



Responsibility of Payment for MVA Clients

1. Depending on the case and previous history of treatments, OCF-18/23 assessments/treatment plans may be refused by insurer. The insurer may decline permanently (where no future treatment will be provided), or temporarily while an insurance examination is being booked and requires to be attended.
2. Insurers have the right to decline payment for treatments received and suspend benefits under Section 33 of the Statutory Accident Benefits Schedule for Medical, Rehabilitation, and Attendant Care if the client does not comply with an insurer's request.
3. Insurers have the right to decline payment for missed appointments and late cancellations.

By signing this document, I agree that should my OCF-18/23 be declined permanently, I agree the \$200 fee for OCF-18 and/or \$215 fee for OCF-23 assessments shall be the responsibility of the client for payment. If temporarily declined awaiting an insurance examination, payment is also responsibility of the client until the examination results are finalized and returned. Should the insurance examination support the client's treatment plan and ultimately lead to approval, Elysian Wellness Centre will refund or credit the \$200/\$215 amount to the client. Should it remain declined, no refund or credit will be provided

I further agree that should my accident benefits be suspended or an invoice declined by my insurer for not complying with an insurer request under the SABS, payment for all treatments incurred shall be responsibility of the client for payment.

I agree that should my insurer decline payment for missed appointments or late cancellations, payment for these charges are the responsibility of the client.

By signing this document, I hereby agree to the policy stated and agree to pay any outstanding balances for any of the reasons above relating to my motor vehicle accident claim. I further agree and understand that all payments are ultimately the responsibility of the client, whether a private client or a motor vehicle accident patient. I hereby agree no negative reviews shall be posted online or in equivalent form relating to any charges falling within this policy.

Name (Printed)

Date (MM/DD/YYYY)

Client Signature

[PLEASE EMAIL THE COMPLETED AGREEMENT TO INFO@EWCENTRE.COM](mailto:INFO@EWCENTRE.COM)