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**NO FAULT INTAKE FORM**

I hereby authorize payment directly to WHITE PLAINS HOSPITAL for services rendered relating to an accident/injury covered under NO FAULT insurance benefits.

I hereby authorize the provider of these services to release any medical records relating to my claims to my insurer liable for payment of such claim.

In the event the provider's charges are outstanding and / or fail to file an application for benefits under NO FAULT law, I understand that I am personally responsible for the payment of the charges related to my claim.

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_ Phone # \_\_\_\_\_

DATE OF ACCIDENT: \_\_\_\_\_ TIME OF ACCIDENT: \_\_\_\_\_ AM / PM

How did accident occur? \_\_\_\_\_

CLAIM # \_\_\_\_\_ POLICY # \_\_\_\_\_

Address for insurance claims (not the agent): \_\_\_\_\_

Insurance Co Address: \_\_\_\_\_

Agent's Name & Phone # \_\_\_\_\_

Agent's Fax # \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PLEASE NOTE THAT FAILURE TO PROVIDE US WITH THE APPROPRIATE CLAIM INFORMATION AND OR FAILURE TO FILE A CLAIM WITH YOUR INSURER WILL NECESSITATE US REQUIRING PAYMENT FROM YOU AT THE TIME OF SERVICE.