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

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

I, Onelia Sanchez **, ("Assignor") hereby assign to** KDV Medical PC **, ("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 06/25/2021 **, 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.

Onelia Sanchez
(Print name of Patient)

Onelia Sanchez
(Signature of Patient)

07/01/2022
(Date of signature)

2384 Paulding Avenue Apt 1E ,Bronx ,NY ,10469
(Address of Patient)

KDV Medical PC
(Print name of Provider)

Ketan Vora
(Signature of Provider)

PO Box 11590

07/01/2022
(Date of signature)

New Brunswick, NJ 08906
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
(This form is not for verification of hospital treatment)

New York City Transit Autority	

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
07/01/202	Onelia Sanchez		06/25/2021	BU2020 625001 4001

Ketan D Vora, DO
PO Box 11590
New Brunswick, NJ 08906

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. **PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER THE TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM.**

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS

Onelia Sanchez 2384 Paulding Avenue Apt 1E ,Bronx ,NY ,10469

2. DATE OF BIRTH	3. SEX	4. OCCUPATION (IF KNOWN)
03/23/1941	Female	

5. DIAGNOSIS AND CONCURRENT CONDITIONS

6. WHEN DID SYMPTOMS FIRST APPEAR?
DATE: _____

7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE: _____

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?

YES [ ] NO IF YES, state when and describe:

9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT?

YES [ ] NO [ ] IF "NO", explain:

10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?

YES NO

11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?

YES [ ] NO [ ] NOT DETERMINABLE AT THIS TIME [ ]
IF "YES", describe:

12. PATIENT WAS DISABLED (UNABLE TO WORK)

FROM: _____ THROUGH:

13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON:

(DATE)

CONTINUE ON PAGE 2

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
PAGE 2

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?
YES ____ NO ____ IF YES, describe your recommendation below:

15. REPORT OF SERVICES RENDERED -- ATTACH ADDITIONAL SHEETS IF NECESSARY

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICE RENDERED	FEE SCHEDULE TREATMENT CODE	CHARGES
			TOTAL CHARGES TO DATE$	

16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING:

TREATING PROVIDER'S NAME	TITLE	LICENSE OR CERTIFICATION NO.	BUSINESS RELATIONSHIP CHECK APPLICABLE BOX		
			EMPLOYEE	INDEPENDENT CONTRACTOR	OTHER (SPECIFY)

17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES ____ NO ____

19. ESTIMATED DURATION OF FUTURE TREATMENT

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (**Authorization to Pay Benefits**) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20 of this form.

20. ____ **(IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #21)**

AUTHORIZATION TO PAY BENEFITS:
I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES ER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

PRINT NAME Onelia Sanchez SIGNED Onelia Sanchez 07/01/2022
PATIENT PATIENT DATE

CONTINUE ON PAGE 3

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
PAGE 3

PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (**Assignment of Benefits**). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in # 21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

21. _____ (IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)

ASSIGNMENT OF NO-FAULT BENEFITS:

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE 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, 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

PRINT NAME Onelia Sanchez		SIGNED Onelia Sanchez	07/01/2022	
PATIENT (Assignor)		PATIENT		DATE
PRINT NAME Ketan Vora DO		SIGNED Ketan Vora		
PROVIDER OF HEALTH CARE SERVICE (Assignee)		PROVIDER OF HEALTH CARE SERVICE		DATE

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED? ☐ YES ☐ NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? ☐ YES ☐ NO

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.

DATE	PROVIDER'S SIGNATURE	IRS/TIN IDENTIFICATION NO.	WCB RATING CODE IF NONE, SPECIALTY
	Ketan Vora	27-3261060	CPM&R/PAIN

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

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

New York City Transit Autority NAME AND ADDRESS OF INSURER	

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
07/01/202	Onelia Sanchez			

TO ENABLE US TO DETERMINE IF YOUR ARE ENTITLED TO BENEFITS UNDER THE 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 SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

Onelia Sanchez
2384 Paulding Avenue Apt 1E ,Bronx ,NY ,10469

1. YOUR NAME	2. PHONE NOS. HOME	BUSINESS
Onelia Sanchez		

3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.
2384 Paulding Avenue Apt 1E ,Bronx ,NY ,10469	03/23/1941	

6. DATE AND TIME OF ACCIDENT	7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE
06/25/2021 A.M. P.M.	

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, ☐ A TRUCK, ☐ AN AUTOMOBILE, ☐ OR A MOTORCYCLE

	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 PERSON(S):

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 ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR 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.

Onelia Sanchez

SIGNATURE

07/01/2022

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. YOUR ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

Onelia Sanchez

NAME (PRINT OR TYPE)

SOCIAL SECURITY NO.

