DR. LAURA E. HARRINGTON
Liverpool Chiropractic & Wellness, PLLC
403 Tulip Street
Liverpool, New York 13088
Telephone: (315) 461-4510

Client Name_____ Date_____

Vehicle Accident Information

Date of Accident_____ Time of Accident_____ □ a.m □ p.m. □ a.m.

Please describe the accident in your own words:_____

_____

_____

_____

Were you the: □ Driver □ Front Passenger □ Rear Passenger □ Pedestrian

How many people were in the accident vehicle?_____

Accident Site

Road/Street Name_____

City/State_____

Nearest intersection_____

Driving conditions □ Dry □ Wet

□ Icy □ Other_____

Vehicle Information

Make and model of vehicle you were in_____

_____

Were you wearing a seatbelt □ Yes □ No

If yes, what type? □ Lap □ Shoulder

Was the vehicle equipped w/ airbags? □ Yes □ No

If yes, did it/they inflate properly? □ Yes □ No

Did your seat have a headrest? □ Yes □ No

If yes, what was the position of the headrest?

□ Low □ Midposition □ High

Direction you were headed?_____

Speed you were traveling?_____

Other Vehicle Information (If applicable)

Make and model of other vehicle_____

_____

Direction other vehicle was headed?_____

Speed other vehicle was traveling?_____

Impact

Did your car impact another vehicle? □ Yes □ No

Did your car impact a structure? □ Yes □ No

If yes, explain_____

Did any part of your body strike anything in the vehicle? □ Yes □ No

If yes, explain_____

Was impact from:

□ Front □ Rear □ Left □ Right □ Other

At the time of impact were you:

□ Looking straight ahead □ Looking to the left

□ Looking to the right □ Looking up

□ Looking down

Were both hands on the steering wheel? □ Yes □ No

If no, which hand was on the wheel? □ Right □ Left

Was your foot on the brake? □ Yes □ No

Were you: □ Surprised by impact □ Braced for impact

Did you go to the hospital? □ Yes □ No

If yes, which hospital?_____

Police

Did the police come to the accident site? □ Yes □ No

Were there any witnesses? □ Yes □ No

Was a police report filed? □ Yes □ No

Was a traffic violation issued? □ Yes □ No

If yes, to whom?_____

Client Name_____ Date_____

Vehicle Insurance Information

Name of Vehicle Owner_____

Vehicle Owner's Address_____

Insurance Company _____

Ins. Co. Address_____ City_____ State_____ Zip_____

Insurance Company Phone_____ Agent's Name_____

Claim #_____ Policy #_____

Legal Representation

Have you retained an attorney? ☐ No ☐ Yes

If yes, Name_____ Phone #_____

Address_____ City_____ State_____ Zip_____

I authorize release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all my insurance submissions.

X_____ _____

Signature of client or parent if minor Date

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

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

I, _____ **, ("Assignor") hereby assign to** Dr. Laura E. Harrington, D.C. **, ("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 _____ **, 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.

(Print name of Patient)	**(Signature of Patient)**
	(Date of signature)
(Address of Patient)	
Dr. Laura E. Harrington, D.C.	
(Print name of Provider)	**(Signature of Provider)**
403 Tulip Street	(Date of signature)
Liverpool, NY 13088	
(Address of Provider)	

NYS FORM NF-AOB (Rev 1/2004)