New York BRAIN SPINE & JOINT

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Assignment of Benefits Form

Name of Insured:_____

Name of Patient :_____

_____I request that payment of authorized insurance benefits, including Medicare if I am a Medicare beneficiary, be made on my behalf to the provider listed below for any services provided to me by that provider.

_____I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related services to the provider, CMS, my insurance carrier, or other entity if requested. The original authorization will be kept on file by the provider.

_____I understand that I am financially responsible to the provider for any charges not covered by health care benefits. It is my responsibility to notify the provider of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the provider and/or my health care insurer if the submitted claim/claims or any part of them are denied for payment.

_____I understand that by signing this form I am accepting financial responsibility as explained above for all payments for services received.

_____I hereby authorize my provider to release all information acquired during the medical examination and treatment for insurance claim filing. Photocopies of this authorization shall be considered as effective and valid as the original.

- The patient issued and explained the NYSDOH Patients' Bill of Rights for Diagnostic and Treatment Centers (Clinics) in their preferred language.

Name of Person signing below (print)_____

Relationship to Insured_____

Signature of Insured or Patient/Guardian_____ 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 Nitin Mariwalla MD PLLC, ("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)

LIEN ASSIGNMENT AGREEMENT

I _____(patient name) residing at _____(address) hereby enter into the following agreement with _____, hereinafter known as "the provider" in order to guarantee payment for services rendered by "the provider" to me, incidental to the accident that occurred on _____.

Non-No Fault Claims: I understand that I am directly and fully responsible to "the provider" for all medical bills for services rendered to me. I understand that I am directly and fully responsible to "the provider" for any remaining balance on all medical bills for services rendered to me that were submitted on my behalf to the responsible insurance carrier as applicable. This document further serves to acknowledge my responsibility to repay **all** remaining balances subsequent to all applicable insurance payments. I agree to make myself available to appear or correspond with "the provider" as often as may be necessary for any collections effort that is undertaken. I have been made aware of the charges for the services rendered under this lien assignment and acknowledge responsibility for the repayment of all outstanding balances. I further direct that my attorney shall not subsequently dispute these amounts and, at my direction, will contact this office to arrange for full payment at the time a settlement, trial or motion proceed becomes ready for disbursement.

No Fault Claims: Provider acknowledges that he may not pursue any balances after partial payments are received from the appropriate No-Fault Carrier pursuant to the statutory language contained in the assignment of benefits form. To the extent applicable, patient agrees to comply with all Insurance Company regulations including, but not limited to examinations under oath and independent medical examinations. I understand that any failure on my part to comply with any condition precedent to insurance coverage, may, at the election of the medical provider, serve to revoke any assignment of No-Fault benefits. The patient herein further acknowledges their responsibility to file a timely notice of claim to the applicable insurance carrier and that any subsequent No-Fault claim denied based on the failure to provide a timely notice, at the election of the provider, may result in recovery efforts in reliance of this lien.

The Provider agrees to seek compensation from the appropriate insurance carrier prior to invoking the terms of this lien based on the accuracy of the information the patient has provided and to the extent the information is made available prior to the date of service. The patient shall provide all necessary insurance information, police reports, and any additional documentation or information deemed necessary by the provider for the submission of the aforementioned insurance claim as applicable. Failure to provide accurate insurance information leading to a viable source of coverage may serve to invalidate any executed assignment of No-Fault benefits and result in the reliance on this lien for reimbursement purposes. I am aware that No-Fault coverage is premised on a viable policy that is not exhausted. If a policy exhausts prior to collection by Provider, I acknowledge that this Lien may be invoked as a primary payment method.

If patient provides insurance information for a No-Fault claim that indicates a third-party administrator and does not provide the name of the underlying insurer, Provider will submit the claim to the named entity but Patient agrees that any assignment of benefits

may be revoked retroactively by provider who will revert to this Lien for payment if no underlying carrier is identified. Patient directs his attorney not to dispute any such revocation in favor of the lien where an entity, such as a third-party administrator cannot be pursued in Court for payment based on jurisdictional issues or where a policy exhausts prior to collection by Provider.

I hereby give and grant this lien on my case to "the provider" against any and all proceeds of any settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf that may be paid to me or my ATTORNEY as a result of the injuries for which I have been treated. I grant "the provider" the aforesaid lien against such sums of the aforesaid settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse "the provider" for services rendered to me and towards all outstanding balances. I hereby agree to provide accurate contact information for the attorney pursuing any litigation on my behalf.

I hereby **direct** and **authorize** direct payment to "the provider", such sums as may be due and owing for medical services rendered to me. I further direct my ATTORNEY to honor the aforesaid lien and to withhold such sums from any settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse "the provider" for services rendered to me towards all outstanding balances. In the event collection efforts are required to enforce or defend this Lien, Patient acknowledges responsibility to pay any legal fees incurred by Provider.

I understand that this document may not be rescinded and that my ATTORNEY shall not honor any such rescission. I hereby instruct that in the event another ATTORNEY is substituted in my case, I direct the substituted attorney to provide the incoming ATTORNEY with a copy of this lien and that I direct any incoming ATTORNEY to honor this lien as inherent to the settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf and enforceable upon the case as if it were executed by him/her. I hereby direct and authorize my attorney, on demand, to provide the status of such litigation to "the provider" or his attorney engaged in any collection efforts. Furthermore, I direct my attorney to contact "the provider" or the attorney representing the provider prior to disbursement of any funds to ascertain any outstanding balances due to Provider.

_____ _____

Patient Name Patient Signature

_____

Dated

_____ _____

Patient Address Patient's Attorney's Name

_____

Attorney Address/Phone