

# CHIROPRACTIC MVA FORM



## PERSONAL INJURY – PATIENT DATA FORM

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

1. Date of Accident: \_\_\_\_\_
2. Time: \_\_\_\_\_ ( AM / PM )
3. Driver of Vehicle: \_\_\_\_\_
4. Where were you seated? \_\_\_\_\_
5. Who owns the car? \_\_\_\_\_
6. Year/Model of the car? \_\_\_\_\_
7. What was the approximate cost of damage done to your vehicle? \$ \_\_\_\_\_
8. Visibility at the time of accident:  Poor  Fair  Good  Other  
Please describe: \_\_\_\_\_
9. Road conditions at time of the accident:  Icy  Rainy  Wet  Clear  Other  
Please describe: \_\_\_\_\_
10. Where was your car struck?  Right  Left  Rear  Front  Side  Other  
Please describe: \_\_\_\_\_
11. Type of accident:
 

<input type="radio"/> Head-on collision	<input type="radio"/> Broad-side collision
<input type="radio"/> Rear-end collision	<input type="radio"/> Front impact, rear-ended car in front collision
<input type="radio"/> Non-collision (please describe: _____)	
12. Describe in your own words what happened to you on impact:  
\_\_\_\_\_
13. Did you see the accident coming? ( YES / NO )  
If yes, did you brace for the accident? ( YES / NO )
14. Were seat belts worn? ( YES / NO )
15. Were shoulder harnesses worn? ( YES / NO )
16. Does your car have headrests? ( YES / NO )  
If yes, what was the position of those headrests compared to your head before the accident?  
 Top of headrest even with bottom of head  
 Top of headrest even with top of head  
 Top of headrest even with the middle of neck
17. Was the car braking? ( YES / NO )
18. Was your car moving at the time of the accident? ( YES / NO )  
If yes, how fast would you estimate you were going? \_\_\_\_\_ (km/hour)
19. How fast was the other vehicle traveling? \_\_\_\_\_ (km/hour)
20. Head/Body position at the time of impact:
 

<input type="radio"/> Head turned to the left/right	<input type="radio"/> Body straight in the sitting position
<input type="radio"/> Head looking back	<input type="radio"/> Body rotated left/right
<input type="radio"/> Head straight forward	<input type="radio"/> Other: _____

FULL NAME: \_\_\_\_\_

21. At the time of the accident, recall what parts of your head or body hit parts of the inside of your car. Please specify: \_\_\_\_\_  
\_\_\_\_\_

