# NOVO HEALTHNET LIMITED

**MVA INTAKE FORM – CLIENT PERSONAL INFORMATION (PLEASE PRINT)**

**NAME:**_____ **ACCIDENT DATE:** _____/_____/_____
DAY MONTH YEAR

**NAME OF POLICY HOLDER: SAME ◯ OR:**_____

**CLAIM #:**_____ **POLICY #:**_____

**ADMIN USE ONLY**
* CLAIMANT HAS 30 DAYS TO MAKE A CLAIM – CALL ADJUSTER BEYOND FOR VERBAL APPROVAL TO ASSESS

**INSURANCE COMPANY:**_____ **CITY:**_____

**ADDRESS:**_____

**ADJUSTERS NAME:**_____ **PH.**_____

**EMAIL:**_____ **FX.**_____

TREATMENT AREA / SYMPTOMS:_____

HAVE YOU BEEN ASSESSED BY SOMEONE ELSE? YES ◯ NO ◯

IF YES WHO?: 1._____

2._____

DO YOU HAVE LEGAL REPRESENTATION? YES ◯ NO ◯

If yes name of legal firm:_____

OCF 1 SUBMITTED ◯ YES ◯ NO

IF YES DATE SENT:_____

SIGNATURE:_____

SIGNATURE INDICATES YOU HAVE SUBMITTED OCF 1
ANY DENIED PAYMENT DUE TO INCOMPLETE OCF 1 WILL BE YOUR RESPONSIBILITY.
YOUR MVA INSURER WILL NOT CONSIDER PAYMENT OF ANY INVOICES WITHOUT RECEIPT OF A COMPLETED OCF 1

**EXTENDED HEALTH BENEFITS**

**DO YOU HAVE EXTENDED HEALTH BENEFITS? YES ◯ (IF YES COMPLETE BELOW) NO ◯**

**IF NO PLEASE SIGN & DATE:**_____
SIGNATURE DATE

**As per FSCO we must bill your extended health prior to billing your car insurance company. We will require a statement from EHB to submit to MVA in order for them to cover the difference.**

**PRIMARY INSURANCE BENEFITS (IF APPLICABLE)**

**NAME OF POLICY HOLDER: SAME AS APPLICANT ◯ OR:** _____

**POLICY HOLDERS DOB:**_____/_____/_____ **DR REFERRAL NAME:**_____
DAY MONTH YEAR IF REQUIRED BY YOUR PLAN – IF NOT WRITE NOT NEEDED

**INSURANCE COMPANY NAME:**_____

**POLICY/CLAIM #:**_____ **ID/CERTIFICATE #:** _____

**EXPIRY / RENEWAL DATE:** _____/_____/_____ **LIMITS & PERCENTAGE:**_____
DAY MONTH YEAR

**SECONDAY INSURANCE BENEFITS (IF APPLICABLE)**

**NAME OF POLICY HOLDER: SAME AS APPLICANT ◯ OR:** _____

**POLICY HOLDERS DOB:**_____/_____/_____ **DR REFERRAL NAME:**_____
DAY MONTH YEAR IF REQUIRED BY YOUR PLAN – IF NOT WRITE NOT NEEDED

**INSURANCE COMPANY NAME:**_____

**POLICY/CLAIM #:**_____ **ID/CERTIFICATE #:** _____

**EXPIRY / RENEWAL DATE:** _____/_____/_____ **LIMITS & PERCENTAGE:**_____

# NOVO HEALTHNET LIMITED

**MVA – CANCELATION POLICY AND PAYMENT POLICY**

**DATE: _____**
**Name: _____ DOB: _____**
**DOL: _____ Claim #: _____**

**We understand that unplanned issues may come up and you will need to cancel an appointment. If this happens, we respectfully ask that you notify us at least 24 hours prior to your appointment time.**

**Our therapists want to be available to meet your needs as well as the needs for all our patients. When a patient does not show up for a scheduled appointment, another patient loses the opportunity to be seen.**

**Although we have always had a cancelation policy, circumstances with MVA claims have caused us to reinforce this policy with a signed agreement. If we are not provided with the appropriate notice, you will be responsible for a Missed Treatment charge of $25.00. Your car insurance will not be billed nor, will they pay for this charge. This will be billed and must be paid by you for you to continue to be treated under your claim. Under certain circumstances management may waive this fee.**

**It is also imperative that when you submit to your EHB company, payment is made to us immediately upon receiving those funds along with the statement. This will then allow us to bill your auto insurance company and not cause any delays with treatment.**

***By signing below, you understand and agree to the cancelation and payment policy*.**

_____ _____

**Patient's Name** **Witness Name**

_____ _____

**Patient's Signature** **Witness Signature**

# NOVO HEALTHNET LIMITED

**MOTOR VEHICLE ACCIDENT CLIENTS INFORMATION**

Dear Patient:

After experiencing a Motor Vehicle accident, we at Novo Healthnet Limited know that the process can be overwhelming, so we have decided to provide some general but important information for this process and what you can expect from your Novo Healthnet Limited team:

- You will receive a package from your car Insurance. This package is called “Accident Benefits Package” and/or “OCF1.” This package must be completed and sent to your Insurance within 30 days of you receiving it. Before you send it off, please provide a copy to your attending Novo Healthnet Limited location so we can keep a copy in your file in case your adjuster has any future questions.

- If you do not have all your Insurance information at the time of your assessment you are to provide this on your 2nd visit. This information includes your policy number, claim number, adjuster name and insurance company name.

- By law, patients **must** provide any attending Clinic with their Extended Health Benefits (EHC/Work Benefits/Group Benefits/Private Insurance) information.

- Novo Healthnet Limited will ask you to pre-sign Claim forms so that we can submit to your Extended Health Carrier twice a month for reimbursement. After approximately 2 weeks of our submission, you will receive payment from your Extended Health carrier by mailed cheque or direct deposit. You are responsible to then forward payment and statement to your attending location. (Without this, we cannot submit to your Auto Insurance for the remaining balance.)

- If you do not provide all the necessary or correct information, you will then be held responsible for any monies outstanding on your account. If you have any questions or concerns, please do not hesitate to ask our staff.

Patient Signature _____ Date _____

Administrator Signature _____ Date _____