

HENRY G. PURSLOW, P.T., P.C.
FARMINGDALE PHYSICAL THERAPY WEST
4277 HEMPSTEAD TPKE, SUITE 209A, BETHPAGE NY 11714
PHONE 516-731-3583 // FAX 516-731-3587

NO FAULT PATIENT INFORMATION SHEET

PATIENT'S NAME: _____

DATE OF ACCIDENT: _____

INSURANCE COMPANY: _____

POLICY #: _____

CLAIM #: _____

POLICY HOLDER'S NAME: _____

PLEASE CIRCLE ONE:

DRIVER

PASSENGER

PEDESTRIAN

PLEASE INCLUDE ANY ADDITIONAL INFORMATION YOU MAY HAVE
REGARDING THIS CLAIM (I.E. ADJUSTOR'S NAME, PHONE NUMBER, CLAIMS
ADDRESS, ETC.) IF YOU HAVE NO ADDITIONAL INFO, LEAVE BLANK.

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM
(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)**

Claim # _____

I, _____, ("Assignor") hereby assign to Henry Purslow and Henry G. Purslow, PT, PC d/b/a Farmingdale Physical Therapy West ("Assignee"), all rights, privileges and remedies to payment for healthcare services provided by Assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law of the State of New York.

The Assignee hereby certifies that the Assignee has 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 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 the 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 INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, 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 STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

(Print name of Patient) (Signature of Patient)

Address

Date

Henry G. Purslow and Henry G. Purslow, PT PC
Name of Provider (Signature of Provider) 