22. As a result of the accident were you:

Rendered unconscious     Dazed, circumstances vague     Other: \_\_\_\_\_

23. Could you move all parts of your body? ( YES / NO )

If no, what parts and why?  
\_\_\_\_\_

24. Were you able to get out of the car and walk unaided? ( YES / NO )

If no, why not? \_\_\_\_\_

25. What bleeding cuts did you get from the accident? \_\_\_\_\_

26. What bruises did you get from the accident? \_\_\_\_\_

27. Please describe how you felt (be specific):

**Immediately after the accident:** \_\_\_\_\_  
\_\_\_\_\_

**Later that \_\_\_\_\_ Day \_\_\_\_\_ Night:** \_\_\_\_\_  
\_\_\_\_\_

**The next \_\_\_\_\_ Day \_\_\_\_\_ Night:** \_\_\_\_\_  
\_\_\_\_\_

28. Check symptoms that are apparent since the accident:

- |                                     |   |  |
|-------------------------------------|---|--|
| <input type="radio"/> Anxious       | <input type="radio"/> Eyes sensitive to light | <input type="radio"/> Neck pain/stiffness  |
| <input type="radio"/> Chest pain    | <input type="radio"/> Fainting                | <input type="radio"/> Nervousness          |
| <input type="radio"/> Cold feet     | <input type="radio"/> Fatigue                 | <input type="radio"/> Numbness in fingers  |
| <input type="radio"/> Cold hands    | <input type="radio"/> Headache                | <input type="radio"/> Numbness in toes     |
| <input type="radio"/> Cold sweats   | <input type="radio"/> Irritability            | <input type="radio"/> Pain behind eyes     |
| <input type="radio"/> Constipation  | <input type="radio"/> Loss of balance         | <input type="radio"/> Ringing/buzzing ears |
| <input type="radio"/> Depression    | <input type="radio"/> Loss of memory          | <input type="radio"/> Shortness of breath  |
| <input type="radio"/> Diarrhea      | <input type="radio"/> Loss of smell           | <input type="radio"/> Sleeping problems    |
| <input type="radio"/> Dizziness     | <input type="radio"/> Loss of taste           | <input type="radio"/> Tension              |
| <input type="radio"/> Mid back pain | <input type="radio"/> Low back pain           |  |
| <input type="radio"/> Other: _____  |   |  |

29. Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

30. Have you missed time from work? ( YES / NO )

If yes, Full-time off work: dates \_\_\_\_\_ to \_\_\_\_\_

Part-time off work: dates \_\_\_\_\_ to \_\_\_\_\_

31. Have you been unable to work since the accident? ( YES / NO )

32. Did you seek medical help immediately/soon after the accident? ( YES / NO )

33. If yes, how did you get there?

Drove own car     Someone else drove me     Ambulance     Police     Other: \_\_\_\_\_

FULL NAME: \_\_\_\_\_

34. **Doctor 1/Hospital/Clinic seen:** \_\_\_\_\_ **Date:** \_\_\_\_\_

35. Were you examined? ( YES / NO )

36. Were x-rays taken? ( YES / NO )

If yes, of what body parts? \_\_\_\_\_

37. What treatment was given to you?

Adjustment

Brace

Physiotherapy

Bed rest

Medications

Other: \_\_\_\_\_

38. What benefits did you receive from the treatment?

\_\_\_\_\_  
\_\_\_\_\_

39. Date of last treatment: \_\_\_\_\_

40. **Doctor 2/Hospital/Clinic seen:** \_\_\_\_\_ **Date:** \_\_\_\_\_

41. Were you examined? ( YES / NO )

42. Were x-rays taken? ( YES / NO )

If yes, of what body parts? \_\_\_\_\_

43. What treatment was given to you?

Adjustment

Brace

Physiotherapy

Bed rest

Medications

Other: \_\_\_\_\_

44. What benefits did you receive from the treatment?

\_\_\_\_\_  
\_\_\_\_\_

45. Date of last treatment: \_\_\_\_\_

46. **Doctor 3/Hospital/Clinic seen:** \_\_\_\_\_ **Date:** \_\_\_\_\_

47. Were you examined? ( YES / NO )

48. Were x-rays taken? ( YES / NO )

If yes, of what body parts? \_\_\_\_\_

49. What treatment was given to you?

Adjustment

Brace

Physiotherapy

Bed rest

Medications

Other: \_\_\_\_\_

50. What benefits did you receive from the treatment?

\_\_\_\_\_  
\_\_\_\_\_

51. Date of last treatment: \_\_\_\_\_

52. Did you have any physical complaints ***just before the accident?*** ( YES / NO )

If yes, please explain in detail: \_\_\_\_\_

53. ***Prior*** to this accident, have you ***ever*** had symptoms similar to what you're experiencing now?  
( YES / NO )

If yes, please explain in detail: \_\_\_\_\_

*(briefly include past falls, injuries, motor vehicle accidents, operations... etc.)*

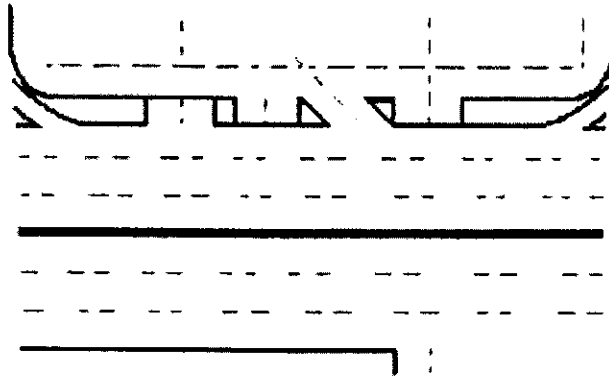
FULL NAME: \_\_\_\_\_

54. Do you notice any activities of your home daily routine which are different **now** than from **before** the accident? ( YES / NO )

