Marty Seyler LMHC PA
1280 N. Congress Ave., Ste 100, West Palm Beach, FL 33409

Payment Agreement

If you will be using insurance please provide the following information:

Insured's information if different from client information:
Last Name:_____First Name_____MI_____

Sex_____Birthdate_____Social Security Number_____

Address_____City_____St____Zip_____

Home Phone_____Work Phone_____Employer_____

Insurance information:
Insurance Company_____Ins. Co. Phone#_____

I.D.#_____Group #_____Deductible amount_____

If Deductible met, check here_____Co-pay amount_____

If you will be paying cash, please provide the following information:
Responsible Party_____Address_____

_____Phone#_____Amount agreed upon_____

I authorize Marty Seyler, LMHC to release information required to process my claims. I understand and agree that, regardless of my payment method or insurance status, I am ultimately responsible for the payment of my therapy.

Signature_____ Date_____

SIGNATURE ON FILE

I authorize the use of this form on all my insurance submissions. _____(initial)
I authorize release of information to all my insurance companies._____(initial)
I understand that I am responsible for my bill.____(initial)
I authorize payment directly to my therapist.____(initial)
I permit a copy of this authorization to be used in place of the original. ___(initial)

Name (please print)_____

Signature_____ Date_____