NeuroRehabilitation and Neuropsychological Services, PC
No Fault Information Sheet

Please fill out this form COMPLETELY, write N/A where applicable and sign it. Thank you.

Referral Source: _____

Is this your First visit to this Office for this complaint? **Yes** ☐ **No** ☐

Patient Social Security # _____ -- _____ -- _____

Patient Name: (Last) _____ (First) _____(MI)_____

Street Address: _____

City:_____ **State:**_____ **Zip:**_____

Home Telephone ( )_____

Age: _____ **Patient's Date of Birth:** _____

Are you Married? (Please Check) Yes No Emergency Phone # _____

Date of Accident: _____ (Required)

Claim # _____ (Required)

Policy Holder Information

Name:_____

Address:_____

City: _____ **State:** _____ **Zip:** _____

Policy # _____**Phone # ( )**_____

No Fault Insurance Carrier Name _____

Insurance Company Address: _____

Insurance Company Phone # ( )_____

Attorney Name and Address: _____ Tel: ( )_____

No-Fault Insurance Assignment Agreement

I hereby Authorize NeuroRehabilitation and Neuropsychological Services, P.C. to bill the Insurance carrier listed above directly for charges incurred by me in connection with the accident dated above. Please make payment directly to NeuroRehabilitation and Neuropsychological Services, P.C. In the event that I fail to prosecute the claim for No Fault Insurance for this illness or condition, or it is determined by the No Fault Carrier that the illness or condition is not a result of a No Fault case, I hereby agree to pay NeuroRehabilitation and Neuropsychological Services, PC the usual and customary fees for services rendered me.

Patient's Signature: _____ **Today's Date:**_____

Revised 05/29/01 HH

Provider's Signature: _____