NEW YORK STATE MOTOR VEHICLE NO-FAULT INSURANCE LAW (ASSIGNMENT OF BENEFITS)

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

I, _____ ("Assignor") hereby assign to AMANDEEP PAL M.D. ("Assignee") 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 motor vehicle accident which occurred on _____ not withstanding any other agreement to the contrary.

This agreement may be revoked by the assignee when benefits are not payable 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 AND 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 CONCERNINGANY 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.

_____ (Name of patient)

_____ (address of patient)

_____

_____ (Patient signature)

_____ (date)

_____

Amandeep Pal M.D. PLLC
6000 Brockton Dr. Ste 101
Lockport N.Y. 14094

_____ (provider signature and date)

DUE TO NO-FAULT INSURANCE COVERAGE, THE FOLLOWING FORM MUST BE COMPLETED. NO OTHER INSURANCE MAY BE BILLED. WE DO NOT PARTICIPATIENT WITH NO-FAULT INSURANCE, BUT WE WILL BILL IT AS A COURTESY TO YOU, PROVIDED THIS FORM IS FILLED OUT COMPLETELY. THE RESPONSIBILITY FOR PAYMENT TO THE DOCTOR IS THE PATIENT'S.

PATIENTS NAME_____

NO FAULT INSURANCE CO_____

ADDRESS_____

PHONE #_____

POLICY#_____

DATE OF ACCIDENT _____

PATIENT SIGNATURE_____

MY SIGNATURE AUTHORIZES DR. AMANDEEP PAL TO RECEIVE PAYMENT DIRECTLY FROM THE NO-FAULT CARRIER.