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# NO-FAULT INFORMATION SHEET

Date: _____

Patient's Name: _____

**PLEASE NOTE: IT IS THE PATIENT'S RESPONSIBILITY TO FILE AN INCIDENT REPORT AND TO PROVIDE THIS OFFICE WITH ALL NECESSARY BILLING INFORMATION.**

Date of Accident: _____

Name of No-Fault Carrier: _____

Address of Carrier: _____

Telephone Number of Carrier: _____

Name of Claims Adjuster/Examiner: _____

Policy Number: _____

File Number: _____

Claim Number: _____

**IN ACCORDANCE WITH NO-FAULT REGULATIONS, IF BENEFITS ARE EXHAUSTED YOU WILL BE RESPONSIBLE FOR THE DOCTOR'S USUAL AND CUSTOMARY FEES FOR ALL SERVICES RENDERED TO YOU.**

_____

**Signature of Patient** (or Guardian if Patient is Under 18 Years Old)