ASCENT
INTEGRATIVE HEALTH

NEW AUTO INSURANCE REFORMS AND YOUR CARE AT DOWNTOWN INTEGRATIVE HEALTH GROUP

www.ascenthealth.ca

At *Ascent Integrative Health* it is our mission to provide integrated natural health care services that lead to health and balance for optimum living. This certainly applies to people who have bee n involved in a motor vehicle accident and require chiropractic, acupuncture, massage and exe rcise therapy or combinations of any of these treatment modalities. We are pleased to provide all these services at one convenient location.
As of October 1, 2004 anyone injured in a motor vehicle accident must adhere to the new regulations that affect both the procedural and financial aspects of motor vehicle accident insurance claims.

If you have been involved in an accident we would encourage you to do the following:

Contact your insurance company immediately
Contact your chiropractor as soon as possible after the accident (within 10 days in order to access pre-approved treatment)
Diagnosing the severity of your injury will determine your eligibility for up to **21 pre-approved visits**. If you have a more serious injury the appropriate referral will be made. Please note that you do not need a medical referral to access chiropractic, acupuncture or massage therapy however under the new regulations you are limited to a combined total of up to 21 treatment visits before further evaluation must occur

You have 90 days from the day of the accident to receive up to 21 pre-approved treatments. Your automobile insurance company will be the first payer for these treatments and all costs will be directly billed to them.

If your injury has not resolved after 90 days, your primary health care practitioner will request further treatment in the concluding report. If the recommended treatment is authorized then you will begin the post-protocol phase of your treatment. Direct billing is generally not an option at this stage and so you will pay the clinic directly for treatment and receive the necessary receipt. You will send this receipt in to your personal extended benefits if you have them. If you exhaust your personal extended benefits or if you do not have extended benefits then receipts are sent to your auto insurance company for coverage under the Section B portion of your policy.

Treatment limits under the Section B are as follows:

- chiropractic care	$750
- massage therapy	$250
- acupuncture	$250
- physiotherapy	$600

If the injury has still not resolved at this point, further treatment can be requested by your treating practitioner or you will be referred to a medical doctor who is qualified as a Certified Examiner for further assessment.

Alberta's *Minor Injury Regulation* was struck down via a court decision released in February 2008. This particular Regulation was specifically related to the cap of $4,000 awarded for general damages to an individual diagnosed with a 'minor injury'. As a result of the *Minor Injury Regulation* being struck down, accident victims will no longer be restricted to a cap of $4,000 regardless of the type of injury.

If you have any questions regarding your insurance as it pertains to a motor vehicle claim please spe ak directly to our office coordinator, Tasha. 403-262-1121 or tasha@ascenthealth.ca

More information can be found at the government website:
www.autoinsurance.gov.ab.ca

Alberta Accident Benefits
Initial Claims Process

Overview

If you have been injured in an automobile accident in Alberta, you are entitled to accident benefits coverage regardless of whether you were at fault for the accident. The benefits you receive depend on the type of injury you have:

- If your injury is a sprain, strain or a whiplash associated disorder I or II, your primary health care practitioner (chiropractor, medical doctor or physical therapist) does not have to seek approval of the insurer for payment for treatment of these injuries **if you provide notice of your claim**. Your primary health care practitioner will be able to bill the automobile insurer for all treatment services outlined in the "Diagnostic and Treatment Protocols" that are not covered by Alberta Health Care Insurance. These protocols have been developed in consultation with primary health care practitioners and are based on the best research and evidence currently available.

- For all other injuries, or if you choose not to follow the diagnostic and treatment protocols, you will need to pay the health service provider for any services not covered by Alberta Health Care Insurance. You will be reimbursed for eligible expenses from your extended health care benefits (e.g., Blue Cross or similar employee benefits plan) and then by your automobile insurer.

What to do if you are injured in a Automobile Accident:

1. **See a primary health care practitioner** (chiropractor, medical doctor, physical therapist) as soon as possible for an assessment of your injury and, if needed, treatment advice.

