Family Physical Therapy

7 PARK AVENUE
COLCHESTER, CT 06415
P (860) 531-3222 **F** (860) 531-3224

3 WEYMOUTH RD
ENFIELD, CT 06082
P (860) 698-6308 **F** (860) 698-9658

NO FAULT INFORMATION

PATIENT INFORMATION

NAME: _____ SS#:_____ DOB: _____

ACCIDENT INFORMATION

DATE OF ACCIDENT: _____ BODY PART INJURED: _____

ACCIDENT DETAILS: _____

_____

AUTO INSURANCE INFORMATION

INSURANCE COMPANY: _____

POLICY / CLAIM NUMBER: _____

ADJUSTER'S NAME: _____

PHONE: _____ FAX: _____

ADDRESS (CLAIM SUBMISSION): _____

CITY: _____ STATE: _____ ZIP CODE: _____

MED PAY ON POLICY? YES OR NO IF YES, AMOUNT: _____

ATTORNEY INFORMATION

NAME: _____FIRM NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____ FAX: _____

ASSIGNMENT OF BENEFITS AND RELEASE

In addition to the assignment of benefits and release of information clauses that I accepted on the main registration form, I also understand that in the event that services rendered are not covered by this No Fault carrier, a bill for services rendered will be sent to my insurance carrier for payment. If benefits are not assigned to Family Physical Therapy, I agree to forward to Family Physical Therapy, all "insurance" payments that I receive for services rendered to me immediately upon receipt and/or to make payments, in full, for the series rendered to me at this time.

SIGNATURE: _____ DATE: _____