DELICATO CHIROPRACTIC, P.C.
NO-FAULT PATIENT INFORMATION

(Please Print clearly)

Patients Name: _____
(Last) (First) (Middle)

Patients Address: _____

Patients Telephone No. _____ Patients Social Security No.: _____

Patients Date of Birth: _____ Patients Sex: ☐ Male ☐ Female

ACCIDENT INFORMATION

Date of Accident: _____ Time of Accident: _____

Location: _____

Describe How Accident Occurred: _____

_____

_____

Insured's Name: _____

Insurance Company (Name, Address, Telephone No.): _____

_____

Policy No.: _____ Claim No.: _____

Did You Go To The Hospital?: ☐ Yes ☐ No

Did You Lose Time From Work?: ☐ Yes ☐ No From: _____ to: _____

Attorney Information: (Name, Address, Telephone No.): _____

_____

AUTHORIZATION AND ASSIGNMENT

AUTHORIZATION TO RELEASE INFORMATION: I AUTHORIZE DELICATO CHIROPRACTIC, P.C. TO RELEASE ANY INFORMATION CONCERNING MY PHYSICAL CONDITION TO ANY INSURANCE COMPANY, ATTORNEY, OR ADJUSTOR IN ORDER TO PROCESS ANY CLAIM FOR REIMBURSEMENT OF CHARGES INCURRED BY ME AS A RESULT OF PROFESSIONAL SERVICES RENDERED BY RAYMOND BARTOLI, D.C. AND I HEREBY RELEASE YOU OF ANY CONSEQUENCE THEREOF.

ASSIGNMENT OF PAYMENT: MY ATTORNEY AND/OR INSURANCE COMPANY ARE HEREBY REQUESTED TO PAY DIRECTLY TO DELICATO CHIROPRACTIC, P.C. ANY MONIES DUE TO RAYMOND BARTOLI, D.C. DUE ON THIS ACCOUNT, THE SAME TO BE DEDUCTED FROM ANY SETTLEMENT MADE ON MY BEHALF OF THIS CLAIM. FURTHER, I AGREE TO PAY THE DIFFERENCE, IF ANY, BETWEEN THE TOTAL AMOUNT OF CHARGES AND THE AMOUNT PAID BY THE INSURANCE CARRIER AND/OR ATTORNEY. IT IS FURTHER UNDERSTOOD, THAT I THE UNDERSIGNED, AGREE TO PAY THE FULL AMOUNT OF CHARGES, SHOULD MY CONDITION BE SUCH THAT IT IS NOT COVERED BY MY POLICY OR IF FOR ANY REASON THE INSURANCE COMPANY/ATTORNEY REFUSED TO PAY MY CLAIM.

PATIENT'S SIGNATURE: _____ DATE: _____

ATTORNEY SIGNATURE: _____ DATE: _____

CONFIDENTIAL PATIENT INFORMATION

(Please Print clearly)

Name: _____ Social Security No.: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: ☐ Male ☐ Female Age_____ Birthdate: _____ Marital Status: M S W D

No. of Children _____ Spouses Name: _____ Referred by: _____

Home Telephone No.: _____ Work Telephone No.: _____

Employer (Name and Address: _____

_____ Occupation: _____

HEALTH INFORMATION

Have You Had Previous Chiropractic Care?: ☐ Yes ☐ No

Main Complaint: _____

_____

Other Complaints: _____

_____

How Long Have You Had This Condition?: _____

Have You Had Similar Conditions in the Past?: _____

Does The Condition Effect Your Work?: ☐ Yes ☐ No

Does This Condition Effect Your Family or Social Life?: ☐ Yes ☐ No

What Aggravates This Condition?: _____

_____

Other Doctors Seen For This Condition: _____

_____

Are You Taking Medication?: _____

What Helps Your Symptoms?: _____

_____

Have You Had Surgery, Falls or Accidents?:

When? _____ Please Describe: _____

_____

Date of Last Physical: _____

Is This Condition Due to:

A, Work Related Injury ☐ Yes ☐ No

B, Automobile Accident ☐ Yes ☐ No

DO YOU SUFFER FROM?:

	YES	NO
Headaches	☐	☐
Neck Pain	☐	☐
Arm/Shoulder Pain	☐	☐
Back Pain	☐	☐
Hip or Leg Pain	☐	☐
Abdominal Pain	☐	☐
Sinus Trouble	☐	☐
Heart Trouble	☐	☐
Palpitations	☐	☐
Circulatory Trouble	☐	☐
Low Blood Pressure	☐	☐
High Blood Pressure	☐	☐
Female Problems	☐	☐
Prostate Disorder	☐	☐
Bladder Problems	☐	☐
Kidney Problems	☐	☐
Lung Disorder	☐	☐
Bronchial Disorder	☐	☐
Constipation	☐	☐
Loose Stool	☐	☐
Diabetes	☐	☐
Swollen Joints	☐	☐
Insomnia	☐	☐
Dizziness	☐	☐
Numbness	☐	☐
Nervousness	☐	☐
Depression	☐	☐
Fatigue	☐	☐
Anemia	☐	☐
Poor Memory	☐	☐
Hot Flashes	☐	☐

