HUDSON VALLEY RADIOLOGY ASSOCIATES, P.L.L.C.

☐ MRI ☐ CIA ☐ MHI ☐ NPI ☐ KDC
☐ TLM ☐ RAMAPO ☐ OBS-GYN ☐ BERG

NO-FAULT REGISTRATION FORM MUST FILL OUT COMPLETELY

Date_____ MR#_____

Patient Name_____ Date Of Birth_____

Address _____ City_____ State_____ Zip Code_____

Home Phone ( ) - SSN# ___ ___ ___ / ___ ___ / ___ ___ ___ ___

AUTO INSURANCE CLAIMS CARRIER (*NOT* the insurance agent name or address)

Insurance Name_____

Insurance Address_____ City_____ State_____ Zip Code_____

Phone ( ) -

Name of Insured _____

Insured Address_____ City_____ State_____ Zip Code_____

Date of Accident _____ Policy Number _____ Claim #_____

Hour of Accident Occurred_____ In what State did Accident Occur_____

Claims Examiner Name_____ Examiner Phone #_____

How did accident occur_____

_____

_____

Have you stopped working because of accident ___YES ___NO Last Day/Date worked_____

Return date to work_____

Onset of Symptoms Date_____ Similar Symptoms Date_____

IN THE EVENT THE PROVIDER'S CHARGES ARE OUTSTANDING AND I FAIL TO FILE AN APPLICATION FOR BENEFITS UNDER THE NEW YORK STATE NO-FAULT INSURANCE LAW, I HEREBY AUTHORIZE THE PROVIDER TO FILE SUCH CLAIM ON MY BEHALF SO THAT THE PROVIDER MAY REALIZE PAYMENT OF ITS CHARGES.
I UNDERSTAND THAT IF THE PROVIDER DOES NOT RECEIVE PAYMENT FROM THE INSURER, I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT OF THE PROVIDER'S CHARGES.

_____ _____
PATIENT SIGNATURE DATE

I HERE BY AUTHORIZE HUDSON VALLEY RADIOLOGY ASSOCIATES, PLLC TO RELEASE MEDICAL INFORMATION TO MY INSURANCE COMPANY.

_____ _____
PATIENT SIGNATURE DATE