2. **File an injury accident report with the police.**

3. **Complete the attached Notice of Loss and Proof of Claim Form (AB-1),** retain a copy for your records and send the original signed form(s) to the insurance company. If you are unable to send the form within the following timeframes, submit it to your insurance company as soon as practicable and explain the reason for the delay.

    - If your injury is diagnosed as a sprain, strain or a whiplash associated disorder I or II, submit this form within 10 days of the accident so that you can access accident benefits described as the "Diagnostic and Treatment Protocols."
    - If you have other types of injuries, or you choose not to access the accident benefits described as the "Diagnostic and Treatment Protocols", submit the form within 30 days of the accident.
    - If a family member is fatally injured in the collision, you can access funeral, grief counseling and death benefits. This form should be submitted within 30 days of the accident.

4. **You will be contacted** about the benefits you are entitled to receive after the insurance company reviews your completed form. If your insurance company needs any additional information in order to process your application, they will contact you.

If you have further questions about this form, the process or your benefits, please contact your claims adjuster. If you do not know who your claims adjuster is, contact your insurer or the Insurance Bureau of Canada, at 1-800-377-6378.

Important Notice Concerning Your Personal Information

The personal information you provide in forms AB-1, AB-1a (Claim for Disability Benefits) or AB-2 (Treatment Plan) is collected under the authority of the Insurance Act, Alberta's Automobile Insurance Accident Benefits Regulation, Diagnostic and Treatment Protocols Regulation and all applicable privacy legislation.

- Your primary health care practitioner or dentist will need to collect personal information from you and from other health service providers and will need to use and disclose your personal information to provide you with appropriate diagnosis, treatment and care.
- Your insurance company and its agents will need to collect, use and disclose personal information from you, your primary health care practitioner, and other health service providers concerning the accident, your injuries, any pre-existing conditions that may impede your recovery progress, the amount of treatment and care provided to you, and any assessments of your injuries and indications as to your treatment progress in order to facilitate contact with you, to determine your eligibility for accident and/or disability income benefits, and to administer your claim.

Under applicable privacy legislation, it is necessary to obtain your consent to authorize the sharing of your personal information as specified above. The legislation also regulates how primary health care practitioners, dentists, other health service providers, and insurance companies can use and disclose your information once they have it. Section 2 of form AB-1 will ask for your consent or that of your agent. Refusal to provide your authorization and consent could result in an inability to provide you with the treatment and care you require (if not covered by Alberta Health Care Insurance) and may result in an inability for your insurance company to process your claim, in whole or in part.

Your primary health care practitioner, dentist or other health service provider and insurance company will retain and rely on a copy of your consent for the period of time that your treatment and care is ongoing and your claim is active. You may revoke your consent at any time in writing to your primary health care practitioner or dentist and your insurer or any other person to whom you give consent, subject to continuing legal obligations. If you have any questions concerning the collection, use or disclosure of your personal information, please ask your primary health care practitioner, dentist, or your insurance claims representative or adjuster.

Send this form to the appropriate insurer:

Fax # (____)_____-_____

Notice of Loss & Proof of Claim Form

(Form AB-1)

This form is effective on November 20, 2004 for accidents that occur on or after October 1, 2004.

This part is to be comleted by your Insurer	
Claim Number:	
Insurance Company	
Claim Representative	
Policy Number:	
Date of Accident:	

Section 1: Claimant Information

Part 1
Claimant Information

Last Name	First Name	Middle Name(s)	
Address			
City, Town or County	Province	Postal Code	
Telephone Number (Home) (Include area code)	Telephone Number (Work) (Include area code)	Fax Number (Include area code)	
Date Of Birth (DDMMYYYY)	Gender ☐ Male ☐ Female	You can best be reached: ☐ By telephone ☐ By personal visit ☐ At home ☐ At work ☐ Other	
When is the best time to reach you?	Day(s) of the week		
Insurance Company	Policy Number		
Will this be an Alberta Workers' Compensation Board Claim? ☐ Yes ☐ No	Are Extended Health Care Benefits Available? (e.g., Blue Cross or similar Employee benefits plans) ☐ Yes ☐ No Details:		
Are you currently employed or engaged in training activities? ☐ Full Time ☐ Part Time ☐ Self-employed ☐ Retired ☐ Student ☐ Not employed	If you are making a claim for disability benefits, please also complete Form AB- 1a.		

