

McLaren Print System Order

Order No: 42711
 Order Date: 2019-02-07
 User: Denise Maginity
 Phone: 810-342-5470

Ship Location: BARIATRIC & METABOLIC INSTITUTE/BEECH HILL CENTRE
 G-3200 Beecher Road, MBI
 Flint, MI 48532

Forms

Quantity: 100
 Paragon Dept No: 36810
 Dept Name: BARIATRIC & METABOLIC INSTITUTE
 Company Number: 60

Order Total Price: 56.45

Item Number: M-13067
 Item Description: Service Agreement
 Revision Date: 10/2014
 Print: 1 sided black and white
 Paper: 3 Part (White, Yellow, Pink)
 Size: 8.5 x 11
 Fold:
 Finish: None
 Drill: None
 Misc Info: ss; black; 3 part

MCLAREN FLINT
 Flint, Michigan
BARIATRIC INSTITUTE
 SERVICE AGREEMENT

--- PRINTABLE AT TIME OF SERVICE ---

Client Name: _____

Contact # _____ DOB: ____/____/____

BC McLaren Health Advantage
 PEP (If Required) McLaren Health Plan
 MESA OONA (Need Referral)
 SF of 10 (Need Referral 10%) OON GEN (20 Visits At 100% Next 15 Visits At 75%)
 Ford or Chrysler (Need Referral) HEALTH PLUS (Need Referral 20 Sessions Per Yr)
 Out of State _____ MEDICARE (Part B Approved Therapist Only)
 Ameritech _____ PPO/M Phone It _____
 PPO _____ Other Commercial, Etc.: _____
 BCN (Need Referral)

Amount billed to insurance \$ _____ per initial visit \$ _____ copy
 Amount billed to insurance \$ _____ per testing hour \$ _____ copy
 Amount billed to insurance \$ _____ group therapy \$ _____ copy
 Amount billed to insurance \$ _____ psychotherapy \$ _____ copy
 Client's yearly deductible \$ _____
 Yearly maximum paid by insurance \$ _____

I am responsible for payment of services should the yearly maximum be reached or should the insurance company not cover the service for any reason. It is my responsibility to notify McLaren Bariatric Institute of any change in my insurance coverage. McLaren Bariatric Institute is not responsible for incorrect information they may have received from the insurance company.

INITIAL BELOW:

_____ **TREATMENT FOR MINORS:** I understand and agree that as parent/guardian of this minor, I am responsible to McLaren Bariatric Institute for payment of any deductibles, co-payments or non-reimbursable services. Any agreement with another responsible party, either verbal, written, or court ordered, is an agreement between that party and myself. McLaren Bariatric Institute will not be held responsible or liable for seeking payment from that other party.

_____ I have read this agreement and have had the opportunity to ask questions which were answered to my satisfaction. I understand and agree to the conditions specified herein.

Spec Info:

Client Signature: _____ Date: ____/____/____

Witness Signature: _____ Date: ____/____/____

Guardian/Guardian Signature: _____ Date: ____/____/____

WHITE - Office
 YELLOW - Patient
 PINK - Chart
SERVICE AGREEMENT
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