Flat Fee Program Schedule F
Treatment Confirmation and Consent Form

If ICBC accepts your claim, it will pay the reasonable expenses you incur for necessary chiropractic treatment in one of two ways. The two options, namely on a per treatment basis or through a flat fee payment made to your Chiropractor, are described herein.

If you decide to obtain your chiropractic services on a per treatment basis, ICBC will pay $22.27 for your Initial chiropractic visit and $17.35 for your subsequent treatments. Coverage of your chiropractic treatments on a per treatment basis will be limited to the amounts indicated in this paragraph and you will be responsible for any additional fees charged by the Chiropractor over and above these amounts. If you choose to receive your chiropractic services on a per treatment basis, you will have chosen not participate in the Chiropractic Flat Fee Program as described in the section below.

If you decide to participate in the Chiropractic Flat Fee Program, ICBC will pay a flat fee directly to your Chiropractor and you will not be charged any additional fees regardless of the number and types of necessary treatments. The Chiropractic Flat Fee Program has a time based treatment limit of 14 weeks. The limit of 14 weeks of chiropractic care may be extended for an additional 5 weeks depending on the extent of your injury and your clinical circumstances. Treatments past 19 weeks will be considered on a case by case basis as separate from the coverage provided under this Program. The terms and conditions of the Chiropractic Flat Fee Program are described in more detail below.

Terms and Conditions of Your Participation in the Chiropractic Flat Fee Program

1. If you want to change chiropractors, you may only do so once and must do so within two weeks from the day of your Initial visit with your First Chiropractor and before your second treatment. If you elect to change, you must advise your ICBC adjuster immediately. After the two week period, all your chiropractic funding from ICBC for this claim will have been allotted to the First Chiropractor and ICBC will not pay for treatments received from any other Chiropractor. In exceptional circumstances such as you or your Chiropractor moving to another geographic region or your Chiropractor ceasing practice will not be considered a change of Chiropractors for the purposes of this section.
2. Your Chiropractor will provide all necessary chiropractic treatments relating to your injury from the motor vehicle accident and manage your treatment plan.
3. Your Chiropractor will communicate the status of your treatment plan to ICBC. Section 28 of the Insurance (Vehicle) Act authorizes ICBC to obtain a report as often as requested, from the treating Chiropractor, without the patient's authorization.
4. Your treatment will continue until you are recovered to pre-accident status or when you have reached maximum chiropractic recovery.
5. It is important that you attend all of your appointments. If you are not able to attend, you are required to call the Chiropractor's office 24 hours prior to the appointment. Missing two treatments in a row or four treatments within the course of treatment with no good reason will result in a discharge from care and you will not have access to further chiropractic funding for this claim.
6. Failing to follow the Chiropractor's recommended treatment plan may result in a discharge from care and a termination of chiropractic funding for this claim.
7. ICBC will not provide funding for ongoing chiropractic treatment after you are discharged from the Chiropractic Flat Fee Program, nor will ICBC be obligated to provide funding for any Treatments related to maintenance under the Program.
8. Discharge from the Chiropractic Flat Fee Program will not have an impact on the settlement of your claim.

Patient Determination: Option One

Patient wishes to participate in the chiropractic flat fee program.

I wish to participate in the Chiropractic Flat Fee Program and agree to the terms listed in the Treatment Confirmation and Consent Form above, and consent to my Chiropractor and ICBC exchanging information, including my personal information, relevant to my claim. This exchange may be verbal, or through electronic transmission including email or facsimile.

Please check off the applicable box, complete necessary information, and sign below to select Option One.

☐ I acknowledge that I have not been treated by another Chiropractor for this claim.

☐ I wish to change my Chiropractor. I have visited another Chiropractor in the past two (2) weeks for this claim but only for a single treatment. The name of the other Chiropractor I visited is Dr. _____

and the date of my visit to the other Chiropractor was on _____ (dd/mmm/yyyy).

To be completed if patient is 19 years old or older

I confirm that I am 19 years old or older, have read and understood the foregoing, and agree to be bound by it.

Signed at_____, B.C. on the_____day of _____, 20_____.

In the presence of:

_____	_____
WITNESS SIGNATURE	PARTICIPANT SIGNATURE
_____	_____
WITNESS PRINTED NAME	PARTICIPANT PRINTED NAME
_____	
WITNESS ADDRESS	

To be completed by parent or legal guardian if patient is younger than 19 years old

I, the undersigned, represent that I am the _____(parent or legal guardian) of _____, the patient named above, and as such I am fully authorized and entitled to enter into this Treatment Confirmation and Consent, and hereby agree to all of the above, on behalf of the patient. I confirm that I am 19 years old or older, have read and understood the foregoing, and agree to be bound by it.

Signed at_____, B.C. on the_____day of _____, 20_____.

In the presence of:

_____	_____
WITNESS SIGNATURE	PARENT OR LEGAL GUARDIAN SIGNATURE
_____	_____
WITNESS PRINTED NAME	PARENT OR LEGAL GUARDIAN PRINTED NAME
_____	
WITNESS ADDRESS	

Collection of information on, by, or on behalf of ICBC is in accordance with Section 26 of the Freedom of Information and Protection of Privacy Act and Section 9 of the Insurance Corporation Act. This information will be used primarily in evaluation and settlement of your claim. There is also a possibility it will be referenced on future claims you may have. Questions about collection of personal information should be directed to your adjuster.

Patient Determination: Option Two

Patient does not wish to participate in the chiropractic flat fee program.

I do not wish to participate in the Chiropractic Flat Fee Program described in the Treatment Confirmation and Consent Form above. I understand that ICBC will pay $22.27 for my Initial chiropractic visit and $17.35 for subsequent treatments. I understand that coverage of my chiropractic treatments on a per visit basis will be limited to the amounts indicated in this paragraph and that I will be responsible for any additional fees charged by the Chiropractor over and above these amounts. I consent to my Chiropractor and ICBC exchanging information, including my personal information, relevant to my claim. This exchange may be verbal, or through electronic transmission including email or facsimile.

Please sign below to select Option Two.

To be completed if patient is 19 years old or older

I confirm that I am 19 years old or older, have read and understood the foregoing, and agree to be bound by it.

Signed at_____, B.C. on the_____day of _____, 20_____.

In the presence of:

_____ _____
WITNESS SIGNATURE PARTICIPANT SIGNATURE

_____ _____
WITNESS PRINTED NAME PARTICIPANT PRINTED NAME

_____
WITNESS ADDRESS

To be completed by parent or legal guardian if patient is younger than 19 years old

I, the undersigned, represent that I am the_____(parent or legal guardian) of

_____, the patient named above, and as such I am fully authorized and entitled to enter into this Treatment Confirmation and Consent, and hereby agree to all of the above, on behalf of the patient. I confirm that I am 19 years old or older, have read and understood the foregoing, and agree to be bound by it.

Signed at_____, B.C. on the_____day of _____, 20_____.

In the presence of:

_____ _____
WITNESS SIGNATURE PARENT OR LEGAL GUARDIAN SIGNATURE

_____ _____
WITNESS PRINTED NAME PARENT OR LEGAL GUARDIAN PRINTED NAME

_____
WITNESS ADDRESS

Collection of information on, by, or on behalf of ICBC is in accordance with Section 26 of the Freedom of Information and Protection of Privacy Act and Section 9 of the Insurance Corporation Act. This information will be used primarily in evaluation and settlement of your claim. There is also a possibility it will be referenced on future claims you may have. Questions about collection of personal information should be directed to your adjuster