physiomobility HEALTH GROUP
6 Maginn Mews, Suite 211 Toronto, ON M3C 0G9
Phone: 416-444-4800 | Fax: 416-444-4811
www.physiomobility.com | reception@physiomobility.ca

MVA INTAKE FORM

Patient ID: _____ (For Office Use)

PATIENT INFORMATION

Date: _____

Last Name: _____ First Name: _____

Date of Birth (mm/dd/yyyy): _____

Date of Accident (mm/dd/yyyy): _____

PRIVATE INSURANCE INFORMATION

The laws in Ontario require that all invoices related to your treatments for injuries sustained in a motor vehicle accident be submitted to your private/employer health insurance provider(s) if available.

PRIMARY PRIVATE INSURANCE INFORMATION (SELF)

Insurance Company: _____

Policy / Group #: _____ ID/Certificate No.: _____

Policy Holder's Name (if different from patient): _____

Policy Holder's D.O.B: _____

SECONDARY PRIVATE INSURANCE INFORMATION (SPOUCE)

Insurance Company: _____

Policy / Group #: _____ ID/Certificate No.: _____

Policy Holder's Name: _____

Policy Holder's D.O.B: _____

AUTO INSURANCE INFORMATION

Insurance Company: _____

Policy #: _____ Claim #: _____

Address: _____

Policy Holder's Name (if different from patient): _____

Policy Holder's D.O.B: _____ Adjuster: _____

Phone #: _____ Fax #: _____

E-mail: _____

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LEGAL REPRESENTATIVE

Company: _____

Legal Representative`s Name: _____

Address: _____ City: _____

Province: _____ Postal Code: _____

Phone #: _____ Fax #: _____

E-mail: _____

- ✓ I hereby authorize Physiomobility to collect and release medical records, copies of treatment plans and financial and any other information related to my MVA claim to above mentioned legal representative and third party payers (Private Insurance payer & Car Insurance).
- ✓ I understand that I am legally responsible for providing Physiomobility Health Group with all information for my claim including any updates.
- ✓ I direct all third party payers to pay Physiomobility directly for fees related to services provided for my injuries to this claim.
- ✓ In the event of any settlement or agreement with insurance company, I will ensure all the unpaid services at Physiomobility Health Group for my injuries are paid in full including any interest. I understand that I will remain responsible for any unpaid balance.

Patient's Name: _____

Patient/ Guardian's Signature (Printed name serves as signature): _____

Date: _____

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