If yes, list them as:

- a. Those you are **unable** to do: \_\_\_\_\_
- b. Those that are **painful** to do: \_\_\_\_\_
- c. Those that are **difficult** to do: \_\_\_\_\_

55. Indicate on this diagram how the accident occurred:



56. Do you have an attorney on this case? ( YES / NO )

Name/Firm: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

\_\_\_\_\_  
(PATIENT SIGNATURE) (DATE)

**AUTOMOBILE ACCIDENT**

**1. Patient's insurance company information**

Company name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Policy #: \_\_\_\_\_ Adjustors name: \_\_\_\_\_

**2. Insured's insurance information**

Insured's name if other than patient: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Policy #: \_\_\_\_\_ Adjustors name: \_\_\_\_\_

**3. Other driver's insurance information**

Other driver's name (if another car was involved): \_\_\_\_\_

Company name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Policy #: \_\_\_\_\_ Adjustors name: \_\_\_\_\_

**MVA / WCB Symptom Checklist**  
**History (Patient/Claimant to Complete)**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**1. Symptom Checklist**

*For each symptom, check YES (if present) or NO (if not present), and rate severity on a scale of 0 to 10 where indicated 0 is "No Pain" and 10 is "Pain as Bad as it Could Be."*

**Neck or shoulder pain**       YES       NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

**Upper or Mid-back pain**       YES       NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

**Low back pain**       YES       NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

**Headache**       YES       NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

**Pain in Arm(s)**       YES       NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

**Pain in Hand(s)**       YES       NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

**Pain in Face or Jaw**       YES       NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

**Pain in Leg(s)**       YES       NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

**Pain in Foot/Feet**       YES       NO

No Pain

Pain as Bad  
as Could Be

0	1	2	3	4	5	6	7	8	9	10
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**Pain in Abdomen or Chest**    YES       NO

No Pain

Pain as Bad  
as Could Be

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

**Feeling of numbness, tingling in arms or hands**       YES       NO

**Feeling of numbness, tingling in legs or feet**       YES       NO

**Dizziness or unsteadiness**       YES       NO

**Vision problems**       YES       NO

**Hearing problems**       YES       NO

**Anxiety or worry**       YES       NO

**Nausea or vomiting**       YES       NO

**Difficulty swallowing**       YES       NO

**Problems concentrating**       YES       NO

2.    **Loss of consciousness**       YES       NO

3.    **Have the injuries prevent you from carrying out any of the following:**

Explain

- Daily home activities
- Employment
- Schooling
- Sports or recreation
- Other

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4.    **Do you think your injury will:**

- get better soon
- get better slowly
- never get better
- don't know

## Neck Pain And Disability Index (Vernon-Mior)

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please read instructions:**

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in every day life. Please answer every section and mark in each section only the **ONE** box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.

