Accident Benefits: Please note according to the Financial Services Commission of Ontario (FSCO) the regulatory body for Motor vehicle insurance companies, ALL automobile accidents involving bodily injury must be reported to the police. Claims for certain accident benefits must be made within 7 days. Please contact your adjuster for further information.

AUTHORIZATION FOR ACTING UPON

Date:______________________________

To Whom It May Concern:

I hereby authorize Taylor Creek Chiropractic to act on my behalf to deal with the appropriate claims caused by the automobile accident on: ____

Patient Name (print): _____________________________**DOB:** _______________________

Patient Signature: ____

Name of Auto Insurance Co: _________________________________

Name of Insurance Adjuster:_________________________________

Claim Number: ____

Policy Number: ____

You will need to complete the **Application for Accident Benefits OCF-1** when you are applying **for the first time** as a result of an accident, including if you are applying for income replacement benefits.

Additionally, the **Permission to Disclose Health Information OCF-5** must be completed.

Disability Certificate OCF-3 If your insurance company asks you to, please fill out the first section and return the form to the office. The second half of the document needs to be completed by the Doctor.

The Doctors will complete online the **Treatment Confirmation Form OCF-23** to confirm treatment received under the Minor Injury Guideline (some exceptions apply).

Motor Vehicle Accident Claimant Information

Name: ____

Today's Date: (DD/MM/YR)____

Date of Birth: (DD/MM/YR)____

Date of the collision: (DD/MM/YR)____

Full Address:____

____

Email Address:____

Home Telephone #: ___________________________ Cell #______________________________

Your Car Insurance Information

Name and Address of Your Car Insurance Company:

Adjuster's Name:	Telephone #: Fax #: Email:

Name of Policy Holder: ☐ Same as applicant or ☐Other/ Name:

Claim #:	Policy #:

3735 St Joseph Blvd, Suite A
Orléans, Ontario | K4A 0Z7
613.830.3337
admin@taylorcreekchiro.com
TaylorCreekChiro.com

Extended Health Care Benefits (EHCB):

Do you have extended health coverage for chiropractic or massage therapy? ☐ YES ☐ NO

The Statutory Accident Benefits Schedule requires that all of your EHCB must first be exhausted PRIOR to us submitting an invoice to your auto insurance company.

We appreciate your cooperation in promptly providing us with a Statement Benefit from your Extended Health Insurance detailing your eligible reimbursement.

Extended Health Care Benefits (1)

Name of your Extended Health Insurance Company	
Name of Policy Holder	
Policy #	
Group #	
Yearly Maximum for Chiropractic Care:	
Yearly Maximum for Registered Massage Therapy	
Fiscal Year Renewal date is:	
Have you submitted any claims to your EHCB since the beginning of your fiscal year	☐Yes / ☐No

Extended Health Care Benefits (2)

Name of your Extended Health Insurance Company	
Name of Policy Holder	
Policy #	
Group #	
Yearly Maximum for Chiropractic Care:	
Yearly Maximum for Registered Massage Therapy	
Fiscal Year Renewal date is:	
Have you submitted any claims to your EHCB since the beginning of your fiscal year	☐Yes / ☐No

I confirm that the above information is accurate and I understand that I must promptly provide my EHCB statement. I also understand that any funds reimbursed to me for Chiropractic care since the date of my car accident must be applied to my account.

Signature:____Date: ____________________________

taylor creek
CHIROPRACTIC

Motor Vehicle Collision Injury Information

Name:____Date:____________________

Date of Collision:______________________________

Were you the driver or the passenger of the vehicle? Driver ☐ Passenger ☐ (front or back)
Were you wearing a seat belt? Yes ☐ No ☐
Was the vehicle moving or stopped when it was hit? Moving ☐ Stopped ☐
What were you attempting to do at the time of impact? (E.g. Making a left/right hand turn, changing lanes…)____
Did you see the vehicle coming towards you as the collision occurred (did you brace yourself for the impact?)____

How was the vehicle struck? (E.g. Rear-end, Head On, Side)________________________________

Were the airbags activated? Yes ☐ No ☐____

Did your head strike the windshield, side window, or did your chest strike the steering wheel? Explain:
____

Were you wearing glasses or a hat at the time of the collision? Yes ☐ No ☐
If yes, did the impact throw them off? Yes ☐ No ☐
Did you have any cuts / bruises / stitches? (Describe where?) ______________________________

How did you react to the collision? ____
Were you able to get out of the car? Yes ☐ No ☐ Were you unconscious? Yes ☐ No ☐
Were you able to get out of the car on your own? Yes ☐ No ☐
Were you taken to the hospital? Yes ☐ No ☐ If yes, how? Ambulance ☐ Other Means ☐
Did they use a stretcher? Yes ☐ No ☐ Did they use a neck brace? Yes ☐ No ☐
Was your car drivable following the collision? Yes ☐ No ☐
How long did it take following the collision before you felt the pain? _________________________

Where did you feel the pain? ____

Rate your pain on a scale of 0 to 10. (0=No pain 10=Severe)

0 1 2 3 4 5 6 7 8 9 10

What type of pain is it?

Burning ☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐
Tingling ☐ Numbness ☐ Shooting ☐ Cramps ☐ Stiffness ☐
Swelling ☐ Other ☐ ____

Who did you consult after the collision (E.g. Chiropractor, Physiotherapist, Medical Doctor…) before coming into our office?____

What kind of treatments or medication did you receive from them?__________________________

What other changes have you noticed since the collision?

☐Difficulty Sleeping (number of hours you are sleeping post collision ______ number of hours you were sleeping before the collision_______)
☐ Muscle Tension / Spasms (where?) ____
☐ Digestive Problems (explain) ____
☐ Headaches (how often?) ____
☐ Stiffness (where? is it constant or worse at certain times?) ____________________________
☐ Limited Movements (of what body parts?)____
☐ Decreased Appetite
☐ Irritable
☐ Memory Problems
☐ Ringing in the Ears
☐ Fatigue
☐ Visual Disturbances
☐ Low Back Pain

List any other changes that are not mentioned:____

Has this problem prevented you from doing anything (going to work, hobbies, activities, sleeping, sitting, standing, walking, life in general, etc.…)? Describe how these activities of daily living have been affected? Please list ***anything*** that you ***can't*** do now that you ***used to be able to do*** with ease and explain ***why*** you can't do these activities now. (E.g. Too much pain, fatigue, headaches…)

Which activities are difficult to perform?
Sitting ☐ Standing ☐ Walking ☐ Bending ☐
Lying Down ☐ Reaching Up ☐Picking things up from the floor ☐

Are you currently employed: Y ☐ N ☐ If yes, have you lost any time at work/ or did you have to modify your work due to this accident, please describe:_______________________________________

Have you ever broken any bones or torn ligaments in the past? Yes ☐ No ☐
If yes, specify: ____

Have you ever injured the present area of pain in your body in the past? Yes ☐ No ☐
If yes, specify: ____

Have you ever been a recipient of Workers' Compensation Benefits? Yes ☐ No ☐
If yes, specify type of injury: ____

Have you ever had a previous motor vehicle collision? Yes ☐ No ☐
If yes, specify what injuries you sustained: ____

Signature: ____ Date: _______________________

Informed Consent to Chiropractic Care

Doctors of Chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms, rib fractures, or muscles and ligament strains and sprains as a result of manual therapy techniques;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence do not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

d) There are infrequent reported cases of skin irritation/ bruising with the use of some types of instrument or therapy offered by some doctors of chiropractic.

e) Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that association with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my Chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care in this office. ______

Dated this__________________________day of _______________________________, 20____________.

Patient Signature (Legal Guardian) Witness of Signature

Print Name Print Name

PRIVACY POLICY

Privacy of personal information is important to **Taylor Creek Chiropractic.** We are committed to the collection, use and disclosure of this information in a responsible way. We will also try to be as open and transparent as to how we handle personal information.

Personal Information

Personal information is information about an identifiable individual. Generally, the information we collect is limited to your name, home contact information, gender and age. As part of your patient file we retain your health history; health measurements and examination results; health conditions, assessment results and diagnoses; the health services provided to you or received by you; your prognosis and other opinions formed; compliance with treatment; and the reasons for your discharge and discharge recommendations. We also maintain records for payment and billing purposes. Only necessary information is collected about you. We only share your information with your consent; the use, retention and destruction of your personal information complies with existing legislation and privacy protection protocols. Privacy protocols comply with privacy legislation standards of our regulatory body, the College of Chiropractors of Ontario and the law.

Staff Members

Staff members who come into contact with your personal information are aware of the sensitive nature of the information you have disclosed to us. They are all trained in the appropriate uses and protection of your information. These individuals may include clinic administration, therapists, and when necessary, authorized individuals who may inspect our records as part of the regulatory activities in the public interest.

Disclosure of Personal Information

We understand the importance of protecting your personal information. To help you understand how we are doing that, we outline below how we use and disclose this information:

- To deliver safe and effective patient care
- To enable us to contact you
- To communicate with other health care providers
- To complete and submit the necessary documentation to the WSIB, or third-party payers
- To comply with legal and regulatory requirements under the Chiropractic Act and the Regulated Health Professions Act
- To process payments and collect unpaid accounts Please do not hesitate to discuss our privacy policy with any of the clinic staff.

By signing the consent section of this form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance. Patient Consent I have reviewed the above information that explains how your clinic will use my personal information. I agree that the Doctors and Staff at Orleans Gardens Chiropractic can collect, use and disclose my personal information as set out above in the clinic's privacy code.

____

Print Name | Signature

____

Print Name of Witness | Signature of Witness

Date: ______________________________________