NO FAULT INFORMATION

(FILL THIS OUT IF YOU WERE INJURED IN A CAR ACCIDENT.)

*Please note: Ulster Medical and Surgical Specialists requires that you pay for all services at the time of visit at the discounted No Fault "rates". You will receive a form for claims submission upon payment.

INSURANCE COMPANY: _____

INSURANCE COMPANY ADDRESS: _____

INSURANCE COMPANY PHONE#: _____

POLICY OR CLAIM #: _____ DATE OF ACCIDENT: _____

NAME OF INSURED (IF OTHER THAN CLAIMANT): _____

ADDRESS OF INSURED: _____

NAME OF CLAIMANT: _____

ADDRESS OF CLAIMANT: _____

DATE LAST WORKED: _____ LOCATION OF ACCIDENT: _____

HISTORY OF ACCIDENT: _____

_____

LAWYER: _____ ADDRESS: _____

_____

I HEREBY AUTHORIZE ULSTER MEDICAL AND SURGICAL SPECIALISTS TO RELEASE MEDICAL INFORMATION ON MY INJURY TO THE NO FAULT CARRIER: _____

_____

PATIENT SIGNATURE: _____ DATE: _____

_____

WORKMEN'S COMPENSATION INFORMATION ONLY

WORKER'S COMPENSATION INSURANCE CARRIER: _____

ADDRESS OF CARRIER: _____

DATE OF INJURY: _____ TIME: _____ LOCATION: _____

POLICY OR CLAIM #: _____

HOW WERE YOU INJURED? _____

_____

DATE LAST WORKED: _____ DID YOU SEE ANOTHER PHYSICIAN?: _____ 0=NO 1=YES

IF SO, NAME: _____ ADDRESS: _____

_____

IN THE EVENT I FAIL TO PROSECUTE THE CLAIM FOR WORKER'S COMPENSATION FOR THIS ILLNESS OR CONDITION OR IT IS DETERMINED BY THE WORKER'S COMPENSATION BOARD THAT THE ILLNESS OR CONDITION IS NOT A RESULT OF A COMPENSABLE WORKER'S COMPENSATION CASE OR IF I FAIL TO PROVIDE ALL THE ABOVE NEEDED INFORMATION WITHIN 48 HOURS FROM THE DATE OF SERVICE, I, _____, HEREBY AGREE TO PAY **ULSTER MEDICAL AND SURGICAL SPECIALISTS** THEIR USUAL AND CUSTOMARY FEES FOR SERVICES RENDERED TO THE ABOVE NAMED CLAIMANT IN THE ABOVE IDENTIFIED CASE.

PATIENT SIGNATURE: _____ DATE: _____