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,

11.	YES	NO
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

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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

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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.

DRS. ABRAMS, PIAZZA & JULEWICZ
THE FIRST CHOICE IN CHIROPRACTIC CARE

Patient Data **Date____________ _____**

First Name __________________ Middle Initial ____ Last Name______________

Address____

City _____________________________ State _____________Zip Code ________

Home Phone (_____) ________-__________Work Phone (_____) _______-_________

Cell Phone (_____) ________-__________ Email _________________________

Date of Birth ______/______/_______ **Sex:** Male Female

Social Security Number: ______-_____-______ **Marital Status: S M D O**

Emergency Contact: **Contact Name ___________________________**

Relationship to Patient __________________Contact Phone (_____) _____-_______

Employer Data *****If unemployed, disabled or retired please note below*****

Employer ____

Your Occupation ______________________Your Job Description _____________

Address ____

City __________________________State _____________Zip Code ____________

How did you hear about our office?

____

***Medical Conditions*:** (Circle all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke

Other ______________

Surgeries: (Circle all that apply to you)

Appendectomy   Cardiovascular procedure   Cervical spine   Hysterectomy
Joint Replacement   Prostate   Lumbar spine   Gall Bladder
Brain   Shoulder   Thoracic spine   Knee
Carpal Tunnel   Gastro-intestinal   Uro-genital   Hernia
Other _______________

Family History: (List any pertinent family history)

1.____
2.____
3.____

Please list any other doctor you are currently treating with and what for:

1)____
2)____
3)____

Are you pregnant? Yes_____ No ______N/A______

***Payment/Insurance Information*:**

NF :

Ins Carrier:____________________________

CLAIM #______________________________________

Policy#:________________________________

Adjustor:____

Date of accident: ____/____/____ Time of accident: ______am / pm

Attorney: Yes No

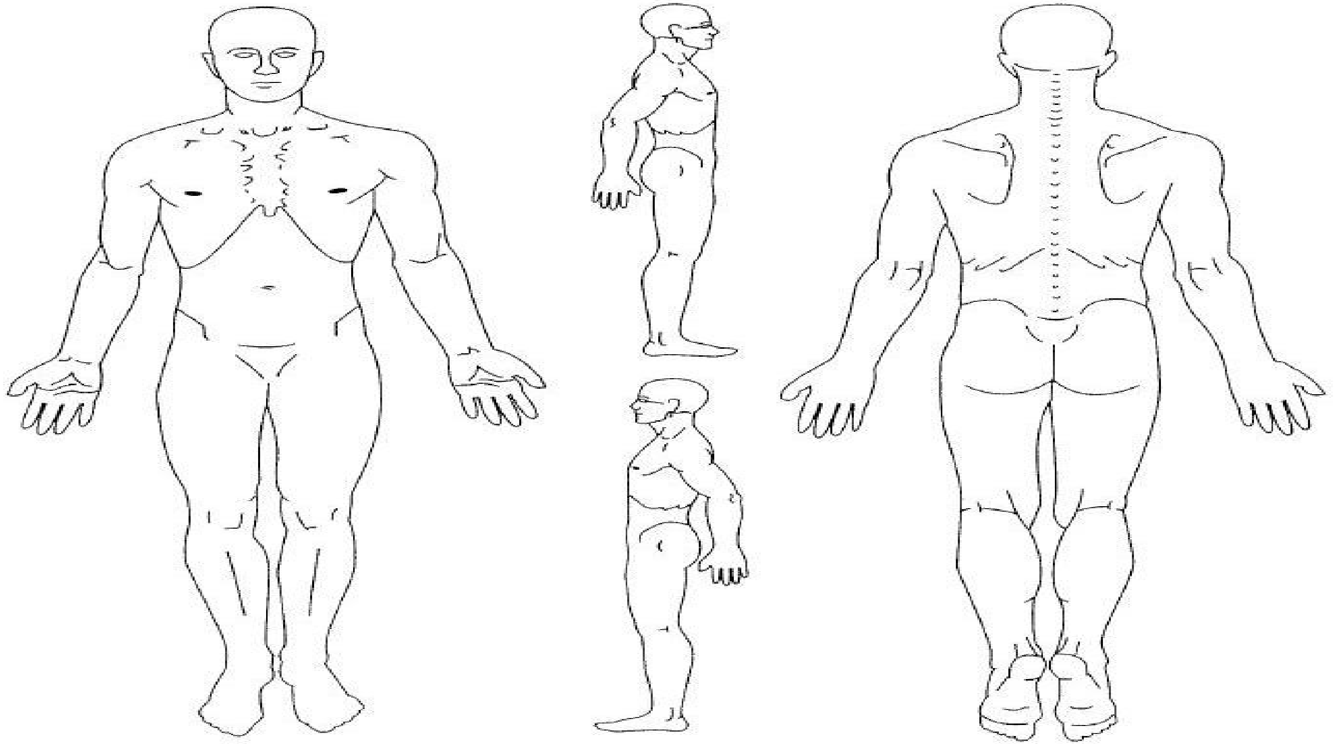
Name:______________________________________

Address:_______________________________________

Phone:____

DRS. ABRAMS, PIAZZA & JULEWICZ
THE FIRST CHOICE IN CHIROPRACTIC CARE

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:
N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1:
____
____

When did your symptoms begin? Month_______Day______Year _______

Are your symptoms a result of: Motor Vehicle Accident Work related Accident
Other_________________

How did your symptoms begin?
____
____

How often do you experience your symptoms?

Constantly	Frequently	Occasionally	Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

DRS. ABRAMS, PIAZZA & JULEWICZ

THE FIRST CHOICE IN CHIROPRACTIC CARE

Assignment of Benefits – Drs. Abrams, Piazza & Julewicz, DAVID ABRAMS, D.C, JOHN P. PIAZZA, D.C., DENNY JULEWICZ, D.C., ANTHONY VERRILLI, D.C.

Assignment of Insurance Benefits: I, the undersigned patient, or guarantor of the patient, hereby authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Drs. Abrams, Piazza & Julewicz, for all covered medical services and supplies provided to me (or, to the patent if I am the guarantor of the patient) during all courses of treatment and care provided by Drs. Abrams, Piazza & Julewicz, and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Drs. Abrams, Piazza & Julewicz and will constitute a continuing authorization, maintained on file with Drs. Abrams, Piazza & Julewicz which will authorize and allow for direct payment to Drs. Abrams, Piazza & Julewicz of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Drs. Abrams, Piazza & Julewicz.

Authorization to Submit Insurance Claims: I hereby authorize Drs. Abrams, Piazza & Julewicz to submit claims, on my behalf to my Insurance Company(s), which is/are the insurance company(s) ["my Insurance Company(s)"] listed on the copy of the current insurance card(s) I have provided Drs. Abrams, Piazza & Julewicz which I represent I have provided to Drs. Abrams, Piazza & Julewicz "in good faith" and which I represent provide current medical coverage for the contemplated Medical Services. I fully agree and understand that the submission of a claim does not absolve me (or the patient, if aim the guarantor) of my responsibility to ensure the claim is paid in full.

Limited Attorney-in Fact to Obtain Payment: I hereby irrevocably designate, authorize and appoint Drs. Abrams, Piazza & Julewicz as my true and lawful personal representative and attorney-in-fact for the limited purpose of obtaining payment from my Insurance Company(s) with the regard to the Medical Services; including the power to receive any and all payments from the Medical Services from my Insurance Company(s) or other third parties, submit any and all requests for benefits information to my Insurance Company(s), receive and review any and all applicable plan documents from my Insurance Company(s) and to pursue all remedies as to claims as to the Medical Services with or against my Insurance Company(s), including but not limited to formal complaints, appeals, administrative reviews or litigation to any State or Federal agency, insurance board or insurance company that has jurisdiction over benefits that are or may be available to pay for all or part of the Medical Services. *This is power of attorney shall automatically terminate. Without formation action being taken, as soon as Drs. Abrams, Piazza & Julewicz has received payment in full and all remedies available there to under applicable regulatory guidelines for all medical care services provided to me. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein.*

