# BACK ON TRACK PHYSIOTHERAPY

**MVA INTAKE FORM – CLIENT PERSONAL INFORMATION (PLEASE PRINT)**

**PAYMENT FOR SERVICES IS DUE AT THE TIME OF YOUR APPOINTMENT**

| | | |
|---|---|---|
| **LAST NAME:** | **FIRST:** | **DOB:** |
| **STREET ADDRESS:** | **CITY:** | **POSTAL CODE:** |
| **PRIMARY PH NUMBER:** | **ALTERNATE PH NUMBER:** | **EMERGENCY NAME & PH NUMBER:** |
| **FAMILY DOCTOR:** | **ADDRESS:** | |

**CHOSE CLINIC BECAUSE/REFERRED TO CLINIC BY?** (please tell us how you heard of back on track)

**EMAIL ADDRESS:** (Your email address will only be used by our clinic to communicate with you. It will not be sold or distributed)

## PLEASE CHECK CURRENT AND PREVIOUS CONDITIONS & WRITE THE APPROXIMATE DATE BESIDE

### MUSKOSKELETAL CONDITIONS

_____OSTEOPOROSIS
_____OSTEOARTHRITIS
_____METAL IMPLANTS
_____PREVIOUS MOTOR VEHICLE ACCIDENTS
_____TMJ / DENTAL APPLIANCES / DENTURES
_____OTHER _____
_____NONE OF THE ABOVE

### CARDIOVASCULAR CONDITIONS

_____ANGINA / HEART ATTACK
_____HIGH / LOW BLOOD PRESSURE
_____CIRCULATION PROBLEMS
_____ANEMIA / BLEEDING DISORDERS
_____PACEMAKER
_____OTHER _____
_____NONE OF THE ABOVE

### NEUROLOGICAL CONDITIONS

_____STROKE _____PARKINSON'S
_____SEIZURES _____CONCUSSIONS
_____MULTIPLE SCLEROSIS
_____OTHER _____
_____NONE OF THE ABOVE

### SYSTEMIC / OTHER

_____PREVIOUS SURGERIES _____DIZZINESS / FAINTING
_____ASTHMA _____PREGNANCY
_____EMPHYSEMA _____RINGING IN EARS
_____TUBERCULOSIS _____SWALLOWING PROBLEMS
_____THYROID PROBLEMS _____RECENT WEIGHT CHANGES
_____RHEUMATOID ARTHRITIS _____VISION / HEARING PROBLEMS
_____TUMOUR / MALIGNANCY _____ULCER
_____NERVOUS DISORDERS _____CIRCULATION PROBLEMS
_____KIDNEY /BLADDER /BOWEL PROBLEMS _____HERNIA
_____TRANSMITTABLE DISEASES _____
_____NONE OF THE ABOVE

**PLEASE LIST ANY MEDICATIONS OR ANY OTHER CONDITIONS YOU WOULD LIKE KNOWN:**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

**THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. BY SIGNING BELOW I HAVE READ AND UNDERSTAND THE PAYMENT AND CANCELATION POLICIES**

**PRINT NAME OF GUARDIAN IF PATIENT IS UNDER 16:** **RELATIONSHIP TO PATIENT:**

**PHONE NUMBER IF DIFFERENT FROM ABOVE:**

_____

**PATIENT / GUARDIAN SIGNATURE(IF PATIENT IS UNDER 16)** **DATE** **WITNESS SIGNATURE**

# BACK ON TRACK PHYSIOTHERAPY

**MVA INTAKE FORM – CLIENT PERSONAL INFORMATION (PLEASE PRINT)**

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

**NAME OF POLICY HOLDER: SAME** ◯ **OR:**_____

**CLAIM #:**_____ **POLICY #:**_____

**INSURANCE COMPANY:**_____ **CITY:**_____

**ADDRESS:**_____

**ADJUSTERS NAME:**_____ **PH.**_____

**EMAIL:**_____ **FX.**_____

**ADMIN USE ONLY**
* CLAIMANT HAS 30 DAYS TO MAKE A CLAIM – CALL ADJUSTER BEYOND FOR VERBAL APPROVAL TO ASSESS

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:_____

OCF 1 SUBMITTED ◯ YES ◯ NO

IF YES DATE SENT:_____

SIGNATURE:_____

SIGNATURE INDICATES YOU HAVE SUBMITTED OCF 1
ANY DENIED PAYMENT DUE TO INCOMPLETE OCF 1 WILL BE YOUR RESPONSIBILITY.
YOUR MVA INSURER WILL NOT CONSIDER PAYMENT OF ANY INVOICES WITHOUT RECEIPT OF A COMPLETED OCF 1

**EXTENDED HEALTH BENEFITS**

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

**IF NO PLEASE SIGN & DATE:**_____
SIGNATURE DATE

**As per FSCO we must bill your extended health prior to billing your car insurance company. We will require a statement from EHB to submit to MVA in order for them to cover the difference.**

**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:**_____

## MVA – Cancelation Policy and Payment 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.

Although we have always had a cancelation policy, circumstances with MVA claims have caused us to reinforce this policy with a signed agreement. 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. Your car insurance will not be billed, nor will they pay for this charge. This will be billed and must be paid by you for you to continue to be treated under your claim. Under certain circumstances management may waive this fee.

It is also imperative that when you submit to your EHB company, payment is made to us immediately upon receiving those funds along with the statement. This will then allow us to bill your auto insurance company and not cause any delays with treatment.

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

_____ _____
Patient's Name Witness Name

_____ _____
Patient's Signature Witness Signature

# BACK ON TRACK PHYSIOTHERAPY

**MOTOR VEHICLE ACCIDENT CLIENTS INFORMATION**

Dear Patient:

After experiencing a Motor Vehicle accident, we at Back on Track Physiotherapy know that the process can be overwhelming, so we have decided to provide some general but important information for this process and what you can expect from your Back on Track Physiotherapy team:

- You will receive a package from your car Insurance. This package is called “Accident Benefits Package” and/or “OCF1.” This package must be completed and sent to your Insurance within 30 days of you receiving it. Before you send it off, please provide a copy to your attending Back on Track Physiotherapy location so we can keep a copy in your file in case your adjuster has any future questions.

- If you do not have all your Insurance information at the time of your assessment you are to provide this on your 2nd visit. This information includes your policy number, claim number, adjuster name and insurance company name.

- By law, patients **must** provide any attending Clinic with their Extended Health Benefits (EHC/Work Benefits/Group Benefits/Private Insurance) information.

- Back on Track Physiotherapy will ask you to pre-sign Claim forms so that we can submit to your Extended Health Carrier twice a month for reimbursement. After approximately 2 weeks of our submission, you will receive payment from your Extended Health carrier by mailed cheque or direct deposit. You are responsible to then forward payment and statement to your attending location. (Without this, we cannot submit to your Auto Insurance for the remaining balance.)

- If you do not provide all the necessary or correct information, you will then be held responsible for any monies outstanding on your account. If you have any questions or concerns, please do not hesitate to ask our staff.

Patient Signature _____ Date _____

Administrator Signature _____ Date _____