

# Adult Medicine & Pain Management

1 Pinnacle Place, Ste. 203, Albany, NY 12203  
Phone: 518-438-4700, Fax: 518-438-3190

## New York Motor Vehicle No-Fault Insurance Law

(Assignment Of Benefits Form)  
(For Accidents Occurring On Or After 3/1/2002)

I, \_\_\_\_\_ (“Assignor”) hereby assign to ADULT MEDICINE PC, (“Assignee”) all rights, privileges and  
*(Print Patient's Name)*  
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 aid Assignee for injuries sustained due to the motor vehicle accident  
which occurred on \_\_\_\_\_, not withstanding any other agreement to the contrary.  
*(Print 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,  
COMMITTS 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)

\_\_\_\_\_  
(Print Name Of Provider)

\_\_\_\_\_  
(Signature Of Provider)

\_\_\_\_\_

\_\_\_\_\_  
(Date Of Signature)

\_\_\_\_\_  
(Address)

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