



**Department of
Consumer Affairs**

HEALTH CARE CLINIC REPORT

(If your answers require more space, attach additional pages to this form.)

1. State the legal name of health care clinic ("clinic"):

2. Doing business as (DBA) name, if applicable:

3. Provide all telephone and fax numbers of the clinic:

4. Provide all web and e-mail addresses of the clinic:

5. State all names the clinic has been previously known as. Please cite the respective periods.

6. State the address(es) where the clinic is physically located:

7. State the name(s) and address(es) of all clinics where treatments are rendered at the direction of this clinic or any of its owners, along with the TIN/SSN of the clinic:

8. State which of the above clinics are a PC/INC/LLP/LLC/PLLC

9. State which, if any, of the above clinics have a mailing address that is different from the clinic's address.

10. State all parties who have an ownership interest in the clinic (if multiple partners, state the percentage of ownership.) List their home address, date of birth, and social security number:

11. Has the clinic, or have persons named on this application, ever been licensed by the New York City Department of Consumer Affairs? If so, provide the license number.

12. Has the clinic, or have persons named on this application, ever been denied a permit/license by the City of New York? If so, list the date and agency.

13. Please state if there are any current violations issued by the New York City Departments of Health, Sanitation, Environmental Protection, etc., against the clinic. If so, state the date, the nature of the violation(s), the agency that issued the violation(s), and the corrective action(s) deemed necessary:

14. Please list the durable medical equipment companies with whom you regularly conduct business. Provide the companies' names and addresses.

15. Please list the transportation companies with whom you regularly do business. Provide the companies' names and addresses.

16. Does any owner of the clinic have any financial interests in any durable medical equipment or transportation companies? If so, please state the person's name, address, and portion of ownership of entity:

17. If the clinic advertises its services in any newspaper, magazine, television, or radio station, state the name(s) of such publications and/or stations. If no advertising is done, please so indicate.

18. Does the clinic use a billing company or companies? If so, list the name, address and principal of all billing companies:

19. Does the clinic use a management company or companies? If so, list the name, address and principal of all management companies.

20. Describe all treatment modalities performed at the clinic including the equipment used to perform treatments:

21. List all doctors, and their NYS license numbers, who are affiliated with the clinic:

22. List the names of all entities which rent or use space; state the name of the business, type of business, and owner of the business:

23. Has any individual named in this report been the subject of any disciplinary action by any medical association, licensing authority or any other governing body/ies? If so, provide the dates and name(s) of the individual(s), the entity/ies which brought the disciplinary action, the charges brought and the result of the action(s):

24. Does any individual named in this report have any pending charges brought by any medical association, licensing authority or any other governing body/ies? If so, provide the dates and names of the individual(s), description of the charges, name(s) of the entity/ies which brought the charges:

25. Has any clinic or individual named in this report been convicted of a crime? If so, state the date, individual(s), and charges resulting in conviction and sentencing:

26. Does any clinic or individual named in this report have any pending criminal charges? If so, state the date the charge(s) was/were brought, what governmental entity brought the charge(s), what the charge(s) are, the individual(s) involved:

HEALTH CARE CLINIC REPORT ACKNOWLEDGEMENTS:

Please answer question "A or "B", but not both. Place your initials next to your choice:

_____A: Our no-fault billings during the reporting period comprise 50% or more of our overall billings. The name of each insurance company, including any municipalities or other government programs, that are billed for services rendered under no-fault and the percentage of the no-fault billing compared to the overall clinic billings are:

_____B: This clinic is exempt from insurance reporting requirements because the amount of our no-fault billings does not total 50% or more of our overall no-fault billings. Instead, our no-fault billings comprises _____% of our overall billings with the balance being made up by:

I acknowledge that the clinic has not ever used, nor currently uses, any person to solicit any accident victim to receive any medical treatment at this clinic or any affiliated medical provider.

I have read the entire health care clinic report submitted to the New York City Department of Consumer Affairs and I swear/affirm under the penalty of perjury that all information is correct and current as of this date. Any false statements are punishable by fine, imprisonment, or both.

SIGNED:

PRINT NAME:

TITLE:

Sworn to me this _____ Day of _____, 20_____

Notary Public _____