1314 S. King St., Suite 724 Honolulu, Hi 96814
O: 291.2254 F: 596.2384 E: dtcofhawaii@outlook.com

ACKNOWLEDGEMENT OF FINANCIAL AGREEMENT

Thank you for choosing Dental Technology Center of Hawaii. Please understand that payment of your bill is considered a part of your service. The following is a statement of our Financial Policy, which we require you read and sign prior to any service.

Payment Is Due at Time of Service. We accept Cash, Check, and ALL Major Credit Cards.

Regarding Medical Insurance: ________(initial)

As a courtesy, Dental Technology Center of Hawaii will submit a medical insurance claim on your behalf for services rendered. We cannot guarantee your medical insurance carrier will reimburse on services. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be a non-covered service and not considered reasonable and necessary by the medical insurance carrier.

Assignment of Benefits: ________(initial)

I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dental Technology Center of Hawaii for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance or the agreed amount for services rendered.

Medical Reimbursement: ________(initial)

Your medical insurance carrier may reimburse you directly for the services you received today. Should this scenario happen, ***PLEASE*** know the payment is due to Dental Technology Center of Hawaii. If we do not receive the medical reimbursement within 30 days of the issued check, your medical insurance will hold you liable for repayment.

Usual and Customary Rates: ________(initial)

Our center is committed to providing the best service to ALL patients and we charge what is usual and customary to our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Adult patients are responsible for payment at time of service. The adult accompanying a minor and the parents (or guardians of the minor) is responsible for payment at the time of service.

I have read and understand the Financial Policy:

X____ Date: ________________________
Signature of Patient/Parent or Legal Guardian of Minor

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