CATALYST
PHYSICAL THERAPY & WELLNESS

Financial Agreement

Thank you for choosing Catalyst Physical Therapy and Wellness for your rehabilitation needs. Please review the following policy regarding financial responsibility for your care.

Patient Responsibility:
- All copays, coinsurance, and self-pay balances are due at the time of service.
- Insurance and Personal information provided must be accurate and up to date.
- You may pay with cash, credit card or check made payable to: Catalyst PT & Wellness at the time of visit.
- Missed appointments or cancellations less than 24 hours will be charged 50% of service cost.
- A $25 fee will be charged for any returned check unpaid by your financial institution.

I certify I am 18 years of age and/or the legal guardian/guarantor. I understand and accept full financial responsibility for the patient listed below.

Printed Name of Patient: _____

Date: _____

Signature of Patient and/or Legal Guardian: _____

Insurance

The cost of your services may be covered by your insurance provider. **It is your responsibility to verify your physical therapy benefits before the time of service.** Please fill out the form below and on the reverse side by calling your primary and secondary insurance companies to verify your coverage and bring the information with you on your initial evaluation.

Patient Name: _____ Subscriber Name: _____

Primary Insurance

Insurance Company: _____
Policy # _____
Group/Claim # _____
Insurance Type eg. HMO, PPO: _____
Claims Address: _____
City: _____ State: ____ Zip: _____
Insured Name: _____
Relationship to Patient: _____
Employer: _____
Soc Sec # _____
DOB: _____

Secondary Insurance

Insurance Company: _____
Policy # _____
Group/Claim # _____
Gender: _____ DOB: _____
Relationship to Patient: _____
Soc Sec # _____
Claims Address: _____
City: _____ State: ____ Zip: _____
Insured Name: _____
Employer: _____
Phone: _____

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Please fill out following information by calling your Insurance Provider

A Guide to Calling to Verify Benefits:

IMPORTANT: ASK IF WE ARE IN NETWORK, AND IF YOU NEED PRIOR AUTHORIZATION FROM YOUR INSURANCE PROVIDER, OR A PHYSICANS REFERAL. THIS INFORMATION IS IMPERATIVE FOR YOUR INSURANCE COVERAGE OF YOUR CARE.

Date of Call: _____ Contact Person: _____(located on back of card)

Effective Coverage Dates: _____ through _____

Do you have physical therapy benefits? Yes ___ No ___

Do you have "out-of-network" physical therapy benefits? Yes ___ No ___

Benefit Details

Are there limits to these physical therapy benefits? Yes ___ No ___

Maximum number of Visits: _____ Dollar Amount: _____

Have any benefits been used this year? Yes ___ No ___

If **yes**, what is **remaining** of your benefits? Remaining # of Visits: _____ Dollar Amount: _____

Deductible/Co-Pay/Co-Insurance

Does this plan have a **deductible**? Yes ___ No ___ How much is this deductible?_____

How much of it has been met? _____

What percentage of the allowable charge is **paid by insurance**? _____

What percentage of allowable charge is **patient responsibility**? _____

Is there a **co-pay**? Yes____ No____ How much?_____

ARE EITHER OF THE FOLLOWING **REQUIRED** FOR PHYSICAL THERAPY TO BE COVERED?

PRIOR AUTHORIZATION/REFERRAL - The process for this varies depending on the insurance company. Typically, the doctor referring the patient to physical therapy submits a request for prior authorization to the insurance company. The insurance company then authorizes how much physical therapy they will cover. Yes____ No____

REFERRAL/WRITTEN ORDER/PRESCRIPTION - Referring doctor gives this to patient to bring to physical therapy. _____

Call reference # _____

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