New York
Orthopaedic & Comprehensive
Medical Services, P.C.

A **NYSI** Affiliate

☐ Salvatore Corso, MD, FAAOS ☐ Jeffrey Guttman, MD, FAAOS ☐ Teresa Bianchi, DO

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

If Under 18, Parents Name: _____ Tel: _____

Tel.#: (Home) _____ Cell: _____

Tel.#: (Work) _____ Email: _____

S.S.#: _____ Sex: ☐ Male ☐ Female D.O.B: _____ Age: _____

Height: _____ Weight: _____ Race: _____ Ethnicity: _____

Preferred Language: _____

Reason For Visit (Body Part): _____

_____

_____

How Did It Happen (NF/WC): _____

_____

_____

Was This Work Related? ☐ Yes ☐ No _____ Were You In A Car Accident? ☐ Yes ☐ No

Date Symptons Started: _____ ☐ Left ☐ Right: _____ Were X-Rays Taken? ☐ Yes ☐ No

Where?: _____ Date Of X-Rays: _____

How Did You Hear About Us

☐ Primary Care Physician ☐ Social Media ☐ Advertising ☐ Family/Friend ☐ Other (Please List)

_____

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Date of Visit: _____

Patient Name: _____ **Date of Birth:** _____

Private Insurance ID#: _____

NO FAULT INSURANCE INFORMATION

Name of Car Owner: _____ Date of Accident: _____

Adjuster Name: _____

Name of Insurance Company: _____

Address of Insurance Company: _____

_____

Policy #: _____ Claim #: _____

Private Insurance Name: _____

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New York Orthopaedic & Comprehensive Medical Services, P.C.
761 Merrick Ave. • Westbury, New York 11590 • 516-357-8777

ASSIGNMENT OF RECOVERY PROCEEDS AND AUTHORIZATION TO NEW YORK ORTHOPAEDIC & COMPREHENSIVE MEDICAL SERVICES, P.C.

Patient: _____

Address: _____

Attorney: _____

I, _____, theundersigned, do hereby assign to **New York Orthopaedic & Comprehensive Medical Services, P.C**. any sums due and payable, received by me or on my behalf, from any source for any and all medical treatment and or fees for services rendered to me and/or my attorney.

I authorize and direct my attorney to deduct and immediately pay **New York Orthopaedic & Comprehensive Medical Services, P.C.** and such fees as may be due and payable for the assigned monies that may come into my hands or my attorney's hands in any recovery resulting from any claims or lawsuit. I further direct my attorney to contact **New York Orthopaedic & Comprehensive Medical Services, P.C.**, to determine the exact amount owed before any money is paid to me from any recovery resulting from any claim or lawsuit. I further direct my attorney to advise **New York Orthopaedic & Comprehensive Medical Services, P.C.**, upon request, of the status of my lawsuits and/or any claims which may result in a monetary recovery from which the fees due and payable to , may be satisfied. If my attorney is replaced by another attorney, I direct that the outgoing attorney not forward my file until written acknowledgement from my new attorney is signed and forwarded to the undersigned acknowledging the terms and conditions set forth in this assignment.

New York Orthopaedic & Comprehensive Medical Services, P.C., agrees to provide reasonable cooperation in connection with securing payment for all insurance claims to the extent required by law.In the event of any breach of this assignment by the patient and/or the patient's attorney, it is understood that the patient shall remain responsible for all legal fees required to either obtain insurance information and/or collect any monies owed to **New York Orthopaedic & Comprehensive Medical Services, P.C.**, plus the expense of litigation and/or arbitration.

It is understood that this agreement, in no manner whatsoever, makes the payment of the fees due and payable to **New York Orthopaedic & Comprehensive Medical Services, P.C.,** contingent upon securing a recovery in any lawsuit or in any insurance claim that I may have. I understand that I remain personally responsible for all fees for medical treatment, as well as for services rendered on my behalf to my attorney and that I am personally liable for payment of the same. Further, I acknowledge that this assignment does not, in any fashion, preclude or otherwise prevent, **New York Orthopaedic & Comprehensive Medical Services, P.C.**,from demanding payment at any time after such services, as embraced within this assignment, are rendered.

_____

(Patient or Legal Guardian Signature)

_____

Witness

THE TERMS AND CONDITIONS OF THE FOREGOING ASSIGNMENT ARE UNDERSTOOD AND AGREED TO, BY:

Attorney: _____

Address: _____

Attorney Signature: _____ Date: _____

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NEW YORK MOTOR VECHILE NO-FAULT INSURANCE LAW ASSIGNMENT OF BENEFITS FORM (FOR ACCIDENTS OCCURING IN AND AFTER 3/1/02)

I, _____ **("Assignor")** hereby assign NYO&CMS, P.C., Dr. Jeffrey N. Guttman, Dr. Salvatore, J. Corso, Dr. Teresa Bianchi, and Dr. Mark Decker. 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.

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 ORTHOPAEDIC & COMPREHENSIVE MEDICAL SERVICES, P.C.
Dr. Jeffrey N. Guttman, Dr. Salvatore, J. Corso, Dr. Teresa Bianchi, Dr. Mark Decker

_____ (Signature of Provider)

_____ (Print Name of Provider)

761 MERRICK AVENUE
WESTBURY, NEW YORK 11590
(Address of Provider)

_____ (Date of Signature)