

Office Financial Policy

In our continued commitment to provide the highest quality dental care available to all of our patients and to have those services comfortable affordable, we are pleased to offer you these options for payment:

- Cash/Checks
- VISA, MasterCard, DiscoverCard, American Express
- Financing through CareCredit (*ask us for an application!*)
- 5% pre-payment courtesy for service over \$300.00

I agree that I am fully responsible for the total payment of all procedures performed in this office-this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that all services are due to be paid in full at the time services are rendered, unless prior arrangements have been made and approved by the financial office.

Signature: _____ Date: _____

Missed Appointments:

Appointment times are reserved especially for you. If for any reason you should need to change your appointment, there will be no fee, provided you give us 72-hour notice. A \$75 fee will be applied for all 'No Show' and short notice cancellation appointments (unless due to illness or an emergency). Please help us serve you better by keeping your scheduled appointments.

Signature: _____ Date: _____

Notice of Privacy Practices:

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Jared Kanemaru, D.D.S. (808) 622-4354.

You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Printed Name: _____

Signature: _____ Date: _____



410 Kilani Avenue Suite 221
Wahawa, HI 96786
Phone: (808) 622-4354
www.Kanemarufamilydental.com