SIGNATURE

07/01/2022

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).

Onelia Sanchez

NAME (PRINT OR TYPE)

SIGNATURE

07/01/2022

DATE

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

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

New Patient Consent to Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I, Onelia Sanchez, understand that as part of my health care, Non-Surgical Orthopedics of New Jersey originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or discloses to carry out treatment, payment, or health care operations

I understand that Non-Surgical Orthopedics of New Jersey is required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization my refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Non-Surgical Orthopedics of New Jersey reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Non-Surgical Orthopedics of New Jersey change their notice, they will send a copy of any revised notice to the address I've provided (whether US mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosures for these permitted uses, including disclosures via fax.

I fully unde[r] Onelia Sanchez [t]his consent.

_____

Patient's Signature

07/01/2022

Date

KETAN D VORA DO, PC

2801 GLENWOOD RD
BROOKLYN, NY 11210
PHONE: (646) 820-PAIN (7246)

INFORMATION SHEET AND INFORMED CONSENT

KETAN D VORA DO, PC, I firmly believe that "every human being has the right to determine what shall be done with his own body." During the course of your treatment and evaluation with KETAN D VORA DO, PC, you may be subjected to a number of different types of tests and treatments. It is our responsibility to explain the nature and purpose of these as well as known risks, benefits and alternatives. Listed below is a brief summary.

MRI (Magnetic Resonance Imaging) is an imaging technique, which uses electromagnetic forces, not potentially harmful Radiation. It is generally safe but should not be performed in individuals who have a ***PACEMAKER*** or ***METAL*** in their body from a Previous surgery or injury. **MRI WITH CONTRAST** is performed with intravenous administration of a contrast agent. Allergic Reaction or mild side effects are possible. If you have *known allergies*, please inform your doctor of them. *Claustrophobic* individuals should discuss the possibility of sedation or other alternatives to MRI with the doctor prior to scheduling this test.

BAER (Brainstem Auditory Evoked Response) is an electro diagnostic test, which evaluates the auditory and vestibular System. Delivering a series of "clicks" in each ear performs it. **VER (Visual Evoked Response)** is an electro diagnostic test Which evaluates the visual system. Delivering a series of light flashes performs it.

SSEP (SomatoSensory Evoked Potentials) is an electro diagnostic test which measures the condition of impulses from the arms and/or legs, through the spina· cord to the brain. It requires a small electrical current but is not painful. **NCV (Nerve Conduction Velocity)** is an electro diagnostic test, which measures the condition of impulses in the peripheral nerves of the arms and/or legs.

It requires a slightly stronger electrical impulse than the SSEP, but both the NCV and SSEP are generally safe and well tolerated.

EEG (ElectroEncephatoGram) is an electro diagnostic test, which records the brain's electrical activity. No electrical current is delivered by the machine. This test can be performed either with paste or small needle electrodes. **DOPPLER (carotid/Tran cranial/Arterial Doppler study)** is a test, which uses ultrasound to detect the rate of flow inside blood vessels.

PHYSICAL THERAPY is a treatment program which is individually designed to relieve pain, rehabilitate injured tissue, and Restore function ability. Various modalities may be utilized including message, electrical stimulation, ultrasound, traction etc; the Physical therapist will further explain the treatment plan for you. Physical therapy may result in increased soreness and discomfort Initially since injured tissue is being rehabilitated. This should improve as the healing process occurs. If you are experiencing Significant or ongoing pain, please bring this to the attention of your therapist or doctor.

EMG (Electromyography) is an electro diagnostic test which detects muscle and nerve damage. It requires placement of a Thin needle in various muscles. In general, it is a safe and well-tolerated procedure although thee is a small risk of bleeding, Infection, and damage to adjacent structures. If you have a ***bleeding disorder*** or take ***anticoagulants like Coumadin***, please Bring this to the attention of the doctor.

INJECTION THERAPY consists of administration of local anesthetics (such as Lidocaine) and/or steroids (such as Cortisone). These medications are injected into the appropriate location (such as a joint, trigger point, nerve or epidural space) to relieve pain And promote healing. In general, these procedures are safe and well tolerated although there is a risk of bleeding, infection, and Damage to adjacent structures. Furthermore, potential side effects of a local anesthetics includes dizziness, drowsiness, Allergic reaction, low blood pressure, and slow heart rate. Potential side effects of steroids include retention, ulcers, and increased Blood sugar. These side effects usually occur with long-term administration or over-dosage. Injection therapy is effective since The medication is delivered directly to the injured tissue, lower doses are required, and there are fewer systemic side effects.

MEDICATIONS may be prescribed. All drugs have potential side effects and interactions. Your doctor will discus these with you and if medications are prescribed.

