



5065 Benson Drive • Burlington, Ontario • L7L 5N7
 t: 905 319 9659 e: frontdesk2@absoluterw.com

Patient Name:		Primary Insurance Co:	
Date of Birth: mm/dd/yyyy:		Group Policy #	
Home Address:		ID #	
City:	Postal Code:	Name of Insured:	
Phone # :	Cell # :	Date of Birth of Insured: mm / dd / yyyy	
Email :		Secondary Insurance:	
Employer:	Occupation:	Group Policy #	
Work Phone # :	Work Fax #:	ID #	
Family Doctor: Referral Source (who referred you?) :		Name of Insured:	
Doctor Phone # :	Doctor Fax # :	Date of Birth of Insured: mm / dd / yyyy	

DATE	PT	ND	DC	RMT	Payment Info
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25.					
26.					
27.					
28.					
29.					
30.					

Chart Check List Completion
ensuring all documents are completed and signed

whom referred the patient & it has been inputted in to P.M.S.

Email verification

Fee Schedule

Physiotherapy Consent

Acupuncture Consent

Spinal Manipulation

Massage Consent

Chiropractor Consent

Office Policies & Procedures

Electronic Billing Consent

Electronic Assignment of Benefits

Insurance Call Sheet

Claim Forms

Credit Card Authorization

-if MVA:

OCF 1 completed and a copy made

AB Package completed and sent to corresponding insurance company

Verified Identification – Photocopy of ID was taken

Patient's Name: _____

Verified and chart completed by

staff (print name): _____

signature: _____

date: _____