McLaren Business Products

McLaren Print System Order

Order No: 80581
Order Date: 2023-10-17
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 FLINT
Flint, Michigan
BARIATRIC INSTITUTE
SERVICE AGREEMENT

-- PAYABLE AT TIME OF SERVICE --

Client Name: _____

Contact #: _____ DOB: ____ / ____ / ____

- ☐ BC
- ☐ FEP (SM Required)
- ☐ MESSA
- ☐ ST of MI (Need Referral MBH)
- ☐ 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	$_____	per initial intake	$_____ copay
Amount billed to insurance	$_____	per testing hour	$_____ copay
Amount billed to insurance	$_____	group therapy	$_____ copay
Amount billed to insurance	$_____	psychotherapy	$_____ copay
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.

Client Signature: _____ Date: ____ / ____ / ____

Witness Signature: _____ Date: ____ / ____ / ____

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

WHITE - Office
YELLOW - Patient
PINK - Chart
SERVICE AGREEMENT

(6708)

Spec Info: