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

COMMERCIAL INSURANCE REGISTRATION

AUM PHYSICAL THERAPY, PC

Name: _____
Last First Middle Initial

Address: _____

City: _____ State: ____ Zip: _____

Please check the primary phone number to contact you:

☐ Home Phone: _____ ☐ Cell 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

How did you hear about us? _____

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

Marital Status: M ___ S ___ D ___ W ___

Patient employer: _____

Occupation: _____

In case of emergency who should be notified? _____

Phone: _____

_____ _____ _____
Patient / Responsible Party Relationship Date

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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COMMERCIAL INSURANCE INFORMATION

AUM PHYSICAL THERAPY, PC

INSURANCE INFORMATION:

Primary Insurance: _____

Secondary Insurance: _____

Subscriber's Name: _____
Last First
Middle Initial

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: _____

_____

ASSIGNMENT AND RELEASE:

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____, and I assign all insurance benefits directly to AUM Physical Therapy, PC. I understand that I am financially responsible for all charges that are not paid by insurance. I hereby 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 Person, if minor Signature Relationship Date

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