

SPINE SURGERY

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No-Fault Information

(Please Print)

Please complete all the requested information - this information is vital to the processing of your compensation claim.

Name: _____ Telephone: _____

Address: _____ Social Security #: _____

_____ Date of Birth: _____

No-Fault Carrier: _____

Claims Address: _____

Telephone: _____ Case Mgr: _____

Policy Holder Name: _____

Claim #: _____ Policy #: _____

File #: _____

Date of Accident: _____ Time of Accident: _____

Description of Accident: _____

Unable to Work From: _____

Is your condition solely a result of the accident listed above: () Yes () No

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on my behalf. I further acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered without obtaining my signature on each and every claim to be submitted.

(Authorized Signature)

(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 Patrick F. O'Leary, MD PC, ("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 FRAUD 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.

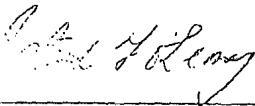
(Print name of Patient)

(Signature of Patient)

(Date of signature)

(Address of Patient)

Patrick F. O'Leary, MD PC
(Print name of Provider)


(Signature of Provider)

1015 Madison Avenue

(Date of signature)

New York, NY 10021
(Address of Provider)