Ancheta Pediatric Dental LLC
98-1247 Kaahumanu St. #205 Aiea, HI 96701
Tel: (808) 487-1000 Fax: (808) 487-1004

FINANCIAL AGREEMENT

Thank you for choosing us to provide your child's dental care. Our philosophy in serving people is to be informative, honest and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions about our Financial Agreement please do not hesitate to ask our business office staff.

DENTAL INSURANCE: As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- You must provide us with an insurance card and all the information necessary to verify your child's coverage and file your claim.
- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you and NOT your insurance company.
- You are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable" all of which vary from one company to another.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely the insurance member's/ parent's responsibility. Receiving our services indicates your acceptance of responsibility for payment regardless of our estimate.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for noncovered services, along with deductibles and copayments are due at the time of treatment.

PAYMENT POLICY

- We accept cash, personal checks, Visa and MasterCard.
- After dental insurance has paid its portion, a statement is sent to the mailing address on record for the remaining balance. Payment is expected within 30 (thirty) days of the statement date, to avoid finance charges.

PATIENTS WITHOUT INSURANCE COVERAGE: We provide written estimate of fees, and payment is expected at each visit for services rendered.

MINOR PATIENTS: A parent or legal guardian must accompany all minors (under the age of 18 years) to the appointments. **If the parent or legal guardian is unable to be present, we will require a letter of authorization for the person who will accompany the minor. Arrangement for payment must be made by the parent or legal guardian prior to the date of service.** The parent or guardian who signs this financial agreement is responsible for full payment. In the case of divorced or separated parents, the parent who agrees to this financial agreement and who accompanies the minor is responsible for payment, **without any exception**. This office will not attempt to collect payment from a parent or legal guardian who does not agree to this financial agreement.

RETURNED CHECKS: A $30.00 charge will be applied when a personal check is returned by the bank. We will then accept payment by cashier's check, cash or credit card for fulfillment of the original balance and the returned check fee.

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FINANCE CHARGES AND COLLECTION FEES: Finance charges will be applied to all balances not paid within 30 days of the monthly billing date. A late charge of 1.0% on the unpaid balance will be assessed each month until it is paid. It is your responsibility to ensure your insurance company pays promptly so you can avoid finances charges. We understand temporary financial problems may affect timely payment of your balance. ***In those situations we encourage you to communicate any such problems immediately so we may assist you in the management of your account.***

OVER DUE BALANCE: After 90 days that the account is delinquent, we will inform you of the delinquent account by letter, and if no action is taken this office will employ a collection agency to collect the debt. The responsible party agrees to pay any related attorney fees which may be associated with the collection of your debt.

FEE FOR MISSED APPOINTMENT IF 24-HOUR NOTICE NOT GIVEN: Appointments not kept or changed with less than 24 hours notice are considered broken. Broken appointments prevent others from receiving the dental care they deserve. We take them seriously so please be considerate and inform us in advance if you need to change your appointment. For the first broken appointment, a reminder of this policy is given. For a second **broken appointment, a fee of $35.00 will be charged**. For a family with multiple appointments missed, the broken appointment fee will be applied for every two appointments missed. ***Our office reserves the right not to schedule any further appointments until the broken appointment charge(s) is paid. Thereafter, any subsequent broken appointments (missed or not rescheduled without a 24 hours notice) will incur a broken appointment fee of $35.00 per missed appointment per child.***

RECORDS AND REIMBURSEMENTS: Original records including radiographs are the property of this office. If you desire we will provide you with a copy of your child's record or radiographs for a nominal duplication fee.

ORAL SEDATION: **A 50% non-refundable deposit must be paid to schedule a sedation appointment. The remaining 50% will be due in full on the date of service**.

CONSENT & AUTHORIZATION: I authorize dental treatment on my child and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understand this document in its entirety, outlining office policies and financial policies of Ancheta Pediatric Dental LLC. Without any reservations, I agree to abide by the policies outlined herein.

Form completed by:

Name______________________________________Signature____________________________________

Relationship to child ____ Date_____________________

Are you the person legally responsible for this child? Yes ______ No _______

Reviewed by staff member ________________________________ Date ______________________