CATALYST PHYSICAL THERAPY P.C.

117 N 4th St Ste A2
Hamilton MT 59840
Phone: 406-363-2494
Fax: 406-363-7232

"Feel the Difference"

PAYMENT OF PHYSICAL THERAPY SERVICES

we accept all major credit cards, cash, check and money order*
Return checks will be subject to a $25 service fee
COPAYS ARE DUE AT THE TIME OF SERVICE

*Where we do try and verify your insurance coverage, it is ultimately **your responsibility to contact your insurance provider** regarding any preauthorization and physical therapy benefits. Any information you receive from us is not a guarantee of payment; only an outline of the benefits provided to us.*

RESPONSIBILITY FOR PAYMENT OF SERVICES: I, ***(print** name)* _____, am responsible for the total amount billed for services received by Catalyst Physical Therapy. I authorize direct payment to the provider for all insurance and/or Medicare benefits for services received at Catalyst Physical Therapy.

***Please initial** that you have read and understand:* _____

UNPAID BALANCE: We at Catalyst Physical Therapy, reserve the right to place all overdue unpaid balances with a third party for the purpose of collections and you, the client, will be responsible for all finance charges, collection fees, and attorney fees in addition to the outstanding balance. At our discretion, there may be a 1.25% monthly charge added to all balances 60 days or older.

***Please initial** that you have read and understand:* _____

I authorize payment directly to Catalyst Physical Therapy, PC for physical therapy services rendered, and I understand that I am financially responsible for charges not covered by third party payers, Medicare and private insurances.

Signature: _____ ***Date:*** _____

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SCHEDULING APPOINTMENTS: As we are a small clinic, and very busy, it is important that you keep your appointments. If this is not possible, please call to cancel or reschedule as soon as possible (preferably at least 24 hours before) so that we may schedule another patient in your time slot. If you cancel or do not show for 3 consecutive visits, you will not be able to schedule out, but will need to call in for an appointment on the day you wish to be seen and if one is not available, you will be put on a wait list for that day. **NO SHOWS WILL BE CHARGED $5 FOR THE FIRST, $10 FOR THE SECOND, AND $15 FOR THREE AND MORE.**

***Please initial** that you have read and understand:* _____

TREATMENT OF A MINOR: As the parent/legal guardian, I authorize Catalyst Physical Therapy to treat _____, while I am not present.

Parent/Guardian Signature: _____ ***Date:*** _____