KIDSHINE Pediatric Dental Group

Pearl City Shopping Center
850 Kamehameha Highway, #215
Pearl City, Hawaii 96782
(808) 638-3313

FINANCIAL & OFFICE POLICIES

FINANCIAL AGREEMENT:
In our continued commitment to provide the highest quality dental care to you and your family, we are pleased to offer these different forms of payment. We appreciate payment for services at the time they are rendered. Patients who have dental insurance can pay their estimated co-payments and deductibles at time of service. Payments may be made with Cash, Check, Visa, Mastercard or Discover.

Alternative Payment Options:

1. <u>Pay-In-Full Discount</u>: We offer a 5% discount for all services over $300, if paid in full prior to services being rendered.
2. <u>Term Loan</u>: We offer CareCredit, which is a financial option for healthcare expenses. Through CareCredit, we can offer (upon approval) an interest-free term loan for up to 18 months, with no down payment, no annual fee, and no prepayment penalty.

TREATMENT PLAN ESTIMATES:
As a courtesy to our patients, we will provide treatment plan estimates prior to treatment rendered so that you may have an estimate for your patient portion. Please note that **treatment plans may change** and that it is **only an estimate** of what your insurance will cover.

INSURANCE INFORMATION:
As a courtesy to our insured patients, we will submit claims to your insurance company on your behalf. In order to help you to receive your maximum benefits allowed, we ask that you provide us with your insurance card and any updated insurance information.

MISSED / CANCELLED APPOINTMENTS:
We require at least **48 hours notice** for any appointment that needs to be rescheduled or cancelled. Without notice, we charge a **$50 missed appointment fee**. After 3 missed appointments, our office will only schedule your child on an emergency basis for 90 days.

LATE POLICY:
Be on time for your appointment so that subsequent patients are not forced to wait. **Patients arriving more than 15 minutes late may be rescheduled.**

Thank you for choosing our practice! We encourage you to ask questions, so that you may fully understand your treatment plan as well as our financial policy.

I understand and agree to the terms of the financial, cancellation and late policies.

______________________	______________________	__________
Parent Name	Parent Signature	Date

Consent by Proxy for Dental Treatment

Please list any adult(s) (proxy) that may be bringing your child(ren) to their dental visits that will be able to consent for their dental treatment and inform us of their medical history. Be advised that protected patient health information may be shared with the proxy to facilitate informed decision making.

Proxy Name:	Relationship to the Child:	Phone #:

This consent form applies to the following child(ren):

Child Name:	Date of Birth:

If there are any limitations for the types of dental services for which this consent by proxy is given, please list below (if none, state "None"):

If there are any limitations for the time frame for which this consent by proxy is given, please list below (if none, state "None"):

Contact information for Parent(s) and Legal Guardian(s):

Parent Name: ____________________

Daytime Phone: ____________________

Evening Phone: ____________________

Cell Phone: ____________________

Parent Name: ____________________

Daytime Phone: ____________________

Evening Phone: ____________________

Cell Phone: ____________________

I consent to have the above listed proxies consent to dental treatment for my child(ren).

Signature: ____________________

Date: ____________________

Signature: ____________________

Date: ____________________