Westney Heights Chiropractic Centre
Dr. David Surette BPHE, BEd, DC / Dr. Karen Martindale-Sliz BSc, DC

MOTOR VEHICLE ACCIDENT INFORMATION

In order to complete your billing process to your insurance company, we require the following information:

Client Name _____ Date of Accident_____

MOTOR VEHICLE ACCIDENT INSURANCE COMPANY:

Name of Company _____

Complete Address _____

_____

Claim Number _____ Policy Number _____

Name of Policy Holder _____ Claims Adjuster _____

Adjuster's Phone Number _____ Adjuster's Fax Number_____

EXTENDED HEALTH CARE COVERAGE:

Some places of employment have extended health care coverage for chiropractic/acupuncture/massage therapy. If you have an extended health care plan, regardless of the coverage, we require the following information:

Name of Company _____ Member's Name _____

Policy Number _____ Plan Identifier Number_____

Amount of Coverage (include % coverage, limit per treatment and limit per year) _____

_____

ALTERNATE EXTENDED HEALTH CARE COVERAGE: (Insured partner or guardian – if applicable)

Name of Company _____ Plan Member's Name _____

Policy Number _____ Plan Identifier Number _____

Plan Member's Date of Birth _____

Amount of Coverage (include % coverage, limit per treatment and limit per year) _____

_____

Please read carefully and sign below:
It is the policy of the Westney Heights Chiropractic Centre that all motor vehicle accident clients are responsible for providing all of the above information and thereby activating payment by your insurance company to the Westney Heights Chiropractic Centre. If, for any reason, your insurance company does not cover our treatment costs, this acknowledges your responsibility for payment.

Client Signature _____ **Date** _____

ACCIDENTAL INJURY QUESTIONNAIRE

Check symptoms you have noticed since the accident:

____ Headache
____ Fatigue
____ Neck Pain/Stiff
____ Upper Back Pain/Stiff
____ Low Back Pain/Stiff
____ Jaw Pain/Stiff
____ Shortness of Breath
____ Leg Pain
____ Arm Pain
____ Head Seems too Heavy
____ Difficulty Swallowing
____ Chest Pain
____ Nausea/Vomiting
____ Diarrhea
____ Constipation
____ Numbness or Tingling in Arms
____ Numbness or Tingling in Legs
____ Dizziness
____ Fainting
____ Depression
____ Irritability
____ Loss of Memory
____ Nervousness
____ Cold Feet
____ Cold Hands
____ Vision Problems
____ Ringing/Buzzing in Ears
____ Sleeping Problems
____ Face Flushed
____ Loss of Taste
____ Loss of Smell
____ Fever
____ Loss of Balance

Symptoms other than above:
_____

_____

Have you made contact with an Insurance Adjuster or Agent? Yes No

Were you taken to the hospital after the accident? Yes No
If so, list treatment or tests done: _____

_____

Have you seen any doctors since the accident? Yes No
If so, list their names and when they were seen: _____

_____

What were you told was wrong with you? _____

_____

Were you or are you taking medication as a result of the accident? Yes No
If so, list medications: _____

_____

What other treatments have you received since the accident? _____

_____

Have you been off work/school? Yes No
If so, how long? _____

Did you return to modified duties? Yes No
Please describe:_____

Have you been advised by an attorney on this case? Yes No
If so, please give name and address: _____

_____

Phone Number ( ) _____ Fax Number ( ) _____

WHIPLASH-ASSOCIATED DISORDERS (WAD)
Minimum Data / Initial Visit

Check the appropriate box or write answers where applicable

A. GENERAL INFORMATION

Height: _____ □ cms
□ feet/inches

Weight: _____ □ kg
□ lbs

Employment Status:
□ Paid Full-Time
□ Paid Part-Time
□ Homemaker
□ Student
□ Unemployed
□ Retired
□ Other

Main Work Activity:
□ Heavy Labour
□ Light Labour
□ Mostly Sitting at a Desk
□ Mostly Standing
□ Mostly Walking or Moving around
□ Driving or Operating a Vehicle

B. COLLISION INFORMATION

Collision Date: Day __ Month __ Year__

Did the collision occur in the course of your work?
□ Yes
□ No

Were you……
□ Occupant of a Car or Van
□ Occupant of a Bus
□ On a Bicycle
□ On a Motorcycle
□ A Pedestrian

From which direction was the main impact to your vehicle?
□ Front
□ Rear
□ Driver Side
□ Passenger Side
□ Do Not Know

Did your vehicle roll over?
□ No
□ Yes
□ Do Not Know

Was the vehicle drivable after the accident?
□ No
□ Yes
□ Do not know

Circle the place where you were seated during the time of the collision:

Front Left (driver)	Front Centre	Front Right (passenger)
Middle Left	Middle Centre	Middle Right
Rear Left	Rear Middle	Rear Right

Was your seat belt fastened?
□ No
□ Yes, lap only
□ Yes, shoulder only
□ Yes, lap and shoulder
□ Not applicable
□ Do not know

Was there a headrest on your seat?
□ No
□ Yes, fixed
□ Yes, adjustable
□ Yes, type unknown
□ Not applicable
□ Do not know

C. GENERAL HEALTH BEFORE COLLISION:

How was your health **before** this collision:
□ Excellent
□ Very good
□ Fair
□ Poor

How often did you have any of the following <u>before</u> this collision?

	Never or almost never	Some-times	Often	Always or almost always
Headache	□	□	□	□
Ache/pain in lower back	□	□	□	□
Ache/pain in neck/shoulder	□	□	□	□
Ache/pain in jaw	□	□	□	□

Have you been injured in a motor vehicle collision **in the past?**
□ No
□ Yes
□ Do not know

If yes, which part(s) of the body were injured?
□ Head/face
□ Neck/shoulder(s)
□ Back
□ Arm(s)
□ Leg(s)
□ Other

D. POST-COLLISON SYMPTOMS

Did you lose consciousness?
□ No
□ Yes
□ Do not know

Did you hit your head?
□ No
□ Yes
□ Do not know

Did you break any bones?
□ No
□ Yes
□ Do not know

ACTIVITIES OF NORMAL LIFE

Name: _____ Date:_____

Please go through the list of activities and use a checkmark to indicate your activities before and after the accident. Describe any limitations.

PHYSICAL ABILITIES:

	Task	Before Accident				After Accident				Limitations (Briefly explain)
		Can Do			Can Not	Can Do			Can Not	
		All	Partially	With Help	Do	All	Partially	With Help	Do	
Personal Care	Bathing / Toilet									
	Grooming									
	Dressing / Undressing									
Mobility	Walking									
	Climbing Stairs									
	Driving									
	Sitting									
	Standing									
Shopping Meals	Groceries / Other									
	Meal Preparation									
	Washing Dishes									
Cleaning	Sweeping									
	Dusting									
	Vacuuming									
	Bed Making									
	Bathrooms									
	Washing Floors									
	Oven									
	Refrigerator									
	Garbage Removal									
Laundry	Washing / Drying									
	Ironing									
Home Maintenance Activities	Grass Cutting/Snow Removal									
	Gardening									

OTHER ABILITIES:

	Task	Before Accident				After Accident				Limitations (Briefly explain)
		Can Do			Can Not	Can Do			Can Not	
		All	Partially	With Help	Do	All	Partially	With Help	Do	
Cognitive Activities	Keeping Appointments									
	Remembering to do Errands									
	Reading and Remembering What you have Read									
	Planning and Organizing Meals or Shopping									
	Remembering and Following Directions									
	Prioritizing Activities									
Controlling Emotion / Behaviour	Relating to Others Without Irritability or Temper									
	Participate in Social Activities									
Communication	Keeping Track of Conversation									

NECK PAIN AND DISABILITY INDEX (Vernon-Mior)

Patient Name: _____ **Date**: _____

This questionnaire has been designed to enable us to understand how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only ***ONE CHOICE*** which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please **just mark the one box which most closely describes your problem right now.**

SECTION 1 – PAIN INTENSITY

- □ I have no pain at the moment.
- □ The pain is very mild at the moment.
- □ The pain is moderate at the moment.
- □ The pain is fairly severe at the moment.
- □ The pain is very severe at the moment.
- □ The pain is the worst imaginable at the moment.

