VirtualCareNS
virtualcarens@nshealth.ca
P: 902-418-4929 | F: 888-745-0435

Paramedical Services Referral Form

Date: 2022-09-13

After assessing Danielle MacDonald , they have been advised to seek:

- [x] Physiotherapy — concussion management. diagnosis: concussion
- [ ] Massage Therapy _____
- [ ] Orthotics _____
- [ ] Chiropractor _____
- [ ] Sleep Assessment _____
- [ ] Other

Sincerely,

Adam Rostis

Dr. Adam Rostis
NS: 016880

VirtualCareNS
virtualcarens@nshealth.ca
P: 902-418-4929 | F: 888-745-0435

Paramedical Services Referral Form

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- [ ] Physiotherapy — concussion management. diagnosis: concussion
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- [ ] Orthotics
- [x] Chiropractor — concussion management. diagnosis: concussion
- [ ] Sleep Assessment
- [ ] Other

Sincerely,

Adam Rostis

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NS: 016880

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Paramedical Services Referral Form

Date: 2022-09-13

After assessing Danielle MacDonald , they have been advised to seek:

☐	Physiotherapy	concussion management. diagnosis: concussion
☐	Massage Therapy	_____
☐	Orthotics	_____
☐	Chiropractor	_____
☐	Sleep Assessment	_____
☒	Other	occupational therapy. concussion management. diagnosis: concussion

Sincerely,

Adam Rostis

Dr. Adam Rostis
NS: 016880

nova scotia health authority

Certificate of Illness

MACDONALDKAPLUN,DANIELLE
7-61589-87

This patient was seen in this Emergency Department on:

YYYY/MM/DD) August 17th, 2022

Signature: (ROSS)

The estimated date to return to school/work is:

YYYY/MM/DD) unknown

Comments: will be further assessed.

Prin A 797

COBEQUID COMMUNITY HEALTH CENTRE

0001470853 1993/02/20 F 29Y
MACDONALDKAPLUN,DANIELLE CEMR
HC 0008751141 NS EXP 25/01/31
3673 ST PAULS STREET
HALIFAX NS B3K 3R1
(902)759-6325 UCC 7-61589-87
FP NO.FAMILY DOCTOR 97008

Name.....

Address.....

SECURITY FEATURES ON BACK Date Aug 17/22

Rx

Physio Therapy
- Concussion Mgmt

/

RXS2206061021998128

☐ No Repeat ☐ Repeat

Physician'sSignature ROSS M.D.

Print Name _____ CPSNS#_____

EMPLOYER'S CONFIRMATION OF INCOME BENEFITS

I.B.C. CLAIM FORM NO. 15

TO	Employer **MacGillivray Injury and Insurance Law Office**
	Your employee has authorized us, by the attached, to obtain details of his/her pay and benefits in order that we may determine the amount of disability payments. Your co-operation in completing and returning this form will be appreciated.

CLAIMANT	Employee Macdonald Danielle Claim No. / Policy No. Q8065627		
OCCUPATION	**Associate Lawyer**		
PHYSICAL REQUIREMENTS OF JOB	☐ Heavy Manual ☒ Light Manual ☐ Sedentary		Accident Date Aug 17, 2022
IF ON SALARY	Rate (Gross) $ **75,000**	☐ Per Week ☐ Per Month ☒ Per Year	
IF ON HOURLY RATE	Basic hours worked per week $	Basic Rate per hour (Gross) $	Cost of Living Bonus (Gross) $
	Shift Bonus paid in last three months preceding accident $	Overtime paid in last three months preceding accident $	
Last Day Worked **Aug 17, 2022**	Date salary or wages ceased **Aug 17, 2022**		Length of time employed **4 years**
INCOME REPLACEMENT PAID WHILE OFF WORK	Amount $ **961.59**	per week/month **per week**	
	By whom paid? **Blue Cross**		Length of time payable **17 weeks**
WORKERS' COMPENSATION	Is this employee eligible for Workers' Compensation as a result of the accident?	☐ Yes ☒ No	
MEDICAL EXPENSE RECOVERY PLAN IN FORCE	☐ Yes ☒ No	If "yes" with what company?	
If returned to work, give Date			

Date **Aug 31, 2022**	Signature *Heather Douthwright*	Title **HR Manager**

AFC60261
958 725 (2003-05)

* **
Short term disability has not yet been approved. The $961.59 is a rough estimate.

Application for STD was submitted Aug 31/22. NO payments received to date.

JOB ANALYSIS

Your employee (our client) was involved in a motor vehicle accident. We are the auto insurers working with the client to facilitate an early return to work. Please complete & return this form as soon as possible, along with the Employers Confirmation of Income Form. Thank you for your assistance.

Any questions please call Phandanouvong David
AB Claims Advisor ph (855) 212-1745 #6325225

Our Claim # Q8065627

Employee Name Macdonald Danielle

Job Title **Associate lawyer** Full Time [X] or Part-time [ ] # hrs/day **8** # hrs/week **40**

Company **MacGillivray Injury and Insurance Law Office**

OVERALL JOB CLASSIFICATION: Sedentary [ ] Light [X] Medium [ ] Heavy [ ] Very Heavy [ ]

ESSENTIAL TASKS:
Computer work, Reading, Writing, Research

PHYSICAL DEMANDS:

	TASK	% OF TIME IN WORK DAY			TOTAL # of MINUTES or HOURS	COMMENTS
		Never 0%	Sometimes to 50%	Frequently over 75%		
Activity	Sit			X	6 hrs	
	Stand		X		1hrs	
	Walk		X		1 hr	
	Drive		X			
	Climb	X				
	Kneel	X				
	Crawl/Crouch	X				
	Reach/Handle	X				

Strength		WEIGHT				
		10 lbs	20 lbs	50 lbs	100 lbs	>100 lbs
	Lift	X				
	Carry	X				
	Push	X				
	Pull	X				

Controls						COMMENTS
	Machinery	X				Printers, scanners, computers
	Tools/Equipment		X		8 hrs	
	Other					

ENVIRONMENTAL: **n/a**
(Inside, Outside, Dust, Hazards, etc.)

Supervisor (please print) **Heather Douthwright** ph: **902-755-0398**

Signature *Heather Douthwright* Date **Aug 31, 2022**

AFD60241
958 723 (2003-09)

MEDAVIE BLUE CROSS

ATTENDING PHYSICIAN'S STATEMENT - GENERAL

644 MAIN ST. PO BOX 220 | 230 BROWNLOW AVE. DARTMOUTH | PO BOX 2000 185 THE WEST MALL, SUITE 1200 | 1981 MCGILL COLLEGE AVENUE, SUITE 100
MONCTON NB E1C 8L3 | PO BOX 2200 HALIFAX NS B3J 3C6 | ETOBICOKE ON M9C 5P1 | MONTREAL, QC H3A 3A7
TEL: 1-877-849-8509 | TEL: 1-877-849-8509 | TEL: 1-877-849-8509 | TEL: 1-877-849-8509
FAX: 1-800-644-1722 | FAX: 1-800-644-1722 | FAX: 1-800-644-1722 | FAX: 1-800-644-1722
disability@medavie.bluecross.ca | disability@medavie.bluecross.ca | disability@medavie.bluecross.ca | salary@medavie.bluecross.ca

INSTRUCTIONS:

1. Please Print.
2. Part I to be completed by patient.
3. Part II through VI to be completed by physician.
4. Any charge for completing this form is the patient's responsibility.

PART I: PATIENT AUTHORIZATION

Name: MacDonald (Last) Danielle (First) J (Initial) Date of Birth (DD/MM/YYYY): 20/02/1993

I hereby authorize the release of any information herein requested by my insurer or its agents.

Signature: [signature] Date (DD/MM/YYYY): _____

PART II: ATTENDING PHYSICIAN'S STATEMENT

Name: DIEMSO SMALE Specialty: CCFP

Address: _____

Telephone: _____ Fax: _____

PART III: HISTORY OF PRESENT CONDITION(S)

1. If the condition is related to pregnancy, indicate the date or expected date of delivery (DD/MM/YYYY): _____
   (Please attach prenatal clinical notes)
2. Is the condition due to injury or sickness arising out of the patient's employment? ☐ Yes ☑ No ☐ Unknown
   Have Workers' Compensation/CNESST forms been completed? ☐ Yes ☐ No ☐ Unknown
3. a) Primary Diagnosis: CONCUSSION Scale: DSM (____) Grade (____) Class (____) Stage (____)
   b) Secondary Diagnosis: WHIPLASH GRADE 1 Scale: DSM (____) Grade (____) Class (____) Stage (____)
   c) Date symptoms first appeared or accident happened (DD/MM/YYYY): 17/08/2022
   d) Initial Examination Date (DD/MM/YYYY): 17/08/22
   e) Date patient ceased working due to this condition (DD/MM/YYYY): 18/08/2022
   f) Symptoms (include severity and frequency): HEADACHE, N/V, DOUBLE VISION, DIZZINESS, FATIGUE, NECK PAIN
   g) Clinical Findings **(Please attach copies of X-rays, test results, etc)**: CT XRAY IN ER
   h) Functional Limitations/Restrictions **(Please specify length of time or maximum weight)**
   Sitting: _____ Standing: ✓ Walking: ✓ Lifting: _____ Carrying: _____ Bending: ✓
   i) Expected duration of restriction/limitations: ADDITIONAL 4 WEEKS

PART IV: FACTORS AFFECTING RECOVERY

☐ Addiction _____ ☐ Family History of Present Condition _____

☐ Diet _____ ☐ Current: Height: _____ Weight: _____ Right or left hand dominant: _____

☐ Work Environment _____ ☐ Past Medical History _____

☐ Home Environment _____ ☐ Pre-existing Conditions _____

Has the patient previously had a similar condition? ☐ Yes ☑ No If yes, please specify date of initial onset. _____

MEDAVIE BLUE CROSS

ATTENDING PHYSICIAN'S STATEMENT - GENERAL

644 MAIN ST PO BOX 220 MONCTON NB E1C 8L3 TEL: 1-877-849-8509 FAX: 1-800-644-1722 disability@medavie.bluecross.ca

230 BROWNLOW AVE DARTMOUTH PO BOX 2200 HALIFAX NS B3J 3C6 TEL: 1-877-849-8509 FAX: 1-800-644-1722 disability@medavie.bluecross.ca

PO BOX 2000 185 THE WEST MALL SUITE 1200 ETOBICOKE ON M9C 5P1 TEL: 1-877-849-8509 FAX: 1-800-644-1722 disability@medavie.bluecross.ca

1981 MCGILL COLLEGE AVENUE, SUITE 100 MONTREAL, QC H3A 3A7 TEL: 1-877-849-8509 FAX: 1-800-644-1722 salary@medavie.bluecross.ca

Name of Patient: _____

PART V: MANAGEMENT PLAN FOR THE CURRENT CONDITION

		Date YYYY	MM	DD
☐	Frequency of visits: THE SECOND TIME			
☐	Date of most recent visit:	2022	08	31
☐	Date of re-evaluation: WITH PHYSIO			
☐	Hospitalization dates - **Please include Admission/Discharge Summaries**			
☐	Surgery date(s) and type - **Please include Operative Report**			
☐	Medication - **(Please include dosage and date first prescribed)** TYLENOL 500 DAY ADVIL 400 DAY CONTROL 30 DAY			

		Name	Specialty	YYYY	MM	DD
☐	Specialist					
☐	Chiropractor					
☐	Counsellor					
☐	Additional Planned Testing					
☐	Therapist					
☐	Other					

Is patient following the recommended treatment program? ☑ Yes ☐ No

PART VI: ESTIMATED TIME FOR RECOVERY

Patient Progress: ☐ None ☐ Regressed ☑ Minimal Improvement ☐ Significant Improvement ☐ Plateaued ☐ Resolved

Prognosis: ☐ Poor ☑ Good

Expected duration of recovery period: MONTHS

In your opinion, is the patient a suitable candidate for medical or functional rehabilitation (i.e. conditioning program, counselling, etc.)?

☑ Yes ☐ No Please elaborate on your opinion: SHE IS ALREADY ON PHYSIO SHE WILL HAVE ADDT WITH OCCUPATIONAL THERAPIST

In your opinion, is the patient a suitable candidate for a work re-entry program (i.e. ease back, modified duties, gradual return to work, etc.)?

☐ Yes ☑ No Please elaborate on your opinion: SHE IS IN CONTACT WITH PHYSIO, STILL NEED ASSESSMENT IN NEXT MONTH

Please specify any additional information or details that may have a significant impact on the patient's recovery from this condition:

Physician Signature: _____ Date (DD/MM/YYYY): 31/08/22

Return this form to:

thePersonal

P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7

Received
SEP 09 2022

Claim for Disability Benefits (Form NS-1a)

Use this form for accidents that occur on or after April 1, 2013.

This part is to be completed by the claimant or their representative or a Medical Doctor	Insurance Company:
	Policy Number:
	Date of Accident: (DD MM YYYY)

Part 1 Claimant Information

Name: Danielle MacDonald

Address: 3673 St. Pauls St

City, town or county: Halifax | Province: NS | Postal Code: B3K 3R1

Home Telephone: Area Code 902 7519631 95 | Work Telephone: Area Code | FAX Number: Area Code

Date of Birth (DD MM YYYY): 20/02/1993

Gender: ☐ Male ☒ Female

Part 2 Claim for Disability Benefits

(To be completed by Claimant or agent)

Are you claiming disability income benefits under the Mandatory Automobile Accident Insurance Benefits Regulation? ☐ Yes ☐ No

If yes, please complete the remainder of this part of the form. Your insurance claims adjuster may request additional information from you or your medical practitioner at a later date to assist the claims process. If no, then please do not complete or submit this form at this time.

Were you employed on the date of the accident? ☒ Yes ☐ No

Date first unable to work (DD MM YYYY): 08/18/2022

Between what dates are you claiming a Loss of Income? 08/18/2022 to present

History of Employment during the 12 months preceding the accident

Name of employer:	Name of employer:
MacGillivray Law Office	
Address: 5777 west St	Address:
City, town or county: Halifax | Province: NS | Postal Code: B3K 1H9	City, town or county | Province | Postal Code
From: Aug 2018 To: present	From: To:
Occupation: lawyer	Occupation:

If you were unemployed at the date of the accident, for how much of the 12 months preceding the accident were you employed and working?

Average gross weekly income $ .. $75,000/yr

Are you entitled to disability or other income benefits from your employer or any other source as a result of this accident? ☒ Yes ☐ No

If yes, from whom?

	Name	Amount	Per Week/Month
1.	Blue Cross	unsure. not yet approved	
2.			

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

I CERTIFY THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I CONFIRM THAT I HAVE CONSENTED TO THE COLLECTION, USE AND DISCLOSURE OF MY PERSONAL INFORMATION FOR THE DETERMINATION OF MY ELIGIBILITY FOR ACCIDENT AND/OR DISABILITY INCOME BENEFITS AS OUTLINED ON FORM NS-1.

Name (Please Print): Danielle MacDonald

Signature: [signature] Date: Sept 1/22

AFO61313 - 958 107 (2013-03)

Part 3 Information of Medical Doctor

(To be completed by Medical Doctor)

Name of Professional			Profession
Address			
City, town or county		Province	Postal Code
Administrative Contact Name		Facility Name	
Telephone Number	Area Code	FAX Number	Area Code

Part 4 Signature of Medical Doctor for Disability Benefits Claim

To the best of my knowledge, the claimant is totally disabled (unable to work)

From _____ to _____ inclusive.

If still disabled give approximate date patient should be able to return to work, _____ .

Name (Please Print) _____

Signature _____ Date _____

AFO61313 - 958 107 (2013-03)

Djemso Saric
Family Focus Medical Clinics - Walk In
4 Forest Hills Parkway
P.O. Box 21019
Dartmouth, NS B2W 6B2

Patient Information	**Claim Details**
Name: Danielle K MacDonald	**Attending Provider:** Dr. Djemso Saric
Address: 3673 St Pauls st halifax, NS B3K 3R1	

Notes

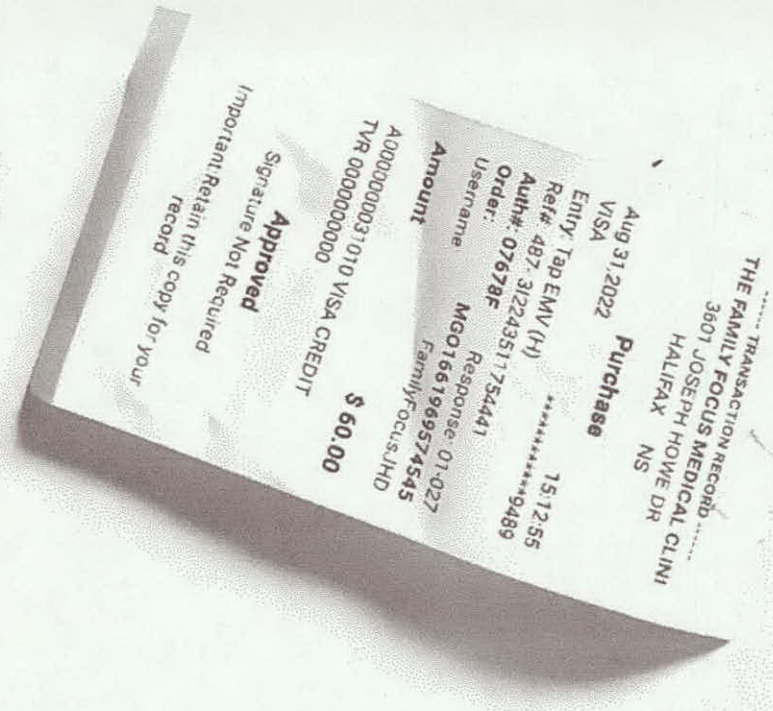
DR SARIC FORMS

Summary of Payments (Claim # 265442)

Service: PB020 Medical Report or Form 31-Aug-2022 **Calls:** 1

Payment Date	Payment Type	Payment Note	Payment Amount
31-Aug-2022	Visa		$ 60.00

Subtotal:	$ 60.00
Total Payment:	- $ 60.00
Write Off:	$ 0.00
Outstanding Balance:	$ 0.00



Printed: 31-Aug-2022 03:12 PM

AUTHORIZATION FOR WAGE INFORMATION

Claim No.: Q8065627

Claimant: Danielle Macdonald

Date: Sept 1/22

This form or a photostat thereof, will authorize you to give THE PERSONAL INSURANCE COMPANY or its representative, all information in your possession regarding my rate of pay, hours worked, amount of overtime, commissions, vacation allowance, nature of my employment, time lost from work and other information which they may require.

