NOVO HEALTHNET LIMITED

WSIB INTAKE FORM – CLIENT PERSONAL INFORMATION (PLEASE PRINT)

NAME: _____ ACCIDENT DATE: _____/_____/_____
DAY MONTH YEAR

CLAIM #: _____ HEALTH CLAIMS ADJUSTER: _____

NURSE PRACTITIONER: _____ PH._____

EMAIL:_____ FX._____

TREATMENT AREA / SYMPTOMS: _____

HAVE YOU BEEN ASSESSED BY SOMEONE ELSE? YES ◉ NO ○

IF YES WHO?: 1._____

2._____

DO YOU HAVE LEGAL REPRESENTATION? YES ○ NO ○

If yes name of legal firm:_____

CLAIM OPEN WITH WSIB? ○YES ○NO

IF YES DATE OPENED: _____

SIGNATURE:_____

SIGNATURE INDICATES YOU HAVE OPENED A FILE WITH WSIB

EXTENDED HEALTH BENEFITS

DO YOU HAVE EXTENDED HEALTH BENEFITS? YES ○ (IF YES COMPLETE BELOW) NO ○

IF NO PLEASE SIGN & DATE:_____
SIGNATURE DATE

PRIMARY INSURANCE BENEFITS (IF APPLICABLE)

NAME OF POLICY HOLDER: SAME AS APPLICANT ○OR: _____

POLICY HOLDERS DOB:_____/_____/ _____ DR REFERRAL NAME:_____
DAY MONTH YEAR IF REQUIRED BY YOUR PLAN – IF NOT WRITE NOT NEEDED

INSURANCE COMPANY NAME:_____

POLICY/CLAIM #:_____ ID/CERTIFICATE #: _____

EXPIRY / RENEWAL DATE: _____/_____/_____ LIMITS & PERCENTAGE:_____
DAY MONTH YEAR

SECONDAY INSURANCE BENEFITS (IF APPLICABLE)

NAME OF POLICY HOLDER: SAME AS APPLICANT ○OR: _____

POLICY HOLDERS DOB:_____/_____/ _____ DR REFERRAL NAME:_____
DAY MONTH YEAR IF REQUIRED BY YOUR PLAN – IF NOT WRITE NOT NEEDED

INSURANCE COMPANY NAME:_____

POLICY/CLAIM #:_____ ID/CERTIFICATE #: _____

EXPIRY / RENEWAL DATE: _____/_____/_____ LIMITS & PERCENTAGE:_____

Cancelation Policy

DATE: _____

Name: _____ DOB: _____
DOL: _____ Claim #: _____

We understand that unplanned issues may come up and you will need to cancel an appointment. If this happens, we respectfully ask that you notify us at least 24 hours prior to your appointment time.

Our therapists want to be available to meet your needs as well as the needs for all of our patients. When a patient does not show up for a scheduled appointment, another patient loses the opportunity to be seen.

If we are not provided with the appropriate notice, you will be responsible for a Missed Treatment charge of $50.00. For any Missed Massage Treatment, you will be charged in accordance with the RMTAO as follows: 2nd missed massage – 50% of the massage fee / 3rd missed massage – 100 % of the massage fee.

This charge will not be billed to any third-party payors, you will be billed, and it must be paid by you for you to continue to be treated under your claim. Under certain circumstances management may waive this fee.

By signing below, you understand and agree to the cancelation and payment policy.

_____ _____
Patient's Name Witness Name

_____ _____
Patient's Signature Witness Signature