McLaren Flint
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 Plan
☐ CIGNA (NEED REFERRAL)
☐ CON GEN (20 VISITS AT 100% NEXT 15 VISITS AT 75%)
☐ HAP (NEED REFERRAL 20 SESS MAX PER YR)
☐ MEDICARE (PART B APPROVED THERAPISTS ONLy)
☐ PPOM PHONE #_____
☐ OTHER: COMMERCIAL, ETC.
_____

Amount billed to insurance $_____ per initial intake. $ _____ copay

Amount billed to insurance $_____ °per 45-60 minutes session.

Client's yearly deductible $_____

Client's co-pay per 45-60 session $_____

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 Behavioral Medicine of any change in my insurance coverage. McLaren Behavioral Medicine is not responsible for incorrect information they may have received from the insurance company.

INITIAL HERE

_____ **TREATMENT FOR MINORS:** I understand and agree that as parent/ guardian of this minor, I am responsible to McLaren Behavioral Medicine for payment of any deductibles, co-payments or non reimbursable services. Any agreement with another responsible, either verbal, written or court ordered, is an agreement between that party and myself. McLaren Behavioral Medicine 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 question which were answered to my satisfaction. In understand and agree to the conditions specified herein.**

Client Signature _____ Date _____

Witness Signature _____ Date_____

Guardian/Guarantor Signature _____ Date _____