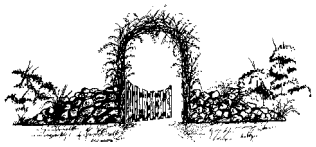

ArborGate Associates, Inc.

Counseling and Psychological Services

THIRD PARTY PAYMENT: SUBMISSION AND REIMBURSEMENT

Clients are responsible for verifying their own insurance coverage. We will assist you in this process. Our office routinely contacts insurance companies to verify benefits.

Upon payment of the full fee, clients may submit their own insurance. Their insurance company then usually sends reimbursement checks directly to the client.

Payment for sessions is expected at the time of the service. Payment is subject to the benefits for which the patient is eligible under the terms of his or her insurance contract at the time services are rendered. The co-pay amount will be accepted as payment once we have received verification from your insurance company that the annual deductible has been met and ArborGate Associates, Inc. begins receiving insurance payments.

Insurance claim forms are submitted on a timely basis. Payment usually is then made directly to ArborGate Associates, Inc. These checks are applied to the client's account against the session they were submitted for. Payment in excess of the balance is either reimbursed to the client by ArborGate Associates, Inc. or applied to future sessions. This is the client's decision. Reimbursement checks are written on the 1st and 16th of each month. Should the insurance company reimburse a check to a client who has an outstanding account balance, it is their responsibility to immediately forward this check to ArborGate Associates, Inc.

I request that payment of authorized Medicare or insurance benefits be made to ArborGate Associates, Inc. for any services furnished me or my dependent by that provider. I authorize said assignee to release all necessary information to the insurance carrier and its agents required to determine benefits payable for related services and to secure payment.

I further agree that should the amount be insufficient to cover the entire medical expense, I will be responsible for payment of the difference; and if the services are not covered by my insurance policy, I will be responsible (to the provider) for payment of the entire bill.

I understand that as of this date my insurance carries a $ _____ deductible with a $ _____ co-pay. Insurance then covers _____ % of the remaining charges.

This information was provided "as is" without warranty of any kind, either expressed or implied. I further understand that eligibility and benefit information does not guarantee payment of a related claim. Eligibility and benefit plan limitations are subject to change and will be determined at the time that the applicable claim is processed.

_____	_____	_____
Patient / Parent (Guardian) Signature	Relationship to Client	Date