First Class Medical P.C. Mani Ushyarov,DO.MD

87-15 115 street First Floor
Richmond Hill NY 11418

Tel: (718)-805-2000
Fax: (718)-805-2015

Patient's name: _____ _____
Last name First name

Patient's mailing address: _____ _____
Street Name Apt

City:_____State_____ZIP_____DOB:_____/____/____

SS:___-____-____Home phone: (___)-____-___Cell phone : (___)-___-____

Emergency (____)-_____-_____ Contact person: _____

Date of accident: _____/_____/_____Type: • AUTO • JOB INJURY •SLIP & FALL

Were you: • Driver • Passenger • Pedestrian • Bicyclist • Other

As a result of this accident have you received any medical treatment? • Yes • No

Have you been involved in the other car accident within a year? • Yes • No
If'Yes':When? ___/_____/_____

Is there a lawsuit pending on your accident or injury? • Yes • No

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORAMTION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERERO 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 VEHICLE OR AN INSURANCE COMPANY,COMMITS A FRADULENT 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.

DECLARATION: UNDER OF PERJURY, I UNDERSIGNED CERTIFY THAT THE FOREGOING IS TRUE AND CORRECT.

•_____,•_____,•_____/_____/_____
(Print you last and first name) (Signature) (Today's Date)

NEW YORK MOTOR VEHICLE NO-FAUL T INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

ADJUSTER NAME: *TELEPHONE:*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
[redacted]	[redacted]			

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER 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 ALSO SIGN ANY ATTACHED AUTHORIZATIONS.
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

YOUR NAME: *YOUR ADDRESS:*

1. YOUR NAME	1. PHONE NOS. HOME	BUSINESS
3. YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE, 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, ☐ OR A MOTORCYCLE ☐ A TRUCK, ☐ AN AUTOMOBILE,

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	☐	☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	☐	☐
WERE YOU A PEDESTRIAN?	☐	☐
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	☐	☐
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?
YES ☐ NO ☐

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSONS:

13. IF YOUR 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(S)?	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
$ _____	YES ☐ NO ☐	YES ☐ NO ☐

17. DID YOU LOSE TIME FROM WORK?	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK?
YES ☐ NO ☐		YES ☐ NO ☐

IF YES, DATE RETURNED TO WORK:	AMOUNT OF TIME LOST FROM WORK:
_____	_____

18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?
YES ☐ NO ☐

20. LIST NAMES AND ADDRESSES OF YOUR EMPLOYER ANDOTHER EMPLOYERS FOR ONEYEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

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

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?
YES ☐ NO ☐

IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

	YES	NO
NEW YORK STATE DISABILITY?	☐	☐
WORKERS' COMPENSATION?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE THREE

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 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.

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

NAME (PRINT OR TYPE) _____ SOCIAL SECURITY NO. _____

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

NAME (PRINT OR TYPE) _____

SIGNATURE* _____ DATE _____

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

Notice of Intention to Make Claim

This form must be subscribed and sworn to. Fax or e-mail notification is not acceptable.

To: MOTOR VEHICLE ACCIDENT INDEMNIFICATION CORPORATION
100 WILLIAM ST, 14th Floor
NEW YORK, N.Y. 10038 phone: 646-205-7800

State of New York -
County of _____ -ss.

Pursuant to Article 52 and/or pertinent sections of Article 18 of the Insurance Law of the State of New York, this affidavit is presented to the Motor Vehicle Accident Indemnification Corporation for the purpose of giving my Notice of Intention to Make Claim against said Motor Vehicle Accident Corp. for injuries sustained by me. I have been duly sworn and state:

My name is _____; my date of birth is _____

I reside at _____;_____
Street Address /Apt City - State - Zipcode

My Social Security # is: _____ My email is: _____
My telephone number is: _____

I am employed by: _____ [ ] Unemployed
_____
_____

I was involved in an automobile accident on: _____
Month Day Year time (am/pm)

Place of Accident: _____
Street or highway City State

I was driver [ ] a passenger [ ] of vehicle #1 [ ] a pedestrian [ ]
vehicle #2 [ ] a bicyclist [ ]

Vehicle #1 _____ Vehicle #2_____
Year/Make/Model/Color Year/Make/Model/Color

License Plate #:_____State_____ License Plate #:_____State____

Owner:_____ Owner: _____
Address:_____ Address:_____
_____ _____

Driver:_____ Driver:_____
Address:_____ Address:_____
_____ _____

Insured by:_____ Insured by:_____
Policy #:_____ Policy #:_____
Effective Date:_____Expiration date:____ Effective Date:_____Expiration date:____

The accident was reported to the Police on _____, in _____
Date Precinct - City – State

Description of Injury & Expense Incurred:_____

Is your injury covered by insurance? Yes[ ] _____No[ ]
Name of Insurance Company

Are you receiving Worker's Compensation? Yes [ ] _____No[ ]
Name of Insurance Co.

