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 for massage, acupuncture, personal training, & gavilan, and $35 for physical therapy.
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. As a courtesy, our office may verify your benefits in advance, however it is also ***your*** responsibility to verify your physical therapy benefits before the time of service.

Patient Name_____ Subscriber Name_____

Primary Insurance

Insurance Company_____
Policy # _____
Group #/Claim _____
Phone _____
Claims Address _____
City_____ State_____ Zip_____
Insured Name_____
Relationship to Patient_____
Employer_____
Soc. Sec_____ D.O.B. _____

Secondary Insurance

Insurance Company_____
Policy # _____
Group #/Claim # _____
Phone # _____
Claims Address _____
City_____ State_____ Zip_____
Insured Name_____
Relationship to Patient _____
Employer_____
Soc. Sec. _____ D.O.B. _____