I understand the risks and benefits of the treatment and evaluation protocol, which has been prescribed. If not, they have been further clarified By a KETAN D VORA staff MEMBER. Furthermore, I have read and understood the patient bill of rights and responsibility posted at the reception Desk.

PRINT NAME: Onelia Sanchez

SIGN NAME: _____

DATE: 07/01/2022

DR. KETAN D. VORA, DO

FEE GUARANTEE AGREEMENT FOR MEDICAL PROVIDER NAME HERE

PATIENT: Onelia Sanchez

DATE OF BIRTH: 03/23/1941

TREATMENT DATES: 07/01/2022

ACCIDENT DATE: 06/25/2021

I, the above noted Patient, do hereby authorize and direct my present and any future attorney to honor this fee guarantee agreement. This agreement is made in favor of the above named Medical Provider and shall be termed a "Letter of Protection." The Letter of Protection shall serve to place a continuing lien on any proceeds I recover in any legal action related to the above noted accident date.

Consideration. In consideration of the medical treatment provided and time provided to pay for said medical treatment, I hereby grant a direct lien on any and all funds I may recover in any legal action related to the above accident date.

Protection of Outstanding Charges. The above named Patient hereby agrees that if s/he recovers any money from any person or entity in connection with any legal action related to the above noted accident date, the Patient shall withhold from those funds, sufficient money pay the full outstanding balance of any bill(s) owed to the above named Medical Provider for treatment or any work completed in relation to the above noted accident date. Those funds shall be deducted prior to any other party removing funds for any reason, including but not limited to attorney's fees, costs, other court fees, or any other bill or lien whatsoever. Patient hereby directs their present and/or future attorney to pay said outstanding medical bill in connection with the above noted treatment. This agreement shall obligate each attorney who represents the above named patient in any way and recovers any funds related to the above noted accident date and creates a constructive trust with said attorney. Further, this agreement shall extend pay any outstanding balance for any copies, costs or reports the above named Medical Provider endures in relation to any legal issue for the above accident date. The Patient hereby agrees to waive any rights they have, under contract, law or equity, to have the Medical Provider bill a third party entity, including but not limited to any contracted payer, health insurer or government payer and further desires to pay for the medical treatments through the legal action's proceeds.

Patient Responsibility. It is the Patient's responsibility to advise each and every attorney of the existence of this agreement. Further the Patient must advise the above named Medical Provider at reasonable intervals the status of the legal case. It is also the Patient's responsibility to advise the Medical Provider within 5 days of legal matter collecting any funds and to request a bill for any and all outstanding charges. The Patient hereby directs their present attorney and any future attorney to advise the Medical Provider, as soon as possible, about any funds related to the accident case becoming available to the above named Patient. Further, if the legal action fails to fully pay the Medical Provider's outstanding balance(s) then the remaining amounts are to be paid by the Patient. The Medical Provider may, at his/her discretion at any time, bill any third party payer or government payer.

Disputes. If there is a dispute over the Medical Provider's outstanding charges the Patient agrees to submit the full amount due to the Medical Provider and agrees to bring an action in New Jersey State Court for recovery of the disputed difference. If the Patient fails to pay the Medical Provider's full outstanding balance, and thereafter Medical Provider brings suit to collect said sums, Medical Provider shall then have the right to recover attorney fees and costs for bringing an action to enforce this particular provision.

Approval Required. This agreement becomes effective when the Patient signs the agreement below. This agreement does not need the approval of any present or future attorney for the Patient.

The parties agree that no party shall be considered the drafting party to this contract.

DATED: 07/01/2022

Onelia Sanchez

PATIENT SIGNATURE

Dr. Ketan D. Vora

Phone#: (732) 441-7177 Fax#: (732) 441-7165

Date: 07/01/2022

RE: _____

D/A: _____

Dear Sir or Madam:

I hereby authorize the above doctor to furnish you my attorney, with a full report of his examination, diagnosis treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for professional services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect said doctor. I hereby further give a **lien** on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Dated: 07/01/2022 Patient's Signature: Onelia Sanchez

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect the said doctor named above. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

I hereby consent to honor the terms of the above agreement in its entirety. I further agree to dispense all fees to my client's provider pursuant with R.P.C.1.15 in NJ, and DR9-102 in NY.

Dated: 07/01/2022 Attorney's Signature: _____

Attorney: Please acknowledge this letter by returning a copy to the doctor's office at once.
Keep one copy for your records.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Onelia Sanchez	03/23/1941	
Patient Address		
2384 Paulding Avenue Apt 1E ,Bronx ,NY ,10469		

I, or my authorized representative, request that health information regarding my care and treatment be released 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:

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 from (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**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☐ Other:	
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. Onelia Sanchez

_____ Date: 07/01/2022

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.**