ERISA Authorization: For good and valuable consideration I do hereby designate, authorize and convey to Drs. Abrams, Piazza & Julewicz and the above named to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: a) the right and ability to act on my behalf in connection with any claim, right or chose in action that I may have under such insurance policy and/or any employee health care benefit plan; and b) the right and ability to act on my behalf to pursue such claim, right or chose in action with said insurance policy and/or employee health care benefit plan (including but not limited to, the right to act in my behalf in respect to an employee health care benefit plan governed by the provisions of Employment Retirement Income Security Act of 1974 as provided in 29 CFR §2560.503-1(b)(4)) with respect to any medical or health care expense incurred as a result of the services I received from the above-named doctor and, to the extent permissible under the law, to claim on my behalf, such medical or other health care service benefits, insurance or health care benefit plan reimbursement and any other applicable remedy.

Direct Payment Authorization: I hereby instruct and direct Insurance Company(s) to pay Drs. Abrams, Piazza & Julewicz and its associates directly. I understand the ERISA that I have the right and authority to direct where payment for services rendered is sent. If my current insurance policies with my Insurance Company(s) prohibit direct payment to the provider of services, I (under my rights per state and federal ERISA regulations) hereby instruct and direct my Insurance Company(s) to provide SPD documentation evidencing the existence of such non-assign ability clause to myself and Drs. Abrams, Piazza & Julewicz and its associates. Upon receipt by Drs. Abrams, Piazza & Julewicz of nonassignability documentation, I instruct that the Insurance Company(s) to make out the check to me (or the patient, if I am the guarantor) and I will mail it directly to Drs. Abrams, Piazza & Julewicz, 3077 Hylan Blvd, Staten Island, NY 10306 for the professional or medical expense benefits and otherwise payable to me (or the patient, if I am the guarantor) under my current insurance policy as payment towards the total charges for the Medical Services rendered. I agree and understand that any funds I receive from my Insurance Company(s) due me (or due the patient, if I am the guarantor) for services rendered by Drs. Abrams, Piazza & Julewicz will be immediately signed over by me and sent directly to Drs. Abrams, Piazza & Julewicz.

Check Deposit Authority: Whenever, with or without authority, my Insurance Company(s) might send a check directly to me for Medical Services provided by Drs. Abrams, Piazza & Julewicz and its associates. If I deposit such a check into an account other than Drs. Abrams, Piazza, I agree to send Drs. Abrams, Piazza & Julewicz a payment for the equivalent amount. If I receive from an insurance company, Medicare or Medicaid, an Explanation of Benefits (EOB), I agree to send a copy of the EOB, by U.S. Mail or fax directly to: Drs. Abrams, Piazza & Julewicz (718)987-9240. This is a direct assignment of my rights

and benefits under my Insurance Policy(s). Upon receipt by Drs. Abrams, Piazza & Julewicz of any and all checks made payable to me or patient, I authorize Drs. Abrams, Piazza & Julewicz and its associates to receive and such check, endorse it for deposit only, and to deposit it and to apply all the proceeds toward payment on my account for Medical Services.

Submission of Insurance Claims Courtesy/Financial Arrangements: Unless Drs. Abrams, Piazza & Julewicz has agreed as a courtesy to submit my claim to my Insurance Company(s) for Medical Services, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Drs. Abrams, Piazza & Julewicz for payment. If my account with Dr. Abrams, Piazza & Julewicz is referred to an attorney or outside agency for collection, the undersigned shall pay reasonable attorney fees and collection expenses. All delinquent accounts bear interest at the legal rate. I understand and agree that if my account is delinquent, I may be charged a service fee.

Confession of Judgment: In addition to Drs. Abrams, Piazza & Julewicz other remedies at law, I, the undersigned authorize any attorney to appear in a court of record and confess judgment, without process, against me, in favor of Drs. Abrams, Piazza & Julewicz and its associates, for any sum unpaid and due thereto, together with collection costs including attorneys' fee at 25% of the principle balance due, which percentage is stipulated and deemed reasonable.

