office notes (except psycllotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers,

O Other: _____

Include: *(Indicate by Initialing)*

Alcohol/Drug Treatment

Mental Health Information

HIV-Related Information

Authorization to Discuss Health Information

(b) D By initialing here-------·-- I authorize _____ _____

Initials — Name of individunJ heallb care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

{Atlurney/Fhm Name or Govcrnmeulal AlLOIICY Name)

10. Reason for release of information: D At request of individual D Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority lo sign on behalf of patient:

Alllterns 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 thai causes AIDS. The New Vorl< State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

No Social Security Number

Date:_____

To Whom ItMay Concern:

This letter is to certify that does not possess a social security number. Please accept this letter in lieu of a social security number.

Thank you,

_____
(Patient's Signature)

_____
(Please Print Name in full)

_____
(Witness)