

**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 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 to the contrary.

(Print accident date)

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 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)	(Print name of Provider)
_____	_____
(Print address of Patient)	(Print address of Provider)
_____	_____
(Date of Signature)	(Date of Signature)
_____	_____
(Signature of Patient)	(Signature of Provider)

The Massage Approach at
The Vitality Center
66 Austin Blvd.
Commack, NY 11725
www.themassageapproach.com

To Attorney: _____

Therapist: _____

RE: Reports and Therapist's Lien:

Patient: _____
I do hereby authorize the above therapist (as per referring doctor) to furnish you, my Attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my Attorney, to pay directly to said Therapist such sums as may be due his/her office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said therapist. And I hereby further give a lien on my case to said Therapist against any and all proceeds of any settlement, judgment, or verdict which may have been paid to you, my Attorney, or myself as the result of the injuries for which I have been treated or injuries in connection herewith.

I understand that I am directly and fully responsible to said Therapist for all medical bills submitted by him/her for services rendered me and that this agreement is solely made for said Therapist's additional protection and in consideration of him/her awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict buy which he/she may eventually recover said fee.

DATED: _____
Patient's Signature: _____
The undersigned being Attorney's of record for the aforementioned patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said Therapist above named.
DATED: _____
Attorney's Signature: _____

Attorney: Please sign, date and return to Therapist's office at once. Reply envelope attached. Keep one copy for your records.