ORTHOPAEDIC ASSOCIATES OF ROCHESTER, P.C.
MOTOR VEHICLE ACCIDENT - NO FAULT AGREEMENT

Patient Name: Last _____ First _____ MI ____
Address_____ Home phone _____
City, State, Zip _____ Cell phone _____

Patient Date of Birth _____ Social Security # _____

Date of Injury / Accident _____
Date reported to insurance company _____
Insurance Claim Number _____ contact person _____

Automobile Insurance Company _____
Insurance Company Address _____
_____
Insurance Policy Number _____

Name of Policy Holder (if not patient) _____
Address (if different from patient) _____
_____

ALL NO FAULT CLAIMS MUST BE FILED WITHIN 45 DAYS OF SERVICE!
If we do not have correct insurance information to submit claims, the patient will be responsible for all charges associated with this visit.

I, the undersigned, hereby authorize payment directly to Orthopaedic Associates of Rochester, PC, for any benefits for medical expenses that I may be entitled to. I hereby give permission to OAR, PC, to release information, if requested, to my primary care physician, hospitals, insurance carrier or No Fault carrier for coordination of benefits.

I understand that I am financially responsible for charges not covered by this assignment, and that my failure to provide the necessary information to OAR, PC, will make me personally responsible for all charges related to this injury.

In the event that my No Fault Insurance Company finds my injury non-related to my accident, I hereby agree to pay Orthopaedic Associates of Rochester, PC, 2410 Ridgeway Avenue, Rochester, NY 14626, their usual and customary fees for services rendered to me in this case. Or, if applicable, the claim will be sent to my primary insurance company for consideration for payment, with the proper notice of decision.

Date_____ Claimant Signature_____

If signed by other than patient, print name, address, and relationship of signer:
PRINT name _____ relationship _____
Address of signer, if not patient _____