

MOTOR VEHICLE ACCIDENT HISTORY

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

NAME _____ DATE OF ACCIDENT _____ TIME _____ AM/PM
 LOCATION _____ CITY _____
 AUTO INSURANCE CO. _____ POLICY # _____
 NAME OF INSURED (Policy Holder) _____ CLAIM # _____
 INSURANCE ADJUSTER _____ PHONE # _____ FAX# _____
 ADDRESS (Insurance Co.) _____ City/Prov. _____ Postal Code _____
 Do you have private health insurance coverage for chiropractic? Yes No \$ _____ / year
 HEALTH INSURANCE CO. _____ Policy # _____
 NAME OF INSURED (Policy Holder) _____ Member # _____

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 Passanger'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.

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" including a "Permission to Disclose Health Information" (OCF 5), a "Disability Certificate" (OCF - 3/59) and a "Treatment Plan" (OCF - 18/59) for your doctor to complete, outlining your injuries and required therapy. According to government legislation, this 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. Due to delays in processing claims, you **may** be required to pay for services that you receive before your claim has been approved. If you do not pay for these services, and for any reason your claim is denied, you (the patient) will be responsible for paying the entire balance owing for services that have been rendered.

I, _____ have read and fully understand the above financial policy related to motor vehicle accident claims and would like Norfolk Chiropractic Wellness Centre to hold a balance for me pending insurance approval for my claim. (Patient Signature) _____