Description of Accident

_____

_____

_____

Did anyone live with you on the date of accident? Yes [ ] No [ ]

If yes, list all the people that lived with you on the date of accident:

Name	*Relation*	*Date of Birth*	*Social Security Number*

Do any of the people you live with own a vehicle: Yes [ ] No [ ]
Owners name _____
Insurance Company_____
Policy #:_____Effective:_____Expires:_____

Witnesses to the Accident

Name:_____ Name:_____
Address:_____ Address:_____
_____ _____
Telephone:_____ Telephone:_____

Reason for application to Motor Vehicle Accident Indemnification Corporation:
Uninsured Car [ ] Stolen Car [ ]
Denial of Coverage [ ] *attach copy* Unidentified Car [ ]
Disclaimer of Coverage [ ] *attach copy*

>>>>>>>>>>> ***Attach a copy of both sides of Police Report*** <<<<<<<<<<<<<

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON WHO FILES A 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 VIOLATION.

Sworn to before me this day _____
Of ,20___ (Signature of person making claim)

_____
Notary Public (signature)

HOUSEHOLD AFFIDAVIT

On _____ [date of accident], I, _____, resided at

_____.

I am currently residing at (if different from the above) _____.

Check the correct response:

- o At the time of the accident I was living alone; no one else lived with me.

or

- o The following people lived with me on the date of accident:

NAME	Social Security #	DATE of BIRTH	RELATIONSHIP

Please list ALL members of the your household, including Social Security #, dates of birth & relationship to you. [*use reverse if necessary*]

****** *MUST BE NOTARIZED* ******

_____
Signature date

Notary:

Sworn to before me this day
Of 20___

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON WHO FILES A 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 VIOLATION.

FIRST CLASS MEDICAL, P.C.

PATIENT HIPPA AWARENESS

With my awareness, First Class Medical P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payments and healthcare operations (TPO). Please refer to First Class Medical PC's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. First Class Medical P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, The office of First Class Medical P.C. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of First Class Medical P.C may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patients statements as long as they are marked Personal and Confidential.

With my permission, the office of First Class Medical P.C may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patients statements. I have the right to request that First Class Medical P.C. restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bout by this agreement.

By signing this, I am allowing First Class Medical P.C to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent.

_____

Signature of Patient or Legal Guardian

_____

Patient's Name

_____

Print Name of Patient or Legal Guardian

____/_____/_____

Today's date

First Class Medical P.C.
87-15 115 street, First Floor
Richmond Hill, NY 11418
Tel: (718)-805-2000 Fax (718)-805-2015

AUTHORIZATION OF DIRECT PAYMENTS OR LIEN

Re: Patient Records and Lien

I do hereby authorize **First Class Medical P.C.** to furnish you, my attorney, with full report of diagnostic tests or any treatments performed on me in reference to the accident in which I was involved on ____/ _____/ _____.

I hereby authorize and direct you, my attorney, to pay directly to **First Class Medical P.C.** such sums as may be necessary to adequately compensate **First Class Medical P.C** for medical services rendered to me both reason to this accident and by any reason of any other bills that are due by his/her office and to withhold such sums from any settlement, judgment or verdict as may be necessary to protect said **First Class Medical P.C.**

Prior to my being seen by **First Class Medical P.C.** I executed an insurance assignment and payment order, whereby I directed the insurance company responsible for the payment of my medical expenses to pay **First Class Medical P.C** directly, for services rendered. I understand that I am personally and fully responsible to **First Class Medical P.C.** for services rendered to me and that this agreement is made solely for the additional protection and in consideration of **First Class Medical P.C.** awaiting payments.

Dated : ____ / _____/ _____ **Patient's name : _____**

Patient's signature: _____

The undersigned, being the attorney of records for the above patient does hereby acknowledged receipt of the above lien.

Dated: _____/ _____/_____ **Attorney's Signature: _____**

Attorney:

( ) Please, date, sign and return one copy to our office
( ) Keep one copy for your records

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Medical Record Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
FIRST CLASS MEDICAL P.C 87-15 115 street, First Floor, Richmond Hill, NY 11418

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record form (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**
_____ **Genetic Testing**

Authorization to Discuss Health Information

(b). ☐ By initialing here _____ I authorize _____
Initials Name of individual health care provider
to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All Items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of Patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**