

Upper Ottawa Physiotherapy and MVA Services

A OHIP/EH/MVA/WSIB Fee: _____ Physio: _____
Intake Date: _____ Appt. Date: _____ Time: _____
Mr/Mrs/
Miss/Ms (last): _____ (first): _____
Address: _____
City: _____ Postal Code: _____
Home Phone: _____ Work Phone: _____
Your email address: _____
Birth Date: ___/___/___ Health Card No: _____ VC: _____
 D M Y
Referring Physician: _____ Main Problem: _____

How did you find us?

- Phone book Website Friend/Family Doctor
 Previous Patient Other: _____

B Extended Health Benefits Yes No

Policy No: _____ ID #: _____
Insurance Co: _____ Address: _____
Max/year PT Coverage: _____ Max/visit PT Coverage: _____
Deductible Amount: _____

C Motor Vehicle Accident (MVA) Claims: MVA Claims No: _____

Policy No: _____ Name on Insurance: _____
Insurance Co: _____ Address: _____
Adjustor Name: _____ Phone No: _____
Date of Accident: _____ Ext. Health Benefits? Yes No
(if yes, please complete section B)

D WSIB Claims: WSIB No: _____ Date of Accident: _____

Adjudicator Name: _____ Employer Name: _____
Employer Contact Name and Number: _____
Job Title: _____

*Note: UOP request all payments up front except from WSIB and MVA clients.
It is the client's responsibility to submit all receipts to their extended health insurance.*

