1201 Britannia Road W, Unit no 7C, Mississauga, ON L5V1N2
info@realignphysio.ca Tel: +1647 945 7561 Fax: 647 499 7521

Motor Vehicle Accident (MVA) Pre-Assessment Form

At Realign Physio & Wellness Center we understand that a motor vehicle accident insurance claim can feel tiring and tedious to fill out all the paperwork. We have created a process to help simplify and expedite the administration. Please help us by completing the following form, and remember we are here to help if you have any questions or require assistance.

Have you ever been a patient here before? ☐ Yes ☐ No If Yes, date of last visit: _____

How did you learn about us? If referred, please mention the name: _____

Patient Name: _____ DOB: _____

Address: _____ Apt/Unit #: _____

City/Town: _____ Province: _____ Postal Code: _____

Home # _____ Cell # _____ Work # _____

Email Id: _____

How would you like us to contact you: ☐ Text msg ☐ Phone ☐ Email

Emergency Contact: Name: _____ Contact No: _____

Workplace: _____

Address: _____ Postal Code: _____

PLEASE NOTE: Under Ontario law your MVA claim must go through your Extended Health Coverage (EHC) first. Once your Extended Health Coverage has been exhausted then your auto insurer will begin the role of the claim processor.

Extended Health Coverage Insurance Company:

Group/Policy no # _____ Member ID/ Certificate # _____

Policy Holder Name: _____ DOB: _____

Relationship to Member: _____ Policy Holder Workplace: _____

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MVA:

Insurance Company: _____ Date of loss: _____

Claim #: _____ Policy No: _____

Adjuster name: _____ Email: _____

Fax: _____ Phone no: _____

Address: _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? □ Yes □ No

Have you completed and sent in an OCF 1 form (Application for Benefits) to your insurance company? □ Yes □ No

Have you received therapy from a previous clinic for this current insurance claim? □ Yes □ No

If yes, how long did you attend for? _____

Approximately how many therapy sessions did you attend? _____

Were you ever denied treatment through your Motor Vehicle Accident insurance? □ Yes □ No

LAWYER INFORMATION:

Do you have a lawyer that had advised you in this case? □ Yes □ No

If yes, please provide information below

Name of Company: _____ Name of Lawyer/Paralegal: _____

Address: _____

Telephone: _____ Email: _____

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Health History Questionnaire

The information requested below will assist us in treating you safely. Feel free to ask us any questions about the information being requested. Please note that all information provided will be kept confidential unless allowed or required by law. Your written consent will be required to release any information.

Have you travelled outside Canada in last 4 weeks? □ Yes □ No If yes, where? _____

Are you experiencing Flu like Symptoms such as cough, fever, shortness of breath? □ Yes □ No

If yes, have you consulted your physician? □ Yes □ No

Briefly describe the Accident:

_____

_____

_____

Road condition at the time of the accident: □ Wet □ Dry □ Icy □ Other

At the time of impact:

- was your car: □ Stopped □ Slowing down
- was the other vehicle: □ Stopped □ Slowing down □ Gaining speed □ At a constant speed

You were the □ Driver □ Passenger Sitting- Front seat/ Back seat

Did you Brace yourself prior to impact: □ Yes □ No

Did your head? □ Strike Object □ Not strike Object

Did you experience: □ Shock □ Flash of Light Seen Upon Impact

Did the Air bag Deploy? □ Yes □ No

Were you wearing a lap belt and a shoulder harness? □ Yes □ No

Was your head rest in its proper position (Positioned at the back of the skull)? □ Yes □ No

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Were you looking in any direction prior to impact? (Rear-view mirror, to the side, into the back seat, adjusting radio) □ Yes □ No If yes, please specify: _____

Did any part of your body strike the interior of the vehicle? □ Yes □ No

Were you surprised by the impact? □ Yes □ No

Were you rendered unconscious because of the accident? □ Yes □ No

Did you feel pain immediately after the accident? __Yes __No

Were you able to get out of your vehicle on your own? □ Yes □ No

Did you go to a hospital? □ Yes □ No If Yes, who took you to hospital? _____

Please describe any treatment/ investigation done at hospital: _____

Were the police notified? □Yes □No Please provide this office with a copy of the police report

Did you have any physical complaints BEFORE the accident? □Yes □No If yes, please describe

_____

_____

Please describe how you felt:

DURING the accident: _____

IMMEDIATELY AFTER the accident: _____

LATER THAT DAY: _____

THE NEXT DAY: _____

Have you been treated by another doctor since this accident? □Yes □No

What type of treatment did you receive? _____

Did this Accident occur while you were performing your regular Job duties? □ Yes □ No

