

# 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 _____		
INSURANCE COMPANY _____	POLICY # _____		
NAME OF INSURED (Policy Holder) _____	CLAIM # _____		
INSURANCE ADJUSTER _____	PHONE # _____	FAX# _____	
ADDRESS (Insurance Co.) _____	City/Prov. _____	Postal Code _____	

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 claim 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 on motor vehicle accident insurance claims, 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) \_\_\_\_\_.