



NO - FAULT INFORMATION & BILLING AGREEMENT

Claimant Name: _____ Date of Accident: _____

Claimant's Date of Birth: _____ Claim #: _____

Address: _____ Policy #: _____

Phone #: _____

Soc. Sec. #: _____

Is This Case In Litigation?: YES ___ NO ___

Insurance Carrier's Name: _____

Insurance Carrier's Address: _____

(Please specify the address to which your Physical Therapy Bills should be sent)

Name of Claims Adjuster: _____ Phone #: _____ Fax #: _____

Name of Lawyer: _____ Phone #: _____ Fax #: _____

ACCIDENT INFORMATION

Place of Accident (State): _____

Please Describe Your Injuries / Illness (indicate body part(s) affected): _____

How Did Accident Occur?: _____

Were you Hospitalized for Injuries sustained in This Accident?: YES: ___ NO: ___

If yes (please give dates): From: ___/___/___ to ___/___/___

Are you **Currently** being treated by a Chiropractor **For This Injury**?: YES ___ NO ___

Are you **Currently** out of work **Due to This Accident**?: YES ___ NO ___

Have you **Previously** missed any work **Due to This Accident**? YES ___ NO ___

If yes (Please give dates): From ___/___/___ to ___/___/___

BILLING AGREEMENT

As a courtesy, **Glover Physical Therapy & Pain Rehabilitation** agrees to bill the above No-Fault insurance carrier on my behalf.

However, I understand that I am financially responsible for all physical therapy charges incurred. Furthermore, I understand that I am financially responsible for any collection / attorney fees that may be assessed to my account due to non-payment of these charges.

Signature

Date

Have you had an IME? YES: ___ NO: ___

If yes:

DATE: ___ / ___ / ___

Were you denied Physical Therapy? YES: ___

NO: ___

If no: