

**NO FAULT INFORMATION**

Patient Name: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

Carrier Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Carrier Phone Number: \_\_\_\_\_

Claim Handler's Name : \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Injury/Accident: \_\_\_\_\_ State of Accident: \_\_\_\_\_

Injured Body Part(s): \_\_\_\_\_

Claim #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Disability Status: Are you currently working?      Yes                      No

\_\_\_\_ Full Duty    \_\_\_\_ Light Duty    \_\_\_\_ Restricted Duty    \_\_\_\_ Not Working?    Date last worked \_\_\_\_\_

Brief Description of Accident and what treatment you have received thus far: \_\_\_\_\_

\_\_\_\_\_

**PATIENT TREATMENT WAIVER - NO FAULT**

Thank you for choosing Buffalo-Niagara Physical Therapy for your rehabilitation needs. We look forward to serving you and providing efficient, quality care. Since you have elected to treat with Buffalo-Niagara Physical Therapy for your injury you must be aware of office policy. Should your No Fault Carrier deny your claim, you are responsible for 100% of billed charges.

I, (print name) \_\_\_\_\_ understand that the Physical Therapist does not participate with my private insurance, or I do not have private insurance. I understand and am aware of office policy regarding responsibility of medical bills. I have decided I wanted to continue with visits beginning today, and therefore assume responsibility for paying the bill.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Insurance Name \_\_\_\_\_

THIS FORM IS VALID FOR THE ENTIRE TREATMENT FOR THIS INJURY