INSURANCE INFORMATION

First Name		Last Name	
Date of Birth mm/dd/yyyy		Date of Injury mm/dd/yyyy	

Incident Occurred Due To: ☐ **Motor Vehicle Collision (MVC)** ☐ **Workplace Injury (WSIB Claim)**

MVC ONLY

Motor Vehicle Insurance Co			
Address			
Policy Number		Claim Number	
Adjustor Name		Phone	
Fax		Email	
Extended Health Benefits Information (Self/Spouse)			
EHB Insurer (self)		EHB Insurer (spouse)	
Coverage $Amount		Coverage $Amount	
Renews (date)		Renews (date)	

WSIB ONLY

Claim Number		Occupation	
Case Manager		Phone	
Employer		Phone	
Address			
Length of Time in Current Job	☐ Full Time ☐ Part Time		
Supervisor Name		Phone	

PAYMENT OF SERVICES AGREEMENT

I agree to assume the responsibility for all fees for services/products incurred by me at Back Works Spinal and Sports Rehabilitation should my insurance company (MVC or EHCB) fail to cover fees or, in the case of a work-place injury, if the Workplace Safety and Insurance Board (WSIB) denies payment.

Back Work does not offer direct billing for privately paid appointments.

A charge will be applied for a missed appointment or if an appointment is cancelled on the same day as the appointment.

Signature _____ Date _____

FOR STAFF USE

- ☐ Patient ID Verified
- ☐ MVC - OCF-1 su**bmitted to MVC Insurance**
- ☐ **MVC - Copy of OCF1** & EHBC card on file
- ☐ MVC – Direct Billing Authorized
- ☐ WSIB - Form 6, 7 and 8 submitted to WSIB
  - ☐ - Approved ☐ - Pending

Initials _____ Date _____

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Team Physiotherapists