Aloha Pediatric Dentistry
Financial Policy

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We are committed to providing your child with the best possible dental care. We will be happy to answer any questions regarding our policy or fees at any time.

- All patients must complete our "PATIENT REGISTRATION FORM" before being seen by the doctor.
- FULL PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.
- WE ACCEPT CASH, CHECKS, AND VISA/MASTERCARD.
- THERE WILL BE A $25.00 CHARGE FOR CHECKS RETURNED TO OUR OFFICE.

MINORS ACCOMPANIED BY AN ADULT: The adult accompanying a minor, his/her parents (or guardians), are responsible for FULL PAYMENT at the time services are rendered.

UNACCOMPANIED MINORS: The patient is to bring payment with them at the time services are provided. Non-emergency treatment will be DENIED unless charges have been pre-authorized to an approved Visa/Mastercard credit card, or paid by cash or check at the time services are rendered.

SEPERATED OR DIVORCED PARENTS: The parent accompanying the child is responsible for payment unless prior arrangements are made.

REGARDING INSURANCE: For those insured by Delta Dental Premier, we will provide direct insurance billing for you. Once payment is received from Delta, you will be responsible for the remaining balance. For non-Delta insured patients, payments are expected at the time services are rendered. We will provide you the necessary information for you to submit to your insurance carrier. Reimbursement from your insurance company will be made directly to you. YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT. Failure to pay the outstanding balance within the first billing cycle will result in a $5.00 service charge.

Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We may contact your insurance company to obtain benefits. Benefits obtained are subject to change by your employer or group policy. We will not become involved in disputes between you and your insurance company.

MISSED APPOINTMENTS: Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $25.00 - $50.00. Please help us to serve you better by keeping scheduled appointments. However, if your child is ill on the day of their appointment, please call our office to reschedule.

Responsible Party (signature)_____ Date:_____