

NO FAULT ASSIGNMENT OF BENEFIT FORM

NAME OF PATIENT: _____

In consideration of services rendered or to be rendered, I hereby assign the provider of services, **Life Physical Therapy & Wellness, P.C.**, and/or its assignees so much of my first party No-Fault automobile insurance benefits and rights, attended thereto, as shall equal the full amount of the bill for such services and the provider of her assignee may secure in my name.

I further understand if said sum is no collected, I will remain personally liable therefore.

_____ date
signature of patient / parent/ guardian

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Kindly furnish my insurance company or their representatives with all information you may have regarding my condition while under your treatment or observation, including the history obtained, X-ray and physical findings, diagnosis and prognosis. You are authorized to provide the information in accordance with the New York Automobiles Reparations Act (No-Fault Law).

_____ date
signature of patient / parent/ guardian

NO FAULT INSURANCE INFORMATION

No-Fault Insurance Name: _____ Tel. #: _____

No-Fault Insurance Address: _____

Name of Insured: _____ Your Relation to Insured: _____

Policy #: _____ Claim #: _____ Date of Accident: _____

Name of Attorney: _____ Tel. # _____

Address of Attorney: _____

PRIMARY PRIVATE INSURANCE INFORMATION

In the event that my No-Fault Benefits are denied, I hereby assign to the service provider, **Life Physical Therapy & Wellness, P.C.**, and/or her assignees so much of my first party insurance benefits and rights as shall equal the full amount of the bill for such services and the provider or her assignees may secure in my name.

Insurance Company's Name: _____ Tel. #: _____

Insurance Company's Address: _____

Name of Insured: _____ Your Relation to Insured: _____

Insured's Employer: _____

Insured's Social Security #: _____ Policy/Group #: _____

_____ date
signature of patient / parent/ guardian