Are you taking any prescribed/over the counter medications now? □ Yes □ No

If yes, please describe it and what are you taking it for? _____

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WHERE WERE YOU HURT BEFORE THE ACCIDENT

Area: Head/ Neck/ Upperback/ Lowback/ Shoulders/ Elbow/ wrist/ Hip/ Knee/ Ankle or feet/

Other: _____

Please rate the level of this pain on the following scale: 0 is no pain, 10 is severe pain or the worst pain you have ever felt: 1 2 3 4 5 6 7 8 9 10

WHERE DID YOU HURT IMMEDIATELY AFTER THE ACCIDENT

Area: Head/ Neck/ Upperback/ Lowback/ Shoulders/ Elbow/ wrist/ Hip/ Knee/ Ankle or feet/

Other: _____

Please rate the level of this pain on the following scale: 0 is no pain, 10 is severe pain or the worst pain you have ever felt: 1 2 3 4 5 6 7 8 9 10

How do you feel now, what is your number one problem or the one area of greatest pain?

_____

Please rate the level of this pain on the following scale: 0 is no pain, 10 is severe pain or the worst pain you have ever felt. If your pain varies from day to day, please circle two numbers to indicate a range of your pain. 0 1 2 3 4 5 6 7 8 9 10

Describe the nature of your pain: Achy Burning Dull Sharp Throbbing Other

Do you experience Radiating Pain/Numbness/Tingling/Burning/Weakness? □ Yes □ No

If yes, please mention the area:

_____

Since this injury occurred, is your pain: □ Improving □ Getting worse □ Staying the Same

How often do you experience the pain? □ 1-2 hours/day □ About half of the day

□ Most of the day □ The pain never goes away

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How does the pain affect your daily activities?

□ It does not affect my daily activities □ I have had to change how I do things

□ I can do some of my daily activities □ I am unable to perform daily activities

What/ which activities makes current pain worse? _____

What/ which activities makes current pain better? _____

Have you every experienced this problem before? □Yes □No

If yes, when was the last time you experienced the problem? _____

Are your Job Duties Physically demanding for you? □ Yes □ No

Have you had any disability time? □ Yes □ No

If you are currently working which, are you performing?

□ Regular Duties □ Limited/Light Duties □ Other (please describe) _____

Have you lost time from work because of this accident? □Yes □No

a. Type of employment_____

b. Last day worked_____

Have you ever been involved in an accident before? □Yes □ No If yes, please mention the date of accident, treatment taken: _____

Do you presently have or ever had any of the following? Check all that apply:

Cardiovascular

□ High Blood Pressure □ Heart Attack

□ Low Blood Pressure □ Phlebitis / varicose veins

□ Stroke / CVA / TIA □ heart disease

□ Chronic congestive heart failure □ None of the above

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Respiratory

□ Chronic Cough □ Shortness of Breath

□ Asthma □ Emphysema

□ Bronchitis □ None of the above

Infections

□ Hepatitis □ Skin Conditions

□ TB □ HIV

□ Herpes □ None of the above

Head / Neck

□ History of Headaches □ History of Migraines □ Dizziness

□ Vision Problems □ Vision Loss □ Vomiting

□ Ear Problems □ Hearing Loss □ None of the above

Other Conditions

□ Loss of Sensation □ Diabetes

□ Allergies / Hypersensitivity □ Cancer

□ Arthritis □ Epilepsy

□ Fracture/ Broken bone □ Osteoporosis

□ Thyroid □ Bruise easily

□ Weakness in any part of body □ None of the above

Is there a family history of any of above? _____

Is there a Family history of Arthritis: □ Yes □ No □ Not aware

Women: Pregnant? □ Yes □ No

Gynecological conditions? □ Yes □ No If yes, please specify: _____

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Please give a list of all surgeries, past injuries, or major dental work you have had:

_____

Do you have any other diagnosed diseases or medical conditions? (Digestive conditions, hemophilia, osteoporosis, mental illness) □ Yes □ No If yes, please specify: _____

Do you have an internal pins, wires, artificial joints or special equipment? * □ Yes □ No

If yes, please specify: _____

History of oral steroid use? (Cortisone, Prednisone) □ Yes □ No If yes, please specify: _____

During last month, have you felt depressed/ bothered by feeling down □ Yes □ No

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify my therapist of any changes to my health or personal information.

