

7 Park Avenue  
Colchester 06415  
P: (860) 531-3222  
F: (860) 531-3224



205 East High Street  
East Hampton 06424  
P: (860) 467-6248  
F: (860) 467-6178

## 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: \_\_\_\_\_