

McLaren Print System Order

Order No: 74246
 Order Date: 2022-12-21
 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
 Poster:
 Misc Info: ss; black; 3 part

McLAREN FLAT
 Via. Michigan
BARIATRIC INSTITUTE
SERVICE AGREEMENT

- PRINTABLE AT TIME OF SERVICE -

Client Name: _____
 Contact #: _____ DOB: ____/____/____

- | | |
|---|---|
| <input type="checkbox"/> BC | <input type="checkbox"/> McLaren Health Advantage |
| <input type="checkbox"/> PEP (If Required) | <input type="checkbox"/> McLaren Health Plan |
| <input type="checkbox"/> MESA | <input type="checkbox"/> COBA (Need Referral) |
| <input type="checkbox"/> ST of MI (Need Referral 15%) | <input type="checkbox"/> COB GEN (20 Visits At 100% Next 15 Visits At 75%) |
| <input type="checkbox"/> Ford or Chrysler (Need Referral) | <input type="checkbox"/> HEALTH PLUS (Need Referral 20 Sessions Max Per Yr) |
| <input type="checkbox"/> Out of State _____ | <input type="checkbox"/> MEDICINE (Part B Approved Therapists Only) |
| <input type="checkbox"/> Ameritech _____ | <input type="checkbox"/> PROM Phone #: _____ |
| <input type="checkbox"/> PRG _____ | <input type="checkbox"/> Other Commercial, Etc.: _____ |
| <input type="checkbox"/> 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.

Spec Info: 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/Guardian Signature: _____ Date: ____/____/____

WHITE - Office
 YELLOW - Patient
 PINK - Client
SERVICE AGREEMENT
 10/2014/10/14



81702