SECTION 2 – PERSONAL CARE

- □ I can look after myself normally without causing extra pain.
- □ I can look after myself normally but it causes extra pain.
- □ It is painful to look after myself and I am slow and careful.
- □ I need some help but manage most of my personal care.
- □ I need help every day in most aspects of self care.
- □ I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 – LIFTING

- □ I can lift heavy weights without extra pain.
- □ I can lift heavy weights but it gives me extra pain.
- □ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned – (eg; on a table).
- □ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- □ I can only lift very light weights.
- □ I cannot lift or carry anything at all.

SECTION 4 – READING

- □ I can read as much as I want to with no pain in my neck.
- □ I can read as much as I want with slight pain in my neck.
- □ I can read as much as I want to with moderate pain in my neck.
- □ I can't read as much as I want because of moderate pain in my neck.
- □ I can hardly read at all because of severe pain in my neck.
- □ I cannot read at all.

SECTION 5 – HEADACHES

- □ I have no headaches at all.
- □ I have slight headaches which come infrequently.
- □ I have moderate headaches which come infrequently.
- □ I have moderate headaches which come frequently.
- □ I have severe headaches which come frequently.
- □ I have headaches almost all of the time.

SECTION 6 - CONCENTRATION

- □ I can concentrate fully when I want to with no difficulty.
- □ I can concentrate fully when I want to with slight difficulty.
- □ I have a fair degree of difficulty in concentrating when I want to.
- □ I have a lot of difficulty in concentrating when I want to.
- □ I have a great deal of difficulty in concentrating when I want to.
- □ I cannot concentrate at all.

SECTION 7 - WORK

- □ I can do as much work as I want to.
- □ I can only do my usual work, but no more.
- □ I can do most of my usual work, but no more
- □ I cannot do my usual work.
- □ I can hardly do any work at all.
- □ I can't do any work at all.

SECTION 8 – DRIVING

- □ I can drive my car without any neck pain.
- □ I can drive my car as long as I want with slight pain in my neck.
- □ I can drive my car as long as I want with moderate pain in my neck.
- □ I can hardly drive at all because of severe pain in my neck.
- □ I can't drive my car at all.

SECTION 9 – SLEEPING

- □ I have no trouble sleeping.
- □ My sleep is slightly disturbed (less than I hour sleepless).
- □ My sleep is mildly disturbed (1-2 hours sleepless).
- □ My sleep is moderately disturbed (2-3 hours sleepless).
- □ My sleep is greatly disturbed (3-5 hours sleepless).
- □ My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10 – RECREATION

- □ I am able to engage in all my recreation activities with no neck pain at all.
- □ I am able to engage in all my recreation activities with some pain in my neck.
- □ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- □ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- □ I can hardly do any recreation activities because of pain in my neck.
- □ I can't do any recreation activities at all.

PAIN SEVERITY SCALE:

Rate the severity of your pain by ***circling*** one number on the following scale.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Excruciating Pain

LOW BACK PAIN AND DISABILITY QUESTIONNAIRE (Revised Oswestry)

Patient Name: _____ **Date:** _____

This questionnaire has been designed to enable us to understand how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only ***ONE CHOICE*** which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just **mark the one box which most closely describes your problem right now.**

SECTION 1 – PAIN INTENSITY

- □ The pain comes and goes and is very mild.
- □ The pain is mild and does not vary much.
- □ The pain comes and goes and is moderate.
- □ The pain is moderate and does not vary much.
- □ The pain comes and goes and is severe.
- □ The pain is severe and does not vary much.

