HONOLULU *endodontics*

Your dental benefit program will assist you in obtaining and maintaining a superlative level of oral health.

Our office **understands** dental insurance, and we will be glad to assist you in obtaining the maximum benefits specified in your contract, without compromising our standard of care for you.

YOU MUST REALIZE, HOWEVER THAT:

1. Your dental benefit program is a contract between you, your employer and the insurance company. **We are not a party to that contract.**

2. Our fees are generally but not necessarily, covered in full by the maximum **allowance** determined by **your** carrier.

3. Not all-dental services are a covered benefit in all contracts.

4. **You are responsible to us for all of our fees for services rendered to you.**

All of us will gladly discuss your proposed dental treatment and answer any questions you might have as to the involvement of your dental benefit program in receiving this care.

Our aim is to provide each patient with the finest dental care in a professional environment, which inspires trust and confidence. Our dental office is a business that must be managed efficiently, if we are to continue serving our community with quality endodontic dentistry. Our fees are fair and reflect the care and expertise with which we treat each patient.

To keep our fees from rising considerably and to minimize expenses of billing and bookkeeping, we are offering patients payment options. **We ask that all accounts be paid at the time services are rendered unless other arrangements have been made with the financial office.**

Please choose below so we will know how you want to handle payment of your account.

- ❒ I will pay for my services today with cash or personal check.
- ❒ I will pay for my services today with a credit card.
- ❒ I need information on payment options available through this office.
  ***Any balance over 30 days will incur a finance charge of 1.5% per month.*

My signature on this form constitutes signature on file. This enables Honolulu Endodontics, Inc. to submit insurance forms on my behalf without my signature.

I have read and understand the above information. I understand and agree that I am responsible for the payment of all treatment fees on my account. If my insurance company fails to make payment or denies any services, I will be responsible for the full amount owed.

Print Name Signature Date