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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)