Signed 

Address 3673 St. Pauls St

Halifax NS B3K 3R1

pt Health and Wellness Centre Gladstone Halifax
2751 Gladstone St, Unit 8
Halifax, Nova Scotia B3K 4W6
Phone: (902) 492-4791 x2
Fax: (902) 429-8338

Bill To:

The Personal Insurance
Nova Scotia

Attention: David Phandanouvong

Invoice Number:	132.3849279.8
Invoice Date:	06-Sep-2022
Client Name:	Danielle MacDonald
Claim/Id Number:	Q8065627
Date of Injury:	17-Aug-2022
Area of Injury:	Neck
Primary Therapist:	P.Trivedi (002126)

Service Date	Provider	Description	Tax	Our Fee	Your Portion
23-Aug-2022	Purva Trivedi (PT,002126)	MVA Protocol Initial Assessment		$100.00	**$100.00**
		Total this Invoice:		**$100.00**	**$100.00**

FOR PAYMENT BY CHEQUE: Please make payable to **pt Health and Wellness Centre Gladstone Halifax** and quote the invoice number on your payment as a reference.

Balance is due upon receipt. Thank You.

Next Appointment(s):

4:00 PM	Thursday September 8, 2022	Purva Trivedi	MVA Physiotherapy Treatment

Facsimile

Note:

ATTN: D. Macdonald OOP Aug 30, 2022

To: ***From:*** (eFax) pt Health Gladstone

Phone: ***Phone:*** (647) 498-6546 * 97045

Fax: (844) 306-4550 ***Fax:*** 19024298338

Date: 2022-08-30

Pages: 2

lifemark pt Health **Initial Assessment Report** – Non protocol or Post protocol

Claimant Information	Claimant Name	Danielle MacDonald	Phone	
	Claim number		Claimant D.O.B (dd/mm/yyyy)	
	Insurer			
	Contact\adjuster		Phone	
			Fax	
	Date of Assessment	August 23, 2022	Date of Injury	

Injury and Assessment Information	Details of MVA: Rear ended. Hit face/head on the steering wheel.
	Diagnosis: Concussion + WAD II + Cervicogenic headaches.
	Subjective: - Nausea, Headaches, increased sensitivity to Light and Noise, Double vision, Tinnitus, Dizziness, loss of depth perception, Brain fog, Nightmares. Neck soreness + pain. Headaches worst at EOD.
	Objective: C-SP ROM: 70% of WNL + painful and stiff. VOMS: convergence + visual tracking: provocates the symptoms. Balance: Berg Balance scale: 50/56, Increased sensitivity to any visual/balance testing.
Barriers to recovery	Yes ☐ No ☑ Orebro Score: 132

Treatment Plan	Goals: - Rehabilitation and graduated Return to life post-concussion - Regain Neck ROM and strength. - Regain pre-accident level of function.	Plan: - Manual therapy - Exercises - Concussion Rehab - Balance training	Duration \Frequency: Physio - 3/wk for 8wks. Occupational therapy Assessment + consult - 1/wk

pt Health and Wellness Centre Gladstone Halifax | 2751 Gladstone St, Halifax, NS B3K 4W6 | P(902)492-4791 F(902)429-8338 | Website: pthea

Practitioner:	Purva Trivedi.	Profession:	physiotherapist
Signature:		Date:	Aug 30, 2022.
Report cc:			

Occupational therapy Assessment + consult will aid in graduated return to work/life activities.

thePersonal

Aug. 20, 2022

MACDONALD DANIELLE
3673 ST PAULS ST
HALIFAX B3K 3R1

Date of Loss: Aug. 17, 2022
Our Claim No.: Q8065627
Our Insured: MACDONALD DANIELLE

Our Claimant: Danielle Macdonald

Thank you for taking the time to speak with me today regarding your involvement in the above-noted motor vehicle accident. You indicated during our conversation that you did sustain injuries.

You may be eligible for Accident Benefits under your automobile policy. As discussed, the following forms are enclosed:

- Nova Scotia Accident Benefits Initial Claims Process
- Notice of Loss & Proof of Claim (Form NS-1)
- Claim for Disability Benefits (Form NS-1a)
- Treatment Plan (Form NS-2)
- Job Analysis Form
- Wage Information
- Employer's Confirmation of Income & Benefits

In order to apply for Accident Benefits, you should fully complete the enclosed forms and promptly return them to me in the envelope provided.

If you require assistance to complete the forms, or additional information, please do not hesitate to contact me. Please note that throughout the handling of your claim, calls may be recorded for accuracy, quality, and documentation purposes.

Yours truly,

David Phandanouvong
Claims Advisor - Accident Benefits
Tel. No.: (855) 212-1745#6325225
Fax No.: (844) 306-4550

P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7
Enclosures

thePersonal

Nova Scotia Accident Benefits Initial Claims Process

Overview

If you have been injured in an automobile accident in Nova Scotia, 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 found in the regulations, 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 to your Insurer**. Your primary health care practitioner will be able to bill the automobile insurer for all treatment services outlined in the "Diagnostic and Treatment Protocols" found in the Nova Scotia Automobile Policy (N.S.P.F. No.1) that are not covered by Nova Scotia 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, 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 Nova Scotia 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. **File an injury accident report with the police and your insurance company**.
2. **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.
3. **Complete the attached Notice of Loss and Proof of Claim Form (NS-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 a sprain, strain or 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 counselling 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 1-800-565-7189.

AFO61317 - 958 111 (2013-03)

Important Notice Concerning Your Personal Information

The personal information you provide in forms NS-1, NS-1a (Claim for Disability Benefits) or NS-2 (Treatment Plan) is collected under the authority of the Insurance Act, Nova Scotia'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 your insurance representative 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 NS-1 will ask for your consent or that of your insurance representative. 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 Nova Scotia 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.

Return this form to:

thePersonal

P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7

Notice of Loss and Proof of Claim (Form NS-1)

This form is effective on April 1, 2013 for accidents that occur on or after April 1, 2013.

This part is to be completed by your insurer	
	Claim Number: Q8065627
	Insurance Company: THE PERSONAL INSURANCE COMPANY
	Claim Representative: Phandanouvong David
	Policy Number: K9283904
	Date of Accident: 08/17/2022

Section 1: Claimant Information

(This section is to be completed by the injured person (the claimant) or the claimant's authorized representative (agent)

Part 1 Claimant Information

Name: Macdonald Danielle

Address

City, Town or County | Province | Postal Code

Home Telephone | Area Code | Work Telephone | Area Code | FAX Number | Area Code

Birth Date: year month day

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 a Nova Scotia Workers' Compensation Board Claim? ☐ Yes ☐ No

Are Extended Health Care Benefits Available? ☐ 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 NS-1a.

Part 2 Claimant's Authorized Representative Information, if applicable

Name

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 | Area Code | Work Telephone | Area Code | FAX Number | 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)

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

AFO61315 - 958 109 (2018-06)

Part 3 Claimant's Accident Details (con't)

(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	Area Code	FAX Number	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 NS-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 outlined on Form NS-1 and administering my claim.

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

Signature _____ Date _____

AFO61315 - 958 109 (2018-06)

Return this form to:

thePersonal

P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7

Claim for Disability Benefits (Form NS-1a)

Use this form for accidents that occur on or after April 1, 2013.

This part is to be completed by the claimant or their representative or a Medical Doctor	Insurance Company:
	Policy Number:
	Date of Accident: (DD MM YYYY)

Part 1 Claimant Information

Name					
Address					
City, town or county			Province		Postal Code
Home Telephone	Area Code	Work Telephone	Area Code	FAX Number	Area Code
Date of Birth (DD MM YYYY)		Gender ☐ Male ☐ Female			

Part 2 Claim for Disability Benefits

(To be completed by Claimant or agent)

Are you claiming disability income benefits under the Mandatory Automobile Accident Insurance Benefits Regulation? ☐ Yes ☐ No

If yes, please complete the remainder of this part of the form. Your insurance claims adjuster may request additional information from you or your medical practitioner at a later date to assist the claims process. If no, then please do not complete or submit this form at this time.

Were you employed on the date of the accident? ☐ Yes ☐ No	Date first unable to work (DD MM YYYY)
Between what dates are you claiming a Loss of Income?	to

History of Employment during the 12 months preceding the accident

Name of employer:			Name of employer:		
Address:			Address:		
City, town or county	Province	Postal Code	City, town or county	Province	Postal Code
From: To:			From: To:		
Occupation:			Occupation:		

If you were unemployed at the date of the accident, for how much of the 12 months preceding the accident were you employed and working?

Average gross weekly income $

Are you entitled to disability or other income benefits from your employer or any other source as a result of this accident? ☐ Yes ☐ No

If yes, from whom?

	Name	Amount	Per Week/Month
1.			
2.			

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

I CERTIFY THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I CONFIRM THAT I HAVE CONSENTED TO THE COLLECTION, USE AND DISCLOSURE OF MY PERSONAL INFORMATION FOR THE DETERMINATION OF MY ELIGIBILITY FOR ACCIDENT AND/OR DISABILITY INCOME BENEFITS AS OUTLINED ON FORM NS-1.

Name (Please Print) _____

Signature _____ Date _____

AFO61313 - 958 107 (2013-03)

Part 3 Information of Medical Doctor

(To be completed by Medical Doctor)

Name of Professional			Profession
Address			
City, town or county		Province	Postal Code
Administrative Contact Name		Facility Name	
Telephone Number	Area Code	FAX Number	Area Code

Part 4 Signature of Medical Doctor for Disability Benefits Claim

To the best of my knowledge, the claimant is totally disabled (unable to work)

From _____ to _____ inclusive.

If still disabled give approximate date patient should be able to return to work, _____ .

Name (Please Print) _____

Signature _____ Date _____

Return this form to:

thePersonal

P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7

Treatment Plan (Form NS-2)

Use this form for accidents that occur on or after April 1, 2013.

This part is to be completed by the claimant or their representative or a Primary Health Care Practioner	Insurance Company:
	Policy Number:
	Date of Accident: (DD MM YYYY)

Part 1 Claimant Information

Name	
Date of Birth (DD MM YYYY)	Date of Accident (DD MM YYYY)

Part 2 Claimant's Authorized Representative

Name			
Address			
City , town or county		Province	Postal Code
Relationship with Claimant ☐ Parent ☐ Guardian ☐ Other			
Home Telephone	Area Code	Work Telephone	Area Code
FAX Number	Area Code		

Part 3 Therapy Status Report

(To be completed by Primary Health Care Practitioner)

Diagnosis:

Key Subjective/Physical Examination Findings:

Diagnosis	ICD-10-CA Injury Code*
Sprain 1 ☐ 2 ☐ 3 ☐	
Strain 1 ☐ 2 ☐ 3 ☐	
WAD 1 ☐ 2 ☐ 3 ☐ 4 ☐	
Other	

Is the claimant employed or engaged in training activities?

☐ Full Time ☐ Part Time ☐ Seasonal ☐ Self-employed ☐ Retired ☐ Student ☐ Not employed

* ICD-10-CA injury codes are only required for Sprains, Strains and WAD injuries. It is recommended, not required, that ICD-10-CA injury codes be used for other injuries when practical.

Functional Goals (outcomes to be measured):

1.

2.

3.

Comments

Expected Number of Visits

Do you expect these visits to be sufficient to meet functional goals?

☐ Yes ☐ No If no, please provide details of expected further assessment and treatment

Do you expect to reassess within three weeks due to alerting factors?

☐ Yes ☐ No If yes, please describe

Date of expected treatment discharge : (DD MM YYYY)

Part 4 Treatment

(To be completed with reference to the Diagnostic and Treatment Protocols Regulation)

Treatment Provided

Do you expect the claimant to return to normal & essential activities?

☐ Yes ☐ Unable to determine ☐ No If yes, Date Expected?

Part 5 Primary Health Care Practitioner Information

Name of Primary Health Care Practitioner ☐ Medical Doctor ☐ Chiropractor ☐ Physical Therapist

Address

City, town or county | Province | Postal Code

Administrative Contact Name | Facility Name

Telephone Number (Area Code) | FAX Number (Area Code)

Part 6 Signature of Primary Health Care Practitioner

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

Name (Please Print) _____

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 NS-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 to 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 NS-1.

Name (Please Print) _____

Signature _____ Date _____

JOB ANALYSIS

Your employee (our client) was involved in a motor vehicle accident. We are the auto insurers working with the client to facilitate an early return to work. Please complete & return this form as soon as possible, along with the Employers Confirmation of Income Form. Thank you for your assistance.

Any questions please call Phandanouvong David
AB Claims Advisor ph: (855) 212-1745 #6325225

Our Claim # Q8065627

Employee Name: Macdonald Danielle

Job Title: Full Time ☐ or Part-time ☐ # hrs/day _____ # hrs/week _____

Company:

OVERALL JOB CLASSIFICATION: Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy ☐

ESSENTIAL TASKS:

PHYSICAL DEMANDS:

	TASK	% OF TIME IN WORK DAY			TOTAL # of MINUTES or HOURS	COMMENTS
		Never 0%	Sometimes to 50%	Frequently over 75%		
Activity	Sit					
	Stand					
	Walk					
	Drive					
	Climb					
	Kneel					
	Crawl/Crouch					
	Reach/Handle					

						WEIGHT				
						10 lbs	20 lbs	50 lbs	100 lbs	>100 lbs
Strength	Lift									
	Carry									
	Push									
	Pull									

						COMMENTS
Controls	Machinery					
	Tools/Equipment					
	Other					

ENVIRONMENTAL: _____
(Inside, Outside, Dust, Hazards, etc.)

Supervisor (please print) _____ ph: _____

Signature: _____ Date _____

AUTHORIZATION FOR WAGE INFORMATION

Claim No.: Q8065627

Claimant: Danielle Macdonald

Date: _____

This form or a photostat thereof, will authorize you to give THE PERSONAL INSURANCE COMPANY or its representative, all information in your possession regarding my rate of pay, hours worked, amount of overtime, commissions, vacation allowance, nature of my employment, time lost from work and other information which they may require.

Signed _____

Address _____

_____

EMPLOYER'S
CONFIRMATION OF INCOME BENEFITS

I.B.C. CLAIM FORM NO. 15

TO	Employer
	Your employee has authorized us, by the attached, to obtain details of his/her pay and benefits in order that we may determine the amount of disability payments. Your co-operation in completing and returning this form will be appreciated.

CLAIMANT	Employee Macdonald Danielle Claim No. / Policy No. Q8065627	
OCCUPATION		
PHYSICAL REQUIREMENTS OF JOB	☐ Heavy Manual ☐ Light Manual ☐ Sedentary	Accident Date Aug. 17, 2022
IF ON SALARY	Rate (Gross) $	☐ Per Week ☐ Per Month ☐ Per Year
IF ON HOURLY RATE	Basic hours worked per week $	Basic Rate per hour (Gross) $ / Cost of Living Bonus (Gross) $
	Shift Bonus paid in last three months preceding accident $	Overtime paid in last three months preceding accident $
Last Day Worked	Date salary or wages ceased	Length of time employed
INCOME REPLACEMENT PAID WHILE OFF WORK	Amount $ / per week/month	
	By whom paid?	Length of time payable
WORKERS' COMPENSATION	Is this employee eligible for Workers' Compensation as a result of the accident? ☐ Yes ☐ No	
MEDICAL EXPENSE RECOVERY PLAN IN FORCE	☐ Yes ☐ No	If "yes" with what company?
If returned to work, give Date		

Date	Signature	Title

thePersonal

March 01, 2023

PT HEALTH AND WELLNESS CENTRE GLADSTONE
2751 GLADSTONE STREET UNIT 8
HALIFAX NS B3K 4W6

Our Insured: MACDONALD DANIELLE

Date of Loss: Aug. 17, 2022

Our Claim No.: Q8065627

Claimant: Danielle Macdonald

Your claim and/or the documents, which were submitted with respect to a claim under the Accident Benefits coverage have been reviewed. Based on our review we are paying part or all of the benefits and/or expenses submitted. Please see below for an explanation of the amounts paid.

Type of Expense	From	To	Amount Claimed	Amount Paid
1- CONC TX	2022/10/04	2022/10/31	$890.00	$890.00

Reasons
1- Payable as submitted.

Where eligible and agreed upon, funds have been electronically deposited into your account.

Should you have any questions or wish to discuss this further, please do not hesitate to contact me.

Yours truly,

David Phandanouvong
Claims Advisor - Accident Benefits
Tel. No.: (855) 212-1745 #6325225
Fax No.: (844) 306-4550
P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7

Enclosure

thePersonal

March 01, 2023

PT HEALTH AND WELLNESS CENTRE GLADSTONE
2751 GLADSTONE STREET UNIT 8
HALIFAX NS B3K 4W6

Our Insured: MACDONALD DANIELLE

Date of Loss: Aug. 17, 2022

Our Claim No.: Q8065627

Claimant: Danielle Macdonald

Your claim and/or the documents, which were submitted with respect to a claim under the Accident Benefits coverage have been reviewed. Based on our review we are paying part or all of the benefits and/or expenses submitted. Please see below for an explanation of the amounts paid.

Type of Expense	From	To	Amount Claimed	Amount Paid
1- OT AX	2022/10/17	2022/10/17	$360.00	$210.00

Reasons
1- Payable as submitted.

Where eligible and agreed upon, funds have been electronically deposited into your account.

Should you have any questions or wish to discuss this further, please do not hesitate to contact me.

Yours truly,

David Phandanouvong
Claims Advisor - Accident Benefits
Tel. No.: (855) 212-1745 #6325225
Fax No.: (844) 306-4550
P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7

Enclosure

thePersonal

This fax is sent from DAVID PHANDANOUVONG
Please contact me in case of transmission problem

PO Box 7065
Mississauga ON
L5A 9Z9

855-212-1745 ext. #6325225

844-306-4550

Cover Page

February 24, 2023

This fax is being sent to:
PT HEALTH AND WELLNESS CENTRE GLADSTONE
via fax: 902-429-8338

CC:

CC:

This fax is about:
Client: DANIELLE MACDONALD
Client's address: 3673 ST PAULS ST
HALIFAX
B3K 3R1

Client's telephone number: 902-759-6325
Claim Number: Q8065627
Accident date: August 17, 2022

Hi Emily,
Further to our telephone conversation, the last treatment approval for Danielle was based on report dated January 13, 2023.
Physio 2x/week
OT 1x/week
Osteo 2/week
All for 8 weeks

Number of pages (including this page): 1

KB8B 51 040K
9823106400
20170919130101
W4 95 0L

KD


B730
NOVA SCOTIA
GHR 879


B730


EUROVAC
Aug 17/22
KD


CX-5
AWD
City
mazda
HALIFAX

MFD. BY MAZDA MOTOR CORPORATION

DATE 06/17

FRONT GAWR/PNBE AV 2370 LB 1075 KG
WITH/AVEC P225/55R19 99V TIRES/PNEUS
19X7J RIMS/JANTES
240 KPA/35 PSI COLD/A FROID

GVWR/PNBV 4643 LB 2106 KG
REAR GAWR/PNBE AR 2280 LB 1034 KG
WITH/AVEC P225/55R19 99V TIRES/PNEUS
19X7J RIMS/JANTES
240 KPA/35 PSI COLD/A FROID

VIN: JM3KFBDL3H0175448 TYPE:MPV/VTUM COLOR CODE:25D MADE IN JAPAN


km/h
mph
RANGE
26 km
95489 km
28 °C
E
F


3:49
Communication
RANGE
26 km
95489 km
ON
RES/+
OFF/CAN
SET/-
AUTO ON
AUTO
OFF
INT


INFO
ON
OFF/CAN
RES/+
SET/—
SRS
AIRBAG


NOVA SCOTIA
GHR 879
CX-5
AWD
City
mazda
HALIFAX

thePersonal

The Personal
Insurance Company
P.O. Box 7065, Station A
Mississauga, ON L5A 4K7

February 22, 2023

MACGILLIVRAY LAW
134, PROVOST STREET
PO BOX 753
NEW GLASGOW NS
B2H 5G2
lwhynott@macgillivraylaw.com

RE: **Policy Number: K9283904**
Date of Loss: August 17, 2022
File Number: Q8065627
Client Name: MACDONALD DANIELLE

Dear Madam/Sir:

Thank you for your letter dated January 30, 2023. Please find enclosed a copy of MACDONALD DANIELLE's (Accident Benefits/Property Damage) file, as requested. Paid to date is as follows:

Medical Rehabilitation Benefits	$ 6 309.49
Weekly Benefits	$ 3 453.30

If you have any questions or concerns, please do not hesitate to contact us and we will be happy to help.

Sincerely,

PHANDANOUVONG DAVID/SU
Claim Advisor, Accident Benefits
Toll Free: 1-855-212-1745 ext 6325225
Fax: 1-844-306-4550

Chapman Auto Body Harbourside CSN

259 Windmill Rd, Dartmouth, NS B3A 1G5
Office: (902) 466-6676
Fax: (902) 466-1059
info@chapmanautobody.com

Estimate ID
4906356
S1

Claim Number
Q8065627-018742025

Owner
MACDONALD DANIELLE
3673 ST PAULS ST
HALIFAX, NS B3K3R1
(902) 759-6325 (Home)
daniellejmacdonald@hotmail.com

Insured
MACDONALD DANIELLE

Appraiser
Alyssa Gillingham
alyssa@chapmanautobody.com

Classification
None

Supplemented By
Shelley Fifield
shelley@chapmanautobody.com

Underwriter
THE PERSONAL INSURANCE COMPANY

Classification
None

THE PERSONAL INSURANCE COMPANY

Insurance Company
THE PERSONAL INSURANCE COMPANY

Loss Type
Unknown

Claim Number
Q8065627-018742025

Policy Number
K9283904

Adjuster
NAVEED BAREKZAI
(866) 688-3888+4321964 (Work)

Deductible
Unknown

Loss Date
08-17-2022

Inspection Site
Unknown

Repair Facility
Unknown

2017 Mazda CX-5 GT 4 Door Utility 2.5L 4 Cyl Gas Injected AWD

Exterior Color
25D (Snowflake White Pearl Metallic)

License
NS-GHR 879

VIN
JM3KFBDL3H0175448

Condition
Good

Drivable
No

Odometer
95489

Mitchell Service Code
911974

Primary Point of Impact
Rear (6)

Secondary Point(s) of Impact
Front (12)

Options

4WD or AWD	Air Conditioning	All Wheel Drive	Anti-Lock Brake Sys. (ABS)	Auto Air Condition
Automatic Headlights	Daytime Running Lights	Driver Seat With Power Lumbar Support	Driver-Front Air Bag	Dual A/C
Electric Defogger	Electronic Stability Control	First Row Bucket Seat	Fog Lights	Front Heated Seats
Genuine Wood Trim	HD Radio	Heated Mirror	Heated Seats	Heated Steering Wheel

Interior Automatic Day/Night Or Electrochromatic Mirror	Keyless Entry System	Leather Seats	Left-Curtain Air Bag	Manual Sunroof
Navigation Sys.	Passenger-Front Air Bag	Power Driver Seat	Power Passenger Seat	Power Rear Liftgate
Power Remote Mirror	Power Windows	Premium Sound Sys.	Privacy Glass	Rain Sensing Wipers
Rear Bench Seat	Rear Gate Wiper	Rear Spoiler	Rearview Camera	Remote Decklid Or Tailgate Release
Second Row Side Airbag With Head Protection	Side Airbags	Side Blind Zone Alert	Smart Key System	Steering Wheel Mounted Audio Control
Tilt Steering Wheel	Tire Pressure Monitoring System	Traction Control/Electronic	Trip Computer	Universal Garage Door Opener

MACDONALD DANIELLE | 2017 Mazda CX-5 GT

Parts Profile
N/A

Parts Profile Version
N/A

				LABOR		PART			
Line #	Description	Operation	Type	Total Units	Type	Number	Qty	Total Price	Tax
Front Bumper									
S1 1 101659	Frt Bumper Cover	Repair	Body	1.5*#	Aftermarket New			$268.82*	Yes
S1 2 AUTO	Frt Bumper Cover	Refinish Only	Refinish	1.8*# C	Existing				
3 900501	Modified Refinish With Full Clear Coat								
4 101664	L Frt Bumper Tow Hook Cover	Remove / Replace	Body	0.0	New	KL2F-50-A11-BB	1	$30.09	Yes
5 AUTO	Frt Tow Hook Cover	Refinish Only	Refinish	0.2 C					
Grille									
6 AUTO	Grille Assy	Overhaul	Body	1.2#	Existing				
S1 7 101438	Grille Mesh	Remove / Replace	Body	INC#	New	KB8A-50-719A	1	$85.27	Yes
S1 8 AUTO	Grille Assy	Remove / Install	Body	INC#					
9 101440	L Lwr Grille Moulding	Remove / Replace	Body	INC#	New	KB8A-50-7K1B	1	$124.04	Yes
10 AUTO	Frt Bumper Cover	Remove / Install	Body	1.8					
11 101419	Grille Emblem	Remove / Replace	Body	INC	New	KA0G-51-730	1	$57.78	Yes
S1 12 102082	Grille Ornament Base	Remove / Replace	Body	INC	New	KB8A-50-721	1	$38.42	Yes
S1 13 102120	Upr Grille Cover	Remove / Replace	Body	INC#	New	KB8A-50-7E1B-BB	1	$186.17	Yes
S1 14 AUTO	Upr Grille	Refinish Only	Refinish	1.0 C					
S1 15 101295	Upr Grille Bracket	Remove / Replace	Body	INC#	New	KB8A-50-717D	1	$68.52	Yes
Front Lamps									
S1 16 101444	L Frt Combination Lamp	Remove / Replace	Body	0.3#	New	KL2L-51-041C	1	$2,282.86	Yes
S1 17 900510	Line Markup 0.0%							$0.00	
18 900501	lkq Not available								
Front Inner Structure									

			LABOR			PART				
Line #		Description	Operation	Type	Total Units	Type	Number	Qty	Total Price	Tax
19	101299	Frt Body Radiator Support (Com)	Remove / Replace	Body	4.2#	New	K157-53-110B	1	$376.23	Yes
20	AUTO	Headlamps	Check / Adjust	Body	0.4					
21	AUTO	R Front Combination Lamp	Remove / Install	Body	0.3#					
22	AUTO	L Front Combination Lamp	Remove / Install	Body	INC#					
23	AUTO	Evacuate & Recharge A/C -M	Remove / Replace	Mechanical	1.4					
24	AUTO	Add To R&I/R&R Mechanical Components -M	Remove / Replace	Mechanical	1.0#					
25	101305	Upr Frt Body Front Crossmember	Remove / Replace	Body	INC#	New	KB7W-53-150B	1	$77.45	Yes
Exhaust										
26	101503	Frt Exhaust Gasket	Remove / Replace	Body	INC	New	PE23-40-305	1	$20.09	Yes
S1 27	101506	Exhaust Pipe & Converter -M	Remove / Replace	Mechanical	INC	New	[PYE9-20-55X]	1	$919.66*	Yes
28	101542	Exhaust Muffler Gasket	Remove / Replace	Body	INC	New	PE23-40-305	1	$20.09	Yes
29	AUTO	Exhaust System Components -M	Remove / Replace	Mechanical	1.6#				$0.00	
30	101559	Exhaust Muffler -M	Remove / Replace	Mechanical	INC	New	PYD8-40-100A	1	$842.42	Yes
31	101551	Exhaust Muffler Heat Shield	Remove / Replace	Body	INC#	New	KD53-56-451	1	$32.00	Yes
Quarter Panel										
32	100007	R Quarter Panel Outside	Blend	Refinish	0.9 C	Existing				
33	100038	L Quarter Panel Outside	Blend	Refinish	0.9 C	Existing				
34	100556	R Quarter Wheel Opening Mldg	Remove / Install	Body	INC#	Existing				
35	100557	L Quarter Wheel Opening Mldg	Remove / Install	Body	INC#	Existing				
Quarter Glass										
36	100807	R Quarter Glass	Remove / Install	Glass	2.2#	Existing				
37	100808	L Quarter Glass	Remove / Install	Glass	2.2#	Existing				
38	100652	Qtr Glass Adhesive	Remove / Replace	Body	0.0	New	N.A.	1	$64.00*	Yes
Liftgate										
39	100653	Liftgate Shell	Remove / Replace	Body	6.3#	New	KBY1-62-02XD	1	$1,481.87	Yes
40	AUTO	Liftgate Outside	Refinish Only	Refinish	2.6 C					
41	AUTO	Add For Liftgate Inside	Refinish Only	Refinish	1.3 C					
42	AUTO	Add w/Pinch Sensor	Remove / Replace	Body	0.6					
43	100801	Finish Panel	Refinish Only	Refinish	1.0 C	Existing				
44	100803	Garnish Moulding	Refinish Only	Refinish	1.2 C	Existing				
45	101055	L Liftgate Adhesive Nameplate	Remove / Replace	Body	0.1	New	DD1H-51-781	1	$18.49	Yes

				LABOR			PART			
Line #		Description	Operation	Type	Total Units	Type	Number	Qty	Total Price	Tax
46	101054	L Liftgate Adhesive Nameplate	Remove / Replace	Body	0.1	New	KB7W-51-721A	1	$34.93	Yes
47	101053	R Liftgate Adhesive Nameplate	Remove / Replace	Body	0.1	New	KB7W-51-771	1	$58.85	Yes
S1 48	100608	Liftgate Latch	Remove / Replace	Body	INC#	New	G33M-62-310B	1	$511.99*	Yes
S1 49	AUTO	Liftgate Trim Panel	Remove / Install	Body	INC#					
50	100874	Liftgate Glass	Remove / Install	Glass	INCr#	Existing				
51	AUTO	Liftgate Garnish	Remove / Install	Body	INC#					
52	AUTO	Liftgate Spoiler	Remove / Install	Body	INC#					
53	100883	Liftgate Glass Adhesive	Remove / Replace	Body	0.0	New	N.A.	1	$60.00*	Yes
Rear Suspension										
S1 54	100958	Rear Susp Crossmember -M	Remove / Replace	Mechanical	5.8#	Qual Recycled Part	~325690161	1	$370.00*	Yes
S1 55	900510	Line Markup 20.0%							$74.00	
Rear Body										
56	100668	Rear Body Panel	Repair	Body	3.0*#	Existing				
57	AUTO	Rear Body Panel	Refinish Only	Refinish	1.6 C	Existing				
58	101637	Keyless Entry Antenna	Remove / Replace	Body	0.2#	New	KD47-67-6NXA	1	$70.25	Yes
Rear Lamps										
59	100817	R Rear Combination Lamp	Remove / Install	Body	0.3	Existing				
Rear Bumper										
60	101995	Rear Bumper Cover	Remove / Replace	Body	INC#	New	KLYF-50-22X-BB	1	$669.00	Yes
61	AUTO	L Rear Combination Lamp	Remove / Install	Body	0.3					
62	AUTO	Rear Bumper Cover	Refinish Only	Refinish	2.6# C					
63	101996	R Rear Bumper Tow Hook Cover	Remove / Replace	Body	INC	New	KL2F-50-EK1-BB	1	$24.12	Yes
64	AUTO	R Rear Tow Hook Cover	Refinish Only	Refinish	INC C					
65	101997	L Rear Bumper Tow Hook Cover	Remove / Replace	Body	INC	New	KB8A-50-EL1-BB	1	$4.74	Yes
66	AUTO	L Rear Tow Hook Cover	Refinish Only	Refinish	INC C					
67	101151	R Rear Bumper Cover Retainer	Remove / Replace	Body	0.2#	New	KB8A-50-2H1B	1	$21.97	Yes
68	101152	L Rear Bumper Cover Retainer	Remove / Replace	Body	0.2#	New	KB8A-50-2J1B	1	$21.97	Yes
69	101148	R Rear Bumper Reflector	Remove / Replace	Body	INC#	New	KB8A-51-5L0C	1	$128.58	Yes
70	AUTO	Rear Bumper Cover	Remove / Install	Body	INC#					
71	101162	Rear Bumper Reinforcement Bar	Remove / Replace	Body	0.4#	New	KD35-50-260D	1	$262.61	Yes
72	AUTO	Rear Bumper Cover Assy	Overhaul	Body	2.4#	Existing				
Additional Costs & Materials										

		LABOR			PART				
Line #	Description	Operation	Type	Total Units	Type	Number	Qty	Total Price	Tax
73 AUTO	Paint/Materials	Additional Cost						$752.00*	Yes
74 AUTO	Hazardous Waste Disposal	Additional Cost						$5.00*	Yes
75 AUTO	Shop Materials	Additional Cost						$35.60*	Yes
76 936014	Flex Additive	Additional Cost						$20.00*	Yes
Additional Operations									
77 AUTO	Clear Coat	Additional Operation	Refinish	3.7				$0.00	
78 933006	Frame/Rack Set Up	Additional Operation	Frame	2.0*				$0.00	
79 933036	Sheetmetal Pull	Additional Operation	Frame	2.0*				$0.00	
80 931128	Post Repair Scan	Additional Operation	Mechanical	0.5*				$0.00	
81 931127	Pre Repair Scan	Additional Operation	Mechanical	0.5*				$0.00	
Body Components									
82 931105	Four Wheel Alignment	Repair	Mechanical	0.0*	Sublet			$99.95*	
Special / Manual Entry									
83 900500	Align Front Sheet Metal	Additional Labor	Body*	1.0*	Existing				

***** Judgment Item
C Included in Clear Coat Calculation
T Included in Two Tone Calculation
A Included in Clear Coat and Two Tone Calculation
Labor Note Applies
r CEG R&R Time Used for this Labor Operation
d Discontinued by Manufacturer
[ ] Verify the part number and price before ordering

Recycled Part Vendors

LKQ Vance Hanes
(902) 897-0252 (Work)

Line	Part #	Total Price	Vehicle	Description	VIN
54	~325690161	**$370.00**		Suspension Crossmember/K-Frame - LKQ Quote #: 1411588733 Desc: Suspension Crossmember/K-Frame REAR, AWD Stock Number: $HL603-975 Cond: A Year: 2017 Damage: 000 GUID #: 325690161	

Supplier Notes: APU, Quote#: 111662873923764 Stock Number: ~325690161 / RECY

Disclaimer: Recycled part pricing may represent either actual pricing (the price at which the recycler is willing to sell the part for in its existing condition) or undamaged pricing (the price at which the recycler would sell the part if it was in undamaged condition). If you are unsure, please contact the automotive recycler.

Estimate Totals

Labor	Units	Rate	Sublet Add'l Amount	Totals

Estimate Totals

Body Labor	24.9	$62.00			$1,543.80
Refinish Labor	18.8	$62.00			$1,165.60
Glass Labor	4.4	$62.00			$272.80
Frame Labor	4.0	$62.00			$248.00
Mechanical Labor	10.8	$82.00	$99.95		$985.55
Total Labor	62.9				$4,215.75
				Taxable	$4,215.75
				HST 15.0000%	$632.36
				Non-Taxable	$0.00
				Labor Total	$4,848.11

Parts	Amount			
Taxable Parts	$9,233.28			$9,233.28
			Parts Adjustments	$74.00
			HST 15.0000%	$1,396.09
			Non-Taxable	$0.00
			Parts Total	$10,703.37

Costs	Amount			
Other Additional Costs	$60.60			$60.60
Paint Materials	$752.00			$752.00
			Taxable	$812.60
Paint Materials Rate: $40.00			HST 15.0000%	$121.89
Rate Max: 99.9 units			Non-Taxable	$0.00
Additional Rate: $0.00			**Costs Total**	$934.49

Gross Totals	Amount			
Gross Total	$16,485.97			$16,485.97
			Taxable	$14,335.63
			HST	$2,150.34
			Non-Taxable	$0.00
			Gross Total	$16,485.97

Adjustments	Amount	
Total Customer Responsibility		$0.00

Net Estimate Total Can $16,485.97

Less Original Net Total	$15,735.09
Net Supplement Amount	$750.88

S1: Shelley Fifield **$750.88**

Cycle Time Information

Due In	2022-09-09
Arrived At Shop	2022-09-09
Repair In Progress	2022-11-07
Ready for Delivery	2022-11-30

Estimate Event Log

Job Created	8-17-2022 05:02 PM
Supplement 1 Started	8-17-2022 05:12 PM
Supplement 1 Printed	11-30-2022 01:30 PM
Supplement 1 Committed	11-30-2022 01:30 PM
Estimate Version	1

Date: 11/30/2022 1:30:33 PM
Estimate ID: 4906356
Supplement: 1 - 11/30/2022 1:30:32 PM
Profile ID: DGIG Shop Nova Scotia

Supplement Delta Report
Comparison of Estimate 4906356 Supplement 0 and Supplement 1

Damage Assessed By: Alyssa Gillingham
Supplemented By: Shelley Fifield

Insured: MACDONALD DANIELLE
Owner: MACDONALD DANIELLE
Vehicle: 2017 Mazda CX-5 GT
Date of Loss: 08/17/2022

Line Item	Labor Type	Operation	Line Item Description	Part Type/Num	Dollar Amount	Labor Units	CEG Unit
Changed Entries							
1	Body	REPAIR	Frt Bumper Cover	Existing Existing	0.00	1.5*	0.00
1	Body	REPAIR	Frt Bumper Cover	Aftermarket New< Aftermarket New	268.82*<	1.5*	0.00T<
6	Body	REMOVE/REPLACE	L Lwr Grille Moulding	New KB8A-50-7K1B	124.04	0.20	0.20T
9<	Body	REMOVE/REPLACE	L Lwr Grille Moulding	New KB8A-50-7K1B	124.04	INC	0.20T
8	Body	REMOVE/REPLACE	Grille Emblem	New KA0G-51-730	57.78	0.20	0.20T
11<	Body	REMOVE/REPLACE	Grille Emblem	New KA0G-51-730	57.78	INC	0.20T
9	Body	REMOVE/REPLACE	L Frt Combination Lamp	Recycled ~327689367	1,371.00	0.30	0.30T
16<	Body	REMOVE/REPLACE	L Frt Combination Lamp	New< KL2L-51-041C	2282.86<	0.30	0.30T
10		LINE MARKUP	Line Markup 20.0%		274.20		
17<		LINE MARKUP	Line Markup 0.0%<		0.00		
20	Mechanical	REMOVE/REPLACE	Exhaust Pipe & Converter -M	New PYE9-20-55X	2,254.77	INC	1.90T
27<	Mechanical	REMOVE/REPLACE	Exhaust Pipe & Converter -M	New PYE9-20-55X	919.66*<	INC	1.90T

23	Body	REMOVE/REPLACE	Exhaust Muffler Heat Shield	New KD53-56-451	32.00	0.40	0.40T
31<	Body	REMOVE/REPLACE	Exhaust Muffler Heat Shield	New KD53-56-451	32.00	INC	0.40T
44	Mechanical	REMOVE/REPLACE	Rear Susp Crossmember -M	Recycled ~325690161	354.00	5.80	5.80T
54<	Mechanical	REMOVE/REPLACE	Rear Susp Crossmember -M	Recycled ~325690161	370.00*<	5.80	5.80T
45		LINE MARKUP	Line Markup 20.0%		70.80		
55<		LINE MARKUP	Line Markup 20.0%		74.00		
58	Body	REMOVE/REPLACE	R Rear Bumper Cover Retainer	New KB8A-50-2H1B	21.97	INC	0.20T
67<	Body	REMOVE/REPLACE	R Rear Bumper Cover Retainer	New KB8A-50-2H1B	21.97	0.20<	0.20T
59	Body	REMOVE/REPLACE	L Rear Bumper Cover Retainer	New KB8A-50-2J1B	21.97	INC	0.20T
68<	Body	REMOVE/REPLACE	L Rear Bumper Cover Retainer	New KB8A-50-2J1B	21.97	0.20<	0.20T
63		ADD'L COST	Paint/Materials		704.00*		T
73<		ADD'L COST	Paint/Materials		752.00*<		T
67	Refinish	ADD'L OPR	Clear Coat		0.00	3.50	0.00
77<	Refinish	ADD'L OPR	Clear Coat		0.00	3.70<	0.00

Added Entries

6	Body	OVERHAUL	Grille Assy	Existing Existing	0.00	1.20	1.20
7	Body	REMOVE/REPLACE	Grille Mesh	New KB8A-50-719A	85.27	INC	0.20T
8	Body	REMOVE/INSTALL	Grille Assy			INC	0.40
12	Body	REMOVE/REPLACE	Grille Ornament Base	New KB8A-50-721	38.42	INC	0.00T
13	Body	REMOVE/REPLACE	Upr Grille Cover	New KB8A-50-7E1B-BB	186.17	INC	0.40T
14	Refinish	REFINISH	Upr Grille			1.00	1.00
15	Body	REMOVE/REPLACE	Upr Grille Bracket	New KB8A-50-717D	68.52	INC	0.30T
18			lkq Not available				
48	Body	REMOVE/REPLACE	Liftgate Latch	New G33M-62-310B	511.99*	INC	0.30T
49	Body	REMOVE/INSTALL	Liftgate Trim Panel			INC	0.70

Global Changes

No Deductible, Deductible Reduction Credit, Customer Responsibility, Labor Rate, or Part Adjustment changes were made.

		Amount
Original Estimate		15,735.09
Supplement 1	750.88	
Orig Total Tax	2052.40	
Supp 1 Total Tax	2150.34	
Net Supplement Amount		750.88
Net Total		16,485.97

	Program Calc Version	Data Versions
Supp 0	4	SEP_22_V
Supp 1	11	SEP_22_V

Software Version: 22.4

thePersonal

Feb. 16, 2023

PT HEALTH AND WELLNESS CENTRE GLADSTONE
2751 GLADSTONE STREET UNIT 8
HALIFAX NS B3K 4W6

Our Insured: MACDONALD DANIELLE

Date of Loss: Aug. 17, 2022

Our Claim No.: Q8065627

Claimant: Danielle Macdonald

Your claim and/or the documents, which were submitted with respect to a claim under the Accident Benefits coverage have been reviewed. Based on our review we are paying part or all of the benefits and/or expenses submitted. Please see below for an explanation of the amounts paid.

Type of Expense	From	To	Amount Claimed	Amount Paid
1- REPORT FEE	2023/01/13	2023/01/13	$50.00	$50.00

Reasons
1- Payable as submitted.

Where eligible and agreed upon, funds have been electronically deposited into your account.

Should you have any questions or wish to discuss this further, please do not hesitate to contact me.

Yours truly,

David Phandanouvong
Claims Advisor - Accident Benefits
Tel. No.: (855) 212-1745 #6325225
Fax No.: (844) 306-4550
P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7

Enclosure

thePersonal

Feb. 16, 2023

PT HEALTH AND WELLNESS CENTRE GLADSTONE
2751 GLADSTONE STREET UNIT 8
HALIFAX NS B3K 4W6

Our Insured: MACDONALD DANIELLE

Date of Loss: Aug. 17, 2022

Our Claim No.: Q8065627

Claimant: Danielle Macdonald

Your claim and/or the documents, which were submitted with respect to a claim under the Accident Benefits coverage have been reviewed. Based on our review we are paying part or all of the benefits and/or expenses submitted. Please see below for an explanation of the amounts paid.

Type of Expense	From	To	Amount Claimed	Amount Paid
1- Non-Protocol Inv.132.9279.33	----------	----------	$276.00	$276.00
2- Non-Protocol Inv.132.9279.33	----------	----------	$120.00	$120.00
3- Non-Protocol Inv.132.9279.33	----------	----------	$550.00	$210.00

Reasons

1- See reverse for invoice details
2- See reverse for invoice details
3- See reverse for invoice details

(see over)

Treatment	Visits Paid	Amount Claimed	Collateral Amount	Amount Payable	Interest
1 - Invoice: 132.9279.33	2	$276.00	$0.00	$276.00	$0.00
2 - Invoice: 132.9279.33	2	$120.00	$0.00	$120.00	$0.00
3 - Invoice: 132.9279.33	5	$550.00	$340.00	$210.00	$0.00

Reasons

1 - Expense is Covered as submitted.
2 - Expense is Covered as submitted.
3 - Expense is Covered as submitted.

Where eligible and agreed upon, funds have been electronically deposited into your account.
Should you have any questions or wish to discuss this further, please do not hesitate to contact me.

Yours truly,

David Phandanouvong

Claims Advisor - Accident Benefits

Tel. No.: (855) 212-1745 #6325225
Fax No.: (844) 306-4550

P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7

Enclosures

thePersonal

Feb. 16, 2023

PT HEALTH AND WELLNESS CENTRE GLADSTONE
2751 GLADSTONE STREET UNIT 8
HALIFAX NS B3K 4W6

Our Insured: MACDONALD DANIELLE

Date of Loss: Aug. 17, 2022

Our Claim No.: Q8065627

Claimant: Danielle Macdonald

Your claim and/or the documents, which were submitted with respect to a claim under the Accident Benefits coverage have been reviewed. Based on our review we are paying part or all of the benefits and/or expenses submitted. Please see below for an explanation of the amounts paid.

Type of Expense	From	To	Amount Claimed	Amount Paid
1- Non-Protocol Inv.132.9279.13	----------	----------	$110.00	$25.00

Reasons

1- See reverse for invoice details

(see over)

Treatment	Visits Paid	Amount Claimed	Collateral Amount	Amount Payable	Interest
1 - Invoice: 132.9279.13	1	$110.00	$85.00	$25.00	$0.00

Reasons

1 - Expense is Covered as submitted.

Where eligible and agreed upon, funds have been electronically deposited into your account.
Should you have any questions or wish to discuss this further, please do not hesitate to contact me.

Yours truly,

David Phandanouvong

Claims Advisor - Accident Benefits

Tel. No.: (855) 212-1745 #6325225
Fax No.: (844) 306-4550

P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7

Enclosures

MACGILLIVRAY LAW OFFICE

PAYMENT DATE: 20230209 (Y/A M/M D/J)
PAY END DATE: 20230210 (Y/A M/M D/J)

STATEMENT OF EARNINGS AND DEDUCTIONS

EARNINGS	DATE YMMDD	RATE	CURRENT HRS/UNITS	CURRENT AMOUNT	YTD HRS/UNITS	YTD AMOUNT
REGULAR		0.0000	40.00	1557.69-	0.00	0.00
REGULAR		0.0000	40.00	3115.38	94.25	3670.27
TXB RRSP		0.0000	0.00	50.00	0.00	150.00
TOTAL EARNINGS				1607.69		3820.27
LESS TAXABLE BENEFITS				50.00		150.00
TOTAL GROSS				1557.69		3670.27

DEDUCTIONS	CURRENT AMOUNT	YTD AMOUNT	DEDUCTIONS	CURRENT AMOUNT	YTD AMOUNT
GOV PENS	87.65	203.28	EI CONT	26.21	62.27
FEDL TAX	245.32	478.66	RRSP	50.00	150.00
MEDICAL	66.44	199.32			
TOTAL DEDUCTIONS				475.62	1093.53

NET PAY 1082.07

OTHER	CURRENT	YTD
FED EXEM	15000.00	0.00
PROV. EXEM.	8481.00	0.00

NON NEGOTIABLE

1BBL 16
MACDONALD DANIELLE
3673 ST. PAUL'S STREET
APT A
HALIFAX NS B3K 3R1
CANADA

SAVINGS ACCT:
DEDN. DEP. ACCT:
EMPL./PAYEE ID.: 1BBL 16
OCCUPATION: ASSOCIATE LAWYER
NO. PAY PER.: 03 OF 26

NET PAY: **$***1082.07**

NOTIFICATION OF DEPOSIT TO ACCT.: XXXXXXXXXXX7182

pt Health and Wellness Centre Gladstone Halifax
2751 Gladstone St, Unit 8
Halifax, Nova Scotia B3K 4W6
Phone: (902) 492-4791
Fax: (902) 429-8338

Bill To:

The Personal Insurance
Nova Scotia

Attention: David Phandanouvong

Invoice Number:	132.3849279.33
Invoice Date:	03-Feb-2023
Client Name:	Danielle MacDonald
Claim/Id Number:	Q8065627
Date of Injury:	17-Aug-2022
Diagnosis:	41 Concussion
Area of Injury:	Neck
Primary Therapist:	P.Trivedi (PT) Registered Physiotherapist (002126)

Service Date	Provider	Description	Tax	Our Fee	Your Portion
03-Jan-2023	Sophie Arsenault (OS,NSAO 21114, OAO 31298, MT7028)	Osteopathic Treatment	H	$120.00	**$120.00**
04-Jan-2023	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
05-Jan-2023	Sophie Arsenault (OS,NSAO 21114, OAO 31298, MT7028)	Osteopathic Treatment	H	$120.00	**$120.00**
05-Jan-2023	Nicole Kelly (OT,Occupational therapist)	Occupational Therapy Services		$60.00	**$60.00**
06-Jan-2023	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$25.00**
11-Jan-2023	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$25.00**
13-Jan-2023	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Non-Protocol Report		$50.00	**$50.00**
19-Jan-2023	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$25.00**
19-Jan-2023	Nicole Kelly (OT,Occupational therapist)	MVA Occupational Therapy Treatment		$60.00	**$60.00**
24-Jan-2023	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$25.00**
		HST(807448758RT0001)		$ 36.00	$ 36.00
		Total this Invoice:		**$996.00**	**$656.00**

H - HST

FOR PAYMENT BY CHEQUE: Please make payable to **pt Health and Wellness Centre Gladstone Halifax** and quote the invoice number on your payment as a reference.

Balance is due upon receipt. Thank You.

Next Appointment(s):

12:30 PM	Tuesday February 7, 2023	Purva Trivedi	MVA Physiotherapy Concussion TX

MACGILLIVRAY LAW OFFICE

PAYMENT DATE: 20230126 Y/A M/M D/J
PAY END DATE: 20230127 Y/A M/M D/J

STATEMENT OF EARNINGS AND DEDUCTIONS

EARNINGS	DATE YMMDD	RATE	CURRENT HRS/UNITS	CURRENT AMOUNT	YTD HRS/UNITS	YTD AMOUNT
REGULAR		0.0000	35.00	1752.40-	0.00	0.00
REGULAR		0.0000	35.00	3115.38	54.25	2112.58
TXB RRSP		0.0000	0.00	50.00	0.00	100.00
TOTAL EARNINGS				1412.98		2212.58
LESS TAXABLE BENEFITS				50.00		100.00
TOTAL GROSS				1362.98		2112.58

DEDUCTIONS	CURRENT AMOUNT	YTD AMOUNT	DEDUCTIONS	CURRENT AMOUNT	YTD AMOUNT
GOV PENS	76.06	115.63	EI CONT	23.03	36.06
FEDL TAX	190.63	233.34	RRSP	50.00	100.00
MEDICAL	66.44	132.88			
TOTAL DEDUCTIONS				406.16	617.91

NET PAY 956.82

OTHER	CURRENT	YTD
FED EXEM	15000.00	0.00
PROV. EXEM.	8481.00	0.00

NON NEGOTIABLE

1BBL 16
MACDONALD DANIELLE
3673 ST. PAUL'S STREET
APT A
HALIFAX NS B3K 3R1
CANADA

SAVINGS ACCT:
DEDN. DEP. ACCT:
EMPL./PAYEE ID.: 1BBL 16
OCCUPATION: ASSOCIATE LAWYER
NO. PAY PER.: 02 OF 26

NET PAY: **$****956.82**

NOTIFICATION OF DEPOSIT TO ACCT.: XXXXXXXXXXX7182

thePersonal

Jan. 26, 2023

PT HEALTH AND WELLNESS CENTRE GLADSTONE
2751 GLADSTONE STREET UNIT 8
HALIFAX NS B3K 4W6

Our Insured: MACDONALD DANIELLE

Date of Loss: Aug. 17, 2022

Our Claim No.: Q8065627

Claimant: Danielle Macdonald

Your claim and/or the documents, which were submitted with respect to a claim under the Accident Benefits coverage have been reviewed. Based on our review we are paying part or all of the benefits and/or expenses submitted. Please see below for an explanation of the amounts paid.

Type of Expense	From	To	Amount Claimed	Amount Paid
1- Non-Protocol Inv.132.9279.21	----------	----------	$240.00	$240.00
2- Non-Protocol Inv.132.9279.21	----------	----------	$552.00	$466.00
3- Non-Protocol Inv.132.9279.21	----------	----------	$770.00	$770.00

Reasons

1- See reverse for invoice details
2- See reverse for invoice details
3- See reverse for invoice details

(see over)

Treatment	Visits Paid	Amount Claimed	Collateral Amount	Amount Payable	Interest
1 - Invoice: 132.9279.21	2	$240.00	$0.00	$240.00	$0.00
2 - Invoice: 132.9279.21	4	$552.00	$86.00	$466.00	$0.00
3 - Invoice: 132.9279.21	7	$770.00	$0.00	$770.00	$0.00

Reasons

1 - Expense is Covered as submitted.
2 - Expense is Covered as submitted.
3 - Expense is Covered as submitted.

Where eligible and agreed upon, funds have been electronically deposited into your account.
Should you have any questions or wish to discuss this further, please do not hesitate to contact me.

Yours truly,

David Phandanouvong

Claims Advisor - Accident Benefits

Tel. No.: (855) 212-1745 #6325225
Fax No.: (844) 306-4550

P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7

Enclosures

MACGILLIVRAY LAW OFFICE

PAYMENT DATE: 20230112 Y/A M/M D/J
PAY END DATE: 20230113 Y/A M/M D/J

STATEMENT OF EARNINGS AND DEDUCTIONS

EARNINGS	DATE YMMDD	RATE	CURRENT HRS/UNITS	CURRENT AMOUNT	YTD HRS/UNITS	YTD AMOUNT
REGULAR		0.0000	19.25	2365.78-	0.00	0.00
REGULAR		0.0000	19.25	3115.38	19.25	749.60
TXB RRSP		0.0000	0.00	50.00	0.00	50.00
TOTAL EARNINGS				799.60		799.60
LESS TAXABLE BENEFITS				50.00		50.00
TOTAL GROSS				749.60		749.60

DEDUCTIONS	CURRENT AMOUNT	YTD AMOUNT	DEDUCTIONS	CURRENT AMOUNT	YTD AMOUNT
GOV PENS	39.57	39.57	EI CONT	13.03	13.03
FEDL TAX	42.71	42.71	RRSP	50.00	50.00
MEDICAL	66.44	66.44			
TOTAL DEDUCTIONS				211.75	211.75

NET PAY 537.85

OTHER	CURRENT	YTD
FED EXEM	15000.00	0.00
PROV. EXEM.	8481.00	0.00

NON NEGOTIABLE

1BBL 16
MACDONALD DANIELLE
3673 ST. PAUL'S STREET
APT A
HALIFAX NS B3K 3R1
CANADA

SAVINGS ACCT:
DEDN. DEP. ACCT:
EMPL./PAYEE ID.: 1BBL 16
OCCUPATION: ASSOCIATE LAWYER
NO. PAY PER.: 01 **OF** 26

NET PAY: **$****537.85**

NOTIFICATION OF DEPOSIT TO ACCT.: XXXXXXXXXXX7182

January 23, 2023

Danielle MacDonald
3673 St. Paul's Street
Halifax, NS, B3K3R1

Re: Long Term Disability / Waiver of Premium, MacGillivray Law Office Incorporated
Policy No: 14802-000
Identification No: 000000036
Case No: GDC-11345-02

Danielle MacDonald,

Thank you for taking the time to speak with me on 23-Jan-2023 regarding your claim for Long Term Disability benefits. We have completed our assessment of your claim in accordance with the terms and conditions of your policy and have approved benefits effective 15-Dec-2022.

This letter explains your benefit details, applicable contractual information, as well as your responsibilities moving forward. Please keep this letter for future reference.

Under Group Policy 14802, Disability means:

> During the Elimination Period and for the following Own Occupation Duration specified in the Summary of Benefits, a Member is Totally Disabled for the purposes of this benefit if the Member is completely and continuously unable to perform the Regular Duties of their own occupation as a result of Illness or Accident.
>
> Afterward, a Member is Totally Disabled if the Member is completely and continuously unable to perform the Regular Duties of any occupation for which the Member:
>
> - would earn 60% or more of the Member's Pre-disability Salary; and
> - is reasonably qualified or may so become by training, education or experience.
>
> If a Member was performing modified work duties for at least 6 months before applying for long term disability benefits, these modified work duties constitute the Member's own occupation for purposes of assessing Total Disability.
>
> The loss of a professional or occupational licence or certification does not, in itself, constitute Total Disability.
>
> The availability of work is not considered when assessing the Member's disability.

The approval of your claim is based on information indicating that you are unable to perform the duties of Any Occupation.

Change in Definition Expectation
We will continue to review your eligibility for benefits under the Own Occupation definition of disability as per your policy. Please note that effective 15-Dec-2024 the criteria that we use to assess your claim will change. At that time, we will be assessing your ability to perform the regular duties of any occupation, as outlined above. We will send you a letter in the future reminding you of this date.

Information on file currently supports that you will be returning to work prior to this date. Therefore, we do not expect that your claim will reach the end of the Own Occupation period.

Benefit Details
Based on information in your file, your absence from work began on 18-Aug-2022. Benefits commence following an elimination period of 17 Week(s), which extends from 18-Aug-2022 to 14-Dec-2022. Therefore, your benefits will begin on 15-Dec-2022. Please note that benefits are paid on a monthly basis and you should receive your payment on or around the 15th of each month.

In accordance with your policy, your monthly benefit has been calculated at $4167.00, which represents 66.67% of your monthly salary. Your first payment in the amount of $743.75 covering the period from 15-Dec-2022 to 20-Dec-2022 has been issued to you by direct deposit.

Taxable Status
Please note that disability benefits payable under your group policy are considered non-taxable income, therefore no tax statement will be issued.

Other Income
According to your policy, your monthly benefit may be reduced by income received from other sources. Examples of other sources include Canada Pension Plan (CPP) disability benefits, worker's compensation benefits, employment income or pension plan payments. If you have applied for or are receiving payments from any other sources, please inform our office immediately as this may impact the amount of benefits you are entitled to receive.

Waiver of Premium
Premiums for Long Term Disability coverage will be waived effective 15-Dec-2022. Payment of these premiums will not be required as long as you remain eligible for benefits.

Premiums will also be waived effective 15-Dec-2022 for the following coverage:

- Member Life
- Member AD&D
- Critical Illness

These premiums will continue to be waived as long as you remain disabled and eligible under the policy, but not beyond the age of 65.

Next Steps
We will continue to follow up on your recovery and return to work progress. Occasionally, we may request updated medical information from your treating clinician(s).

Your Responsibilities
At Medavie Blue Cross, we encourage your active participation in the management of your claim and look forward to working with you on your road to recovery. While in receipt of Long Term Disability benefits, it is expected you will make reasonable efforts to:

- Participate in reasonable treatment and rehabilitation
- Keep us informed of any changes in your medical condition or treatment plan
- Work towards returning to your own occupation
- Accept reasonable offers of alternate or modified work from your employer
- Keep us advised of any return to work plans with your current or alternate employer
- Report any changes to your contact or banking information

In developing a return to work plan, we will collaborate with all parties to ensure a safe and sustainable return to work. If due to your medical condition you feel you are unable to return to your pre-disability occupation, we expect that you take the necessary steps to prepare for an alternate occupation as soon as you are fit to do so.

Should you have any questions or concerns about this letter, please do not hesitate to contact me at 1-877-849-8509, ext. (506) 867-3620.

Sincerely,

Meagan Paynter
Disability Claims Specialist
Life & Disability Services

Cc: MacGillivray Law Office Incorporated

pt Health and Wellness Centre Gladstone Halifax
2751 Gladstone St, Unit 8
Halifax, Nova Scotia B3K 4W6
Phone: (902) 492-4791
Fax: (902) 429-8338

Bill To:

The Personal Insurance
Nova Scotia

Attention: David Phandanouvong

Invoice Number:	132.3849279.13
Invoice Date:	06-Oct-2022
Client Name:	Danielle MacDonald
Claim/Id Number:	Q8065627
Date of Injury:	17-Aug-2022
Diagnosis:	41 Concussion
Area of Injury:	Neck
Primary Therapist:	P.Trivedi (PT) Registered Physiotherapist (002126)

Service Date	Provider	Description	Tax	Our Fee	Your Portion
23-Aug-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Concussion AX		$180.00	**$70.00**
24-Aug-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$25.00**
26-Aug-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$25.00**
29-Aug-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$25.00**
30-Aug-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$25.00**
30-Aug-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Non-Protocol Report		$50.00	**$50.00**
01-Sep-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$60.00**
06-Sep-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
08-Sep-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
09-Sep-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
13-Sep-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
15-Sep-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
20-Sep-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
22-Sep-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
27-Sep-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
29-Sep-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
		Total this Invoice:		**$1770.00**	**$1270.00**

(Cheque 1118462) on 13-Oct-2022	**$ 100.00**
(Cheque 1132980) on 25-Nov-2022	**$ 1150.00**
Invoice Balance	**$ 20.00**

FOR PAYMENT BY CHEQUE: Please make payable to **pt Health and Wellness Centre Gladstone Halifax** and quote the invoice number on your payment as a reference.

Balance is due upon receipt. Thank You.

Next Appointment(s):

1:30 PM	Thursday January 19, 2023	Purva Trivedi	MVA Physiotherapy Concussion TX
2:30 PM	Thursday January 19, 2023	Sophie Arsenault	MVA Physiotherapy Concussion TX

pt Health and Wellness Centre Gladstone Halifax
2751 Gladstone St, Unit 8
Halifax, Nova Scotia B3K 4W6
Phone: (902) 492-4791
Fax: (902) 429-8338

Bill To:

The Personal Insurance
Nova Scotia

Attention: David Phandanouvong

Invoice Number:	132.3849279.14
Invoice Date:	03-Nov-2022
Client Name:	Danielle MacDonald
Claim/Id Number:	Q8065627
Date of Injury:	17-Aug-2022
Diagnosis:	41 Concussion
Area of Injury:	Neck
Primary Therapist:	P.Trivedi (PT) Registered Physiotherapist (002126)

Service Date	Provider	Description	Tax	Our Fee	Your Portion
04-Oct-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
06-Oct-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
11-Oct-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
13-Oct-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
17-Oct-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
17-Oct-2022	Nicole Kelly (OT,Occupational therapist)	3.00 x MVA Occupational Therapy Assessment		$360.00	**$210.00**
20-Oct-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
24-Oct-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
27-Oct-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
31-Oct-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
		Total this Invoice:		**$1350.00**	**$1200.00**

(Cheque 1132979) on 29-Nov-2022 **$ 120.00**

Invoice Balance **$ 1080.00**

FOR PAYMENT BY CHEQUE: Please make payable to **pt Health and Wellness Centre Gladstone Halifax** and quote the invoice number on your payment as a reference.

Balance is due upon receipt. Thank You.

Next Appointment(s):

1:30 PM	Thursday January 19, 2023	Purva Trivedi	MVA Physiotherapy Concussion TX
2:30 PM	Thursday January 19, 2023	Sophie Arsenault	MVA Physiotherapy Concussion TX

FAX

Date:	2023-01-13
Pages including cover sheet:	2

To:	
Phone	
Fax Phone	*(844) 306-4550*

From:	(eFax) pt Health Gladstone
Phone	(647) 498-6546 * 97045
Fax Phone	19024298338

NOTE:

Attn: David Phandanouvong
re: Danielle Macdonald
Claim: Q8065627
Date of Injury: 17-Aug-2022

lifemark pt Health

Progress Report — Non protocol or Post protocol

Claimant Information					
Claimant Name	Danielle MacDonald.		Phone		
Claim number			Claimant D.O.B (dd/mm/yyyy)		
Insurer					
Contact\adjuster			Phone		
			Fax		
Date of Assessment		Date of Reassessment	Jan 13, 2023	Date of Injury	

Treatment Summary and Findings

Subjective: Progressing well. Concussion symptoms are settling fairly however still has a lot of factors that trigger her.

MSK: Progressing well.

Objective: (including progress towards original goals)

C-SP AROM: WNL, Strength: 4+/5.

Balance: Improved.

VOMS: Improved. Saccades: Improved.

Number of TX to date:

Total Cancelled/Missed visits:

Treatment Plan

Goals:	Plan:	Duration \Frequency:
Regain Pre-injury levels of function within and outside work.	Physio —	2/wk.
	OT —	1/wk.
	Osteo —	2/wk.
		for 8 wks.

pt Health and Wellness Centre Gladstone Halifax | 2751 Gladstone St, Halifax, NS B3K 4W6 | P(902)492-4791 F(902)429-8338 | Website: pthe

Practitioner:	Purva Trivedi.	Profession:	Physiotherapist
Signature:	[signature]	Date:	January 13 2023.
Report cc:			

pt Health and Wellness Centre Gladstone Halifax
2751 Gladstone St, Unit 8
Halifax, Nova Scotia B3K 4W6
Phone: (902) 492-4791
Fax: (902) 429-8338

Bill To:

The Personal Insurance
Nova Scotia

Attention: David Phandanouvong

Invoice Number: 132.3849279.21
Invoice Date: 05-Jan-2023
Client Name: Danielle MacDonald
Claim/Id Number: Q8065627
Date of Injury: 17-Aug-2022
Area of Injury: Neck
Primary Therapist: P.Trivedi (PT) Registered Physiotherapist (002126)

Service Date	Provider	Description	Tax	Our Fee	Your Portion
01-Dec-2022	Sophie Arsenault (OS,NSAO 21114, OAO 31298, MT7028)	Osteopathic Treatment	H	$120.00	**$45.22**
02-Dec-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
02-Dec-2022	Nicole Kelly (OT,Occupational therapist)	Occupational Therapy Services		$120.00	**$120.00**
05-Dec-2022	Sophie Arsenault (OS,NSAO 21114, OAO 31298, MT7028)	Osteopathic Treatment	H	$120.00	**$120.00**
05-Dec-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
07-Dec-2022	Sophie Arsenault (OS,NSAO 21114, OAO 31298, MT7028)	Osteopathic Treatment	H	$120.00	**$120.00**
09-Dec-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
12-Dec-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
12-Dec-2022	Sophie Arsenault (OS,NSAO 21114, OAO 31298, MT7028)	Osteopathic Treatment	H	$120.00	**$120.00**
16-Dec-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
19-Dec-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
22-Dec-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
22-Dec-2022	Nicole Kelly (OT,Occupational therapist)	Occupational Therapy Services		$120.00	**$120.00**
		HST(807448758RT0001)		$ 72.00	$ 60.78
		Total this Invoice:		**$1562.00**	**$1476.00**

H - HST

FOR PAYMENT BY CHEQUE: Please make payable to **pt Health and Wellness Centre Gladstone Halifax** and quote the invoice number on your payment as a reference.

Balance is due upon receipt. Thank You.

Next Appointment(s):

1:00 PM Friday January 6, 2023 Purva Trivedi MVA Physiotherapy Concussion TX

thePersonal

Dec. 22, 2022

PT HEALTH AND WELLNESS CENTRE GLADSTONE
2751 GLADSTONE STREET UNIT 8
HALIFAX NS B3K 4W6

Our Insured: MACDONALD DANIELLE

Date of Loss: Aug. 17, 2022

Our Claim No.: Q8065627

Claimant: Danielle Macdonald

Your claim and/or the documents, which were submitted with respect to a claim under the Accident Benefits coverage have been reviewed. Based on our review we are paying part or all of the benefits and/or expenses submitted. Please see below for an explanation of the amounts paid.

Type of Expense	From	To	Amount Claimed	Amount Paid
1- Report & Ortho Assessment	2022/11/03	2022/11/09	$200.00	$80.00

Reasons
1- Payable as submitted.

Where eligible and agreed upon, funds have been electronically deposited into your account.

Should you have any questions or wish to discuss this further, please do not hesitate to contact me.

Yours truly,

David Phandanouvong
Claims Advisor - Accident Benefits
Tel. No.: (855) 212-1745 #6325225
Fax No.: (844) 306-4550
P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7

Enclosure

thePersonal

Dec. 22, 2022

PT HEALTH AND WELLNESS CENTRE GLADSTONE
2751 GLADSTONE STREET UNIT 8
HALIFAX NS B3K 4W6

Our Insured: MACDONALD DANIELLE

Date of Loss: Aug. 17, 2022

Our Claim No.: Q8065627

Claimant: Danielle Macdonald

Your claim and/or the documents, which were submitted with respect to a claim under the Accident Benefits coverage have been reviewed. Based on our review we are paying part or all of the benefits and/or expenses submitted. Please see below for an explanation of the amounts paid.

Type of Expense	From	To	Amount Claimed	Amount Paid
1- Non-Protocol Inv.13238492792	----------	----------	$1,250.00	$1,162.50

Reasons

1- See reverse for invoice details

(see over)

Treatment	Visits Paid	Amount Claimed	Collateral Amount	Amount Payable	Interest
1 - Invoice: 13238492792	0	$1,250.00	$87.50	$1,162.50	$0.00

Reasons

1 - Expense is Covered as submitted.

Where eligible and agreed upon, funds have been electronically deposited into your account.
Should you have any questions or wish to discuss this further, please do not hesitate to contact me.

Yours truly,

David Phandanouvong

Claims Advisor - Accident Benefits

Tel. No.: (855) 212-1745 #6325225
Fax No.: (844) 306-4550

P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7

Enclosures

thePersonal

Dec. 17, 2022

MACDONALD DANIELLE
3673 ST PAULS ST
HALIFAX B3K 3R1

Date of Loss: Aug. 17, 2022
Our Claim No.: Q8065627
Our Insured: MACDONALD DANIELLE

Claimant: Danielle Macdonald

Subject: Explanation of Payment

Please find enclosed a cheque, or where eligible and agreed upon, funds have been electronically deposited into your account in the amount of $191.85, with respect to the above mentioned matter and representing payment of the following:

- Expense type: Income Replacement - Employed
  Disability period from 2022/12/15 to 2022/12/21

I trust this meets with your satisfaction.

Yours truly,

David Phandanouvong
Claims Advisor - Accident Benefits

Tel. No.: (855) 212-1745 #6325225
Fax No.: (844) 306-4550

P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7

Enclosure

thePersonal

Dec. 10, 2022

MACDONALD DANIELLE
3673 ST PAULS ST
HALIFAX B3K 3R1

Date of Loss: Aug. 17, 2022
Our Claim No.: Q8065627
Our Insured: MACDONALD DANIELLE

Claimant: Danielle Macdonald

Subject: Explanation of Payment

Please find enclosed a cheque, or where eligible and agreed upon, funds have been electronically deposited into your account in the amount of $383.70, with respect to the above mentioned matter and representing payment of the following:

- Expense type: Income Replacement - Employed
  Disability period from 2022/12/01 to 2022/12/14

I trust this meets with your satisfaction.

Yours truly,

David Phandanouvong
Claims Advisor - Accident Benefits

Tel. No.: (855) 212-1745 #6325225
Fax No.: (844) 306-4550

P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7

Enclosure

thePersonal

Dec. 09, 2022

MACDONALD DANIELLE
3673 ST PAULS ST
HALIFAX B3K 3R1

Our Insured: MACDONALD DANIELLE

Date of Loss: Aug. 17, 2022

Our Claim No.: Q8065627

Claimant: Danielle Macdonald

Your claim and/or the documents, which were submitted with respect to a claim under the Accident Benefits coverage have been reviewed. Based on our review we are paying part or all of the benefits and/or expenses submitted. Please see below for an explanation of the amounts paid.

Type of Expense	From	To	Amount Claimed	Amount Paid
1- Conc Examination	2022/11/10	2022/11/10	$95.00	$95.00

Reasons
1- Payable as submitted.

Where eligible and agreed upon, funds have been electronically deposited into your account.

Should you have any questions or wish to discuss this further, please do not hesitate to contact me.

Yours truly,

David Phandanouvong
Claims Advisor - Accident Benefits
Tel. No.: (855) 212-1745 #6325225
Fax No.: (844) 306-4550
P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7

Enclosure

thePersonal

Dec. 09, 2022

MACDONALD DANIELLE
3673 ST PAULS ST
HALIFAX B3K 3R1

Our Insured: MACDONALD DANIELLE

Date of Loss: Aug. 17, 2022

Our Claim No.: Q8065627

Claimant: Danielle Macdonald

Your claim and/or the documents, which were submitted with respect to a claim under the Accident Benefits coverage have been reviewed. Based on our review we are paying part or all of the benefits and/or expenses submitted. Please see below for an explanation of the amounts paid.

Type of Expense	From	To	Amount Claimed	Amount Paid
1- vision	2022/11/16	2022/11/16	$899.99	$899.99

Reasons

1- Payable as submitted.

Where eligible and agreed upon, funds have been electronically deposited into your account.

Should you have any questions or wish to discuss this further, please do not hesitate to contact me.

Yours truly,

David Phandanouvong
Claims Advisor - Accident Benefits
Tel. No.: (855) 212-1745 #6325225
Fax No.: (844) 306-4550
P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7

Enclosure

pt Health and Wellness Centre Gladstone Halifax
2751 Gladstone St, Unit 8
Halifax, Nova Scotia B3K 4W6
Phone: (902) 492-4791
Fax: (902) 429-8338

Bill To:

The Personal Insurance
Nova Scotia

Attention: David Phandanouvong

Invoice Number: 132.3849279.20
Invoice Date: 02-Dec-2022
Client Name: Danielle MacDonald
Claim/Id Number: Q8065627
Date of Injury: 17-Aug-2022
Area of Injury: Neck
Primary Therapist: P.Trivedi (PT) Registered Physiotherapist (002126)

Service Date	Provider	Description	Tax	Our Fee	Your Portion
03-Nov-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
03-Nov-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Non-Protocol Report		$50.00	**$50.00**
07-Nov-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
07-Nov-2022	Nicole Kelly (OT,Occupational therapist)	Occupational Therapy Services		$120.00	**$10.00**
09-Nov-2022	Sophie Arsenault (OS,NSAO 21114, OAO 31298, MT7028)	Osteopathic Assessment	H	$150.00	**$30.00**
10-Nov-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
14-Nov-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
14-Nov-2022	Nicole Kelly (OT,Occupational therapist)	Occupational Therapy Services		$120.00	**$120.00**
17-Nov-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
21-Nov-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
21-Nov-2022	Nicole Kelly (OT,Occupational therapist)	Occupational Therapy Services		$120.00	**$120.00**
23-Nov-2022	Sophie Arsenault (OS,NSAO 21114, OAO 31298, MT7028)	Osteopathic Treatment	H	$120.00	**$120.00**
28-Nov-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
		HST(807448758RT0001)		$ 40.50	$ 22.50
		Total this Invoice:		**$1490.50**	**$1242.50**

H - HST

FOR PAYMENT BY CHEQUE: Please make payable to **pt Health and Wellness Centre Gladstone Halifax** and quote the invoice number on your payment as a reference.

Balance is due upon receipt. Thank You.

Next Appointment(s):

2:30 PM	Wednesday December 7, 2022	Sophie Arsenault	Osteopathic Treatment

Occupational Therapy Return to Work Report

Client name: Danielle MacDonald	**Claim #:** Q8065627
Referral Source: Kim Cyr Disability Claims Specialist Medavie Blue Cross	**Employer:** MacGillivary Law

Thank you for approving occupational therapy services to assist Ms. MacDonald in returning to work. As you are aware, Ms. MacDonald was involved in a motor vehicle accident and sustained a concussion and whiplash injuries. She is now able to commence a transitional return to work plan with a combination of main office work as well as work from her home office.

Return to work plan:

Date	Days and hours	Duties
December 18th-24th, 2022	Wednesday- 2 hours (main office) Friday- 2 hours (main office) (scheduled 10am-12pm)	-Duties to include developing a training system for paralegals, if possible. -No intakes at present or legal work for the first four weeks of the plan. -The client is capable of managing her email system. –She should implement a closed-door policy in order to reduce excessive environment stimulation (noise, multiple people talking at one time etc.). -The client should have one point of contact for communicating with management to ensure consistency. - The client was encouraged to pace her activity performance as needed, taking micro-breaks from prolonged tasks (such as being seated at her desk). -It is anticipated she may have difficulty when multiple people talk at once, and she may be required to take notes during meetings.
December 25th-31st, 2022	Wednesday-2 hours (main office) Friday-2 hours (main office) (scheduled 10am-12pm)	As above.
January 1st- 7th, 2022	Monday- 2 hour (home office) Wednesday-2 hour	As above.

	(main office) Friday- 2 hour (home office) (scheduled 10am-12pm)	
January 8-14, 2022	Monday-4 hours (home office) Wednesday-4 hours (main office) Friday- 4 hours (home office) (scheduled 10am-12pm)	As above.

*The remainder of the plan will be developed based on the client's tolerance for the above.

If you have any questions or concerns about the above noted plan please contact the writer.

Sincerely,

Nicole Kelly M.Sc. (OT), O.T. Reg.(NS)

Registered Occupational Therapist

thePersonal

Dec. 01, 2022

PT HEALTH AND WELLNESS CENTRE GLADSTONE
2751 GLADSTONE STREET UNIT 8
HALIFAX NS B3K 4W6

Our Insured: MACDONALD DANIELLE

Date of Loss: Aug. 17, 2022

Our Claim No.: Q8065627

Claimant: Danielle Macdonald

Your claim and/or the documents, which were submitted with respect to a claim under the Accident Benefits coverage have been reviewed. Based on our review we are paying part or all of the benefits and/or expenses submitted. Please see below for an explanation of the amounts paid.

Type of Expense	From	To	Amount Claimed	Amount Paid
1- OT AX	2022/10/17	2022/10/17	$360.00	$210.00

Reasons
1- Payable as submitted.

Where eligible and agreed upon, funds have been electronically deposited into your account.

Should you have any questions or wish to discuss this further, please do not hesitate to contact me.

Yours truly,

David Phandanouvong
Claims Advisor - Accident Benefits
Tel. No.: (855) 212-1745 #6325225
Fax No.: (844) 306-4550
P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7

Enclosure

thePersonal

Dec. 01, 2022

PT HEALTH AND WELLNESS CENTRE GLADSTONE
2751 GLADSTONE STREET UNIT 8
HALIFAX NS B3K 4W6

Our Insured: MACDONALD DANIELLE

Date of Loss: Aug. 17, 2022

Our Claim No.: Q8065627

Claimant: Danielle Macdonald

Your claim and/or the documents, which were submitted with respect to a claim under the Accident Benefits coverage have been reviewed. Based on our review we are paying part or all of the benefits and/or expenses submitted. Please see below for an explanation of the amounts paid.

Type of Expense	From	To	Amount Claimed	Amount Paid
1- CONC TX	2022/10/04	2022/10/31	$990.00	$990.00

Reasons
1- Payable as submitted.

Where eligible and agreed upon, funds have been electronically deposited into your account.

Should you have any questions or wish to discuss this further, please do not hesitate to contact me.

Yours truly,

David Phandanouvong
Claims Advisor - Accident Benefits
Tel. No.: (855) 212-1745 #6325225
Fax No.: (844) 306-4550
P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7

Enclosure

thePersonal

Nov. 26, 2022

MACDONALD DANIELLE
3673 ST PAULS ST
HALIFAX B3K 3R1

Date of Loss: Aug. 17, 2022
Our Claim No.: Q8065627
Our Insured: MACDONALD DANIELLE

Claimant: Danielle Macdonald

Subject: Explanation of Payment

Please find enclosed a cheque, or where eligible and agreed upon, funds have been electronically deposited into your account in the amount of $383.70, with respect to the above mentioned matter and representing payment of the following:

- Expense type: Income Replacement - Employed
  Disability period from 2022/11/17 to 2022/11/30

I trust this meets with your satisfaction.

Yours truly,

David Phandanouvong
Claims Advisor - Accident Benefits

Tel. No.: (855) 212-1745 #6325225
Fax No.: (844) 306-4550

P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7

Enclosure

thePersonal

Nov. 18, 2022

PT HEALTH AND WELLNESS CENTRE GLADSTONE
2751 GLADSTONE STREET UNIT 8
HALIFAX NS B3K 4W6

Our Insured: MACDONALD DANIELLE

Date of Loss: Aug. 17, 2022

Our Claim No.: Q8065627

Claimant: Danielle Macdonald

Your claim and/or the documents, which were submitted with respect to a claim under the Accident Benefits coverage have been reviewed. Based on our review we are paying part or all of the benefits and/or expenses submitted. Please see below for an explanation of the amounts paid.

Type of Expense	From	To	Amount Claimed	Amount Paid
1- Non-Protocol Inv.132.9279.13	----------	----------	$1,540.00	$1,150.00

Reasons

1- See reverse for invoice details

(see over)

Treatment	Visits Paid	Amount Claimed	Collateral Amount	Amount Payable	Interest
1 - Invoice: 132.9279.13	14	$1,540.00	$390.00	$1,150.00	$0.00

Reasons

1 - Expense is Covered as submitted.

Where eligible and agreed upon, funds have been electronically deposited into your account.
Should you have any questions or wish to discuss this further, please do not hesitate to contact me.

Yours truly,

David Phandanouvong

Claims Advisor - Accident Benefits

Tel. No.: (855) 212-1745 #6325225
Fax No.: (844) 306-4550

P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7

Enclosures

thePersonal

Nov. 18, 2022

PT HEALTH AND WELLNESS CENTRE GLADSTONE
2751 GLADSTONE STREET UNIT 8
HALIFAX NS B3K 4W6

Our Insured: MACDONALD DANIELLE

Date of Loss: Aug. 17, 2022

Our Claim No.: Q8065627

Claimant: Danielle Macdonald

Your claim and/or the documents, which were submitted with respect to a claim under the Accident Benefits coverage have been reviewed. Based on our review we are paying part or all of the benefits and/or expenses submitted. Please see below for an explanation of the amounts paid.

Type of Expense	From	To	Amount Claimed	Amount Paid
1- CONC AX + AB2	2022/08/23	2022/08/30	$230.00	$120.00

Reasons
1- Payable as submitted.

Where eligible and agreed upon, funds have been electronically deposited into your account.

Should you have any questions or wish to discuss this further, please do not hesitate to contact me.

Yours truly,

David Phandanouvong
Claims Advisor - Accident Benefits
Tel. No.: (855) 212-1745 #6325225
Fax No.: (844) 306-4550
P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7

Enclosure

FYidoctors Optometrists

Date: NOV 15/ 22 Re Donielle MacDonald

Re: Co-management of TBI/ Post concussion, headache and migraine patients.

Dear: _____,

This is to inform you of some of the services and treatments we are able to provide our mutual patients suffering from the above conditions, with sensitivity to their unique struggles. Within our respective scopes of practice, we can work cooperatively with you to provide a cohesive plan that addresses the multiple symptoms that afflict our patients who suffer from some of the following conditions: acute and chronic headaches, migraines, TBI's (vascular and/or accident related) and post-concussion syndrome in general. It would be our privilege to co-manage these symptomatic patients in their journey to recovery. We can provide them with coordinated lifestyle recommendations, other advice, and various treatments to address their symptoms.

Our focus here would be on vision related causes, symptoms and treatments. In addition to an assessment of ocular health to rule out any concomitant ocular disease or injury, we offer various types of therapeutic spectacles, which can provide either temporary or permanent relief of their symptoms. We can recommend simple, inexpensive, short-term solutions (such as bi-nasal occlusion with blue-block lenses). In some cases, where needed, we use prescription glasses with prism, anti-fatigue lenses, tints, etc. We provide follow-up appointments at 4 weeks, 6 months and 1 year to assess the patients' progress and make any necessary changes.

Our vision therapy exam would include a routine comprehensive eye examination that includes retinal imaging (review for eye health diseases). In addition, we would complete a more thorough history related to the area of concern, as well as assessments of binocular vision, colour vision, and dry eyes, tint demonstrations, and peripheral visual field perimetry if necessary. This comprehensive exam costs $195.00 and is typically a 40-minute appointment.

The Neurolens on order will effectively help her Return to work. Dr Miriam Debly OD

We routinely copy all health care team members who are involved in the ongoing care of these patients with our examination and treatment results. Please feel free to reach out to our office for further information if you feel your patients would benefit from a **Vision Therapy Eye Examination.**

Email: Miriam.debly@fyidoctors.com Phone: 902-457-2224

Sincerely,

Miriam Debly, O.D.

PARTNER OF

FYidoctors

Family Vision Clinic
Park West Centre

Date of Examination: 10/11/2022
Patient: Danielle MacDonald

Address: 3673 St. Pauls St
Halifax
NS
B3K 3R1

Optometrist: Dr Miriam Debly

Prescription:

Rx	Sphere	Cylinder	Axis	Add
OD	-2.00			+0.75
OS	-1.75			+0.75

Prism	Distance		Near	
	Vertical	Horizontal	Vertical	Horizontal
OD		2.00 In		
OS		2.00 In		

Prescription Notes:

tonelite 2 w prism and antifatigue

electronically signed

Signed: Miriam Debly O.D.

Dr Miriam Debly

Notes to Ophthalmic Dispenser:

[1] Spectacle prescriptions may require changes in the lens type or power to maximize patient acceptance. Please do not fill this prescription unless it is agreed that doctor's changes will be made at no charge to the patient.
[2] This is a spectacle Rx only.
[3] Valid for 12 months from date of examination.

Exam Report - Danielle MacDonald

Date: 16/11/2022
Practice: FYidoctors - Halifax - Lacewood Dr

Exam Date: 16/11/2022		Doctor: Dr Miriam Debly
History Complaint	Chief Complaint	Comprehensive Eye Exam
	OD Notes:	drops help alot
	OS Notes:	
History Ocular	Ocular History	OD: Neg-Injury/Infection/Diplopia/Flashes/Floaters
		OS: Neg-Injury/Infection/Diplopia/Flashes/Floaters
	OD Notes:	
	OS Notes:	
History	General Health	No problems reported
	Medication	None
	Allergies	No Known Drug Allergies
	Family History	No problems reported
	Personal Hist.	
	CL History	
	OD Notes:	
	OS Notes:	
Assessment/Plan	Assessment/Plan	1 year RTC. Counselled re: refractive & ocular health
	OD Notes:	systane drops taking breaks
	OS Notes:	

Exam Report - Danielle MacDonald

Date: 16/11/2022
Practice: FYidoctors - Halifax - Lacewood Dr

Exam Date: 10/11/2022 | Doctor: Dr Miriam Debly

History Complaint

Chief Complaint
OD Notes: OFF WORK
OS Notes:

History Ocular

Ocular History
OD Notes:
OS Notes:

History

General Health	No problems reported
Medication	bcp
Allergies	No Known Drug Allergies
Family History	No problems reported
Personal Hist.	

OD Notes:
OS Notes:

Visual Acuities

	Distance			near		
	Unaided	Aid Type	Aided	Unaided	Aid Type	Aided
OD:		Glasses	6/6		Glasses	
OS:		Glasses	6/6		Glasses	
OU:		Glasses			Glasses	

Chart Type:
Notes:

Cover Test

Without Glasses

	R/L/A	Horizontal Type and Deviation	Vert. Type and Deviation
Near:			
Dist:			

With Glasses

Near:			
Dist:	No Strabismus OD, OS		

Notes:

Motility

Motility
OD: FROM; Smooth & Accurate
OS: FROM; Smooth & Accurate

OD Notes:
OS Notes:

Subjective Rx

	Sphere	Cylinder	Axis	Aided VA	Inter Add	Near Add	Near Aided VA
OD:	-2.00			6/6		+0.75	
OS:	-1.75			6/6		+0.75	

BCC: BPA: BMA: Test Method:

Notes:

Phoria

Test Method: Von Graefe

Distance

Metres 0 Eye

Horizontal 3 Base In

Vertical

Cyclical

near

Metres 0 Eye

Horizontal 3 Base In

Vertical

Cyclical

Accommodation Convergence Ratio Method: (A - C / A) = to 1

Bases

Distance

Eye				
In	/	/	Up	/
Out	/	/	Down	/

near

Eye				
In	/	/	Up	/
Out	/	/	Down	/

Notes:

Anterior Segment

Lids	OD: Clear and Healthy
	OS: Clear and Healthy
BUT / Tears	OD: Normal Tear Layer
	OS: Normal Tear Layer
Conjunctiva	OD: Clear and Healthy
	OS: Clear and Healthy
Cornea	OD: Clear
	OS: Clear
Aqueous	OD: Clear & quiet
	OS: Clear & quiet
A/C Angle	OD: Open
	OS: Open
Pupil	OD: PERRLA (-) APD
	OS: PERRLA (-) APD
Iris	OD: Healthy
	OS: Healthy

OD Notes:

OS Notes:

Posterior Segment	Lens	OD: Clear
		OS: Clear
	Vitreous	OD: Clear
		OS: Clear
	Disc	OD: Healthy colour / Clear margins
		OS: Healthy colour / Clear margins
	C/D Ratio	OD: 0.4
		OS: 0.4
	Macula	OD: Flat and clear
		OS: Flat and clear
	Vasculature	OD: 2/3 smooth and even calibre
		OS: 2/3 smooth and even calibre
	Periph. Retina	OD: Clear
		OS: Clear
	OD Notes:	
	OS Notes:	
Optomap	Optomap	Taken
	OD Notes:	
	OS Notes:	
FDT / VF	FDT/VF	
	OD Notes:	INCINSISTENT DE3FECTS REPEAT VF DO MORE CO9MPRHENSIVE TEST
	OS Notes:	
Assessment/Plan	Assessment/Plan	1 year RTC. Counselled re: refractive & ocular health
	OD Notes:	DRY EYE MGMT TAKE BREAKS 20/20 RULE MAGNESIUM DE CIDE BW IREVIVE AND NEUROLENS SCORED VERY HIGH ON NEUROLENS REDO VF
	OS Notes:	

Exam Report - Danielle MacDonald

Date: 16/11/2022
Practice: FYidoctors - Halifax - Lacewood Dr

Exam Date: 10/11/2022

Doctor: Dr Miriam Debly

History Complaint

Chief Complaint

OD Notes: head injury in august car accident rear ended hit head on stewering wheel concussioin physio perv apt nicole kelly

OS Notes:

Notes

Notes

OD Notes: sypmtoms reading harder od shky when focusing too long at the 20 min mark photophobia parer work win 5 mins wakes up with headaches every day since accident trying dry needling off wpork as lawyer

OS Notes:

Visual Acuities

	Distance			near		
	Unaided	Aid Type	Aided	Unaided	Aid Type	Aided
OD:		Glasses			Glasses	
OS:		Glasses			Glasses	
OU:		Glasses			Glasses	

Chart Type:

Notes:

Cover Test

Without Glasses

	R/L/A	Horizontal Type and Deviation	Vert. Type and Deviation
Near:			
Dist:			

With Glasses

Near:			
Dist:		No Strabismus OD, OS	

Notes:

Motility

Motility

OD: FROM; Smooth & Accurate

OS: FROM; Smooth & Accurate

OD Notes:

OS Notes:

Tonometry

OD(avg):17 mmHg OS(avg): mmHg Instrument: NCT Date\Time: 10/11/2022 13:31

Pachymetry: OD: .55 OS : .536

Notes: Error Has Occured on Right Eye TONOMETRY Reading Error Has Occured on Left Eye TONOMETRY Reading Individual Pachymetry : Right Eye: Reading1 (0.567) Reading2 (0.547) Reading3 (0.536) Left Eye: Reading1 (0.569) Reading2 (0.503) Reading3 (0.535)

Static Rx

	Sphere	Cylinder	Axis	Aided VA
OD:	-1.50			
OU:				
OS:	-1.50			

Notes:

Keratometry

OD: 43.16/43.83ds@5 OS: 43.1/43.72ds@165 Test Method: Auto Ref-Keratometer

OD Notes: OS Notes:


Your eyes have never worked harder.
Relief is in Sight.
Revolutionary lenses that reduce the painful symptoms of eye misalignment.
neurolens®
Relief is in Sight

PARTNER OF

FYidoctors.

Family Vision Clinic
Park West Centre

Invoice No.: 497-0034273
Date: 16/11/2022

INVOICE

Date of Service: 16/11/2022
Client Acct.# : 53031
Optometrist: Dr Miriam Debly
License #: 132
Assisted By: Jessica

Danielle MacDonald
3673 St. Pauls St
Halifax
NS
B3K 3R1

ORDER FOR:

Danielle MacDonald

Home Phone: 902 759 6325
Cell Phone: 902 759 6325
Work Phone:
Ext.:

ITEM	DESCRIPTION	PRICE	QTY	AMT	SAVINGS	TOTAL	TAX
Frame	ASPEX Group, TK1213, 15, 53x140, 140	249.99	1	249.99		249.99	
Lens	Single Vision, EYENCE, SPECIAL ORDER		2				
Extra	SINGLE VISION, 1.6, CLEAR NONE FRAME TO FOLLOW to Eyence		1				
	Lens Total			800.00	0.00	800.00	
Repair	Protection Plan Declined	0.00	1	0.00		0.00	
	SUBTOTAL			1,049.99	0.00	1,049.99	
	BENEFITS Blue Cross					-150.00	
	TOTAL					$ 899.99	

PAYMENTS

Date	Payment Method	Received By	Amount
16/11/2022	Visa	Jessica	899.99

OUTSTANDING BALANCE $ **0.00**

FYidoctors - Halifax - Lacewood Dr, 287 Lacewood Drive, Halifax, NS, B3M 3Y7, (902) 457-2224

THANK YOU FOR YOUR BUSINESS

FYIDOCTORS
HALIFAX-LACEWOOD DR
287 LACEWOOD DR
HALIFAX NS

CARD **********9489
CARD TYPE VISA
DATE 2022/11/16
TIME 0933 12:53:27
RECEIPT NUMBER
C82017941-001-001-419-0

PURCHASE
TOTAL

$899.99

VISA CREDIT
A0000000031010
8D286E0711D3D6D1
8080008000-6800
94F09D8656EE27D1

APPROVED

AUTH# 09842F 01-027
THANK YOU

CARDHOLDER COPY

IMPORTANT - RETAIN THIS
COPY FOR YOUR RECORDS

BLUE CROSS

Claim Payment Result

Transaction Date 16 Nov 2022
Claim ID 22320-U7086
Invoice Number

Provider Information

Name Family Vision Clinic
Provider Number 9301

Insured Information

Policy 14802-000
Name Danielle MacDonald
Address 3673 St. Paul's Street
Halifax
NS
B3K3R1

Patient Information

Identification Number 000000036-01
Name Danielle MacDonald

This document may be used as an official receipt

Claim Type	Service Date	Description	Billed	Excluded	Deductible	Eligible	%	Payable	Message Code
Frames and Lenses	16 Nov 2022	Frames and Lenses	1,049.99	899.99	0.00	150.00	100%	150.00	01
Totals			**1,049.99**	**899.99**	**0.00**	**150.00**		**150.00**	

01	REDUCED TO AMOUNT ELIGIBLE UNDER THE TERMS OF THE SUBSCRIBER/CLIENT'S COVERAGE

Total Billed	**1,049.99**
- Blue Cross Pays	**150.00**
Patient Pays	**899.99**

FYIDOC

PARTNER OF

FYidoctors.
Family Vision Clinic
Park West Centre

Invoice No.: 497-0034037
Date: 10/11/2022

INVOICE

Date of Service: 10/11/2022
Client Acct.# : 53031
Optometrist: Dr Miriam Debly
License #: 132
Assisted By: Leonora

Danielle MacDonald
3673 St. Pauls St
Halifax
NS
B3K 3R1

ORDER FOR:

Danielle MacDonald

Home Phone: 902 759 6325
Cell Phone: 902 759 6325
Work Phone:
Ext.:

ITEM	DESCRIPTION	PRICE	QTY	AMT	SAVINGS	TOTAL	TAX
Fee	TBI/Concussion Examination Level 1	195.00	1	195.00		195.00	
	SUBTOTAL			195.00	0.00	195.00	
	BENEFITS Blue Cross					-100.00	
	TOTAL				$	**95.00**	

PAYMENTS

Date	Payment Method	Received By	Amount
10/11/2022	Visa	Leonora	95.00

OUTSTANDING BALANCE $ **0.00**

FYidoctors - Halifax - Lacewood Dr, 287 Lacewood Drive, Halifax, NS, B3M 3Y7, (902) 457-2224

THANK YOU FOR YOUR BUSINESS

BLUE CROSS

Claim Payment Result

Transaction Date 10 Nov 2022
Claim ID 22314-U8125
Invoice Number

Provider Information

Name Family Vision Clinic
Provider Number 9301

Insured Information

Policy 14802-000
Name Danielle MacDonald
Address 3673 St. Paul's Street
Halifax
NS
B3K3R1

Patient Information

Identification Number 000000036-01
Name Danielle MacDonald

This document may be used as an official receipt

Claim Type	Service Date	Description	Billed	Excluded	Deductible	Eligible	%	Payable	Message Code
Exams	10 Nov 2022	Comprehensive Service - Existing Patient	195.00	95.00	0.00	100.00	100%	100.00	01,02
Totals			**195.00**	**95.00**	**0.00**	**100.00**		**100.00**	

01	THE FREQUENCY LIMIT FOR THIS BENEFIT HAS BEEN MET WITH THIS PAYMENT.
02	REDUCED TO AMOUNT ELIGIBLE UNDER THE TERMS OF THE SUBSCRIBER/CLIENT'S COVERAGE

Total Billed	**195.00**
- Blue Cross Pays	**100.00**
Patient Pays	**95.00**

TORS
HALIFAX-LACEWOOD DR
287 LACEWOOD DR
HALIFAX NS

CARD **********9489
CARD TYPE VISA
DATE 2022/11/10
TIME 9119 13:20:44
RECEIPT NUMBER
C82017941-001-001-370-0

PURCHASE
TOTAL

$95.00

VISA CREDIT
A0000000031010
97DDF33FF9FB7EDA
8080008000-6800
8F52D63B72278AC7

APPROVED

AUTH# 01341F 01-027
THANK YOU

CARDHOLDER COPY

IMPORTANT - RETAIN THIS
COPY FOR YOUR RECORDS

IPM Nov 16th

30 day Guarantee 40-60% $450/pair

FYidoctors™
Doctors of Optometry

125-287 Lacewood Dr, Halifax NS B3M 3Y7 PH: 902-457-2224 FAX: 902-443-9190

Post-Concussion Patient Visual Therapy

1. We prescribe drops for **Dry Eyes** to decrease eye strain, improve focusing, and help with eye pain. Non-preserved drops preferred (Systane or Hylo). Hot compresses minimum of 3x daily.
2. We prescribe/magnification for farsightedness or fully correct **Astigmatism**, **Myopia**, and **Presbyopia Bifocals** if necessary.
3. We prescribe **Antifatigue lens** for compensating for extended computer work and decreased accommodation.
4. We prescribe **Prism** for convergence insufficiency for muscle weakness to decrease muscle fatigue to help the two eyes work better together.
5. We prescribe **Tonelight Tint** for glare of fluorescent lights or FL 41 #2.
6. We prescribe **Antiglare** or **Blue Blocker Antiglare** for glare of computers.
7. 20/20/20 Rule. When doing close up work, take breaks by looking 20 feet away, every 20 minutes, for 20 seconds. – 60 seconds. timer phone
8. Recheck 3-6 weeks for follow-up covered by MSI after obtaining and wearing glasses.
9. Magnesium supplements – 650 mg/day and Omega 3 supplements – 2000mg/day - optional.
10. Increase hydration. Drink water regularly.
11. Light exercise, increase sleep. Consult family doctor about trying melatonin at bedtime, if necessary.
12. Try Binasal occulusion if necessary for temporary use.

Prepared by Miriam Debly, O.D.

thePersonal

Nov. 12, 2022

MACDONALD DANIELLE
3673 ST PAULS ST
HALIFAX B3K 3R1

Date of Loss: Aug. 17, 2022
Our Claim No.: Q8065627
Our Insured: MACDONALD DANIELLE

Claimant: Danielle Macdonald

Subject: Explanation of Payment

Please find enclosed a cheque, or where eligible and agreed upon, funds have been electronically deposited into your account in the amount of $383.70, with respect to the above mentioned matter and representing payment of the following:

- Expense type: Income Replacement - Employed
  Disability period from 2022/11/03 to 2022/11/16

I trust this meets with your satisfaction.

Yours truly,

David Phandanouvong
Claims Advisor - Accident Benefits

Tel. No.: (855) 212-1745 #6325225
Fax No.: (844) 306-4550

P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7

Enclosure

Facsimile

Note:

D. Macdonald Progress Report

To:		***From:***	(eFax) pt Health Gladstone
Phone:		***Phone:***	(647) 498-6546 * 97045
Fax:	(844) 306-4550	***Fax:***	19024298338
Date:	2022-11-04		
Pages:	3		

lifemark pt Health

Progress Report – Non protocol or Post protocol

Claimant Information	Claimant Name	Danielle MacDonald			Phone	9027596325
	Claim number	Q8065627			Claimant D.O.B (dd/mm/yyyy)	20-Feb-1993
	Insurer	The Personal Insurance				
	Contact\adjuster	David Phandanouvong			Phone	
					Fax	8443064550
	Date of Assessment	Aug 23, 2022	Date of Reassessment	Nov 3, 2022	Date of Injury	

Treatment Summary and Findings

Subjective:

Difficulty with memory, concentration, and word finding difficulties. Occasional stutter.
Pain, soreness and stiffness in the neck and fatigue. Achiness in jaw as well as tension headaches. noise and light sensitivity. Reduced postural tolerances for prolonged walking and standing.
Difficulty with depth perception, difficulty with reading and scanning with her eyes, double and blurred vision particularly at the end of the day.
Tinnitus
Reduced quality of sleep

Objective: (including progress towards original goals)

MSK: C-sp AROM: Improving. Increases tension in UFT, LS, SCM. Strength: 4-/5
Cervicogenic headaches: Headache Disability Index: 83 (Complete Disability)
VOMS: Visual tracking: Improving. Convergence: Triggers headache lasting for about 5 mins.
Balance: Improving. BBS: 52/56
Cognitive Testing: Montréal cognitive assessment (MOCA): 28/30
where normal is greater then 26/30. Her score is indicative of minimal cognitive impairment.

Number of TX to date:		Total Cancelled/Missed visits:

Treatment Plan

Goals:	Plan:	Duration \Frequency:
Regain pain free ROM Regain strength Regain function Regain postural tolerance Regain visual and auditory tolerance to external stimuli Regain cognitive function to return to pre-injury levels of cognitive demands for her job	Physiotherapy: Manual Therapy Exercise program Concussion Rehab Balance training Remedial and compensatory strategies to improve cognitive performance and perception of cognitive skills. Osteopathy: To aid with MSK (c-spine and jaw) release Cranial osteopathy	Physiotherapy: 2/wk for 8 wks Osteopathy: 2/wk for 8 wks To be reassessed at 8 wk mark.

Porters Lake Physiotherapy – pt Health | 5228 Hwy #7, Suite 24, Porters Lake, NS B3E 1J8 | P(902) 827-5223 F(902)827-5306 | Website: pthealth

Practitioner:	Purva Trivedi	Profession: Registered Physiotherapist
Signature:	Purva Trivedi	Date: 03-Nov-2022
Report cc:		

thePersonal

Nov. 04, 2022

MACDONALD DANIELLE
3673 ST PAULS ST
HALIFAX B3K 3R1

Our Insured: MACDONALD DANIELLE

Date of Loss: Aug. 17, 2022

Our Claim No.: Q8065627

Claimant: Danielle Macdonald

Your claim and/or the documents, which were submitted with respect to a claim under the Accident Benefits coverage have been reviewed. Based on our review we are paying part or all of the benefits and/or expenses submitted. Please see below for an explanation of the amounts paid.

Type of Expense	From	To	Amount Claimed	Amount Paid
1- Income Replacement - Employed	2022/08/18	2022/11/02		$2,110.35

Reasons

1- Payment for disability benefits.

Where eligible and agreed upon, funds have been electronically deposited into your account.

Should you have any questions or wish to discuss this further, please do not hesitate to contact me.

Yours truly,

David Phandanouvong
Claims Advisor - Accident Benefits
Tel. No.: (855) 212-1745 #6325225
Fax No.: (844) 306-4550
P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7

Enclosure

pt Health and Wellness Centre Gladstone Halifax
2751 Gladstone St, Unit 8
Halifax, Nova Scotia B3K 4W6
Phone: (902) 492-4791
Fax: (902) 429-8338

Bill To:

The Personal Insurance
Nova Scotia

Attention: David Phandanouvong

Invoice Number: 132.3849279.14
Invoice Date: 03-Nov-2022
Client Name: Danielle MacDonald
Claim/Id Number: Q8065627
Date of Injury: 17-Aug-2022
Area of Injury: Neck
Primary Therapist: P.Trivedi (PT) Registered Physiotherapist (002126)

Service Date	Provider	Description	Tax	Our Fee	Your Portion
04-Oct-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
06-Oct-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
11-Oct-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
13-Oct-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
17-Oct-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
17-Oct-2022	Nicole Kelly (OT,Occupational therapist)	3.00 x MVA Occupational Therapy Assessment		$360.00	**$210.00**
20-Oct-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
24-Oct-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
27-Oct-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
31-Oct-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
		Total this Invoice:		**$1350.00**	**$1200.00**

FOR PAYMENT BY CHEQUE: Please make payable to **pt Health and Wellness Centre Gladstone Halifax** and quote the invoice number on your payment as a reference.

Balance is due upon receipt. Thank You.

Next Appointment(s):

1:00 PM	Monday November 7, 2022	Nicole Kelly	Occupational Therapy Services
2:45 PM	Monday November 7, 2022	Purva Trivedi	MVA Physiotherapy Concussion TX

lifemark

Occupational Therapy
Initial Consultation Report

Client/Plan Member: Danielle MacDonald
Policy #: Q8065627
Date of Disability: August 17th, 2022
Date of Initial Assessment: October 17th, 2022
Referral Source: David Phandanouvong at The Personal Insurance
Referral Objective (as per referral source):

X Own Occupation
Gradual RTW Available: ■ Yes ☐ No
Modified Duties Available: ☐ Yes ☐ No
☐ Alternative Occupation/Fit for Work:

At the start of the Occupational Therapy (OT) consultation Ms. MacDonald was advised of the purpose/process of the consultation and provided verbal and written consent to participate. The role and scope of OT was explained to the client. The client arrived on time for the scheduled assessment and was dressed appropriately for the weather. He presented as polite and engaged in conversation with the writer.

Vocational Description:

Work:
X Not Working
☐ Gradual/Modified Date Set
☐ In Gradual/Modified RTW

Ms. MacDonald reported she worked as a Lawyer, full time, Monday to Friday, 80+ hours a week. As a Lawyer the client reported she worked predominantly from a home office. She does go to the main office 2-3 times per week when she attends discoveries, goes to court or to meet with clients. Ms. Macdonald indicated her duties vary depending on the day but can include taking phone calls, corresponding through email, zoom calls, writing reports, reading and conducting research. She typically takes an hour lunch. The client has not returned to work since her concussion.

Current functional status and subjective report of symptoms:

ADLs and IADLs:
☐ No Issues Reported
X Partially Able to Complete
☐ Unable to Complete

Potential Barriers:

The following have been identified as potential barriers to return to work:

- Difficulty reading due to visual fatigue. She also reported it is challenging to recall what she has read due to difficulty concentrating. She described being able to read (for leisure) 10 pages per day. Her job requires extensive reading for research and supporting her clients.

- Reduced quality of sleep. She indicated she tosses and turns throughout the night.
- Anxiety when in a vehicle as a driver or passenger. She reported being driven past the accident site on one occasion however she has not driven by it independently.
- Tinnitus symptoms impacting function.
- Length of time off work.
- Her reported brain fog leading to fear that she will no longer be able to perform as she once did (physically and cognitively).
- She has had limited exposure to use of a computer.
- The client sit to don her clothes due to depth perception challenges.
- The client has a high expectation for cleanliness for her home. She has been unable to clean to the level she typically would. She has difficulty mopping, putting items in the laundry machines and cleaning the bathroom.
- Ms. MacDonald reported she is typically a very social person. She has been unable to attend social gatherings as she once did.
- The client reported high levels of anxiety and depression symptoms. She has recently commenced psychological sessions.

Ms. MacDonald reported the following:

a) Emotional Issues: The client indicated she goes for walks, completes deep breathing, mindfully meditates and completes journaling as a stress management technique. She reported feeling frustrated by her persistent symptoms.
b) Cognitive Issues: Difficulty with memory, concentration, and word finding difficulties. She reported she experiences a stutter occasionally.
c) Physical Issues: Pain, fatigue, and decreased mobility. The client noted she experienced pain in her neck and jaw as well as tension headaches. She also experiences sensitivity to noise and light. Reduced postural tolerances for prolonged walking and standing.
d) Visual Difficulties: The client reported difficulty with depth perception, she described difficulty with reading and scanning with her eyes. She reported experiencing double vision and blurriness of her vision, particularly at the end of the day.
e) Tinnitus

Please also refer to self-reported questionnaires.

Psychosocial Screens:

Psychosocial variables have been shown to significantly impact pain-related disability and chronicity. Ms. MacDonald completed (self-reported) questionnaires targeting these variables. Raw scores correspond to level of risk and potential psychosocial barriers to recovery.

Questionnaire	Score Date	Comments
Fatigue Severity Scale (FSS) of Sleep Disorders	61	A total score of 36 or more suggests that you may need further evaluation by a physician.
HADS (Hospital Anxiety and Depressions Screen) Mood Questionnaire	Anxiety-16 Depression-15	Abnormal levels of anxiety and depression symptoms.

A measure used to screen for anxiety and depressive symptoms.		
The Patient Health Questionnaire (PHQ-9) Used as a measure of depressive symptoms severity.	22	Severe depression symptoms reported.
Headache Disability Index	83	A total score of 10-28 is considered to indicate mild disability; 30-48 is moderate disability; 50-68 is severe disability; 72 or more is complete disability. Complete disability

Cognitive Screen:

The Montréal cognitive assessment (MOCA) was completed as a cognitive screen. The client demonstrated 28/30 where normal is greater then 26/30. Her score is indicative of minimal cognitive impairment. The client demonstrated errors in the following categories; abstraction 2/3 and delayed recall 4/5.

Throughout the assessment Ms. MacDonald demonstrated some word finding difficulties and a stutter intermittently. She was able to maintain a consistent conversation with the writer, she did not become emotionally labile and was able to maintain eye contact as appropriate for the social context. She did not pause to concentrate and she did not use any accommodation strategies to assist with her memory limitations. She was able to recall the history of her accident and treatment to date,

The client attempted the Comprehensive Trail- Making Test however due to visual difficulties she was unable to finish. She noted her eye was twitching, she experienced a headache, nausea and eye fatigue. She was able to complete the first two trials however demonstrated severely impaired scores as her speed was very slow. Of note she did not make any errors but was observed holding the writing utensil with an increased grip (more so then what was required for the task). The CTMT primarily assesses the effect of brain injury and other forms of central nervous system compromise. It also detects frontal lobe deficits, problems with psychomotor speed, visual search, sequencing, and attention; and impairments in set shifting. It is comprised of five digital search and visual search and sequence tasks that focus on attention, concentration, resistance to distraction, and cognitive flexibility (or set shifting). The client demonstrated the following scores;

Trail 1-Severely Impaired
Trail 2- Severely Impaired
Trail 3-N/A
Trail 4-N/A
Trail 5-N/A
CTMT Composite Index-N/A

The client completed the Hopkins Verbal Learning Test, a test of verbal learning and memory. The test consists of three trials of free-recall of a 12-item semantically categorized list. She demonstrated the following; Trail 1: 6/12, Trial 2: 7/12, Trial 3: 9/12, Total Recall score: 22, Learning: 3, # true-positives: 12/12, # False-positive Errors: (related)-0/6, (Unrelated)-0/6.

Normative data for clients aged 17-30; trial 1-8.1, trial 2-10.3, trial 3-11.0, learning-3.1, total recall-22, true-positive-11.5. They client demonstrated below average abilities during this test.

Strengths:

The following have been identified as strengths to her ability to return to work:

- She has a variety of stress management strategies including journaling, deep breathing, mindful mediation and walking in fresh air.
- The client has a good social support network involving her partner and mother.
- The client advised she has been able to return to driving, short distances.

Summary:

Ms. MacDonald's scores on the questionnaires indicate she appears to exhibit functional barriers due to psychosocial issues. Her scores indicate that she has a high degree of psychosocial barriers including anxiety, brain fog, depression symptoms and increased pain. Cognitive testing identified limitations with respect to visual processing and memory. It is therefore felt that the client would benefit from Occupational Therapy intervention. Ms. MacDonald has indicated that she is a willing participant in Occupational Therapy intervention to address her psychosocial concerns.

Recommendations:

8 sessions over 8 weeks of OT treatment are recommended to facilitate Ms. MacDonald's return to work and other roles of productivity. The sessions will focus on:

- Education on behaviour and anxiety levels, the role of activity in rehabilitation, energy conservation, pacing and symptom management principles.
- Implementing activity planning/scheduling strategies, reflection of symptoms, and behavioural experiments to assist the client with anxiety self-regulation.
- Practical education in the areas of managing stress associated with the transition of returning to work.
- Remedial and compensatory strategies to improve cognitive performance and perception of cognitive skills.
- Return to work planning.

Sincerely,

Nicole Kelly M.Sc. (OT), O.T. Reg.(NS)
Registered Occupational Therapist

pt Health and Wellness Centre Gladstone Halifax
2751 Gladstone St, Unit 8
Halifax, Nova Scotia B3K 4W6
Phone: (902) 492-4791 x2
Fax: (902) 429-8338

Bill To:

The Personal Insurance
Nova Scotia

Attention: David Phandanouvong

Invoice Number:	132.3849279.13
Invoice Date:	06-Oct-2022
Client Name:	Danielle MacDonald
Claim/Id Number:	Q8065627
Date of Injury:	17-Aug-2022
Area of Injury:	Neck
Primary Therapist:	P.Trivedi (PT) Registered Physiotherapist (002126)

Service Date	Provider	Description	Tax	Our Fee	Your Portion
23-Aug-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Concussion AX		$180.00	**$70.00**
24-Aug-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$25.00**
26-Aug-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$25.00**
29-Aug-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$25.00**
30-Aug-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$25.00**
30-Aug-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Non-Protocol Report		$50.00	**$50.00**
01-Sep-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$60.00**
06-Sep-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
08-Sep-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
09-Sep-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
13-Sep-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
15-Sep-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
20-Sep-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
22-Sep-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
27-Sep-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
29-Sep-2022	Purva Trivedi (PT,002126,Registered Physiotherapist)	MVA Physiotherapy Concussion TX		$110.00	**$110.00**
		Total this Invoice:		**$1770.00**	**$1270.00**

FOR PAYMENT BY CHEQUE: Please make payable to **pt Health and Wellness Centre Gladstone Halifax** and quote the invoice number on your payment as a reference.

Balance is due upon receipt. Thank You.

Next Appointment(s):

2:00 PM	Tuesday October 11, 2022	Purva Trivedi	MVA Physiotherapy Concussion TX

Open Completely Before Completing Form

Send this form to the appropriate insurer:

Fax # (844) 306 - 4550

Notice of Loss & Proof of Claim Form (Form NS-1)

This form is effective on April 1, 2013 for accidents that occur on or after April 1, 2013.

To be completed by your insurer	
Claim Number:	Q8065627
Insurance Company	The Personal
Claim Representative	David Phandanouvong
Policy Number:	K9283904
Date of Accident	17 Aug 2022

Section 1: Claimant Information

Part 1 Claimant Information

Last Name	First Name	Middle Name(s)
MacDonald	Danielle	J

Address: 3073 St Pauls St

City, Town or County: Halifax | Province: NS | Postal Code: B3K3R1

Telephone Number (Home) *(Include area code)*: 902 7596375 | Telephone Number (Work) *(Include area code)*: | Fax Number *(Include area code)*:

Date Of Birth (DDMMYYYY): 20/02/1993 | 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? anytime | Day(s) of the week

Insurance Company: The Personal | Policy Number:

Will this be a Nova Scotia 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 NS- 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

You were a: ☒ Driver ☐ Passenger ☐ Pedestrian ☐ Other

Location of Accident: Main Ave | City, Town or County: Halifax | Province: NS

Time of Accident: 4:30 ☐ A.M. ☒ P.M. | Date of Accident (DDMMYYYY): 17/08/2022 | Was the Accident Reported to the Police? ☒ Yes ☐ No | Date Reported: (DDMMYYYY) 17/08/2022

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

Please provide a brief description of how the accident occurred and how you were injured.

Stopped behind vehicle that was stopped waiting to turn left. Was rear ended by SUV and propelled into vehicle in front of me - hit head/face on steering wheel

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

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

Concussion dx @ Cobequid hospital - Severe headache, dizziness, nausea/ vomiting, double/ blured vision
Sore neck + shoulder

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/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 insurance representatives, 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 NS-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 outlined on Form NS-1 and administering my claim.

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

Signature _____ Date Aug 23/22

lifemark pt Health **Initial Assessment Report** — Non protocol or Post protocol

Claimant Information	Claimant Name	Danielle MacDonald	Phone	
	Claim number		Claimant D.O.B (dd/mm/yyyy)	
	Insurer			
	Contact\adjuster		Phone	
			Fax	
	Date of Assessment	August 23, 2022	Date of Injury	

Injury and Assessment Information

Details of MVA: Rear ended. Hit face/head on the steering wheel.

Diagnosis: Concussion + WAD II + Cervicogenic headaches.

Subjective: - Nausea, Headaches, Increased sensitivity to Ligur and Noise, Double vision, Tinnitus, Dizziness, Loss of depth perception, Brain fog, Nightmares. Neck soreness + pain. Headaches worse at EOD.

Objective: C-SP ROM: 40% of WNL + painful and stiff. VOMS: convergence + visual tracking: provocates symptoms. Balance: Berg Balance Scale: 50/56, Increased sensitivity to any visual/balance testing.

-8444-306-4550 PT FAXED AUG 30 2022

Barriers to recovery	Yes ☐	No ☑	Orebro Score: 132

Treatment Plan

Goals:	Plan:	Duration \Frequency:
- Rehabilitation and graduated Return to life post-concussion - Regain neck ROM and strength. - Regain pre-accident level of function.	- Manual therapy - Exercises - Concussion Rehab - Balance training.	Physio - 3/wk for 8wks Occupational therapy Assessment + consult - 1/wk

pt Health and Wellness Centre Gladstone Halifax | 2751 Gladstone St, Halifax, NS B3K 4W6 | P(902)492-4791 F(902)429-8338 | Website: pthea

Practitioner:	Purva Trivedi.	Profession:	physiotherapist
Signature:		Date:	Aug 30, 2022.
Report cc:			

Occupational therapy Assessment + consult will aid in graduated return to work/life activities.

thePersonal

Sept. 28, 2022

MACDONALD DANIELLE
3673 ST PAULS ST
HALIFAX B3K 3R1

Our Insured: MACDONALD DANIELLE

Date of Loss: Aug. 17, 2022

Our Claim No.: Q8065627

Claimant: Danielle Macdonald

Your claim and/or the documents, which were submitted with respect to a claim under the Accident Benefits coverage have been reviewed. Based on our review we are paying part or all of the benefits and/or expenses submitted. Please see below for an explanation of the amounts paid.

Type of Expense	From	To	Amount Claimed	Amount Paid
1- REPORT FEE	2022/08/31	2022/08/31	$60.00	$60.00

Reasons
1- Payable as submitted.

Where eligible and agreed upon, funds have been electronically deposited into your account.

Should you have any questions or wish to discuss this further, please do not hesitate to contact me.

Yours truly,

David Phandanouvong
Claims Advisor - Accident Benefits
Tel. No.: (855) 212-1745 #6325225
Fax No.: (844) 306-4550
P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7

Enclosure

thePersonal

Sept. 28, 2022

PT HEALTH AND WELLNESS CENTRE GLADSTONE
2751 GLADSTONE STREET UNIT 8
HALIFAX NS B3K 4W6

Our Insured: MACDONALD DANIELLE

Date of Loss: Aug. 17, 2022

Our Claim No.: Q8065627

Claimant: Danielle Macdonald

Your claim and/or the documents, which were submitted with respect to a claim under the Accident Benefits coverage have been reviewed. Based on our review we are paying part or all of the benefits and/or expenses submitted. Please see below for an explanation of the amounts paid.

Type of Expense	From	To	Amount Claimed	Amount Paid
1- PT AX FEE	2022/08/23	2022/08/23	$100.00	$100.00

Reasons
1- Payable as submitted.

Where eligible and agreed upon, funds have been electronically deposited into your account.

Should you have any questions or wish to discuss this further, please do not hesitate to contact me.

Yours truly,

David Phandanouvong
Claims Advisor - Accident Benefits
Tel. No.: (855) 212-1745 #6325225
Fax No.: (844) 306-4550
P.O. BOX 7065
MISSISSAUGA ON
L5A 4K7

Enclosure

VirtualCareNS
virtualcarens@nshealth.ca
P: 902-418-4929 | F: 888-745-0435

Paramedical Services Referral Form

Date: 2022-09-13

After assessing Danielle MacDonald , they have been advised to seek:

- ☐ Physiotherapy — concussion management. diagnosis: concussion
- ☒ Massage Therapy — concussion management. diagnosis: concussion
- ☐ Orthotics _____
- ☐ Chiropractor _____
- ☐ Sleep Assessment _____
- ☐ Other

Sincerely,

Adam Rostis

Dr. Adam Rostis
NS: 016880