Katonah Physical Therapy, P.C.
190 Goldens Bridge Road
Katonah, N.Y. 10536

NO-FAULT

Date:___________________

I hereby authorize payment of benefits under the No-Fault Insurance Plan to be paid directly to:

Katonah Physical Therapy, P.C., 190 Goldens Bridge Road, Katonah, N.Y. 10536,

for services rendered to me as a result of an automobile accident which occurred on:____________________.

Location of Accident:____

Name of Insured:____

Address of Insured:____

____ Telephone#______________________

Insurance Company:____

Address of Ins. Co.:____

____ Telephone#____________________

Policy #:____

Claim File #:____

Name of Patient:____

Address:____

____ Telephone#__________________

(not neccesary if same as insured)

If you have retained an attorney, please provide is with the following information:

Attorney's Name:____ Telephone#_____________________

Address:____

Signature:____ Date:______________________________