Riverside Orthopaedic and Sports Medicine ASSOCIATES

5 Columbus Circle
(Broadway betw. 57th & 58th Street)
New York, NY 10019
Tel 212.265.2828 • Fax 212.265.5077

Doctor: _____

# NO-FAULT

Date: ___/___/___

Was an automobile involved? _____ Date of injury: ___/___/___

Injured body part _____

Location of the accident: _____

Are you still working? _____ If no, last date worked? ___/___/___

No Fault Carrier: _____

Address: _____

City: _____ State: _____ Zip: ___/___/___/___/___

Policyholders Name: _____

Claim #: _____ Policy #: _____

Attorney's Name: _____ Phone Number: _____

Adjuster's Name: _____Insurance Phone Number: _____

I hereby authorize payment of the automobile No-Fault benefits directly to the Riverside Orthopaedic and Sports Medicine Associates, but not to exceed the balance due to the medical institute's permissible charge, under Article 18 of the Insurance Law for services rendered. I understand that I am financially responsible to the Riverside Orthopaedic and Sports Medicine Associates for the charges not covered by this authorization including but not limited to denied or exhausted benefits.

I HEREBY AUTHORIZE THE DOCTOR TO RELEASE INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO BE RELEASED TO MY NO-FAULT CARRIER AND/OR TO MY ATTORNEY.

Patient's Signature _____ Date: ___/___/___