Steven E. Hofstad, D.D.S.
400 W Northern Lights Blvd, Suite 1
Anchorage, AK 99503
(907) 561-4082

Thank you for selecting Dr. Hofstad's office for your dental treatment. Please review and choose one of our payment options below. Please speak to our front desk prior to your treatment if you have any payment questions.

{ } Cash { } Credit Card { } Check { } CareCredit (upon approval)

As a courtesy to our patients, we will bill your insurance. You are still responsible for the full amount of your bill. If you ask our office to submit your insurance claim, you are still required to pay your estimated co-payment and any deductibles related to your insurance policy. We ask that you provide us with your credit card information and preauthorization to bill any outstanding balance on your account to this card after your insurance payment is received or when your account reaches 60 days (whichever is earlier). Your receipt will be mailed to the address we have on file. If payment from your insurance companies results in an overpayment, we will refund the difference to the appropriate party.

I acknowledge full responsibility for the payment of such services and agree to pay for them in full at or before completion, unless other specific arrangements have been made with the collections manager in advance. I understand that my insurance coverage is a contract between my insurance and myself, and that Dr. Hofstad is not a party in this contract. Dr. Hofstad, therefore, cannot become involved nor represent me in claim disputes with my insurance carrier. Situations such as, but no limited to, claim denials and "usual and customary" disputes are my responsibility to resolve with my insurance carrier. If a dispute or a denial occurs, I agree to pay the balance of my account in full and contact my insurance carrier personally to resolve the dispute/denial.

I understand that a billing charge is assessed (the maximum allowed by state law) on all accounts over 60 days regardless of their insurance billing status. I agree to inform Dr. Hofstad, in writing, of any change in my billing or mailing address as long as I have an outstanding balance. I accept responsibility for all cost incurred by Dr. Hofstad in collecting my debt owed to him, including, but not limited to: non-sufficient funds, stop-payment fee, skip tracing, and collection fees. Should a professional discount be given and this account is turned over to collections, all discounts will be voided. There will be a $30 NSF fee plus bank fees applied to your account if your check is returned to us.

X_____ _____
Signature of Patient or Guardian (if under 18) Date

Credit Card/Debit Card Information and Preauthorization

{ } I authorize Dr. Hofstad to charge the outstanding balance of my account after my insurance payment is received or when my account reaches 60 days (whichever is earlier).

{ } I authorize recurring charges of $____.___ on the first half or second half of the following months {not to exceed 60 days).

_____ _____
Cardholder Name Credit Card Number

_____ _____/_____/_____
Cardholder Signature Date