Private Contract

Medicaid Participants

I, the Medicaid beneficiary or my legal representative, accept full responsibility for the payment of charges for all services furnished by Colorado Regional Oral Surgery.

I understand that Medicaid limits do not apply to what Colorado Regional Oral Surgery may charge for items or services furnished.

I agree not to submit a claim or ask Colorado Regional Oral Surgery to submit a claim.

Please check the appropriate box listed below.

Applicable: ☐

Not Applicable: ☐

Patient or Legal Representative Signature: ___________________________ Date: ________

Witness: ____ Date: ________