NORFOLK CHIROPRACTIC WELLNESS CENTRE

MOTOR VEHICLE ACCIDENT HISTORY

Please complete the following to help us process your accident claim as quickly as possible, Thank you!

***NAME**_____ ***BIRTHDATE** _____

***DATE OF ACCIDENT**_____ **TIME** _____**AM/PM**

LOCATION_____ **CITY**_____

***AUTO INSURANCE CO.**_____ ***POLICY #**_____

***NAME OF INSURED (Policy Holder)**_____ ***CLAIM #** _____

***INSURANCE CLAIM ADJUSTER** _____**PHONE #**_____ **FAX#** _____

ADDRESS (Insurance Co.) _____ **City/Prov.** _____ **Postal Code** _____

Were you employed at the time of your accident? ☐ Yes ☐ No

**** required field***

Tell Us About The Accident:

What type of accident was it? ☐ Head on ☐ Rear end ☐ Side impact ☐ Other_____

Road Conditions: ☐ Wet ☐ Dry ☐ Snow/Ice ☐ Other_____

Where were you seated in the vehicle? ☐ Driver's seat ☐ Passenger's seat ☐ Back seat
Were you wearing a **seatbelt**? **Yes / No** ☐ Lap belt ☐ Shoulder strap
What speed were you traveling? _____ km/hr **What speed** was the other car traveling? _____ km/hr
Was **your vehicle** ☐ speeding up ☐ slowing down at the time of the accident?
Was the **other vehicle** ☐ speeding up ☐ slowing down at the time of the accident?
Describe, to the best of your ability, **what happened during the accident:**

_____

_____

_____

Were you prepared for the impact at the time of the collision? ☐**Yes** ☐ **No**

Was your head turned at the time of the accident? ☐**Yes** ☐ **No** If yes, ☐ **Left** ☐ **Right** ?

Did you hit your head during the accident? ☐**Yes** ☐ **No**

Did you lose consciousness? ☐**Yes** ☐ **No** If yes, for **how long?** _____

When did you **first notice pain?** ☐ immediately ☐ gradually _____ **hours/days** after the accident?

Were you taken to the **hospital** following the accident? ☐ **Yes** ☐ **No**

Did you have **X-rays taken**? ☐ **Yes** ☐ **No** If yes, what body parts _____

Have you had **any treatment** since the accident? ☐**Yes** ☐ **No** Describe: _____

_____

Have you **lost any time from work** as a result of the accident? ☐**Yes** ☐ **No** **How much** time? _____ days.

Please turn over →

NORFOLK CHIROPRACTIC WELLNESS CENTRE

Do you have private health insurance coverage for Chiropractic and/or Massage? ☐ **Yes** ☐ **No**

If yes, we need the following information about your benefits. (The easiest way to find out the answers is to call your provider (i.e. Greenshield, Blue Cross, Manulife, etc) directly and have them give you the following information.

***Health Insurance Company**: _____ ***Policy #** _____

***Name of Insured (Policy Holder)** _____ **Member #** _____

***What is your total amount of yearly coverage for** Chiropractic $ _____ Massage $ _____

***How much coverage is remaining for this year, for** Chiropractic $ _____ Massage $ _____

What percentage of payment, or specific amount per treatment, does your plan pay?
(i.e. 80% coverage, $15.00 per visit, etc): _____

***Does your benefits plan pay for treatment if you have been in a Motor Vehicle Accident?** ☐**Yes** ☐**No**

**** required field***

FINANCIAL POLICY FOR AUTOMOBILE INSURANCE CLAIMS

If you have been injured in a Motor Vehicle Accident and are filing a claim with an automobile insurance company, please **notify the staff** and **doctor immediately**. Your insurance adjuster should send you an "**Application for Accident Benefits"** (OCF – 1) along with a ***"Permission to Disclose Health Information"*** (OCF 5), a ***"Disability Certificate"*** (OCF - 3/59) and a ***"Treatment Plan"*** (OCF – 23) for your doctor to complete, outlining your injuries and required therapy. According to government legislation, the application **must** be completed and returned to the insurance company before any treatment can be approved. Please **complete this package and return it to your claims adjuster as promptly as possible** in order to expedite approval for your claim and payment for your treatment.

FSCO (Financial Services Commission of Ontario) requires that we confirm the identity of every MVA claimant. We accept the following pieces of identification and will keep a photocopy in your file – Valid Driver's License, Passport, Health Card, or Ontario Photo Card.

If you have private health benefits which cover accident injuries, payment for your treatment is **due at each appointment** until the benefits are exhausted. If for any reason your claim is denied, you (the patient) will be responsible for paying the entire balance owing for goods and services that have been rendered.

I, _____ have read and fully understand the above financial policy related to motor vehicle accident claims.

Patient Signature: _____ *Date:* _____