Back WORKS

INSURANCE INFORMATION

First Name: _____ Last Name: _____

Date of Birth: _____ Date of Injury: _____

INCIDENT OCCURRED DUE TO:

☐ Motor Vehicle Collision (MVC)

☐ Workplace Injury (WSIB Claim)

MVC ONLY

Name of MVC Insurance Company: _____

Address: _____

Policy #: _____ Claim #: _____

Adjuster Name: _____ Phone: _____

Fax: _____ Email: _____

EXTENDED HEALTH BENEFITS INFORMATION (Self/Spouse):

Name of Insurer: _____ Name of Insurer: _____

Coverage: $ _____ % _____ Coverage: $ _____ % _____

Deductible: Yes ☐ No ☐ $ _____ Deductible: Yes ☐ No ☐ $ _____

Renews on: _____ Renews on: _____

Date Date

WSIB ONLY

Claim Number: _____ Occupation: _____

Length of Time in Current Job: _____ ☐ Full Time ☐ Part Time

Employer Name: _____ Employer Phone: _____

Employer Address: _____

Supervisor Name: _____ Phone: _____

WSIB Case Manager: _____ 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 within 24 hours.

_____ _____

Signature Date

FOR STAFF USE

- ☐ Patient ID Verified
- ☐ MVC - OCF-1 submitted to MVC Insurance
- ☐ MVC - Copy of OCF1 & EHBC card on file
- ☐ MVC – eClaims Form authorized
- ☐ WSIB - Form 6, 7 and 8 submitted to WSIB
  - ☐ - Approved ☐ - Pending

_____ _____

Initials Date

102-99 Northfield Drive E, Waterloo ON N2K 3P9 I Phone 519-746-8172 I Fax 519-746-8346 I admin@backworks.ca I www.backworks.ca

Team Physiotherapists

KITCHENER RANGERS