BURSWOOD HEALTH
PROFESSIONALS

MOTOR VEHICLE INJURY REPORT FORM

Client Statement and Authority to Release Information

Chiropractic care is available in WA for some injuries sustained on WA roads. A medical referral is not necessary to commence chiropractic care. The Insurance Commission of Western Australia (ICWA) pays for a portion of chiropractic fees. Please contact ICWA to notify them of your intention to claim. (Tel 08 9264-3344)

It is clinic policy that persons receiving care for motor vehicle injuries pay on the day of treatment. You then recoup these costs from the ICWA Third Party Division by sending them the receipts we provide you. Do not lose them, and send them in periodically.

In exceptional cases the clinic may agree to bill ICWA directly. In this case you will be liable for the difference between ICWA payments and our fee for service. This is payable at each visit or in advance. If your claim is denied or is in dispute then you become responsible for the full fee. Speak with the chiropractor or our office manager.

CLIENT LIABILITY AGREEMENT

This is to state that I (name) _____ agree to pay for expenses incurred for treatment provided by staff at Burswood Health relating to this injury on _____(date).

I understand that if the clinic bills ICWA directly, then I will pay the gap fee at the time of consultation or in advance, and become liable for the full fee if the claim becomes “in dispute” or is denied for any reason.

I acknowledge that I am responsible for **missed appointments** and will pay fees relating to these missed appointments personally.

I have read and understood the above statements. *(Cross out if not applicable and initial)*

Signed: _____ Date: _____ Witnessed: ____
(Client signature) (CA Initials)

AUTHORITY TO RELEASE INFORMATION

I hereby authorise Burswood Hea;th to provide details of my injuries related to the collision on ___/___/___ to the Insurance Commission of Western Australia

Date: / / Client/Guardian Signature _____

Office use only:
3 signatures verified on this form ☐ CA Signature _____ Name (print)_____
Form received Date: ___/ ____/ ____. Notification form completed and sent: Date: ___/ ___/ ___
New file opened Date: ___/ ___ / ____ Claim finalised: Date: ____/ ___ / ____

21 Harvey Street, Burswood WA 6100
Tel: 9361 2628 Fax: 9470 1185

Office use only

File Number: _____

Claim #: _____

Motor Vehicle Injury Report Form

We appreciate your patience in completing this confidential questionnaire. Even if you are already a client of the Team Health Group please complete all parts of this questionnaire except section B (about personal details). For new clients, please complete all sections. Ask for more paper if you need more space for any question.

A: Please describe the collision

Date of Collision

Please describe the collision

Draw a diagram of relevant roads and vehicles involved

In which seat were you sitting?	☐ Drivers	☐ L front ☐ L Rear	☐ Right Rear
Were you wearing a seatbelt?	☐ Yes ☐ No	Lapsash? ☐	Other?
Was a moveable headrest fitted?	☐ Yes ☐ No	Fixed headrest?	☐ Yes ☐ No
Were you prepared for the impact?	☐ Yes ☐ No		
In what position was your head on impact? (Straight, turned)			
Did your body hit any part of the car? If yes, please describe	☐ Yes ☐ No		
How much damage was done to your car? $Approx			
What sort of damage?			
Was your vehicle driveable?	☐ Yes ☐ No		
Did police attend at the scene?	☐ Yes ☐ No	When?	
If not, have you reported the accident to the police	☐ Yes ☐ No	Where?	
Have any charges been laid in respect of the collision?	☐ Yes ☐ No	Yourself ☐	Others ☐
Have you reported the accident and your injury to the ICWA?	Yes ☐ No☐		When?
Has liability been accepted by ICWA?	Yes ☐ No☐	What is the file number?	
Were you taken to hospital?	Yes ☐ No☐	Duration: _____ hrs/days/weeks	
If so, please give details of treatment			

Have you consulted anyone else concerning your injuries?	Yes ☐ No☐

If yes, please give details including name, address, date, examinations done and treatment given including medications you are taking:

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Have you been declared unfit? Yes☐ No☐

If yes, by whom?

