COLORADO FAMILY DENTISTRY
DR. KASPER | DR. SCHOLAND

Colorado Family Dentistry Dental Savings Plan
Preventative Plan

Group

Monthly Cost	*Child*** *$18/month*		*Adult* *$23/month*	
Included Procedures	Allowed Frequency	Usual Cost	Allowed Frequency	Usual Cost
Exams	1 per 6 months	$157	1 per 6 months	$157
X-rays	1 per 12 months	$130	1 per 12 months	$149
Fluoride	1 per 6 months	$96	1 per 6 months	$96
Hygiene	1 per 6 months	$156	**1 per 6** months	$214
Total Yearly Savings	*Regular Cost/yr: $539*		*Regular Cost/yr: $616*	
	Plan Cost/yr: $216		*Plan Cost/yr: $276*	
	$323 savings		***$340 Savings***	

Plans: Perfect for families and businesses

Multi-Subscriber Discounts	
# of Subscribers	*Discount*
3-5	7%
6-10	10%
11-49	14%
50+	17%

This dental savings plan is not insurance. It is an exclusive offer and may not be valid with other offers, specials or plans.

Included benefits:

- **15% off of all services not covered under the savings plan**
- ***20% off of all services not covered under the savings plan where the treatment plan is $1000 or more and is paid in advance, at the time of scheduling.**
- **Doctor's Exam:** 1 Comprehensive exam for new patients and 1 routine exam every 6 months
- **Hygiene Visits:** 1 Prophylaxis (preventative) cleaning every 6 months
- **Fluoride Treatments:** 1 fluoride varnish application every 6 months
- **X-rays:** 1 Full mouth X-ray series for new patients and 1 full mouth x-ray series every 3 years thereafter plus 4 bitewing x-rays & 2 periapical films every 12 months.

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The Colorado Family Dentistry dental savings plan is not an insurance plan, this is a savings plan offered to all customers. This savings plan is an exclusive offer and may not be valid in conjunction with other specials, discounts or offers. The plan covers x-rays for routine hygiene visits and initial examinations based on the aforementioned frequencies for patients who are current on the plan. The plan does not cover additional x-rays or exams required for emergency or other diagnostic visits.

The minimum initial term for this service is 3 months, after which time the plan renews on a monthly basis. Billing failures which are not remedied within 30 days will result in termination of service. Either party may terminate service with 30+ days notice from the current renewal period. Reinstatement of a terminated savings plan will start a new initial term at the current plan rate. The first month of service will be pro-rated.

Utilization of benefits is the patient's responsibility. Rates for the plan are not fixed and may increase after the initial term. Patients will be notified at least 30 days in advance of any fee increases.

* 20% off of additional services is only offered when paying with cash, check or credit card.

**Patients must be under age 12 to qualify as children.

Names of plan subscribers:

Subscriber 1: _____

Subscriber 2: _____

Subscriber 3: _____

Subscriber 4: _____

Subscriber 5: _____

Subscriber 6: _____

Subscriber 7: _____

Subscriber 8: _____

Subscriber 9: _____

Subscriber 10: _____

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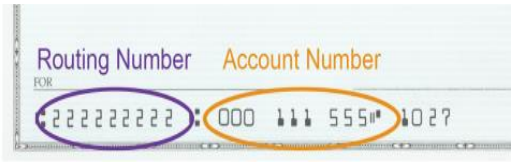
ACH Recurring Payment Authorization Form

You authorize regularly scheduled charges to your checking account, savings account or credit card. You will be charged the amount indicated below each billing period. Charges will appear on your bank statement as an "ACH Debit." You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 30 days prior to the payment being collected.

Please complete the information below:

I _____ authorize Colorado Family Dentistry to charge my bank account indicated below on the 1st of each month for payment.

Total monthly amount:_____

☐ Checking ☐ Savings	☐ Credit Card (5% surcharge)
Bank Routing #:_____	Card Number:_____
Account Number:_____	Expiration:_____
Bank Name:_____	CVV Code:_____
	

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Colorado Family Dentistry in writing of any changes in my account information or termination of this authorization at least 30 days prior to the next billing date. If the above noted periodic payment dates fall on a weekend or holiday, I understand that the payment may be executed on the next business day. I understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that Colorado Family Dentistry may at its discretion attempt to process the charge again within 30 days, and agree to an additional $25 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I agree not to dispute this recurring billing with my bank so long as the transactions correspond to the terms indicated in this authorization form.

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