<p><b>SECTION 1 – PAIN INTENSITY</b></p> <p><input type="checkbox"/> I have no pain at the moment.</p> <p><input type="checkbox"/> The pain is very mild at the moment.</p> <p><input type="checkbox"/> The pain is moderate at the moment.</p> <p><input type="checkbox"/> The pain is fairly severe at the moment.</p> <p><input type="checkbox"/> The pain is very severe at the moment.</p> <p><input type="checkbox"/> The pain is the worst imaginable at the moment.</p> <p><b>SECTION 2 – PERSONAL CARE (Washing, Dressing, etc)</b></p> <p><input type="checkbox"/> I can look after myself normally without causing extra pain.</p> <p><input type="checkbox"/> I can look after myself normally but it causes extra pain.</p> <p><input type="checkbox"/> It is painful to look after myself and I am slow and careful.</p> <p><input type="checkbox"/> I need some help but manage most of my personal care.</p> <p><input type="checkbox"/> I need help every day in most aspects of self-care.</p> <p><input type="checkbox"/> I do not get dressed, I wash with difficulty and stay in bed.</p> <p><b>SECTION 3 – LIFTING</b></p> <p><input type="checkbox"/> I can lift heavy weights without extra pain.</p> <p><input type="checkbox"/> I can lift heavy weights but it causes extra pain.</p> <p><input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on the table.</p> <p><input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.</p> <p><input type="checkbox"/> I can lift very light weights.</p> <p><input type="checkbox"/> I cannot lift or carry anything at all.</p> <p><b>SECTION 4 – READING</b></p> <p><input type="checkbox"/> I can read as much as I want to with no pain in my neck.</p> <p><input type="checkbox"/> I can read as much as I want to with slight pain in my neck.</p> <p><input type="checkbox"/> I can read as much as I want to with moderate pain in my neck.</p> <p><input type="checkbox"/> I can't read as much as I want because of moderate pain in my neck.</p> <p><input type="checkbox"/> I can hardly read at all because of severe pain in my neck.</p> <p><input type="checkbox"/> I cannot read at all.</p> <p><b>SECTION 5 – HEADACHES</b></p> <p><input type="checkbox"/> I have no headaches at all.</p> <p><input type="checkbox"/> I have slight headaches which come infrequently.</p> <p><input type="checkbox"/> I have moderate headaches which come infrequently.</p> <p><input type="checkbox"/> I have moderate headaches which come frequently.</p> <p><input type="checkbox"/> I have severe headaches which come frequently.</p> <p><input type="checkbox"/> I have headaches almost all the time.</p>	<p><b>SECTION 6 – CONCENTRATION</b></p> <p><input type="checkbox"/> I can concentrate fully when I want to with no difficulty.</p> <p><input type="checkbox"/> I can concentrate fully when I want to with slight difficulty.</p> <p><input type="checkbox"/> I have fair degree of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> I have a lot of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> I have a great deal of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> I cannot concentrate at all.</p> <p><b>SECTION 7 – WORK</b></p> <p><input type="checkbox"/> I can do as much work as I want to.</p> <p><input type="checkbox"/> I can only do my usual work, but no more.</p> <p><input type="checkbox"/> I can do most of my usual work, but no more.</p> <p><input type="checkbox"/> I cannot do my usual work.</p> <p><input type="checkbox"/> I can hardly do any work at all.</p> <p><input type="checkbox"/> I can't do any work at all.</p> <p><b>SECTION 8 – DRIVING</b></p> <p><input type="checkbox"/> I can drive my car without any neck pain.</p> <p><input type="checkbox"/> I can drive my car as long as I want with slight pain in my neck.</p> <p><input type="checkbox"/> I can drive my car as long as I want with moderate pain in my neck.</p> <p><input type="checkbox"/> I can't drive my car as long as I want because of moderate pain in my neck.</p> <p><input type="checkbox"/> I can hardly drive at all because of severe pain in my neck.</p> <p><input type="checkbox"/> I can't drive my car at all.</p> <p><b>SECTION 9 – SLEEPING</b></p> <p><input type="checkbox"/> I have no trouble sleeping.</p> <p><input type="checkbox"/> My sleep is slightly disturbed (less than 1 hr. sleepless).</p> <p><input type="checkbox"/> My sleep is mildly disturbed (1-2 hrs. sleepless).</p> <p><input type="checkbox"/> My sleep is moderately disturbed (2-3 hrs. sleepless).</p> <p><input type="checkbox"/> My sleep is greatly disturbed (3-5 hrs. sleepless).</p> <p><input type="checkbox"/> My sleep is completely disturbed (5-7 hrs. sleepless).</p> <p><b>SECTION 10 – RECREATION</b></p> <p><input type="checkbox"/> I am able to engage in all my recreation activities with no neck pain at all.</p> <p><input type="checkbox"/> I am able to engage in all my recreation activities, with some pain in my neck.</p> <p><input type="checkbox"/> I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.</p> <p><input type="checkbox"/> I am able to engage in a few of my usual recreation activities because of pain in my neck.</p> <p><input type="checkbox"/> I can hardly do any recreation activities because of pain in my neck.</p> <p><input type="checkbox"/> I can't do any recreation activities at all.</p>
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**Pain Scale (Rate the severity of your pain by checking one box on the following scale):**

<b>No Pain</b>						<b>Excruciating Pain</b>				
<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>

## Low Back Pain And Disability Questionnaire (Revised Oswestery)

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please read instructions:**

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in every day life. Please answer every section and mark in each section only the **ONE** box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.

