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____

Have you had an IME? YES: ____ NO: ____
If yes:
DATE: ____ / ____ / ____
Were you denied Physical Therapy? YES: ___ NO: ___

If no:
Do you have an IME scheduled? YES: ___ NO: ___
If yes: DATE: ____ / ____ / ____

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

3620 Harlem Rd, Ste 2 * Cheektowaga, NY 14215 * Phone: 716-446-9500 * Fax: 716-446-9501