Dynamic Chiropractic Health & Wellness Centre

Billing Information:

TYPE OF INJURY

Is this a Workplace Safety & Insurance Board Injury? (Please Circle) ***(If not, you do NOT need to fill in the following information)***		Yes	No
Social Insurance Number			
WSIB Claim Number		Date of Accident:	
Employer's Name			
Employer's Address			
Employer's Telephone			

Are your injuries related to a motor vehicle case? (Please Circle) ***(If not, you do NOT need to fill in the following information)***		Yes	No
Date of Accident			
Insurer's Name			
Policy or Claim Number			
Insurer's Address			
Insurer's Telephone			

CONSENT

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

Date: _____ Signature: _____

Date : _____ Guardian: _____

(If patient is under 18 years of age)

Please Note:

All accounts are the responsibility of the patient. Your supplemental or extended health care insurance plan may provide coverage for chiropractic services. We will issue a receipt for each payment for this purpose.