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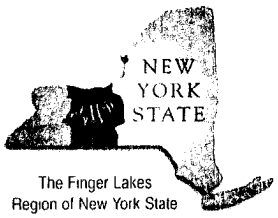

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Daniel Alexander, M.D.
Board Certified
Orthopaedic Surgeon

Christopher Brown, M.D.
Orthopaedic Surgeon
Sports Medicine

David Cywinski, M.D.
Orthopaedic Medicine

Peter Stasko, D.P.M.
Fellowship Trained
Foot & Ankle Surgeon

Paul Stasko, D.P.M.
Fellowship Trained
Foot & Ankle Surgeon

Scott Mattoon, RPA-C
Physicians Assistant

Karole Shaffer, NP
Nurse Practionioner

Erin Wilkinson, P.A.
Physicians Assistant

Ashley Fitzgerald, PA
Physicians Assistant

General Orthopaedic Surgery

Sports Surgery, Including Arthroscopy of the Shoulder & Knee

Hip & Knee Joint Reconstruction

Hand Surgery Including Carpal Tunnel Surgery

Fracture/Trauma Care

Work Injuries

Lumbar Epidurals

Foot & Ankle Reconstruction
Diabetic Limb Salvage

Bunion and Hammer Toe Repair

NO FAULT – MOTOR VEHICLE ACCIDENT INFORMATION REQUEST

Please complete the section below for the patient receiving medical services for any injury involving a motor vehicle. Before we can bill for these services, we need you to provide us with the no fault (motor vehicle) insurance company's information.

This information can be obtained from your motor vehicle insurance agent.

You have 30 calendar days to file your application for no fault benefits to cover injuries that involved a motor vehicle.

Thank you for your assistance in providing this information so that we are able to bill your medical services to the appropriate responsible insurance company.

PATIENT NAME: _____

PATIENT SOCIAL SECURITY NUMBER: _____

DATE OF ACCIDENT/INJURY: _____

BODY PARY INJURED: _____

POLICY HOLDER NAME: _____

INSURANCE AGENT/AGENCY: _____

AGENT/AGENCY TELEPHONE: _____

INSURANCE CARRIER/COMPANY NAME: _____

INSURANCE CARRIER/COMPANY ADDRESS: _____

_____

INSURANCE CARRIER/COMPANY TELEPHONE: _____

CLAIM/FILE NUMBER: _____

INSURANCE POLICY NUMBER: _____

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** _____ **, ("Assignee")**
(Print patient's name) (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**
(Print accident date)
to the contrary.

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)

NYS FORM NF-AOB (Rev 1/2004)