



MG Dodge Chiropractic

MEDICAL LIEN

To Attorney: _____

RE: Reports and Lien for: _____
(Patient Name)

Date of Accident: _____

I do hereby authorize the above doctor/medical facility to furnish, you, my attorney, with a full report, diagnosis, treatment plan, prognosis, etc. for 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/medical facility such sums as may be due and owing said doctor/medical facility for medical services rendered to me by reason of this accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor/medical facility. I further give a lien on my case to said doctor/medical facility against any proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or to myself, 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/medical facility for all medical bills submitted by said doctor/medical facility for services rendered to me and that this agreement is made solely for said doctor/medical facility's additional protection and in consideration of said doctor/medical facility awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict from which I may eventually recover said fee.

In the case of automobile accidents, where no-fault regulations govern the medical reimbursement, this lien will be effective only to the extent of those applicable no-fault regulations.

Date: _____ Patient's Signature: _____
(Guardian Signature if Patient is a Minor)

The undersigned, being the attorney of record for the above patient, does hereby agree to observe 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/medical facility above named.

Date: _____ Attorney's Signature: _____



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**AUTHORIZATION FOR RELEASE OF HEALTH SERVICE
OR TREATMENT INFORMATION**

PATIENT NAME:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:
PATIENT ADDRESS:		

PROVIDER NAME AND ADDRESS:

I hereby authorize the Healthcare Provider indicated above to furnish copies of all information they have regarding my condition while under their observation or treatment, including the history obtained, diagnostic tests and images such as x-rays and MRIs and physical findings, diagnosis and prognosis. The Healthcare Provider indicated above is authorized to provide this information in accordance with the New York Comprehensive Motor Vehicle Insurance Reparations Act (No-Fault Law).

Patient or Guardian Signature: _____

Relationship, if patient is a minor: _____

Date: _____

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

(Print patient's name)

_____, ("Assignee")

(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.

(Date of Accident)

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)

(Print name of Provider)

(Signature of Provider)

(Date of signature)

(Address of Provider)



No-Fault Intake Form

- I require translation assistance
- J'ai besoin de l'aide de traduction
- Я нуждаюсь в помощи переводчика
- Requiero ayuda de la traduccion

Translator Information	
Date of translation:	_____
Print Name:	_____
Signature:	_____

Date of Accident _____

Accident State _____

INSURANCE INFORMATION	INSURANCE NAME			
	INSURANCE ADDRESS		CITY	STATE ZIP
	POLICY NUMBER	CLAIM NUMBER	POLICY HOLDER	
	CLAIM ADJUSTER NAME		INSURANCE PHONE NUMBER	

PATIENT INFORMATION	LAST NAME	FIRST NAME	MIDDLE NAME	
	ADDRESS		SEX	DATE OF BIRTH
	CITY		STATE	ZIP CODE
	REFERRING PROVIDER		ADDRESS	PHONE NUMBER

Description of Accident: _____

Date of Symptoms First Appeared: _____

Date of First Consultation: _____

Do you have a history of same or similar condition? YES NO DON'T KNOW
 If YES, state when and describe: _____ **Patient MUST initial**

Is Condition Solely a Result Of This Auto Accident? YES NO DON'T KNOW
 If NO, please explain: _____ **Patient MUST initial**

Is Condition Due To Injury Arising Out Of Patient's Employment? YES NO DON'T KNOW
 If YES, please explain: _____ **Patient MUST initial**

Will Injury Result in Disfigurement or Disability? YES NO DON'T KNOW
 If YES, please describe: _____ **Patient MUST initial**

Did you miss any IME (Independent Medical Examination)? YES NO
 If YES, please provide date(s): _____ **Patient MUST initial**

Patient Signature

Date