Patient/ guardian Signature: Date:

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Consent and policies

Please read the following carefully

REALIGN PHYSIO & WELLNESS CENTER is a multidisciplinary health care provider where the practitioners work in conjunction to provide you, the patient, thorough care and treatment. All staff members are required to sign a confidentiality form with regards to your personal information and are trained in appropriate use and protection of your information. We will use your information to coordinate your treatment, to communicate with your physician (with your written consent) regarding your status in physiotherapy, to conduct internal audits and quality of care reviews. We also provide information when required by law.

All handling of your information is compliant with existing college guidelines and provincial and federal legislation. Our clinic uses your information to ensure you receive the best care. Please review the intake paperwork you were asked to complete prior to your first visit. If you have any questions, please do not hesitate to speak with your therapist.

I give REALIGN PHYSIO & WELLNESS CENTER, my consent to release / obtain information from the following individuals with respect to*

☐ Physician(s)

☐ Insurer/ Lawyer

☐ Family Member

☐ Employer

☐ WSIB

☐ Other

☐ None of the above / not applicable

E-MAIL

☐ I give permission for Realign Physio & Wellness Center to use the email provided to send reminder emails of scheduled appointments, for paperless billing and for information regarding changes in clinics offerings.

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You have the right to:

- receive courteous professional service
- ask for clarification on your treatment plan and questions pertaining to your care
- review or obtain a copy of your personal health information
- request that we complete information or correct any inaccurate information in your record
- request a list of individuals we release medical information to
- request in writing that specific person(s)/agency(ies) not receive specific information

We ask that you:

- try to keep your appointments, and to call as soon as possible if you must cancel or reschedule any appointment
- keep us aware of any changes in your condition, insurance coverage or other medical appointments
- respect the privacy of others
- respect others in our clinic both verbally and non-verbally

PAYMENT INFORMATION*

 I understand that payments for services at REALIGN PHYSIO & WELLNESS CENTER are my responsibility after every service is received. If my claim is to be submitted to an outside agency for payment, and for any reason the third-party payer, such as insurance or employer denies and/or refuses to pay for the full amount I am billed, I am responsible for payment.

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CLINIC POLICIES AND CONSENT*

In order to serve our clients promptly and professionally, we need to adhere to a precise schedule. To achieve this, we ask that our clients arrive on time for their appointments, and when necessary, provide ample notice for cancellations. Please understand and adhere to the following clinic policies. When you book an appointment, that time is set aside for you, and missed appointments prevent us from accommodating other clients. Please understand that therapists only get paid when they deliver a service.

ARRIVING LATE*

If you arrive late, your treatment may be shortened in order to accommodate other clients whose appointments follows yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment given, you will be responsible to pay for the full session; however, we will do our best to satisfy the scheduled time.

CANCELLATION OF APPOINTMENT*

I understand that REALIGN PHYSIO & WELNESS CENTER requires a minimum of 24 hours notice for any appointment cancellations. Should you give less than 24 hours notice, a $25.00 cancellation charge may be charged. Future appointments will be denied until payment is made.

NO SHOW*

Your appointment time has been reserved specifically for you. Should you book an appointment and not to attend, you are responsible to pay for the entire cost of the appointment, before having any other treatments done

Please note that extended health coverage does not reimburse for missed appointment fees. If you are a WSIB or MVA client and your claim is denied, you are responsible for payment of all treatments rendered.

If an emergency arises, please let us know so that we can treat your specific situation with personal attention. We recognize that there are circumstances that are out of your control (sudden illness, family emergencies, etc.) and your therapist may make an exception to the above policies on those rare occasions.

If making your regularly scheduled appointments is difficult for you for any reason, please let us know and accommodations may be made. Ultimately, your care is the most important thing to us, and being able to attend your full treatment sessions as scheduled is necessary to get the best results in a timely manner.

REALIGN PHYSIO & WELLNESS CENTER may change its policies at anytime without notice. The latest policy will be posted.

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RENDERING OF EVALUATIONS, TREATMENTS AND/OR SERVICES*

 I hereby consent to the rendering of evaluations, treatments and/or services as communicated by the Physiotherapist named below. My consent is voluntary, and I intend this consent to cover the entire course of assessment/treatment commencing on the date indicated below. I understand that I may ask questions at any time regarding the assessment and treatment and that this consent may be withdrawn at any time.

We strive to ensure your time with us is productive and enjoyable, and you are always welcome to call us with questions, to give us feedback or to pass along compliments. You are welcome to contact us at any time.

Thank you for your cooperation.

Patient/Guardian Name:

Signature:

Date:

Physiotherapist:

Signature:

Date: