Cocozzo Physical Therapy

Accelerate Your Functional Movement

NO FAULT QUESTIONNAIRE

Name:

Address:

DOB:

SS #:

Phone #:

Your Local Agent:

Driver's Name:

Driver's Address:

Date of Accident:

Address where accident occurred:

Was alcohol a factor in this accident?

If yes, please specify

Driver's No Fault Insurance Company

Driver's No Fault Insurance Company Phone #:

Claim #:

Did patient present to ER?
Was the patient hospitalized?
Were X-Rays taken?

I accept financial responsibility and promise to pay for all charges billed by Excel Physical Therapy to this account.

Signature: Date: