McLAREN FLINT
Flint, Michigan
BARIATRIC INSTITUTE

SERVICE AGREEMENT

– PAYABLE AT TIME OF SERVICE –

Client Name: _____

Contact #: _____ DOB: _____ / _____ / _____

- ☐ BC
- ☐ FEP (R# Required)
- ☐ MESSA
- ☐ ST of MI (Need Referral VBH)
- ☐ Ford or Chrysler (Need Referral)
- ☐ Out of State: _____
- ☐ Ameritech
- ☐ PPO
- ☐ BCN (Need Referral)
- ☐ McLaren Health Advantage
- ☐ McLaren Health Plan
- ☐ CIGNA (Need Referral)
- ☐ CON GEN (20 Visits At 100% Next 15 Visits At 75%)
- ☐ HEALTH PLUS (Need Referral 20 Sess Max Per Yr)
- ☐ MEDICARE (Part B Approved Therapists Only)
- ☐ PPOM Phone #: _____
- ☐ Other: Commercial, Etc.: _____

Amount billed to insurance $_____
Amount billed to insurance $_____
Amount billed to insurance $_____
Amount billed to insurance $_____
Client's yearly deductible $_____
Yearly maximum paid by insurance $_____

per initial intake $_____ copay
per testing hour $_____ copay
group therapy $_____ copay
psychotherapy $_____ copay

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.**

Client Signature: _____ Date: _____ / _____ / _____

Witness Signature: _____ Date: _____ / _____ / _____

Guardian/Guarantor Signature: _____ Date: _____ / _____ / _____

WHITE - Office
YELLOW - Patient
PINK - Chart
SERVICE AGREEMENT
M-13067 (10/14)

870b

PT.

MR.#/P.M.

DR.