Motor Vehicle Accident Clients

In order for EPA to assist you with your MVA billing, we need to gather some specific information. The "no fault" insurance act in Ontario dictates the method of billing. As of September 1st, 2010 new legislation dictates the amount of medical coverage you have available. You should contact your insurance company for this information and let the clinic know the details of your coverage.

By law you are required to use your extended health benefits **prior** to billing your car insurance for physiotherapy services. When you receive your invoices from EPA you must promptly submit them to your extended health benefits company. Then, upon receipt of payment, you need to return this payment to the clinic as well as the attached explanation of benefits. The clinic will apply your extended health benefit payment to your account and then bill your car insurance company directly for any balance owing.

If you have received a monetary settlement for the MIG program from your motor vehicle company, please inform the receptionist of this immediately so we can pursue the appropriate actions.

Do you have extended health insurance? If yes, please complete the following:
Extended Health Ins Company's Name: _____
Plan/Policy #:_____
Name of Plan Member:_____

Please complete the following, so we have your accurate accident information:
Date of Accident: _____
Company Name: _____
Address: _____
Name of Policy Holder: _____ Policy #/Claim #: _____
Contact Person: _____
Phone # _____ Fax #:_____

PERMISSION TO DISCLOSE HEALTH INFORMATION

Client Name: _____ Date of Birth: _____
Address: _____ Phone #: _____

I hereby authorize my treating health professional to disclose any requested medical information to my Insurance Company / Disability/Rehabilitation Representative / Employer / Lawyer or their representative. I further authorize my health professional to seek and acquire information relating to previous treatments and information for said injury. I also authorize my health professional to disclose to any of the above listed groups and/or individuals any pre-existing health conditions that may be a barrier to my recovery. I understand that this information will be used to determine my eligibility for benefits.

I have read all of the above and agree to be treated and adhere to the above.

_____
Client's name **Date (MM/DD/YY): ____/____/____**