WEST TOWN
PHYSICAL THERAPY

Payment Agreement Form

As a courtesy to its patients, West Town PT is pleased to assist in the submission of medical insurance claims to insurance companies for payment. I understand that my insurance company may not cover 100% of my bills for services provided, and that I will be responsible for the payment of any remaining balance due.

I understand that it is my responsibility to provide West Town PT with appropriate and current insurance information and to notify us immediately upon any change in my insurance coverage to ensure efficient claims billing and payment. In the event that I fail to provide all necessary and current insurance information, I understand that my insurance company may deny payment of claims of services rendered to me, and I understand that I may be fully responsible for my entire account balance.

I understand that I will be responsible for paying co-payments, deductible, and any fees relating to services rendered that are not covered by my insurance company. All co-pays are required at the time of service.

I understand that I will be assessed a $25.00 fee if I miss an office visit without having provided a 24-hour advance notice of cancellation.

I authorize you to collect outstanding balances (co-pays, coinsurance, deductibles, and non-covered services) on my credit card listed below.

Credit Card (circle one) 

Name as it appears on card_____

Card Number_____

Billing Zip Code_____ Expiration Date_____ CVV code_____

Signature_____ Date_____