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# ONLY FILL THIS OUT FOR A MOTOR VEHICLE ACCIDENT OR WORKPLACE SAFTEY AND INSURANCE BOARD INJURY

## BILLING INFORMATION
### MVA

| | |
|---|---|
| Type of injury: | |
| Is this a Workplace Safety & Insurance Board Injury? ❑Y ❑ N | |
| What is your social insurance number? | WSIB claim number? |
| Date of accident: | Employer's name: |
| Employer's address: | Employer's telephone: |

## BILLING INFORMATION
### WSIB

| | |
|---|---|
| Are your injuries related to a motor vehicle case? ❑Y ❑ N | |
| Date of accident: | |
| Insurer's name: | |
| Policy or claim #: | |
| Insurer's address: | Insurer's telephone: |

## CONSENT

I agree and understand that I am responsible for all charges relating to my visit.

I also authorize my Chiropractor or insurance company to release any information required to process my claims relating to MVA or WSIB injuries.

*Patient/Guardian signature* *Date*

***Please note that all accounts are the responsibility of the patient. Your Extended Health Care Insurance Plan may provide coverage for Chiropractic services. We will issue a receipt for each payment for this purpose.***