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 (Does NOT apply to CareCredit payments)

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: _____

Parents in the Dental Operatory

Often we are confronted with the situation of parents wanting to be with their child during dental treatment. There are appropriate times when this is possible, while other times it is a negative experience for parent, child and staff. Studies done in the past surveyed pediatric dental offices in regards to when parents should be allowed with the child patient. Age of the child was the most often cited criteria for appropriateness of the parental attendance: 71% felt it was appropriate from birth to 1 year; 76% 1 to 2 years; 35% 2 to 4 years; and 8% 4 to 6 years of age. It was found that most would make a decision at age 3 years based upon the social, psychological, and emotional maturity of the child.

The following are reasons why it has been clinically proven negative reasons for parental attendance during dental treatment:

1. The child divides his/her attention between the parent and doctor.
2. The doctor has to divide his attention between the parent and the child.
3. Parents will tend to repeat or even offer commands to the child which takes away the authority of the doctor.
4. Parents misinterpret what is going on during procedures and question treatment.
5. Often, although with the best of intention, the presence of the parent will heighten the alarm of the child which allows the child to portray him or herself as the victim, hopefully recruiting the parent into the role of rescuer.
6. Parents usually request being involved due to their own anxiety over the dental appointment. Children pick up on this and will also increase the fear response of the child.

It is our policy to have the child's best interest in mind during any and all phases of treatment. As a result, we ask for your cooperation in participating in providing the best dental environment possible. Sometimes, we may ask that you stay with your child. At other times, we ask that you remain outside the treatment area in order to help your child to grow into the best dental patient possible. Thank you for your understanding and participating in your child's care**.**

Signature: _____ Date: _____ **(OVER)**

Guests in the Dental Operatory

To protect everyone's privacy and safety we do not allow anyone other than the patient to be present once taken into the clinical area. During treatment, it is crucial that our attention be solely on you and that in return, you are not distracted. In addition, we have many instruments and tools in our rooms that are tempting to touch and may be dangerous if not handled by trained personnel.

We understand that at times it may be difficult to find childcare, but for the safety of your children, you, and our staff we cannot allow children to sit in the treatment room while their parents are receiving treatment. If your children need supervision they cannot be left in our reception area by themselves.

There are rare occasions that an exception may be made to our policy but it must be approved by the doctor when the appointment is scheduled.

It is our policy to have your best interest in mind during any and all phases of treatment. As a result, we ask for your cooperation in participating in providing the best dental environment possible. Please feel free ask if you have any questions or concerns. Thank you for your understanding**.**

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 heath care operations.

Printed Name:_____

Signature: _____ Date: _____

kanemaru Family Dental

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