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**NO-FAULT INFORMATION SHEET**

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

**PLEASE NOTE: IT IS THE PATIENT'S RESPONSIBILITY TO FILE AN INCIDENT REPORT AND TO PROVIDE THIS OFFICE WITH ALL NECESSARY BILLING INFORMATION.**

Date of Accident: \_\_\_\_\_

Name of No-Fault Carrier: \_\_\_\_\_

Address of Carrier: \_\_\_\_\_

Telephone Number of Carrier: \_\_\_\_\_

Name of Claims Adjuster/Examiner: \_\_\_\_\_

Policy Number: \_\_\_\_\_

File Number: \_\_\_\_\_

Claim Number: \_\_\_\_\_

**IN ACCORDANCE WITH NO-FAULT REGULATIONS, IF BENEFITS ARE EXHAUSTED YOU WILL BE RESPONSIBLE FOR THE DOCTOR'S USUAL AND CUSTOMARY FEES FOR ALL SERVICES RENDERED TO YOU.**

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**Signature of Patient** (or Guardian if Patient is Under 18 Years Old)