

## McLaren Print System Order

Order No: 49639  
 Order Date: 2019-10-21  
 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: 57.20

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: 5 Hole Top  
 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 1%)  
 Out of State \_\_\_\_\_  MEDICARE (Part B Approved Therapist Only)  
 Ameritech \_\_\_\_\_  PPOM Phone # \_\_\_\_\_  
 PPO \_\_\_\_\_  Other Commercial, Etc.: \_\_\_\_\_  
 BCN (Need Referral)

Amount billed to insurance \$ \_\_\_\_\_ per initial intake \$ \_\_\_\_\_ 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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