



Charles F. Gordon III, MD
Medical Director

NO FAULT

INSURED: _____

INJURED PATIENT: _____

INSURANCE COMPANY: _____

ADDRESS: _____

POLICY NUMBER: _____

INSURANCE AGENT: _____

PHONE NUMBER: _____

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 company my pay this office or its representatives directly for these services.

Signature/date: _____

9 Old Plank Rd, Suite 100, Clifton Park, NY 12065 Phone (518) 371-0777, Fax (518) 371-0366

