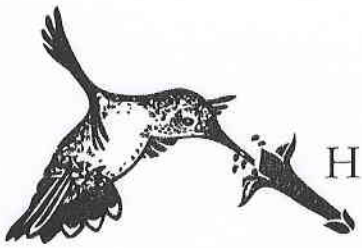

HAKALA FAMILY DENTISTRY

4200 E. 8TH AVENUE, SUITE 200, DENVER CO 80220, 303-321-8967 FAX 303-321-2561

Payment Policy

Payment

We request payment at the time of services unless other arrangements have been made. Cash, Visa, Master Card, Discover and American Express are accepted. Checks are not accepted unless you are an established patient with a good payment history. Accounts not paid in 30 days are subject to 18% per anum interest rate.

Insurance

We will file your insurance claims and assist you with insurance questions, but please realize that the insurance contract is an agreement between you and the insurance company. We have no control over what an insurance company will pay, and can only provide estimates about your coverage. Insurance policies have become increasingly complex and we cannot possibly keep up with all of the available policies.

You will be responsible for verifying eligibility of benefits and for paying the deductible and estimated co-payments at the time of service. You are also responsible for the full balance if the benefits are denied by the insurance company for any reason.

Patients needing treatments that require predetermination of benefits from their insurance company may assign payments to us, but you will be required to pay at least ONE HALF of your co-payment at the time the pre-authorization service is started, and the remainder of the balance the day the treatment is completed.

Extended Payments

We can provide an application form for a finance company, CARE CREDIT. Zero % interest and extended payment plans at varying interest rates are available, depending on approval from Care Credit and the amount of credit needed. We will not provide payment plans to new patients without using CARE CREDIT.

Missed Appointments

We request a minimum of 24 hours notice for cancelled appointments, failed appointments, especially those for which we have reserved one or more hours of time for you, will be subject to a missed appointment fee of $100 per hour.

I have read, understand, and agree to this payment policy.

Printed Name or Guardian: _____

Signature: _____ Date: _____