NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM
(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number:

<style isBold="true">I, ANGEL TORRES, ("Assignor") hereby assign to ABSOLUTE MEDICAL & SURGICAL SUPPLIES, INC.</style>, ("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 the motor vehicle accident which occurred on <style isBold="true">April 09, 2009</style>, notwithstanding any other agreement 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.

ABSOLUTE MEDICAL & SURGICAL	ANGEL TORRES
Provider	Printed patient Name
Provider Signature	Patient Signature
35 MARIE ST STATEN ISLAND , NY 10305	3661WALDOR AVENUE BRONX, NY
Provider Address	Patient Address
5/30/2009	5/30/2009
Signature Date	Signature Date

LAST & FIRST NAME:	**ADDRESS:**
ANGEL TORRES D.O.B: 8/30/1979 SS#: - - MARITAL STATUS: HOME PHONE: (718) 404-1979 MOBILE: BUSINESS PHONE: EMERGENCY CONTACT NAME & #:	3661WALDOR AVENUE **ADDRESS OF DELIVERY IF DIFFERENT FROM ABOVE:** DIAGNOSIS: **PRESCRIBED SUPPLIES/EQUIPMENT:** CPM FOR THE SHOULDER DURATION:43 WATER CIRCULATING PUMP DURATION:43 **PRESCRIBING PHYSICIAN:** ADDRESS: PHONE FAX: License No.:

INSURANCE INFO:

TYPE: NF [X] WC [ ] COMMERCIAL [ ] PVT [ ] **INSURNANCE PROVIDER:** NATIONWIDE INSURANCE CO P.O.BOX 2655 HARRISBURG PA 17105	PHONE: (800) 354-0715 ADJUSTER: ACCIDENT DATE: April 09, 2009 POLICY No.: CLAIM No.:

INSURANCE INFO:

[x]DEVICE CLEAN
[x]DEVICE WORKING
[x]HAND CONTROL ACCESSIBLE
[x]PATIENT HAS TO CALL CPM SOLUTIONS NY IF ANY PROBLEMS
[x]PATIENT OR CAREGIVER HAS DEMONSTRATED COMPETENCY IN USING THE DEVICE
[x]PERSON TAUGHT IF OTHER THAN PATIENT
[x]BILL OF RIGHTS
[x]DEVICE PROTOCOLS
[x] HOW TO REACH CPM SOLUTIONS NY WITH QUESTIONS AND PROBLEMS
[x]DEVICE OPERATION
[x]WHEN TO CONTACT DOCTOR
[x]TO CALL CPM SOLUTIONS NY AS INSTRUCTED

BY SIGNING BELOW PATIENT KNOWS AND UNDERSTANDS ALL OF THE CONTENTS OF THIS ASSIGNMENT.
I ALSO ACKNOWLEDGE THAT I HAVE RECEIVED ABOVE MENTIONED EQUIPMENT AND UNDERSTAND MY RIGHTS AND RESPONSIBILITIES AND UNDERSTAND HOW TO PROPERLY OPERATE THE DEVICE. I ALSO AGREE TO ALLOW ABSOLUTE MEDICAL & SURGICAL SUPPLIES, INC. TO USE MY PROTECTED HEALTH INFORMATION (PHI) FOR HEALTH INCLUDING PAYMENTS OF CLAIMS, OBTAINING INFORMATION FROM MY DESIGNATED HEALTH CARE PROVIDER AND FOR QUALITY ASSURANCE IMPROVEMENTS. IF I CHOOSE NOT TO ALLOW ABSOLUTE MEDICAL & SURGICAL SUPPLIES, INC., TO RELEASE MY PHI, I WILL BE RESPONSIBLE FOR PAYMENT OF ALL PRODUCTS, SERVICES I RECEIVED FROM ABSOLUTE MEDICAL & SURGICAL SUPPLIES, INC.. RELEASE OF MY PHI WILL TERMINATE WHEN MY ACCOUNT BALANCE WITH ABSOLUTE MEDICAL & SURGICAL SUPPLIES, INC., INC IS AT ZERO DOLLARS FOR MORE THAN 60 (SIXTY) DAYS. FOR RENTAL EQUIPMENT I UNDERSTAND HOW TO ARRANGE FOR EQUIPMENT RETURN AND UNDERSTAND THAT IF THIS EQUIPMENT IS DAMAGED, LOST, MISLAID, STOLEN, OR DESTROYED, I AM RESPONSIBLE FOR THE REPAIR CHARGES OR THE PURCHASE PRICE, WHICHEVER IS LESS.

PATIENT OR AUTHORIZED REPRESENTATIVE NAME: ANGEL TORRES

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE:

DATE OF EXECUTION/DELIVERY: 5/30/2009

RELATIONSHIP TO PATIENT/REASON FOR SIGNING:

ABSOLUTE MEDICAL & SURGICAL SUPPLIES, INC. REP. SIGNATURE:

DATE: 5/30/2009

SUPPLY RETURN RECEIPT/AKNOWLEDGMENT

RENTAL START DATE: 5/30/2009

DELIVERY DATE: 5/30/2009

TREATMENT END DATE: 7/11/2009

PICK UP/COMPLETION DATE:

PRESCRIBED SUPPLIES/EQUIPMENT:

CPM FOR THE SHOULDER	DURATION:43
WATER CIRCULATING PUMP	DURATION:43

I, ANGEL TORRES HAVE RETURNED THE ABOVE MENTIONED SUPPLY(IES) ON _____/_____/_____IN THE SAME CONDITION AS WAS DELIVERED TO ME ON 5/30/2009

PATIENT OR AUTHORIZED REPRESENTATIVE NAME: ANGEL TORRES

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE:

DATE OF EXECUTION/DELIVERY:

RELATIONSHIP TO PATIENT/REASON FOR SIGNING:

ABSOLUTE MEDICAL & SURGICAL SUPPLIES, INC. REP. SIGNATURE:

DATE: