Caroline Perras

Medical Expenses Form | 2025

Last name: _____ First name: _____

☐ *Option 1*

Fill out this form, without sending us your receipts and/or the detailed summary of your private insurance. (It is recommended you keep these records for a period of 6 years.)

→ This option allows us to guarantee the appropriate tax treatment, but we cannot guarantee the amounts.

☐ *Option 2*

Provide us with all receipts, insurance statements, etc.

→ This option allows us to guarantee both tax treatment and amounts.

→ Charges will be added to your invoice based on the time required to compile your documents (an hourly rate of $80.00 per 15-minute increment).

Please note: We are nothing if not diligent! If you provide your receipts along with your form, we will most definitely sort through them. In other words, you will be billed for Option 2.

Important Information:

- You can obtain a summary of your medical expenses from your pharmacist or by consulting your file on the website of your private insurer.
- Please indicate the amounts that have not been reimbursed to you by your insurance company or any other organization (the amounts that have come out of pocket).
- You can enter the totals by category for yourself, your spouse, and your minor children. For adult children, please indicate totals separately.
- Main non-eligible expenses are as follows:
  - Massage therapist
  - Orthotherapist
  - Kinesiologist
  - Gym membership
  - Over-the-counter drugs, vitamins, supplements, etc.
  - Any reimbursements from your private insurance
  - Aesthetic procedures (e.g., teeth whitening)

	You, your spouse and your minor children	**Adult children**	**Adult children**
		_____ *Name*	_____ *Name*
Dental Care			
• Examinations, treatments, and orthodontics (including appliances)	$ _____	$ _____	$ _____
Vision Care			
• If you bought glasses for children, did you receive the $250 RAMQ refund?	☐ Yes ☐ No		
• Lenses, exams	$ _____	$ _____	$ _____
• Eyeglass frames	$ _____	$ _____	$ _____
• Laser eye surgery	$ _____	$ _____	$ _____
Healthcare			
• Drugs and equipment prescribed by a doctor and dispensed by a pharmacist	$ _____	$ _____	$ _____
• Ambulance	$ _____	$ _____	$ _____
• Medical examination fees (e.g., electrocardiogram, stool examination, or blood glucose tests)	$ _____	$ _____	$ _____

Caroline Perras

Medical Expenses Form | 2025

	You, your spouse and your minor children	Adult children	Adult children
		Name	Name

Healthcare (continued)

- Fees charged by a health professional to complete medical forms — $ _____ | $ _____ | $ _____
- The following professionals (provincial only): — $ _____ | $ _____ | $ _____
  - homeopath
  - naturopath
  - osteopath
  - phytotherapist
  - psychoanalyst
  - psychotherapist
- Other professionnals (non-exhaustive list): — $ _____ | $ _____ | $ _____
  - acupuncturist
  - audiologist
  - chiropractor
  - denturist
  - dietitian / nutritionist
  - marriage / and family therapist
  - occupational therapist
  - physician
  - physiotherapist
  - podiatrist
  - psychologist
  - registered nurse
  - sexologist
  - social worker
  - speech therapist
- Medical cannabis — $ _____ | $ _____ | $ _____
- If you were 70 years of age or older on December 31st: amount paid for accessibility equipment to maintain independence in your home. For example: — $ _____
  - cane
  - crutches
  - hearing aid
  - hospital bed
  - non-motorized wheelchair
  - panic button
  - safety handle
  - stair chair
  - toilet bowl
  - walk-in bathtub
  - walker
  - warning system
- If you needed to travel <u>at least 40 km</u> from your home (one way) to get medical services, please indicate the **total number** of km travelled _____ km
- If you needed to travel <u>at least 80 km</u> from your home (one way) to get medical services, please also indicate the number of meals consumed at the restaurant _____ meals

Other Eligible Expenses

- Fertility treatments — $ _____ | $ _____ | $ _____
- Premiums paid to a private health insurance plan, <u>if</u> not indicated on your T4, box 85 — $ _____ | $ _____ | $ _____
- Premiums paid to private medical insurance (or for travel medical insurance) **that is not** group insurance paid by the employer — $ _____ | $ _____ | $ _____
- Other (please specify)

_____ — $ _____ | $ _____ | $ _____

_____ — $ _____ | $ _____ | $ _____

_____ — $ _____ | $ _____ | $ _____

Signature _____ Date (MM/DD/YYYY) _____

Clear form