**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 comes and goes and is severe.
- The pain is severe and does not vary much.

**SECTION 2- PERSONAL CARE**

- I would 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 pain.
- Washing and dressing increases the pain but I manage not 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 causes extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on the 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**

- I have no pain when walking.
- I have some pain when walking but it does not increase with distance.
- I cannot walk more than one km. without increasing pain.
- I cannot walk more than ½ km. without increasing pain.
- I cannot walk more than ¼ km. without increasing pain.
- I cannot walk at all without increasing pain.

**SECTION 5 – SITTING**

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more then one hour.
- Pain prevents me from sitting more then a half hour.
- Pain prevents me from sitting more then 10 minutes.
- I avoid sitting because it increases pain immediately.

**SECTION 5 – STANDING**

- I can stand as long as I want without pain.
- I experience some pain while standing but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer then ½ hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain immediately.

**SECTION 7 – SLEEPING**

- I experience no pain in bed.
- I experience pain in bed but it does not prevent me from sleeping well.
- Because of pain my normal night's sleep is reduced by less than ¼.
- Because of pain my normal night's sleep is reduced by less than ½.
- Because of pain my normal night's sleep is reduced by less than ¾.
- 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 pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests (i.e. 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 – TRAVELING**

- I experience no pain while traveling.
- I experience some pain while traveling but none of my usual forms of travel make it any worse.
- I experience extra pain while traveling but it does not compel me to seek alternative forms of travel.
- I experience 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 nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

**Pain Scale (Rate the severity of your pain by checking one box on the following scale):**

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



## **Alberta Accident Benefits Initial Claims Process**

### **Overview**

If you have been injured in an automobile accident in Alberta, you are entitled to accident benefits coverage regardless of whether you were at fault for the accident. The benefits you receive depend on the type of injury you have:

- If your injury is a sprain, strain or a whiplash associated with disorder I or II, your Primary Health Care Practitioner (chiropractor, physician or physical therapist) does not have to seek approval of the insurer for payment for treatment of these injuries **if you provide notice of your claim**. Your Primary Health Care Practitioner will be able to bill the automobile insurer for all treatment services outlined in the Diagnostic and Treatment Protocols Regulation (DTPR) that are not covered by Alberta Health Care Insurance. These protocols have been developed in consultation with Primary Health Care Practitioners and are based on the best research and evidence currently available.
- For all other injuries, if you choose not to follow the DTPR, you will need to pay health service providers for any services not covered by Alberta Health Care Insurance. You will be reimbursed for eligible expenses from your extended health care benefits (e.g., Blue Cross or similar employee benefits plan) and then by your automobile insurer.

### **What to do if you are injured in an Automobile Accident:**

1. **See a Primary Health Care Practitioner** as soon as possible for an assessment of your injury and, if needed, treatment advice.
2. **File an injury accident report with the police.**
3. **Complete the attached Notice of Loss and Proof of Claim Form (AB-1 Form)**, retain a copy for your records and send the original signed form(s) to the insurer of the vehicle you were in at the time of the accident (insurance company). If you are unable to send the form within the following timeframes, submit it to the insurance company as soon as practicable and explain the reason for the delay.
  - If your injury is diagnosed as a sprain, strain or whiplash associated disorder I or II, submit this form within 10 business days of the accident so that you can access accident benefits described in the DTPR.
  - If you have other types of injuries, or you choose not to access the accident benefits described in the DTPR, submit the form within 30 days of the accident.
  - If you have other types of injuries, or you choose not to access the accident benefits described in the DTPR, submit the form within 30 days of the accident.
4. **You will be contacted** about the benefits you are entitled to receive after the insurance company reviews your completed form. If the insurance company needs any additional information in order to process your application, they will contact you.