When? For how long?

Did you feel any symptoms immediately after the collision? If yes, what symptoms? Yes ☐ No☐

If not immediately, when did you start experiencing trouble and what was it?

Has this condition interfered with your job/daily routine? If yes, describe in detail Yes ☐ No ☐

If the injury occurred some time ago, give detailed account of your symptoms and progress to date:

Have you ever suffered from any of these symptoms prior to the accident? Yes ☐ No ☐

Describe in detail

Have you made a written statement to anyone else about this collision? Yes ☐ No ☐

If yes, who?

Have you **ever** made a claim regarding the injured regions (incl workers compensation)? Yes ☐ No ☐

If yes, please outline briefly

Have you **ever** received compensation or a payout regarding a previous injury to the same regions that are now injured? If Yes, please outline briefly Yes ☐ No ☐

B: Some information about you

Now we need some personal details about you. If you are already a client at a clinic of the TEAM HEALTH GROUP please leave this section blank. Please now complete Section C.

Your full name Date of Birth: Age:

Address: Phones◆ Home:

Height: Weight: Occupation Work:

Marital Status: Children: Referred or Recommended by:

Employers name:

Address:

Your previous chiropractor/s Last seen?

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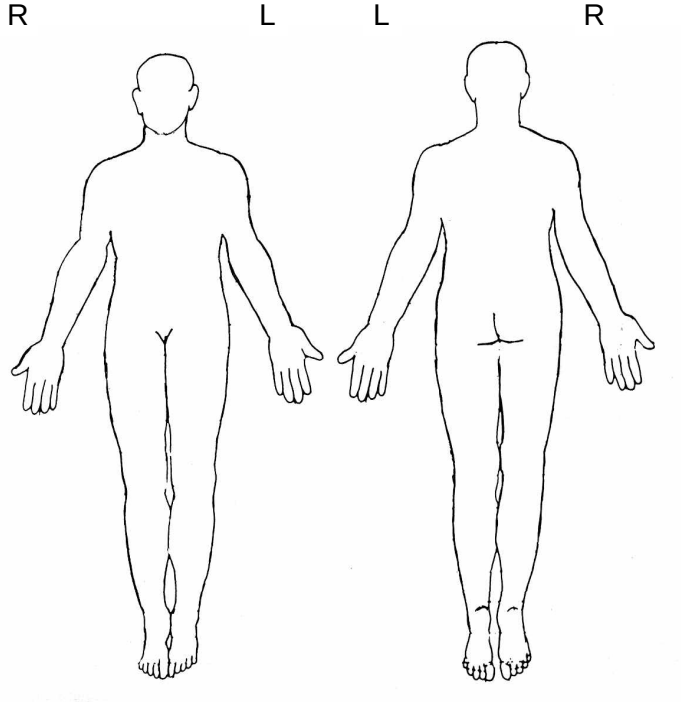
C: Describing your problem

Please indicate where your <u>present</u> symptoms are on the diagram below using the symbols on the right box.

R L L R



Use these symbols to outline your problem area(s)

Aching ====
Pain ====

Burning xxxxx
Pain xxxxx

Numbness or pin & needles
00000
00000

Stabbing ////////
////////

Other - *use your imagination*

Indicate the intensity of your pain on this scale: (tick one) 1 2 3 4 5 6 7 8 9 10

NONE _____ WORST EVER

Do you have any other health problems other than those indicated in diagram above? If so, please indicate below: Tick or comment using the following table.

Nerves, muscles, bones, joints:	Lungs:
Heart, circulation:	Stomach, bowel:
Kidneys, Bladder, Reproductive organs:	Eyes, Ears, Nose, Throat:
Skin	Other

Are you currently under the care of any other health practitioners? ☐ Yes ☐ No

If yes, who and what for? _____

_____

The above information is correct to the best of my knowledge and I acknowledge that providing incorrect information may affect the outcome of a claim.

Signature: _____ Date: _____ Witnessed: ____

(Client/Guardian signature) (CA Initials)

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