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 at 50% of service cost for all non-PT services, and $45 for physical therapy. Your payment information will be stored at your initial visit so that these charges can occur automatically.
- 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. _____