Part 2
Claimant's Authorized Representative Information, if applicable

Last Name	First Name	Middle Name(s)
Address		
City, Town or County	Province	Postal Code
Relationship with Claimant ☐ Parent ☐ Guardian ☐ Other	Relevant Documentation Attached? If no, please authorize your representative by completing part 5 of this form. ☐ Yes ☐ No ☐ Not Applicable	
Home Telephone Number (Include area code)	Work Telephone Number (Include area code)	Fax Number (Include area code)

Part 3
Claimant's Accident Details

(If more space is required please continue on back side of this page)

You were a: ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other			
Location of Accident	City, town or county	Province	
Time of Accident: ___:___ ☐ A.M. ☐ P.M.	Date of Accident (DDMMYYYY)	Was the Accident Reported to the Police? ☐ Yes ☐ No	Date Reported: (DDMMYYYY)
Please provide a brief description of how the accident occurred and how you were injured.			
Have you seen a Medical Doctor, Physical Therapist, Chiropractor, Dentist or other health service provider for diagnosis, treatment and care for an injury related to this accident? ☐ Yes ☐ No ☐ Appointment booked for:			
Have you started treatment? ☐ Yes ☐ No ☐ Appointment booked for:			
Are you currently receiving medical or rehabilitation benefits related to another motor vehicle accident? ☐ Yes ☐ No			

(If more space is required please continue on back side of this page)

Please provide a brief description of your injuries and the symptoms that you are currently experiencing

Part 4

Information of Health Provider providing ongoing treatment and care

Name of Primary Health Care Practitioner or Dentist		Profession	
Address			
City, Town or County		Province	Postal Code
Telephone Number (include area code)	Fax Number (include area code)		

Section 2: Certification and Consent to Share Information

Part 5

Authority to act on claimant's behalf

(This section should be completed only when the claimant chooses not to act on his or her own behalf)

I, _____, hereby authorize _____ to act as my representative concerning the treatment and care of my injury, the submission and ongoing handling of my claim for accident and/or disability income benefits and the collection, use and disclosure of information concerning my injury, diagnosis, assessment, treatment or care resulting from the automobile accident referred to in Section 1 of this form.

I authorize my primary health care practitioner(s), dentist(s), other health service provider(s) and my insurance company, _____ and their agents, to collect relevant information concerning me and my accident from my representative as required. I further authorize primary health care practitioner(s), dentist(s), other health service provider(s) and my insurance company to disclose relevant information concerning my injury, diagnosis, assessment, treatment and care and my claim for accident and/or disability income benefits to my representative.

Signature of Claimant _____ Date_____

Signature of Authorized Representative _____ Date_____

Part 6

Certification and consent to share information

(To be completed by the claimant or their authorized representative)

I certify that the information provided is true and correct to the best of my knowledge.

I authorize all assessing or treating Primary Health Care Practitioners, dentist(s) or other health service provider(s) to collect, use and disclose any relevant information concerning my injury, including diagnosis, assessment, treatment or care resulting from the automobile accident referred to in Section 1 herein, for the purpose of providing ongoing treatment and care.

I further authorize all assessing or treating Primary Health Care Practitioners, dentist(s) or other health service providers to disclose my personal information to my insurance company,_____ and their agents that is relevant for the purpose of determining my eligibility for accident and disability benefits as outlined on Form AB-1 and for the purpose of administering my claim.

I further authorize my insurance company and its agents to collect, use and disclose relevant information concerning my injury, diagnosis, assessment, treatment or care received as a result of the automobile accident referred to in Section 1 herein, including a treatment plan and services provided, for the purpose of determining my eligibility for accident and disability benefits as outline on Form AB-1 and administering my claim.

□ I am the claimant or □ I am the authorized representative of the claimant

Signature _____ Date_____

Part 7

Choice in Following Diagnostic and Treatment Protocols

Please state your preference of treatment within or not within the Diagnostic & Treatment Protocols:

☐ I choose to be treated within the Diagnostic & Treatment Protocols as indicated on Form AB-1

☐ I choose not to be treated within the Diagnostic & Treatment Protocols

☐ I am the claimant or ☐ I am the authorized representative of the claimant

I certify that the information provided is true and correct the best of my knowledge. I confirm that I have consented to the collection, use and disclosure of my personal information for my treatment and care and determination of my eligibility for accident and/or disability income benefits as outlined on Form AB-1.

Name (Please Print) _____

Signature _____ Date_____

Reset Form Print Form

NECK PAIN AND DISABILITY INDEX (Vernon-Mior)

Patient Name: _____ File#: _____ Date: _____

PLEASE READ THE INSTRUCTIONS:
This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only one box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.

Section 1 – PAIN INTENSITY
- ❑ I have no pain at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

Section 2 – PERSONAL CARE (washing, dressing etc.)
- ❑ I can look after myself normally without causing extra pain.
- ❑ I can look after myself normally but it causes extra pain.
- ❑ It is painful to look after myself and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help every day in most aspects of self care.
- ❑ I do not get dressed and I wash with difficulty and stay in bed.

Section 3 – LIFTING
- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can lift very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – READING
- ❑ I can read as much as I want to with no pain in my neck.
- ❑ I can read as much as I want to with slight pain in my neck.
- ❑ I can read as much as I want to with moderate pain in my neck.
- ❑ I can not read as much as I want because of moderate pain in my neck.
- ❑ I can hardly read at all because of severe pain in my neck.
- ❑ I cannot read at all.

Section 5 – HEADACHES
- ❑ I have no headaches at all.
- ❑ I have slight headaches which come infrequently.
- ❑ I have moderate headaches which come infrequently.
- ❑ I have moderate headaches which come frequently.
- ❑ I have severe headaches which come frequently.
- ❑ I have headaches almost all the time.

Section 6 – CONCENTRATION
- ❑ I can concentrate fully when I want to with no difficulty.
- ❑ I can concentrate fully when I want to with slight difficulty.
- ❑ I have a fair degree of difficulty in concentrating when I want to.
- ❑ I have a lot of difficulty in concentrating when I want to.
- ❑ I have a great deal of difficulty in concentrating when I want to.
- ❑ I cannot concentrate at all.

Section 7 – WORK
- ❑ I can do as much work as I want to.
- ❑ I can only do as my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I cannot do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I cannot do any work at all.

Section 8 – DRIVING
- ❑ I can drive my car without any neck pain.
- ❑ I can drive my car as long as I want with slight pain in my neck.
- ❑ I can drive my car as long as I want with moderate pain in my neck.
- ❑ I can not drive my car as long as I want because of moderate pain in my neck.
- ❑ I can hardly drive at all because of severe pain in my neck.
- ❑ I cannot drive my car at all.

Section 9 – SLEEPING
- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed (less than 1 hour sleepless).
- ❑ My sleep is mildly disturbed (1-2 hours sleepless).
- ❑ My sleep is moderately disturbed (2-3 hours sleepless).
- ❑ My sleep is greatly disturbed (3 – 5 hours sleepless).
- ❑ My sleep is completely disturbed (5 – 7 hours sleepless).

Section 10 – RECREATION
- ❑ I am able to engage in all my recreation activities with no neck pain at all.
- ❑ I am able to engage in all my recreation activities with some pain in my neck.
- ❑ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ❑ I am able to engage in few of my usual recreation activities because of pain in my neck.
- ❑ I can hardly do any recreation activities because of pain in my neck.
- ❑ I cannot do any recreation activities at all.

PAIN SCALE:

Rate the severity of your pain by checking one box on the following scale.

NO PAIN — Excruciating Pain

1	2	3	4	5	6	7	8	9	10

LOW BACK PAIN AND DISABILITY INDEX (REVISED OSWESTRY)

Patient Name: _____ Date: _____/_____/_____

Please read instructions carefully.
This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage everyday life. Please read all statements in each section and mark the box which most closely describes your problem.

SECTION 1 - PAIN INTENSITY

- ❑ The pain comes and goes and is very mild.
- ❑ The pain is mild and does not vary much.
- ❑ The pain comes and goes and is moderate.
- ❑ The pain is moderate and does not vary much.
- ❑ The pain comes and goes and is very severe.
- ❑ The pain is severe and does not vary much.

SECTION 2 - PERSONAL CARE

- ❑ I do not have to change my way of washing or dressing to avoid pain.
- ❑ I do not normally change my way of washing or dressing even though it causes some pain.
- ❑ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ❑ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ❑ Because of the pain, I am unable to do some washing and dressing without help.
- ❑ Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 - LIFTING

- ❑ I can lift heavy objects without any extra pain.
- ❑ I can lift heavy objects, but it gives extra pain.
- ❑ Pain prevents me from lifting heavy objects off the floor.
- ❑ Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- ❑ Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- ❑ I can only lift very light objects at the most.

SECTION 4 - WALKING

- ❑ I have no pain on walking.
- ❑ I have some pain but it does not increase with distance.
- ❑ I cannot walk more than one mile without increasing pain.
- ❑ I cannot walk more than 1/2 mile without increasing pain.
- ❑ I cannot walk more than 1/4 mile without increasing pain.
- ❑ I cannot walk at all without increasing pain.

SECTION 5 - SITTING

- ❑ I can sit in any chair as long as I like.
- ❑ I can only sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting more than one hour.
- ❑ Pain prevents me from sitting more than half an hour.
- ❑ Pain prevents me from sitting more than 10 minutes.
- ❑ I avoid sitting because it increases pain.

SECTION 6 - STANDING

- ❑ I can stand as long as I want without pain.
- ❑ I have some pain on standing but it does not increase with time.
- ❑ I cannot stand for longer than one hour without increasing pain.
- ❑ I cannot stand for longer than 1/2 hour without increasing pain.
- ❑ I cannot stand longer than 10 minutes without increasing pain.
- ❑ I avoid standing because it increases the pain.

SECTION 7 - SLEEPING

- ❑ I get no pain in bed.
- ❑ I get pain in bed but it does not prevent me from sleeping well.
- ❑ Pain reduces my normal sleep by 1/4 each night.
- ❑ Pain reduces my normal sleep by 1/2 each night.
- ❑ Pain reduces my normal sleep by 3/4 each night.
- ❑ Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE

- ❑ My social life is normal and gives me no pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ My social life is unaffected by pain apart form limiting more energetic interests.
- ❑ Pain has restricted my social life and I do not go out very often.
- ❑ Pain has restricted my social life to my home.
- ❑ I have hardly any social life because of the pain.

SECTION 9 - DRIVING / RIDING IN CAR, ETC.

- ❑ I get no pain while traveling.
- ❑ I get some pain while traveling but none of my usual forms of travel make it any worse.
- ❑ I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
- ❑ I get extra pain while traveling which compels me to seek alternate forms of travel.
- ❑ Pain restricts all forms of travel.
- ❑ Pain prevents all forms of travel except that done lying down.

SECTION 10 - CHANGING DEGREE OF PAIN

- ❑ My pain is rapidly getting better.
- ❑ My pain fluctuates but overall is definitely getting better.
- ❑ My pain seems to be getting better but improvement is slow at present.
- ❑ My pain is neither getting better or worse.
- ❑ My pain is gradually worsening.
- ❑ My pain is rapidly worsening.

LOW BACK PAIN SCALE

Rate the severity of your **Low Back Pain** by indicating on the following scale.

Absence I----------I Extreme