OFFICE GUIDELINES

Mark A. Kujiraoka, D.D.S.

Our philosophy is to provide the highest quality of patient education and dental care to all patients that choose us for their dental care. Our hope is by providing you the following information we can prevent misunderstandings to ensure you encounter a positive experience. Please feel free to let us know if you have any questions or concerns.

EXPECTED PAYMENT

To keep our fees to you as low as possible, we ask that payment be made at the time of service. For your convenience an estimate for services will be prepared in advance of your appointment/s to ensure you opportunity to plan for your dental care. We believe whether you privately pay or have dental insurance to assist you, everyone deserves the care they need and want. It is necessary to provide accurate insurance information so estimates can be as accurate as possible.

_______ Initials

DENTAL INSURANCE

We are happy to file your dental claims to assist you in receiving the full benefits of your coverage. We request that you be familiar with your insurance benefits, and provide us the correct information to assist you with the submittal of claims. We will accept the estimated insurance payment directly from your insurance company provided payment is received from them within 30 to 45-days. Please realize that your insurance is a contract between you, your employer, and the insurance company; therefore, we cannot guarantee coverage or eligibility and your assistance may be requested to expedite the processing of your claim. Not all services are covered benefits in all contracts; therefore, you are ultimately responsible for the total amount of your dental fees. The treatment recommended for you is indicated regardless of your dental insurance benefits, deductibles, limitations, or maximums.

_______ Initials

PAYMENT OPTIONS

For your convenience, we provide a variety of payment options to help you receive the quality care you need to enjoy a healthy and confident smile. *Please identify which form of payment is most convenient for you at the time of service.*

Cash/Check _ MasterCard__ Visa __ Other__ Extended Payment __ (Please see below)

Please Note: A $25.00 NSF fee will be charged for all returned checks. Should you desire a monthly payment plan we invite you to complete a simple finance company application. There are no application fees or a down payment and the loan can be interest-free.

PAST DUE BALANCES

If applicable balances owing from a prior visit where insurance is not pending, or an insurance payment has not been received within 90-days, or the account has been sent to collections is considered past due. Payment of any past due balance is required to be paid in full before incurring new charges. Balances over 90-days may be subject to a rebilling fee.

_______ Initials

CANCELLATIONS

We consider all appointments confirmed when they are reserved. We do not double book with anticipation of patients not showing for their needed dental care. Our schedule remains open yet fully staffed when patients cancel or fail the same day of their appointment. We require a 48-hour advance courtesy notice so there is sufficient time to offer your appointment to another patient.

_______ Initials

CELL PHONES

We ask that cell phones and pagers be turned off at all times while in the treatment area. If being available for an emergency during your reserved appointment is necessary, please leave our office telephone number so you can be reached. Should an unfortunate emergency arise we would be happy to notify you in the treatment area immediately.

_______ Initials

INFORMATION CHANGES

To ensure your records are current please notify us of any changes related to medical history, telephone number/s, address, employer or insurance information as they occur.

_______ Initials

My signature indicates that I understand the policies as outlined and any questions I have with regard to office policies have been answered.

______________________________ ______________

Signature of Responsible Party or Patient — Date

My signature indicates that I have reviewed the office policies with the responsible party and/or patient.

______________________________ ______________

Signature of Staff Member or Doctor — Date

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