



711 Troy-Schenectady Road

Latham, NY 12110

NO-FAULT

INSURED: _____

INJURED PATIENT: _____

INSURANCE COMPANY NAME & ADDRESS: _____

POLICY NUMBER: _____

INSURANCE AGENT: _____

DATE OF ACCIDENT: _____

PATIENT'S SOCIAL SECURITY NUMBER: _____

Please provide reception with your No-Fault Insurance Card.

I authorize this office to submit medical claims to the above mentioned insurance carrier on my behalf. The insurance carrier may reimburse this office or its representatives directly for these services.

Signature

Date

Image Care Saratoga

Telephone: 518-584-5000 Fax: 518-584-3387