

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR PROVIDER OF HEALTH SERVICE**

DATE	POLICY HOLDER	POLICY NUMBER	DATE OF ACCIDENT	FILE NUMBER
10/03/2023			06/10/2023	233448926

PROGRESSIVE INSURANCE  
P.O.BOX 2930  
CLINTON, IA 52733

Office Location:  
108 KENILWORTH PL  
BROOKLYN, NY 11210

**PROVIDER'S NAME AND ADDRESS**  
HUDSON VALLEY CHIROPRACTIC HEALTH SERVICES, PC  
210 FINLEY AVE  
STATEN ISLAND, NY 10306  
84-3420083

1. PATIENT'S NAME AND ADDRESS      **BANKS, AALIYAL**  
763 E 82ND ST BROOKLYN, NY 11236

2. AGE 26	3. SEX F	4. OCCUPATION (IF KNOWN)
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5. DIAGNOSIS AND CONCURRENT CONDITIONS:

*M54.2 NECK PAIN*

*M54.50 LOWER BACK PAIN*

*M99.05 SEGMENTAL AND SOMATIC DYSF. OF PELVI*

*M54.6 PAIN IN THORACIC REGION*

*M99.04 SEGMENTAL AND SOMATIC DYSF. OF SACRAL R*

6. WHEN DID SYMPTOMS FIRST APPEAR?  
06/10/2023

7. WHEN DID PATIENT FIRST CONSULT YOU FOR THE 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:

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUTAINED IN THIS ACCIDENT  
☒ YES    ☐ NO    IF "YES", DESCRIBE YOUR RECOMMENDATIONS BELOW

SEE ATTACHED BILLS AND REPORTS

CONTINUED