CLARK FORK
DENTAL

PATIENT PAYMENT AGREEMENT for Clark Fork Dental LLC

All patients without dental insurance are expected to pay in full at the time of service. Payment is due in-full at the time of treatment. _____ initials

Patients with dental insurance are responsible for any charges the dental insurance does not pay. We will collect payment in-full if we are unable to verify benefits and eligibility of your insurance. We will also ask for payment in-full if your dental insurance provider pays the subscriber for services directly. We will estimate benefits of your insurance and ask for co-payments and/or deductibles at the time of service. _____ initials

Medicaid approved (children only) patients WILL NOT be rescheduled at this office following a missed or less than 24-hour cancellation. THIS POLICY INCLUDES EXISTING ADULT MEDICAID PATIENTS. _____ initials

- **We are currently not accepting any NEW ADULT MEDICAID patients,**

Payments are an option of last resort, not personal preference. Any and all payment arrangements are to be approved of in advance (*for each transaction*); a finance charge, as well as, a billing/mailing fee will be added monthly. _____ initials

There is a $50.00 rescheduling fee for missed or 24-hours or less cancellations. _____ initials

PAYMENT AGREEMENT

I, _____, authorize treatment for myself and/or minor, and agree to pay all fees and charges for such treatment. I authorize my dental insurance company or third party payer to make payments directly to Clark Fork Dental, LLC., or Russell Blackhurst D.M.D. I authorize the release of personal information or dental records to other health care providers for the purpose of coordinating my healthcare. I also authorize the release of protected information to my insurance company or third party payer for the purpose of reimbursement for services rendered. I understand that Clark Fork Dental, LLC., will bill my insurance as a courtesy to me, however, I am responsible for payment of any unpaid balance due from my insurance company. I also understand that delinquent accounts will be sent to a collections agency and I authorize the use of any information given by me on the registration form to secure payment from the collection agency. I understand that I will be held responsible for any and all legal fees in collection of unpaid debt. I acknowledge receipt of a copy of this agreement.

DATE:_____

Signature of Patient or responsible party_____

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