BAGNELL Dental Clinic
15276 Belker Ln
Frenchtown, MT 59834
406-626-5520

PATIENT PAYMENT AGREEMENT

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. In order to achieve these goals we need your assistance and understanding of our payment policy. We offer the following methods of payment of fees:

A. **Payment in full is due at the time of service**. We cannot grant exemptions. We offer a 5% discount for accounts paid in full at time of service with cash or check. Insurance, credit and debit card transactions are ineligible for this discount.
B. As a courtesy to our patients we will file your insurance. It is the responsibility of the patient to know the limits of your insurance. We cannot guarantee what your insurance will pay. We will estimate as closely as possible what your out of pocket expenses will be. **You will be expected to make payment at the time of service for any deductibles or co-payments for your treatment.** If insurance claims take over 60 days to be paid by the insurance company, we ask that the patient pay the balance in full and once the insurance pays the claim we will issue a refund if there is one coming to the patient.
C. We also offer interest free or extended payment plans through **CareCredit** dental financing (O.A.C.). You may apply by going to www.carecredit.com. If approved, print off approval with your account number and bring to your appointment.
D. In case of divorce or separation, **the parent accompanying the child and authorizing treatment will be the parent responsible for the charges on the day of service.** If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

We will gladly discuss your proposed dental treatment and answer any questions you might have as to the involvement of your dental benefit program in receiving this care. We appreciate the opportunity to serve you.

PAYMENT AGREEMENT:

I, _____, authorize treatment for myself or minor, and agree to pay all fees and charges for such treatment. I understand that I am responsible for payment of any unpaid balance **due** from my insurance company, **within 60 days** of treatment. I understand that overdue accounts will be sent to a collections agency and I authorize release of protected information for collections purposes. I also agree to pay an interest penalty of 1.5% per month on any outstanding balance over 60 days. There will be a service charge on all returned checks. I acknowledge receipt of a copy of this agreement.

Patient or Responsible Party_____Date_____