Today's Standards: I authorize Drs. Abrams, Piazza & Julewicz and its associates to provide medical care and or medical supplies to me/patient reasonable by today's standards.

Release of Medical Records to Obtain Coverage: I authorize the release of any medical or other information reasonably necessary to determine benefits available or benefits payable by my Insurance Company(s) or for the purposes of satisfying charges billed by Drs. Abrams, Piazza & Julewicz and its associates for Medical Services to the Health Care Financing Administration, my Insurance Company(s) or other medical entity. A copy of this assignment will be sent to the Health Care Financing Administration, my Insurance Company(s) or other entity, if requested. I hereby release and forever discharge Drs. Abrams, Piazza & Julewicz and its respective employees, directors, officers, shareholders, agents, assigns and legal representatives (collectively, "Drs. Abrams, Piazza & Julewicz Parties") from any and all obligations, claims, liabilities, damages, debt, liens, and deficiencies arising out of or in connection with Drs. Abrams, Piazza & Julewicz use or disclosure of my health information in accordance with this Financial Responsibility and Assignment of Benefits ("Assignment") A photocopy of this Assignment shall be considered as effective and valid as the original

_______________________________ __________________
Signature of Patient/Guarantor Date

____
Print Name of Patient/ Guarantor

____
Witness

DRS. ABRAMS, PIAZZA & JULEWICZ
THE FIRST CHOICE IN CHIROPRACTIC CARE

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by any of the licensed doctors of chiropractic at Drs. Abrams, Piazza and Julewicz DC, PLLC.

I have had an opportunity to discuss with the doctor the nature and purpose of chiropractic adjustments and other procedures. I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this office. I understand that the chiropractor will use his/her hands or a mechanical device upon my body to adjust a joint, which may cause an audible “pop” or “click.” It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which she feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination,
and the doctor’s interpretation thereof, as well as the doctor’s judgment and expertise in working with like cases.

My doctor has responded to all of my requests for information about the proposed treatment. I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content. By signing below, I consent to chiropractic treatment.

____________________	____________________	__________
Print patient’s name	Signature of Patient	Date
____________________	____________________	__________
Print parent/guardian’s name	Signature of parent/guardian	Date

DRS. ABRAMS, PIAZZA & JULEWICZ
THE FIRST CHOICE IN CHIROPRACTIC CARE

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

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/04)

I, ______________________________, ("Assignor") hereby assign to **DRS. ABRAMS, PIAZZA & JULEWICZ DC, LLP**
(Print patient's name) (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 statue) 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 ASSITS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRADULENT 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)

DRS. ABRAMS, PIAZZA & JULEWICZ DC, LLP
(Print name of Provider)

____
(Signature of Provider)

3077 Hylan Boulevard

STATEN ISLAND, NEW YORK 10306-4113
(Address of Provider)

____
(Date of Signature)

NYS FORM NF-AOB (Rev 1/2004)

DRS. ABRAMS, PIAZZA & JULEWICZ

THE FIRST CHOICE IN CHIROPRACTIC CARE

AUTO FORM

Any person who knowing and with intent to defraud any insurance company or other persons files and application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another person to make a false report of the theft, destruction, damage or conversation 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 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____

Your claim will not be considered unless this form is signed and returned with the attached No-Fault form

DRS. ABRAMS, PIAZZA & JULEWICZ

THE FIRST CHOICE IN CHIROPRACTIC CARE

____

____

____

RE: Medical Reports and Doctor's Lien

Dear Counselor:

I do hereby authorize the above doctor 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 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 to this 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 any settlement, judgment or verdict which may be paid to you, my attorney, or myself as far 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 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 further I understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Patient's Name:______________________________
Patient's Signature:_____________________________ Date: _____________

The undersigned being attorney of record 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.
Counselor's Signature:___________________________ Date: ______________

*Counselor: Please date, sign and return one copy to doctor's office. Reply envelope attached. Keep one copy for your records. Thank you.

Sincerely

Dr. David Abrams
Dr. John P. Piazza
Dr. Denny A. Julewicz