MOTOR VEHICLE INSURANCE INFORMATION:

It is our responsibility to inform you that if you have extended health benefits it is required by law that you have to exhaust all extended health benefits and provide written documentation stating that your benefits have been exhausted prior to Impact Physiotherapy & Performance invoicing your motor vehicle insurance company.

Insurance Company Name: _____

Insurance co. complete address:_____

_____

Insurance co branch (if applicable):_____ Accident Date:_____

Claim #:_____ Policy #: _____

Adjuster's name:_____

Adjuster's Phone #:_____ Adjuster's fax #:_____

Is the applicant the policy holder? Y or N If no, please indicate who is_____

Prior to the accident did you have any condition or disease or injury that may affect response to the treatment for your injuries (ie.diabetes, previous fractures etc.) _____

Since the accident, have you developed any condition, disease, injury not related to the motor vehicle accident that could affect your response to treatment (ie. Infection, depression, etc).____

EXTENDED HEALTH BENEFIT INFORMATION:

Name of Ins. Company _____

Address of Ins. Company _____

Policy/Plan #_____ ID#:_____

Dollar Limit:_____ Percentage coverage:_____

Who is the policy holder?_____

Cancellation Policy:

You will be billed for missed appointments unless 24 hours advanced notice of cancellation is received. In the event that cancellation is not received in a timely fashion, a fee of $60 will be charged to your account.

I hereby agree that I will pay for any missed or cancelled appointments at a fee of $60/incident should they occur.

I hereby agree that I will pay for all services rendered to me by Impact Physiotherapy.

I have read and understood all of the above statements and agree to adhere to them accordingly. I give consent to be assessed by the staff at Impact Physiotherapy.

Client's Name (Print): _____ Client's Signature: _____

Date: _____ Witness: _____