

I, _____, ("Assignor") hereby assign to,
(print patient/client's name)

Jennifer Perlette Dossett, LMT, ("Assignee") 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 my payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for service 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 the 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, 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 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 of Patient/Client Signature

Patient/Client **SIGNATURE**

Patient/Client **PRINT NAME**

PATIENT/CLIENT ADDRESS

Street

Street 2

City, State Zip

DATE of Provider Signature

Provider **SIGNATURE**

Jennifer Perlette Dossett, LMT

Provider **PRINT NAME**

Office/Practice Address

Seneca Springs
3648 Seneca Street
West Seneca, New York 14224-3400

Billing/Mailing Address

Massage By JP
14 Windcrest Drive
Cheektowaga, New York 14225-2520

[NYS FORM NF-AOB (Rev 1/2004)]

_____ Claim Number	_____ Date of Accident
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Name: _____

DOB: _____

Sex: _____

DOS: _____