SECTION 2 – PERSONAL CARE

- □ I do not have to change my way of washing or dressing in order to avoid pain.
- □ I do not normally change my way of washing or dressing even though it causes some pain.
- □ Washing and dressing increases the pain, but I manage not to change my way of doing it.
- □ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- □ Because of the pain, I am unable to do some washing and dressing without help.
- □ Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 – LIFTING

- □ I can lift heavy weights without extra pain.
- □ I can lift heavy weights but it gives me extra pain.
- □ Pain prevents me from lifting heavy weights off the floor.
- □ Pain prevents me from lifting off the floor, but I can manage if they are conveniently positioned (e.g.; on a table).
- □ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- □ I can only lift very light weights, at the most.

SECTION 4 – WALKING

- □ Pain does not prevent me from walking any distance.
- □ Pain prevents me from walking more than 1 mile.
- □ Pain prevents me from walking more than ½ mile.
- □ Pain prevents me from walking more than ¼ mile.
- □ I can only walk using a stick or crutches.
- □ I am in bed most of the time and have to crawl to the washroom.

SECTION 5 – SITTING

- □ I can sit in any chair as long as I like without pain.
- □ I can only sit in my favourite chair as long as I like.
- □ Pain prevents me from sitting more than 1 hour.
- □ Pain prevents me from sitting more than ½ hour.
- □ Pain prevents me from sitting more than 10 minutes.
- □ Pain prevents me from sitting at all.

SECTION 6 - STANDING

- □ I can stand as long as I want without pain.
- □ I have some pain while standing, but it does not increase with time.
- □ I cannot stand for longer than 1 hour without increasing pain.
- □ I cannot stand for longer than ½ hour without increasing pain.
- □ I cannot stand for longer than 10 minutes without increasing pain.
- □ Pain prevents me from standing at all.

SECTION 7 - SLEEPING

- □ I get no pain in bed.
- □ I get pain in bed, but it does not prevent me from sleeping well.
- □ Because of pain, my normal nights' sleep is reduced by less than one-quarter.
- □ Because of pain, my normal nights' sleep is reduced by less than one-half.
- □ Because of pain, my normal nights' sleep is reduced by less than three-quarters.
- □ Pain prevents me from sleeping at all.

SECTION 8 – SOCIAL LIFE

- □ My social life is normal and gives me no pain..
- □ My social life is normal, but increases the degree of my pain.
- □ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
- □ Pain has restricted my social life and I do not go out very often.
- □ Pain has restricted my social life to my home.
- □ I have hardly any social life because of the pain.

SECTION 9 – TRAVELLING

- □ I get no pain while traveling.
- □ I get some pain while traveling but none of my usual forms of travel make it any worse.
- □ I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- □ I get extra pain while traveling which compels me to seek alternative forms of travel.
- □ Pain restricts all forms of travel.
- □ Pain prevents all forms of travel except that done lying down.

SECTION 10 – CHANGING DEGREE OF PAIN

- □ My pain is rapidly getting better.
- □ My pain fluctuates, but overall is definitely getting better.
- □ My pain seems to be getting better, but improvement is slow at present.
- □ My pain is neither getting better or worse
- □ My pain is gradually worsening.
- □ My pain is rapidly worsening.

PAIN SEVERITY SCALE:

Rate the severity of your pain by ***circling*** one number on the following scale.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Excruciating Pain

Permission to Disclose Health Information (OCF-5) Use this form for accidents that occur on or after January 1,1994.	
Claim Number	
Policy Number	
Date of Accident (yyyymmdd)	

Part 1 Applicant Information

Last Name	First Name and Initial	Date of Accident	Year Month Day
Address			
City	Province		Postal Code

Birth Date	Year Month Day	Home Telephone	Area Code ( )	Work Telephone	Area Code ( )

Part 2 Insurance Company Information

Name of Insurance Company					
Name of Insurance Company Representative			Title		
Address				City	
Province	Postal Code	Telephone Number		Fax Number	

Part 3 Treating Health Professional

Name of Health Professional					
Address				City	
Province	Postal Code	Telephone Number		Fax Number	

Part 4 Signature

I authorize my treating health profession to collect, use and disclose to my insurer, any information relating to my health condition and treatment received as a result of the automobile accident and any pre-existing health conditions that may be a barrier to my recovery as a result of the automobile accident, for the purpose of providing treatment and determining my eligibility for benefits. This authorization is valid one year from the date this form is signed.

