A.U.M. Physical Therapy & Wellness Center
The Comfort of Exceptional Care

AUTO INJURY REGISTRATION – AUM PHYSICAL THERAPY, PC

Name: _____
Last First Middle Initial

Address: _____

City: _____ State: _____ Zip: _____

How did you hear about us? _____

Please check the primary phone number to contact you:

☐ Home Phone: _____ ☐ Phone: _____

☐ Work Phone: _____

Email Address: _____

[We will not share your email address with anyone and will only use it to contact you about AUM Physical Therapy]

How do you prefer to be contacted?

☐ Email ☐ Text

Sex: M ___ F ___ Age: ____ Birth Date: _____

Type of Accident: _____

Place of Accident: _____

Claim Number: _____

Insurance Carrier: _____

Address of Insurance: _____

Claim Rep: _____

Claim Rep Telephone: _____

Comprehensive Physical and Occupational Therapy Services
1065 Andrew Drive Suite B-3 West Chester, PA 19380 Telephone: 610.344.7374 Fax: 610.344.7530

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AUTO INJURY INFORMATION – AUM PHYSICAL THERAPY, PC

Treating Physician: _____

Personal Insurance Carrier: _____

Telephone: _____

Member ID#: _____

Group #: _____

Subscriber's Name: _____

Subscriber's Birth Date: _____

Relation to Patient: _____

Subscriber's Address: _____

City: _____ State: ____ Zip: _____

☐ Check if the subscriber address is the same as the patient address

Subscriber's Employer: _____

Subscriber's Occupation: _____

I, the undersigned certify that I have insurance coverage with the above insurance company and assign directly to AUM Physical Therapy, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I agree to pay AUM Physical Therapy, PC any unpaid claims from insurance either in full or as per payment contract of "Self Pay" policy of AUM Physical Therapy, PC. I herby authorize AUM Physical Therapy, PC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Patient / Responsible Party Relationship Date

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