



EXTENDED HEALTH COVERAGE INFORMATION



Please print and complete this form and then return to either Milton Physiotherapy or River Ridge Physiotherapy by mail or fax.

Do you have private extended health coverage (EHC) through any of the following?

Employer: Yes ___ No ___
 Union: Yes ___ No ___
 Educational Institution: Yes ___ No ___
 Other: Yes ___ No ___

Insurance Company Name: _____

Phone Number: _____

ID# / Certificate # _____

Group/Plan # _____

Policy Year Start Date: _____

Address: _____ City: _____ Postal Code: _____

Available Chiropractic coverage: Yes ___ No ___

Maximum amount per policy year: _____

Maximum payable per treatment: _____

Percentage payable per treatment: _____

Amount used to date: _____

Available Massage coverage: Yes ___ No ___

Maximum amount per policy year: _____

Maximum payable per treatment: _____

Percentage payable per treatment: _____

Amount used to date: _____

Other available coverage: Yes ___ No ___

Maximum amount per policy year: _____

Maximum payable per treatment: _____

Percentage payable per treatment: _____

Amount used to date: _____

Patient Name: _____ Date: _____

Patient Signature: _____ Witness: _____

Does your spouse have private extended health coverage (EHC) through any of the following?

Employer: Yes ___ No ___
Union: Yes ___ No ___
Educational Institution: Yes ___ No ___
Other: Yes ___ No ___

Insurance Company Name: _____

Phone Number: _____

ID# / Certificate # _____

Group/Plan # _____

Policy Year Start Date: _____

Address: _____ City: _____ Postal Code: _____

Available Chiropractic coverage: Yes ___ No ___

Maximum amount per policy year: _____

Maximum payable per treatment: _____

Percentage payable per treatment: _____

Amount used to date: _____

Available Massage coverage: Yes ___ No ___

Maximum amount per policy year: _____

Maximum payable per treatment: _____

Percentage payable per treatment: _____

Amount used to date: _____

Other available coverage: Yes ___ No ___

Maximum amount per policy year: _____

Maximum payable per treatment: _____

Percentage payable per treatment: _____

Amount used to date: _____

Patient Name: _____ Date: _____

Patient Signature: _____ Witness: _____