Eval Date: OT_____SLP____PT_____ **NIAGARA THERAPY, LLC** ID#:00__-_____

☐ Returning Patient

(1) PATIENT'S INFORMATION

Patient's LEGAL Last Name, First Name, Middle Initial	Family Physician's NAME	Your Email Address

Patient's Street Address	City, State, Zip	Patient's Telephone Number	Patient's Birth Date
		( ) H ( ) W	

Patient's Gender	Student Status	Marital Status	Employment Status	Patient's Social Security Number
M F	FT PT Not	**S** M D Widowed Separated	PT FT Retired Not Self	

School Name	Employer Name	Employer Address	City, State, Zip

(2) PRIMARY POLICYHOLDER'S INFORMATION

DO NOT FILL OUT THIS SECTION IF IT IS THE SAME AS THE PATIENT INFORMATION ABOVE

Primary Insured's LEGAL Last Name, First Name, Middle Initial	Primary Insured's Street Address	City, State, Zip

Primary Insured's Date of Birth	Gender	Primary Insured's Telephone Number	Primary Insured's Social Security #	Employer's Name
	M F	( ) H ( ) W		

(3) SECONDARY POLICYHOLDER'S INFORMATION

(DO NOT FILL OUT THIS SECTION IF THERE IS ONLY ONE INSURED

Secondary Insured's LEGAL Last Name, First Name, Middle Initial	Secondary Insured's Street Address	City, State, Zip

Secondary Insured's Date of Birth	Gender	Telephone Number	Secondary Insured's Social Security #	Employer's Name
	M F	( ) H ( ) W		

(4) INSURANCE CARRIER INFORMATION

Primary Insurance Company	Insurance ID Number	Insurance Policy/Group Number	Patient's Relationship to Policy Holder
			Individual Spouse Child
Phone #	Policy Holder Name	Group Name	Other: _____

Secondary Insurance Company	Insurance ID Number	Insurance Policy/Group Number	Patient's Relationship to Policy Holder
			Individual Spouse Child
Phone #	Policy Holder Name	Group Name	Other:

Tertiary (3rd) Insurance Company	Insurance ID number	Insurance Policy/Group Number	Patient's Relationship to Policy Holder
			Individual Spouse Child
Phone #	Policy Holder Name	Insurance Policy/Group Number	Other: _____

WORKER'S COMPENSATION INSURANCE

Worker's Comp. Insurance Company Name	Worker's Compensation Claim Number	
Address	Accident Date	Accident State

AUTO ACCIDENT INSURANCE

Auto Insurance Company Name	Auto Insurance Claim Number	
Address	Auto Accident Date	Accident State

(5) PHYSICIAN INFORMATION

PROVIDER, PLEASE FILL OUT ALL AREAS WHERE APPLICABLE

Referring Source:	Referring Provider

(6) EMERGENCY AND RESPONSIBLE PARTY

Responsible party to bill for services if not above	Emergency Contact Name:
Name: Address: ☐ Same as policy holder	Phone: Relationship: ☐ Same as policy holder
Orders received for: OT ____ SLP____ PT(with MC)____ Insurance Verified: _____ Auth Submitted: _____ Auth Approved:_____	POC ___ H&P ____ DC ____ Billing____ Dx____ One time Eval____