Ohana Smiles Financial Policy

Thank you for choosing Ohana Smiles as your dental healthcare provider. We are committed to providing you with quality dental care. The following is a statement of our financial policy, which we require you read, agree to, and sign prior to any treatment. Please note that full payment is due at the time of treatment and all charges incurred are the patient's responsibility regardless of insurance coverage.

Insurance: We do not accept Medicare or Medicaid. As a courtesy, we will file claims on your behalf with your insurance company immediately after your treatment. Please note that an insurance policy is a contract between your insurance company and you. If you have questions regarding coverage, you must contact the insurance company directly. You are responsible for full payment regardless of any insurance company's arbitrary determination of usual and customary rates unless our office is a preferred provider.

If you are a new patient, please present your insurance card prior to treatment. If we are unable to verify your insurance, full payment is due at the time of treatment. If your insurance has changed, it is your responsibility to update our office with the new information.

Payments: Our office does not accept partial payments or payment plans. We accept payment in the forms of cash, check, Visa, or MasterCard. At the time of treatment, the estimated amount is due. After we receive payment from your insurance company, the remaining balance is due in full. Any adult accompanying a minor is responsible for the payment due at the time of service as well as providing us with the appropriate insurance information, if applicable. If we do not receive payment from your insurance company within 30 days of submitting the claim, you will be responsible for full payment. If we receive subsequent payment from your insurance company, you will be refunded. Please note that returned checks will be subject to additional fees.

If you do not have insurance, a 10% discount will be given if paying by cash or check at the time of treatment.

Overdue Accounts: You are responsible for late, legal, or collection-related fees. Any balance unpaid within 60 days of treatment is subject to a $25/$50 late fee for accounts with a balance under/over $400. Accounts past due for 90 days will be sent to collection agencies with a 35% collection fee of the balance.

Late Cancellations/Missed Appointments: We understand that circumstances occur that do not allow you to keep your scheduled appointment. If this is the case, please call us at least 48 hours in advance of your appointment time to reschedule or a $50 late cancellation fee will be assessed to your account. If you are more than 15 minutes late for an appointment, you may need to reschedule. If you miss your appointment without cancellation, a missed appointment fee of $50 per hour will be assessed. Your appointment time is only reserved for you and we have to pay our staff even if you are not here. Please help us serve you better by keeping scheduled appointments or changing it in a timely manner. Excessive abuse of scheduled appointments will result in dismissal from our office.

HIPAA Privacy: We thank you for the opportunity to provide you with quality dental care. We respect all of our patients and wish to keep you notified of our policies. Ohana Smiles follows HIPAA privacy laws and has a copy of HIPAA regulations available at your request. If we change our privacy practices or financial policy, we will post a copy in our office in a prominent location, have copies of the revised notice at our office and on our website, and provide you with a copy upon your request.

Understanding, Authorization, and Release: I have read, understood, and agreed to all of the terms listed in Ohana Smiles Financial Policy. I authorize Ohana Smiles to release any information including the diagnosis and the records of any treatment or examination rendered to my dependent(s) or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Ohana Smiles or dental group insurance benefits otherwise payable to me. I agree to be responsible for payment and related charges of all services rendered on my behalf or my dependent(s).

X _____ Date _____

Signature of Patient or Responsible Party

(Print) _____