**If you have further questions about this form, the process or your benefits, please contact your claims adjuster. If you do not know who your claims adjuster is, contact the insurance company or the Insurance Bureau of Canada at 1-800-377-6378.**

## **Important Notice Concerning Your Personal Information**

The personal information you provide in forms AB-1, AB-1A (Claim for Disability Benefits) or AB-2 (Treatment Plan) is collected under the authority of Alberta's *Insurance Act*, Automobile Insurance Accident Benefits Regulations, Diagnostic and Treatment Protocols Regulation and all applicable privacy legislation.

- Your Primary Health Care Practitioner or dentist will need to collect personal information from you and from other health service providers and will need to use and disclose your personal information to provide you with appropriate diagnosis, treatment and care.
- The insurance company and its agents will need to collect, use and disclose personal information from you, your Primary Health Care Practitioner, and other health service providers concerning the accident, your injuries, any pre-existing conditions that may impede your recovery progress, the amount of treatment and care provided to you, and any assessments of your injuries and indications as to your treatment progress in order to facilitate contact with you, to determine your eligibility for accident and/or disability income benefits, and to administer your claim.

Under applicable privacy legislation, it is necessary to obtain your consent to authorize the sharing of your personal information as specified above. The legislation also regulates how Primary Health Care Practitioners, dentists, other health service providers, and insurance companies can use and disclose your information once they have it. Parts 5 and 6 of form AB-1 will ask for your consent or that of your Authorized Representative. Refusal to provide your authorization and consent could result in an inability to provide you with the treatment and care you require (if not covered by Alberta Health Care Insurance) and may result in an inability for the insurance company to process your claim, in whole or in part.

Your Primary Health Care Practitioner, dentist or other health service provider and the insurance company will retain and rely on a copy of your consent for the period of time that your treatment and care is ongoing and your claim is active. You may revoke your consent at any time in writing to your Primary Health Care Practitioner or dentist and the insurance company or any other person to whom you give consent, subject to continuing legal obligations. If you have any questions concerning the collection, use or disclosure of your personal information, please ask your Primary Health Care Practitioner, dentist, or your insurance claims representative or adjuster.



# Notice of Loss and Proof of Claim (Form AB-1)

This form is effective on November 20, 2004 for accidents that occur on or after October 1, 2004.

## Part 1: Claimant Information

Last Name		First Name		Middle Name(s)	
Mailing Address			City or Town		
Province	Country	Postal Code	Email Address		
Telephone Number (Home)	Telephone Number (Work)	Telephone Number (Cell)	Date of Birth (dd-mm-yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
You can best be reached: <input type="checkbox"/> at home/cell <input type="checkbox"/> at work <input type="checkbox"/> other (personal visit/email): _____					
When is the best time to reach you (include days of the week)?			Will this be an Alberta Worker's Compensation Board Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are Extended Health Care Benefits Available? (e.g. Blue Cross or similar Employee benefit plans)		Provide details (including plan name):			
<input type="checkbox"/> Yes <input type="checkbox"/> No					
Are you currently employed or engaged in training activities?					
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal (provide job and title): _____					
<input type="checkbox"/> Self-employed <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Not employed					

**If you are making a claim for disability benefits, please also complete Form AB0001a.**

## Part 2: Claimant's Authorized Representative Information (if applicable)

Last Name		First Name		Middle Name(s)	
Mailing Address					
City or Town		Province	Country	Postal Code	
Telephone Number (Home)	Telephone Number (Work)	Telephone Number (Cell)	Fax Number		
Relationship with Claimant <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> other: _____					
Relevant Documentation Attached? <i>If no, please authorize your Authorized Representative by completing Part 5 of this form.</i> <input type="checkbox"/> Yes <input type="checkbox"/> No					

