11685 Yonge St. Unit A106 Richmond Hill, ON L4E 0K7
Tel: 905-237-7174
Fax:905-237-7184

MVA INTAKE

Date:___ /___ /_____

______________________________ ______________________________ D.O.B:____ /____ /______

Last name First name

Date of Accident: (D/M/Y): _____ /_____ /_________

PRIVATE INSURANCE INFORMATION

Insurance Company: ____

Policy/group: ______________________________ I.D./Certificate #: ______________________

Policy holder's name: ____________________________ Policy holder's D.O.B:___ /___ /_____

AUTO INSURANCE INFORMATION

Insurance company: ____

Policy #: ______________________________ Claim #: ______________________________

Policy holder`s name: ____________________________ Policy holder's D.O.B. (D/M/Y):______________

Adjuster: ______________________________ Phone: ______________________________

Fax: ______________________________

LEGAL REPESENTATIVE

Company: ______________________________ Legal Representative`s Name: ________________

Address: ______________________________ City: ____________________ Province: _________

Postal Code: ______________________________ Phone: ______________________________

Fax: ______________________________

- ❖ I hereby authorize Premier Care Physiotherapy to collect and release medical records and other information related to my claim to above mentioned legal representative and third party payers.
- ❖ I understand that I am legally responsible for providing Premier Care Physiotherapy with all information for my claim including any updates.
- ❖ I direct all third party payers to pay Premier Care Physiotherapy directly for fees related to services provided for my injuries to this claim.
- ❖ In the event of any settlement with insurance company, I will ensure all the unpaid services at Premier Care Physiotherapy for my injuries are paid in full including any interest. I understand that I will remain responsible for any unpaid balance.

______________________________ ______________________________

Patient/ Guardian's name (*Please Print*) Signature