SEAL Therapeutic Corporation

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Service Payment Agreement for Non Medicaid Clients

Client Name: ____ DOB _____________________
____ DOB _____________________
Address: ____
Telephone Number: ____

$ __________Agency Fee $ ________Client Session Fee $ _____Group Session Fee $ ______ Co Pay

In signing this document, I agree to pay for services provided to me and/or my family by the staff of the SEAL Therapeutic Corporation DBA The Pediatric Behavioral Health Institute.

I agree to assign benefits for covered services at the full fee rate to the SEAL Therapeutic Corporation I am responsible for out of pocket the deductible amount any co-insurance and/or agency fee and the insurance payment for the total cost of service. Total cost for service is $150.00 for an individual/couple/family session and $75.00 for a group session. ***Should the insurer send payment intended for the SEAL Therapeutic Corporation or the Pediatric Behavioral Health Institute to the policyholder, the policyholder agrees to endorse and forward the payment for services to the SEAL Therapeutic Corporation.***

I understand that upon continued failure to pay an outstanding balance, the SEAL Therapeutic Corporation, Inc. may take actions that can result in the collection of these funds. I will bear the full costs of any legal fees and expenses incurred in those collections. I agree that the venue for any such legal action shall be in Palm Beach County, Florida and that Florida Law shall govern.

I accept the right of the SEAL Therapeutic Corporation to change its listed fees upon thirty days written advanced notice to me. I further understand that this Agreement does not obligate the SEAL Therapeutic Corporation to provide services if I have not fulfilled my obligations as a consumer or if, in the judgment of the agency, the needed services can not be furnished by the existing personnel to an acceptable level of quality, satisfaction and effectiveness.

Policy on Insurance Deductibles

A deductible amount is the re-defined amount paid each year by a health plan enrollee before plan coverage begins. When an enrollee or covered dependent sees a provider In-Network or Out-of Network a deductible most often, does apply. Certain plans may also have co-payments/and or co-insurance. Client is responsible for deductibles prior to the insurance making any payments for the year. Clients are responsible to understand their insurance policy coverage. Questions about insurance should be addressed with the enrollee's insurance company.

The SEAL Therapeutic Corporation ("SEAL"), Inc. will send claims to a client's insurance as a courtesy when non-participating. Claims are always submitted to participating insurance plans.

Clients are responsible to SEAL, Inc. the amount of money the insurance applies toward the yearly deductible, payment of any co-payments, payment of any co-insurance amounts with participation plans and/or the amount of the sliding fee that has been predetermined by the program Administrator.

The SEAL Therapeutic Corporation. does collect from clients and/or responsible family members. The client or parent/ guardian of the client is responsible for all services to be paid.

I HAVE CAREFULLY READ THE ABOVE PROVISIONS AND UNDERSTAND THEM I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS WHICH WERE SATISFACTORILY ANSWERED. I UNDERSTAND THAT SIGNING THIS AGREEMENT MAKES ME LEGALLY OBLIGATED TO PAY THE PUBLIC ENRICHMENT AND RESOURCE CENTER, INC. FOR SERVICES RENDERED TO ME AND REQUESTED BY ME ON MY BEHALF.

Client Signature: ____ Date: _____________

Parent/Guardian: ____ _____________

Witness Signature: ____ ____________