KALISPELL FAMILY
DENTAL

FINANCIAL RESPONSIBILITY AGREEMENT AND ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize my signature on all insurance claim forms at the offices of Kalispell Family Dental for payment directly to them for services rendered. I authorize Kalispell Family Dental to make and send copies of dental records that may be needed to file my insurance claims. I understand that I am financially responsible for all charges incurred regardless of whether or not my insurance pays. I understand that office policy requires payment in full or the estimated portion not covered by insurance at the time of service unless other arrangements have been made. I understand that if any unpaid balance is assigned to a third party collection agency for collection or placed with an attorney to obtain judgment or otherwise satisfy payment of my account, a collection fee of up to 45% will be added to my account. I further agree to pay reasonable attorney fees and court costs. I understand and agree to the above terms.

Signature: _____ Date: _____