



ROBERT V. MORIARTY, M.D., F.A.A.O.S.

*Sports Medicine and Orthopedics*

### No Fault Information

The following **must be completed** on all motor vehicle accidents as per NYS No Fault Guidelines. Your cooperation is appreciated.

**Patient** Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Policy Holder** Name: \_\_\_\_\_

Address: \_\_\_\_\_

**Insurance** Name: \_\_\_\_\_

Address: \_\_\_\_\_

Policy #: \_\_\_\_\_

File #: \_\_\_\_\_

**Date of Accident (required):** \_\_\_\_\_

In consideration of services rendered or to be rendered to the above captioned patient, I hereby authorize payment directly to Robert V. Moriarty, MD any and all insurance benefits which I may otherwise be entitled to.

I further authorize Robert V. Moriarty, MD to release any medical information to any insurance company in order for claims to be processed and benefits to be released.

In the event that I Robert V. Moriarty MD has charges outstanding, and I fail to file a claim under NYS No Fault Guidelines, I hereby Robert V. Moriarty, MD to handle such claims on my behalf so he may obtain payment of charges. I further understand that should I fail to follow policy guidelines, as per NYS No Fault guidelines and payment is denied as a result I am responsible for all outstanding balances including but not limited to deductibles or coinsurance.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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