PATIENTS COMMENTS: _____

_____

_____

PATIENTS SIGNATURE: X _____ DATE: _____

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS OF INSURER'S CLAIMS REPRESENTATIV

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU 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 ☐ A TRUCK, OR ☐ AN AUTOMOBILE ☐ A MOTORCYCLE

11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE? ☐ YES ☐ N
WERE YOU A PASSENGER IN THE MOTOR VEHICLE? ☐ YES ☐ N
WERE YOU A PEDESTRIAN? ☐ YES ☐ N
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD? ☐ YES ☐ N
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE? ☐ YES ☐ N

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES? ☐ YES ☐ NO NAME AND ADDRES
OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOU 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? ☐ YES ☐ NO

16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? ☐ YES ☐ NO

17. DID YOU LOSE TIME FROM WORK? ☐ YES ☐ NO
IF YES, HOW MUCH TIME?:

18. WERE YOU RECEIVING UNEMPLOYMENT BENEFIT AT THE TIME OF THE ACCIDENT? ☐ YES ☐ NO

19. WHAT ARE YOUR AVERAGE WEEKLY EARNINGS:
$

20. IF YOU LOST TIME FROM WORK:
DATE ABSENCE FROM WORK BEGAN:
HAVE YOU RETURNED TO WORK? ☐ YES ☐ NO
IF YES, DATE RETURNED TO WORK:
NUMBER OF DAYS YOU WORK PER WEEK:
NUMBER OF HOURS YOU WORK PER DAY:

21. LIST NAMES AND ADDRESSES OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AN DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

22. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? ☐ YES ☐ NO IF YES, ATTACH EXPLANATION AND AMOUNTS O SUCH EXPENSES.

23. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:
NEW YORK STATE DISABILITY? ☐ YES ☐ NO WORKERS' COMPENSATION? ☐ YES ☐ NO

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 IN[illegible]EFRAUD ANY INSURANCE COMPANY OR OTH[illegible]N FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY M[illegible]FALSE INFORMATION, OR CONCEALS FOR TH[illegible]E 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."

SIGNATURE: X _____ 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, SALAR OR OTHER LOSS WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE **NEW YORK COMPREHEI SIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).**

NAME (PRINT OR TYPE) _____ SOCIAL SECURITY N(

X _____

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 WHIL UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YO ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE **NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATION ACT (NO-FAULT LAW).**

NAME (PRINT OR TYPE) _____

X _____

SIGNATURE _____ DATE

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP)

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

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____ (Print patient's name), ("Assignor") hereby assign to _____ (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 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 _____ (Print accident date), not withstanding any other agreement 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)

X _____
(Signature of Patient)

_____
(Address of Patient)

_____
(Date of signature)

_____
(Print name of Provider)

_____
(Signature of Provider)

_____
(Address of Provider)

_____
(Date of signature)

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_____
(Print name of Patient)

X _____
(Signature of Patient)

_____
(Address of Patient)

_____
(Date of signature)

_____
(Print name of Provider)

_____
(Signature of Provider)

_____
(Address of Provider)

_____
(Date of signature)

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

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

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_____
(Print name of Patient)

X _____
(Signature of Patient)

_____
(Address of Patient)

_____
(Date of signature)

_____
(Print name of Provider)

_____
(Signature of Provider)

_____
(Address of Provider)

_____
(Date of signature)

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED X _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED X _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)

FORM OWCP-1500 FORM RRB-1500

DR. RAYMOND BARTOLI
CHIROPRACTOR

1118 AVENUE Y
BROOKLYN, NEW YORK 11235
(718) 332-7873

MEDICAL REPORT AND DOCTOR'S REPORT

TO ATTORNEY: _____

For Doctor: _____
For Patient : _____
For Driver : _____
Date of Loss : _____

I do hereby authorize the above named Doctor to furnish you, my attorney with a full report of my examination, including diagnosis, treatment, etc. in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay said Doctor such sums as my be due, and owed to him for medical services rendered me by reason of this accident and to withhold any sums from any settlement, judgement or verdict as may be necessary to adequately protect said Doctor. Furthermore, I hereby give a lien to said Doctor which may be paid by you, my attorney, or myself as a 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 medical services rendered and that this agreement is made solely for said services of this awaiting payment. I understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

A photograph of this lien shall be considered as valid as the original.

PATIENT'S SIGNATURE: X_____ DATE:_____

The undersigned, being the attorney for the above named patient, does hereby agree to observe all the terms of the above and agrees to withhold and pay directly to the above named physician such sums due to him from any settlement, judgement or verdict arising out of this accident.

ATTORNEY'S SIGNATURE_____DATE_____