Motor Vehicle Accident Intake - *North Ajax Rehab and Sports Injury Clinic*

CLIENT INFORMATION:

Name: First: _____ Last: _____

Date of birth: Month ____Day ____Year_____ **Age _____** **Gender:** ❒ Male ❒ Female

Address: _____

City of: _____ **Postal Code: _____**

Phone #: Home (_____) _____ Cell (_____) _____

Work #: (_____) _____ Ext#:_____

In Case of Emergency call:

Name: **_____** Phone: (____) _____ Relationship to client: _____

Family doctor: _____ **Referring doctor: _____**

Referral Source:

❒ Family Physician ❒ Specialist/Surgeon ❒ Family/Friends ❒Yellow Pages ❒Other: _____

ACCIDENT INFORMATION:

Date of accident: _____

Have you received treatment for this injury? ☐ No ☐ Yes - If yes, where: _____

INSURANCE INFORMATION:

Name of MVA Insurance Company: _____
Address: _____City:_____ Postal Code: _____

Adjusters Name: _____ Phone: (___) _____ **Fax:** (___) _____

Policy Holder: _____ Relationship to Policy Holder: _____
Policy#: _____ Claim #: _____

Extended Health coverage? ❒ Yes ❒ No

If Yes:

1. My plan is with: _____ Plan #: _____ Policy #: _____

What is the maximum coverage available on this plan: Physiotherapy: _____ Massage: _____
What is the calendar year for this plan: _____ Have you used some of your coverage this year? _____

2. My spouse's plan is with: _____ Plan #: _____ Policy #: _____

What is the maximum coverage available on this plan: Physiotherapy: _____ Massage: _____
What is the calendar year for this plan: _____ Have you used some of your coverage this year? _____

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Please tell us about your accident and other health conditions:

You were: ☐ the driver ☐ a passenger ☐ on a motorcycle ☐ riding a bicycle ☐ a pedestrian

You were seated: ☐ driver's seat ☐ front passenger ☐ rear left ☐ rear right ☐ middle

Your vehicle was impacted: ☐ front ☐ rear ☐ driver's side ☐ passenger' side ☐ not sure

Weather conditions: ☐ clear ☐ wet ☐ icy **Did you hit your head?** ☐ Yes ☐ No

Did you lose consciousness during or after the impact? ☐ Yes ☐ No

Were you able to get out/walk around unassisted? ☐ Yes ☐ No

Have your injuries during this accident affect your: ☐ work ☐ activity/sports ☐ home life ☐ sleep

Have you had any prior collisions? ☐ No ☐ Yes **Date:** _____

Symptoms (Check all that apply)	Before Collision	Immediately following	Currently Experience
Headaches	No ❒ Yes ❒	No ❒ Yes ❒	No ❒ Yes ❒
Neck pain and/or stiffness	No ❒ Yes ❒	No ❒ Yes ❒	No ❒ Yes ❒
Shoulder or arm pain and/or stiffness	No ❒ Yes ❒	No ❒ Yes ❒	No ❒ Yes ❒
Back Pain/stiffness – upper back	No ❒ Yes ❒	No ❒ Yes ❒	No ❒ Yes ❒
Back Pain/stiffness – mid - back	No ❒ Yes ❒	No ❒ Yes ❒	No ❒ Yes ❒
Back Pain/stiffness – lower back	No ❒ Yes ❒	No ❒ Yes ❒	No ❒ Yes ❒
Hip or Leg pain/stiffness	No ❒ Yes ❒	No ❒ Yes ❒	No ❒ Yes ❒
Pain – other areas? _____	No ❒ Yes ❒	No ❒ Yes ❒	No ❒ Yes ❒
Jaw, tooth or ear pain	No ❒ Yes ❒	No ❒ Yes ❒	No ❒ Yes ❒
Arm or hand weakness and/or tingling	No ❒ Yes ❒	No ❒ Yes ❒	No ❒ Yes ❒
Loss of co-ordination	No ❒ Yes ❒	No ❒ Yes ❒	No ❒ Yes ❒
Dizziness	No ❒ Yes ❒	No ❒ Yes ❒	No ❒ Yes ❒
Difficulty swallowing and/or speaking	No ❒ Yes ❒	No ❒ Yes ❒	No ❒ Yes ❒
Nausea and/or vomiting	No ❒ Yes ❒	No ❒ Yes ❒	No ❒ Yes ❒
Vision affected?	No ❒ Yes ❒	No ❒ Yes ❒	No ❒ Yes ❒
Numbness around your mouth?	No ❒ Yes ❒	No ❒ Yes ❒	No ❒ Yes ❒
Ringing in the ears (tinnitus), hearing loss	No ❒ Yes ❒	No ❒ Yes ❒	No ❒ Yes ❒
Trouble concentrating and/or memory loss	No ❒ Yes ❒	No ❒ Yes ❒	No ❒ Yes ❒
Sleep and/or personality changes	No ❒ Yes ❒	No ❒ Yes ❒	No ❒ Yes ❒

Major injuries or surgeries (and timeframes):

_____
_____
_____
_____
_____
_____
_____
_____
_____

Current medications:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No

If yes, what treatment are you receiving? _____

Today's Date: _____ **Signature:** _____

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In our Clinic, we will:

1. Assess you
2. Complete a treatment plan (OCF 23 or OCF 18)
3. Submit it to your MVA Insurance Company

Once an approval from your MVA Insurance is received, treatment will be started. We do this to protect you. If your Treatment Plan is 'denied' by your MVA Insurance, you would be responsible for all costs/fees incurred for your treatment.

Extended Health Insurance:

In Ontario, for motor vehicle accidents, the cost/fees for your treatment must first be billed to your Extended Health Insurance. This is why we need your Extended Health information prior to the assessment. The maximum allowable Extended Health benefit for Physiotherapy and Massage Therapy must be reached before we can bill the Motor Vehicle Insurance. Your MVA insurance company will then pay the final amount owing directly to our clinic. If you **do not** have extended health coverage, we will bill your MVA Insurance directly.

Many Extended Health Insurance providers will allow our clinic to do direct billing. If your insurance provider does not permit direct billing to us, they will do one of the following:

1. Send **you** a cheque, along with a statement. **You** must endorse the cheque over to *North Ajax Rehab & Sports Injury Clinic* and bring a copy of the statement to us.
2. Direct deposit into your personal account. These fees must be paid to our clinic and we require a copy of your statement, which you can find online.

**** Proof of payment (the statement) from your Extended Health Insurance is required before we can bill your MVA insurance company. They will not pay us unless this proof is provided. If you do not give us this statement, then the remaining money owed for treatment will be your personal responsibility.

Reports & Letters:

Reports or letters not outlined in the treatment plan will be subject to additional fees. Additional fees are the responsibility of the patient if no other party (Insurer, employer, lawyer, another third party) is willing to accept the charges. No report / letter will be charged to you without your informed consent.

By signing this form, I accept responsibility of my account and I have read and completely understand this form.

_____	_____	_____
Patient Printed Name	**Patient Signature**	**Date Signed**