Name of applicant or substitute decision maker (Print)	Signature of applicant or substitute decision maker	Date (YYYY/MM/DD)

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MOTOR VEHICLE ACCIDENT (MVA) INSURANCE FEE SCHEDULE, PAYMENT OPTIONS AND BILLING PROCEDURES

We at the Westney Heights Chiropractic Centre understand that the paperwork involved in a MVA claim is enormous. Our aim with this document is to help you understand the billing and payment process associated with your claim.

Please review the following MVA fee schedule.

MVA Assessment Fee		$215.00
MVA Treatment Plan		$70.00
MVA Disability Certificate		$70.00
Subsequent Visits:	Adjustment	$60.00
	Acupuncture or Laser	$60.00
	Combined Intensive Treatment	$95.00
	Massage Therapy (1 hour)	$95.00
Assessment and Discharge		$85.00
Reassessments		$85.00

We have two payment options for fees incurred due to your motor vehicle accident. These options include; billing fees directly to your insurance companies for you (our preferred method) **OR** paying fees directly yourself as they arise.

If you choose to have us bill for you directly, we will do our part to ensure that your insurance companies pay for all eligible MVA fees. Please understand that this can be a somewhat complex and time-consuming process. Therefore, it is important that we have your full understanding and full cooperation to achieve our goal. Please read the following information and instructions **carefully**. If you have any questions now or in the future please do not hesitate to ask. You will be asked to sign a statement at the end of this page to confirm your understanding.

1. In order to be eligible for payment for injuries by your MVA insurance company you must return to your MVA insurance company your **completed MVA package within 30 days of the date of accident**. This package can be obtained from your insurance company directly.

2. **In order to bill your MVA Insurance company for the fees above we must first exhaust any private Extended Health Care (EHC) plans carried by you, your significant other or your guardians.** Once exhausted we can then direct the remaining outstanding balance to your MVA Insurance company. Please be aware that each EHC plan is unique to each place of employment regardless of the insurance carrier, and, due to the Canada Privacy Act, EHC insurance companies will not deal with us directly. This makes it difficult for us to determine your coverage for the services above and bill them efficiently without your full and timely cooperation. The completion of the following steps will aid the billing process.
   a) **Completely fill out all the information on the insurance page (page 1) of the MVA information package.** Promptly provide us with any insurance information you do not have access to today.
   b) **Sign EHC insurance forms** to allow us to bill your EHC insurance company directly for you.

c) If your EHC plan accepts direct payment to us, **sign a letter allowing us to have the insurance cheque sent directly to us**, in our name.

d) If your EHC plan will only issue a cheque directly to you, **upon receiving this cheque, promptly <u>bring the EHC statement and payment in the full amount</u> as stated on the cheque to us. W**e cannot accept endorsed MVA cheques. We accept VISA, Master Card, Debit, personal cheque or cash.

e) **Promptly notify us of any billing or payment problems as you become aware of them.** Any reasons for rejection of payment by your EHC plan will be listed on the statement attached to your cheque. This is important information for prompt correction or redirection to your MVA insurance company.

3. In order **to be eligible for coverage for massage therapy treatment most EHC plans require a medical doctor's diagnosis and recommendation for treatment.** Please inquire about this requirement and make arrangements to obtain a note from your medical doctor if necessary.

If you choose to pay directly, the payment will be due at the time each treatment or service is rendered. We accept VISA, Master Card, personal cheque, debit and cash. You then submit your receipts to your insurance companies (EHC plan and MVA insurance plan) on your own.

Please note that if for any reason your MVA Insurance Company denies your claim you will be held directly responsible for all MVA fees for any treatments or services incurred as listed above.

I fully understand the information above and agree to the terms as described.

_____ _____

Patient (Print full name) Signature

_____ _____

Witness (Print) Signature

_____

Date