ARIS DIAGNOSTIC MEDICAL, PLLC

88-09 101 AVENUE
OZONE PARK, NY 11416
TEL: 718-577-5152
FAX: 718-835-7564

PATIENT INFORMATION

Name_____
Address_____
City/State/Zip_____
Home Phone #(___)_____
Business Phone#(___)_____
Date Of Birth_____
Age_____Sex-Male/Female
Social Security____-_____-_____
Employed_____

ACCIDENT INFORMATION

Today's Date_____
Date Of Accident_____
Referred By_____
Dr Phone#(____)_____
Car Accident? YES/NO
Driver/Passenger/Pedestrian
Driver Did You Work At The Time of The Accident?__
Is This Your First MRI After the Accident?___
X-Ray? YES/NO

Did you have an IME (Independent Medical Examination) Appointment. In other words, did you see the doctor from the insurance company YES/NO
IF YES, When?

CAR INSURANCE INFORMATION

Insurance Name_____
Address_____
City_____
State/ZIP Code_____
Phone #(____)_____
Adjuster Name_____
Extention #_____
Policy Holder_____
Claim #_____

ATTORNEY INFORMATION

Attorney's Name_____
Address_____
City_____
State/Zip Code_____
Phone #(____)_____
Fax #(____)_____
Paralegal Name_____

SIGNATURE X_____

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Name_____
Last **First**

Date of Accident_____
Month **Day** **Year**

1. At the time of the accident I was the_____
(Example: Driver, Front or back passenger, pedestrian)

2. List the dates of all prior automobile accidents that you were involved in for the last 3 years and the circumstances surrounding those accidents.

_____
_____
_____
_____
_____

3. Were you injured? _____

4. How did you hear about us? MEDICAL OFFICE

5. What is your relationship to the other passengers in the vehicle you were in?

_____
_____

6. Did you know anyone from the other vehicle(s) involved in the accident?

_____

- **If yes, please specify whom**_____

7. Was this accident staged?_____

- **Please be advised that New York State Law prohibit the filing of a fraudulent claim, which is a crime punishable by imprisonment. By signing this form, I _____, hereby represent that all the statements contained herein are true and accurate.**

Print Name:_____ **SS#**_____
Signature: X_____ **Date:**_____

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Patient's Name_____Date_____

CIRCLE YES OR NO FOR THE FOLLOWING CONDITIONS

Mechanical Heart Valve	**(Yes) (No)**
Pacemaker	**(Yes) (No)**
Intro-Cranial or any Aneurysm Clips	**(Yes) (No)**
Metal Fragment in the eyes	**(Yes) (No)**
Epilepsy	**(Yes) (No)**
Metallic Prosthesis in the ears	**(Yes) (No)**
Hearing Aid (must be removed for the test)	**(Yes) (No)**
Greenfield Filter	**(Yes) (No)**
Any Shrapnel	**(Yes) (No)**
Any Previous Gun Shots	**(Yes) (No)**
Previous Bone Fracture Treated with	
Rods, Plates, Pins, Screws or Braces	**(Yes) (No)**
Body Weight greater than 280 pounds	**(Yes) (No)**
Prosthesis (dental must be removed for the test)	**(Yes) (No)**
Vascular Shunt	**(Yes) (No)**
Are you Pregnant	**(Yes) (No)**

SIGNATURE_____DATE_____

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AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient's Name:_____

Kindly furnish my Insurance Company or their representatives including medical services where I was treated, all information you may have regarding my condition while your treatment or observation, including but not limited to medical history, x-ray, physical finding, diagnosis, prognosis, medical necessity and narrative reports. You are authorized to provide this information in accordance with the New York State Automobile Reparations Act (No-Fault Law).

_____
Signature of Patient

_____**Date:_____/____/____**
Witness

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LIEN ASSIGNMENT AGREEMENT

I _____(patient name)

residing at _____(address)

hereby enter into the following agreement with **ARIS DIAGNOSTIC MEDICAL, PLLC**, here in after known as "the provider" in order to guarantee payment for services rendered by "the provider" to me. 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 will contact this office to arrange for full payment at the time a settlement, trial or motion proceed becomes ready for disbursement.

To the extent applicable, I agree 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 applicable. 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 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.

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 balance in the amount of $_____ due to **ARIS Diagnostic Medical, PLLC**

_____
Dated

_____	_____
Patient's Signature	Attorney's Signature
_____	_____
Patient Name	Patient's Attorney's Name
_____	_____
_____	_____
Patient Address	Attorney

Patient Name:_____ Date of Birth:____/____/____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in details the uses and disclosures of my protected health information that may be made by this practice of my individual rights and practice's legal duties with respect to my protected health information. The notice includes

- A statement that this practice is required by law to maintain the privacy of the protected health information.
- A statement that this practice is required to abide by the terms of this notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclosure protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  *The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that retaliatory actions will be used against me in the event of such complaint.
  *The right to request restriction on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction.
  *The right to receive confidential communications of protected health information.
  *The right to inspect and copy protected health information.
  *The right to amend protected information.
  *The right to receive an accounting disclosure of protected health information.
  *The right to obtain a paper copy of the Notice Of Privacy from this office upon request.

This practice reserves the rights to change the term of its Notice of Privacy Practices and to make new provisions elective for all protected health information that it maintains I understand that I can obtain the practices current Notice if Privacy Practices upon request.

Signature X_____Date:_____

Relationship to patient (if signed by personal representative of patients)_____

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

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

I, _____, ("Assignor") hereby assign to ARIS Diagnostic Medical 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 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 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 ASSIST, 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)

ARIS DIAGNOSTIC MEDICAL, PLLC _____
(Print name of Provider) (Signature of Provider)

88-09 101ST AVENUE _____
(Date of signature)

OZONE PARK, NY 11416
(Address)

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_____ _____
(Print name of Patient) (Signature of Patient)

_____ _____
(Date of signature)

_____
(Address)

ARIS DIAGNOSTIC MEDICAL, PLLC _____
(Print name of Provider) (Signature of Provider)

88-09 101ST AVENUE _____
(Date of signature)

OZONE PARK, NY 11416
(Address)

DOS	Patient’s Signature