FREDONIA PHYSICAL THERAPY, PLLC
12 BRIGHAM ROAD
FREDONIA, NEW YORK 14063

NO FAULT INSURANCE INFORMATION

INSURANCE COMPANY: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____ PHONE: _____
INSURED'S NAME: _____
POLICY #: _____ CLAIM/FILE #: _____
DATE OF ACCIDENT: _____ WAS A MOTORCYCLE OR DWI INVOLVED: _____
ATTORNEY'S NAME: _____
ATTORNEY'S ADDRESS: _____
ATTORNEY'S PHONE #: _____

WORKERS' COMPENSATION INSURANCE INFORMATION

EMPLOYER: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____ PHONE: _____
INSURANCE COMPANY: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____ PHONE: _____
WCB#: _____ CARRIER CASE #: _____
DATE OF INJURY: _____ ADJUSTER'S NAME: _____
SOCIAL SECURITY NUMBER: _____
ATTORNEY'S NAME: _____
ATTORNEY'S ADDRESS: _____
ATTORNEY'S PHONE #: _____

AGREEMENT TO PAY MEDICAL COST IN THE EVENT OF FAILURE TO PROSECUTE OR IF COMPENSATION CLAIM IS DISALLOWED.

In the event that I fail to prosecute Workers' Compensation for this illness or condition or it is determined by the Workers' Compensation Board that the illness or condition is not a result of a compensable Workers' Compensation claim, I _____ *hereby agree to pay Fredonia Physical Therapy, PLLC their usual customary fees for services rendered.*

SIGNATURE: _____ **DATE:** _____

If signed by other than the claimant, print below: Name, Address, and Relationship to signer.

_____
(Name & Relationship)

_____
(Address)

I hereby certify that the information above is to the best of my knowledge complete and accurate. I understand that I am financially responsible to Fredonia Physical Therapy, PLLC for all therapy services rendered at this clinic whether or not covered by insurance. I also hereby authorize release of information pertaining to my medical condition and therapy treatment to my insurance company, Social Security Administration, or Medicare program.

STATEMENT TO AUTHORIZE PAYMENT OF BENEFITS

I certify that the information given by me in applying for payment is correct. I authorize Fredonia Physical Therapy, PLLC to release any medical information required to process my claim. I request that payment be made to Fredonia Physical Therapy, PLLC for services provided to me.

SIGNATURE: _____ **DATE:** _____