C A L L Y L . A D A M S , D D S , L L C

P E D I A T R I C   D E N T A L   C L I N I C

P H O N E : (8 0 8) 8 7 5 - 4 8 0 8

F A X : (8 0 8) 8 7 5 - 4 8 4 1

1 3 2 5 S O U T H K I H E I R O A D , S U I T E 1 0 8 , K I H E I , H A W A I I 9 6 7 5 3

P E D I A T R I C - D E N T I S T @ C A L L Y A D A M S D D S . C O M

Financial Policy / Insurance Disclaimer / Cancellation & No Show Policy

(Please read carefully)

Please note we DO NOT accept nor participate with any HMO insurance plan, pre-pay plan or discount plans.

*** Our mission** is to provide the highest quality of dental care to infants, children, adolescents and special needs. We strive to be the best and most compassionate pediatric dental clinic on Maui. Since our office is also a business with obligations that must be met, we ask that all patients pay for their treatment in full on the day of service unless prior arrangements have been made.

* **Any treatment plan that our office** proposes to you is an **ESTIMATE** of what your insurance coverage will be, it's not a guarantee of payment. If you need an **EXACT** payment of benefits, then a pre-treatment authorization is required. If you would like this done, you must request it from the office manager before any work is started. (**This takes 6-8 weeks**).
________ **(Initial)**

* **Outstanding balances** on your account are discouraged and must be cleared before the next appointment for any account member or within **90 days** of treatment. Appointments for non-emergency treatment may need to be postponed pending payment of outstanding balances. Amount due and not paid in full within **90 days** will be charged interest at a rate of **1.5% per month** in addition to a **$5.00 monthly** billing fee per statement.

* **Delinquent balances** over **90 days** old will be referred to **Credit Associates of Hawaii**. All referred accounts are marked "Inactive". In order to have your account "Reactivated" and continue to receive dental treatment in our office the delinquent balance needs to be paid in full to the referred collection agency. Only after this total account balance has been paid in full can an appointment be made and your account and patient status be reactivated.

* **A returned check fee** of $25.00 (subject to change as balance fees increase) will be added to your account for any returned check. Before we can make another appointment the $25.00 fee plus full payment for the check that did not clear must be paid in cash, VISA, MasterCard, Discover or AMEX.

* **Office hours are by appointment** and we do value your time. This office is a private office and not a dental "clinic". Appointment time is reserved for your child alone. Where appropriate, such as oral sedation visits, we prefer to schedule longer appointments so we can complete as much needed dental treatment as possible during one appointment. We feel this type of scheduling will cause minimal disruption to your daily schedule and will provide efficiency in completing your child's dental care. When you make an appointment, please be sure that you will be able to keep it.

Emergencies and unforeseen patient treatment problems may arise, causing schedule changes. Emergencies are unexpected and seem to come at the most inconvenient times. If your child has a dental emergency that needs immediate attention, we will always offer to see you at once. We expect that other patients who might be slightly inconvenienced by this will understand of the emergency situation. At some point, they may need the same courtesy too!

Confirmation calls are a courtesy! **You are responsible for keeping your child's appointment, even in the event you do not receive a call.** Please make a note of any dental appointments we have scheduled in a place where you will be easily reminded. If you cannot make an appointment as scheduled please notify the office. **There will be a charge of $75.00 plus tax per 30 minutes of scheduled time for a broken appointment or cancellation with less than 48 hours' notice for appointments weekdays.**

C A L L Y L . A D A M S , D D S , L L C

P E D I A T R I C D E N T A L C L I N I C

P H O N E : (8 0 8) 8 7 5 - 4 8 0 8

F A X : (8 0 8) 8 7 5 - 4 8 4 1

1 3 2 5 S O U T H K I H E I R O A D , S U I T E 1 0 8 , K I H E I , H A W A I I 9 6 7 5 3

P E D I A T R I C - D E N T I S T @ C A L L Y A D A M S D D S . C O M

I understand and accept the Financial Policy, Dental Disclaimer and Cancellation & No Show policy listed above and have had any and all questions answered to my satisfaction. I agree to pay for all treatment in a timely manner as described to avoid any additional fees. I realize that I am responsible to pay for any deductible amount(s), my co-insurance portion and for any non-covered services. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by my insurance and I agree to pay such charges in full. I also herby authorize the release or pertinent medical/dental information to insurance carrier(s). This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Name ______________________________ **Parent/Guardian Signature** ______________________________

Date __________ **Staff Initial** __________