

**BOZEMAN DENTAL ASSOCIATES
2018 STADIUM DRIVE
BOZEMAN, MT 59715
(406) 586-9621**

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

Patient _____

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment at the time services are rendered. We accept MasterCard, Visa, American Express, and Discover credit cards. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing date.

IT IS AGREED THAT PAYMENTS WILL NOT BE DELAYED OR WITHHELD BECAUSE OF ANY INSURANCE COVERAGE or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.)

LATE CHARGES: If I do not pay the entire balance within 60 days of the monthly billing date, a finance charge of 1.25% on the past due balance will be assessed each month. I realize that failure to keep the account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the event legal action should become necessary to collect any unpaid balance for dental services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper. If my past due account is referred for outside collection, I agree to pay all collection costs, all attorney fees and all court costs. All returned checks may be assessed a fee of \$30.

Thank you for completing these forms. The information you have provided will help us serve your dental health care needs more effectively and efficiently. If you have questions at any time, please feel free to ask us. We are always happy to help.

Signature of Patient, Parent or Guardian if a Minor

Date