**Part 3: Claimant's Accident Details** (if more space is required please continue on back side of this page)

You were a			
<input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other: _____			
Location of Accident			
City or Town		Province	Country
Date of Accident (dd-mm-yyyy)	Time of Accident _____ : _____	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Was the accident reported to the police? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide a brief description of how the accident occurred and how you were injured.			
Have you seen a Physician, Physical Therapist, Chiropractor, Dentist or other health service provider for diagnosis, treatment and/or care for an injury related to this accident? <input type="checkbox"/> Yes <input type="checkbox"/> No    Appointment was/is booked for: _____			
Have you started treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No    Appointment was/is booked for: _____			
Are you currently receiving medical or rehabilitation benefits related to another motor vehicle accident? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please provide a brief description of your injuries and the symptoms that you are currently experiencing.			

**Part 4: Information of Health Provider Providing Ongoing Treatment and Care**

Full Name of Primary Health Care Practitioner or Dentist		Profession
Mailing Address		
City or Town	Province	Country
Telephone Number	Fax Number	

**Part 5: Authority to Act on Claimant's Behalf**

*This section should be completed only when the claimant chooses not to act on his/her own behalf.*

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_  
to act as my Authorized Representative concerning the treatment and care of my injury, the submission and ongoing handling of my claim for accident and/or disability income benefits and the collection, use and disclosure of information concerning my injury, diagnosis, assessment, treatment or care resulting from the automobile accident referred to in Parts 1 through 4 of this form.

I authorize my Primary Health Care Practitioner(s), dentist(s), other health service provider(s) and the insurance company,

and their agents, to collect relevant information concerning me and my accident from my Authorized Representative as required. I further authorize Primary Health Care Practitioner(s), dentist(s), other health service provider(s) and the insurance company to disclose relevant information concerning my injury, diagnosis, assessment, treatment and care and my claim for accident and/or disability income benefits to my Authorized Representative.

_____ Date (dd-mm-yyyy)	_____ Signature of Claimant
_____ Date (dd-mm-yyyy)	_____ Signature of Authorized Representative

**Part 6: Certification and Consent to Share Information**

*To be completed by claimant or their Authorized Representative.*

I certify that the information provided is true and correct to the best of my knowledge.

I authorize all assessing or treating Primary Health Care Practitioners, dentist(s) or other health service provider(s) to collect, use and disclose any relevant information concerning my injury, including diagnosis, assessment, treatment or care resulting from the automobile accident referred to in Parts 1 through 4 herein, for the purpose of providing ongoing treatment and care.

I further authorize all assessing or treating Primary Health Care Practitioners, dentist(s) or other health service providers to disclose my personal information to the insurance company, \_\_\_\_\_

and their agents that is relevant for the purpose of determining my eligibility for accident and disability benefits as outlined on Form AB-1 and for the purpose of administering my claim.

I further authorize the insurance company and its agents to collect, use and disclose relevant information concerning my injury, diagnosis, assessment, treatment or care received as a result of the automobile accident referred to in Parts 1 through 4 herein, including a treatment plan and services provided, for the purpose of determining my eligibility for accident and disability benefits as outlined on Form AB-1 and administering my claim.

I am the claimant, OR  I am the Authorized Representative of the claimant.

_____ Name	_____ Date (dd-mm-yyyy)	_____ Signature
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This Section to be Completed by Insurer		
Insurance Company	Policy Number	
Date of Accident (dd-mm-yyyy)	Full Name of Claims Representative	Claim Number

**Please forward this form to the Insurance Company.**





## Beacon Hill Chiropractic and Massage

### Payment Authorization Regarding MVA Claims

Please note, on rare occasions, insurance companies do not authorize claims. If your insurance company does not authorize any part of your claim, it is your responsibility as our patient to pay for your chiropractic/massage/acupuncture treatments and any related rehabilitative products or supplements.

As well, if appointments are cancelled or an appointment is missed without 24-hours notice, you will be charged a cancellation fee.

Name: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Name: \_\_\_\_\_ Witness Signature: \_\_\_\_\_

MVA claim number: \_\_\_\_\_