FREDONIA PHYSICAL THERAPY, PLLC
12 BRIGHAM ROAD
FREDONIA, NEW YORK 14063

NO FAULT INSURANCE INFORMATION

INSURANCE COMPANY: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____ PHONE: _____
INSURED'S NAME: _____
POLICY #: _____ CLAIM/FILE #: _____
DATE OF ACCIDENT: _____ WAS A MOTORCYCLE OR DWI INVOLVED: _____
ATTORNEY'S NAME: _____
ATTORNEY'S ADDRESS: _____
ATTORNEY'S PHONE #: _____

WORKERS' COMPENSATION INSURANCE INFORMATION

EMPLOYER: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____ PHONE: _____
INSURANCE COMPANY: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____ PHONE: _____
WCB#: _____ CARRIER CASE #: _____
DATE OF INJURY: _____ ADJUSTER'S NAME: _____
ATTORNEY'S NAME: _____
ATTORNEY'S ADDRESS: _____
ATTORNEY'S PHONE #: _____

AGREEMENT TO PAY MEDICAL COST IN THE EVENT OF FAILURE TO PROSECUTE OR IF COMPENSATION CLAIM IS DISALLOWED.

In the event that I fail to prosecute Workers' Compensation for this illness or condition or it is determined by the Workers' Compensation Board that the illness or condition is not a result of a compensable Workers' Compensation claim, I _____ hereby agree to pay Fredonia Physical Therapy, PLLC their usual customary fees for services rendered.

SIGNATURE: _____ DATE: _____

If signed by other than the claimant, print below: Name, Address, and Relationship to signer.

_____
(Name & Relationship)

_____
(Address)

I hereby certify that the information above is to the best of my knowledge complete and accurate. I understand that I am financially responsible to Fredonia Physical Therapy, PLLC for all therapy services rendered at this clinic whether or not covered by insurance. I also hereby authorize release of information pertaining to my medical condition and therapy treatment to my insurance company, Social Security Administration, or Medicare program.

SIGNATURE: _____ DATE: _____

STATEMENT TO AUTHORIZE PAYMENT OF BENEFITS

I certify that the information given by me in applying for payment is correct. I authorize Fredonia Physical Therapy, PLLC to release any medical information required to process my claim. I request that payment be made to Fredonia Physical Therapy, PLLC for services provided to me.

SIGNATURE: _____ DATE: _____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 03/01/02)

I, _____, ("Assignor") hereby assign to Fredonia Physical Therapy, PLLC, ("Assignee") all rights privileges and remedies to payment for health care services provided by Assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, not withstanding any other agreement to the contrary.

This agreement may be revoked by the Assignee when benefits are not payable based upon Assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the Assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES ANY APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS, OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE, OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ (Patient Name)

_____ (Signature of Patient)

_____ (Address of Patient)

_____ (Date of Signature)

_____

Bradley T. Rinehart, PT

_____ (Provider Name)

_____ (Signature of Provider)

Fredonia Physical Therapy, PLLC (Address of Provider)

_____ (Date of Signature)

12 Brigham Road

Fredonia, New York 14063

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_____ (Patient Name)

_____ (Signature of Patient)

_____ (Address of Patient)

_____ (Date of Signature)

_____

Randall A. Vincek, PT

_____ (Provider Name)

_____ (Signature of Provider)

Fredonia Physical Therapy, PLLC (Address of Provider)

_____ (Date of Signature)

12 Brigham Road

Fredonia, New York 14063