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*MVA Patients Must Complete This Section:*

Although due to privacy regulations our clinic cannot directly invoice your private/extended health coverage (EHC), we are required to include the amount of your EHC coverage on the invoice to your auto insurer before they will issue payment for services rendered. Please check with you EHC carrier to establish your level of coverage with each service.

\*Do you have EHC through your employer? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_ \* Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes: \* EHC Insurer Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \* Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Amount Amount Amount Amount

Chiropractic \_\_\_\_\_\_\_\_\_\_\_\_\_ Acupuncture ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_ Orthotics \_\_\_\_\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_

\*Are you covered under your spouse’s EHC? Yes\_\_\_\_\_ No\_\_\_\_\_ \*Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Amount Amount Amount Amount

Chiropractic \_\_\_\_\_\_\_\_\_\_\_\_\_ Acupuncture ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_ Orthotics \_\_\_\_\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_

Name of Motor Vehicle Insurer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Branch\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Insurance Adjuster’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext.\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* Claim No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \* Date of Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you completed and submitted an Automobile Accident Benefit Package to date? Yes\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_

Are you making a claim for any of the following? Income Replacement Benefits Yes\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_

 Housekeeping Benefit Yes\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_

 Caregiver Benefit Yes\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_

Current Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length of time in present occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you off work because of your injuries? Yes\_\_\_\_ No \_\_\_\_ First Date of Lost Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you working modified hours? Yes\_\_\_\_ No \_\_\_\_ Are you working modified duties? Yes\_\_\_\_ No\_\_\_\_

Employer Name and Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor/Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext. \_\_\_\_\_\_\_\_\_\_