MVA INTAKE FORM

AB-1 FORM (including part 7) MUST ACCOMPANY THIS FORM TO PROCESS CLAIM

NAME: _____

AUTOMOBILE ACCIDENT

Have you reported your injuries to YOUR insurance company ❑ Yes ❑ No Date of Accident?_____

YOUR insurance Company: Adjuster Name: _____ Company Name: _____

Adjuster Phone No.: _____ Policy No.: _____ Claim No.: _____

Do you have legal representative? ❑ Yes ❑ No Legal Representative Name: _____

Is Vehicle registered in your name: _____ Who's name is it Registered: _____

Where you the Driver of the vehicle:_____

MVA INJURY QUESTIONNAIRE

INJURY CARE

HAVE YOU SEEN ANOTHER THERAPIST FOR THIS PARTICULAR INJURYI _____ THERAPIST NAME:_____

❑ Emergency Room / Hospital ❑ Medical Doctor ❑ Chiropractor ❑ Physiotherapist ❑ Massage Therapist ❑ Other: _____

X-Ray, MRI, CAT, Other (please indicate which and what date (do you have a copy) _____

TREATMENT ACKNOWLEDGMENT

After your **initial assessment**, your therapist will submit a report to your **adjuster** outlining the number of treatments **prescribed specifically for our clinic**.

I acknowledge that my treatment plan has been explained to me, and I agree to actively participate in and follow the recommendations provided by my treating therapist to support my care and recovery.

Please note:

- The treatment plan & number of sessions approved are **valid for services provided by therapists at Lime Health**.
- If you choose to seek care at **another clinic**, their practitioners will be required to complete their **own assessment** and submit a separate treatment plan for approval.
- **Treatment counts do not transfer** between clinics. The sessions prescribed at our clinic cannot be shared or split with other clinics.

CANCELLATION & NO SHOW

To ensure fairness and improve access to appointments, a strict cancellation policy is now in place. We value your time and appreciate your understanding in respecting ours.

Same-day cancellations, same-day reschedules & no-shows are charged **100% of the scheduled service fee**. **Cancellations made the day before your appointment**, including messages received after hours or on Sundays, will incur a **$50 charge**. These charges apply to **every occurrence**, regardless of the reason.

I acknowledge that no guarantees have been made regarding the outcome of my treatment.

By signing below, I confirm that I have had the opportunity to ask questions, understand the information provided, and consent to massage therapy assessment and treatment. I understand that consent is an ongoing process and will be confirmed throughout my course of care

Client Printed Full Name Client Signature Full Name