PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Please note that this agreement states your financial responsibility as a patient and addresses the possibility of incurring out of pocket expenses.

Insurance Claims/Payment :

As a courtesy, Pure Smiles Hawaii, LLC will file an insurance claim for you; however, in the event that your insurance company denies payment for any reason or has not paid within 45 days, you or the guarantor will be responsible for any balance due. It is also your responsibility to provide current address, billing information by providing an updated insurance card and by following up on any issues with the insurance carrier and billing issues. We are a dental care provider; our relationship is with the patient and not the insurance company. Our office is not a part of this legal contract and has no influence or control over the actual disbursements. We encourage you to contact your insurance company directly to help facilitate a prompt payment should there be an unreasonable delay or denial of payment. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility for the date of service rendered. (Please initial) _____

Patient Account Charges and Statements:

Estimated co-payment and/or any balance due payments on your account are requested at the time of your scheduled visit; we accept cash, check or credit card. Any unpaid balances after insurance claim submission will be billed and collected within thirty (30) days of receipt/notice. If you have no insurance plan, you will be required to pay 100% of the visit charges at the time of your visit. (Please initial) _____

Collections:

If your account is over 90 days with no payment activity, it will be transferred to a collection agency. A $35.00 fee will be added to account upon transfer. This may include, but not limited attorney's fees and other costs that Pure Smiles Hawaii, LLC considers necessary. To avoid collections, please be sure to pay your co-payment at the time of your visit or mail in payment within thirty (30) days of receiving your statement. (Please initial) _____

Returned Checks:

All returned checks will be subject to an NSF fee (amount as charged by the bank). You will be required to pay the original owed amount in addition to the NSF fee before being seen for another appointment. As a result, you may be placed on a cash/credit card only payment method for future appointments. (Please initial) _____

Receipts and Invoices:

Our patients are responsible to track all receipts for supplements and other cash services. Our system computer does not provide statements for such services. Any such request will be subject to a $25 fee /page. (Please initial) _____

No Show, Late Cancellations , and Late Arrivals (more than 15 minutes):

As a courtesy to our dentists, staff, and other patients, we ask that you cancel your appointments at least 48 business hours in advance. Your appointment time has been specially reserved for you. There is a **$54.00** fee for not showing up or for canceling with less than 48 business hours notice. (Please initial) _____

After-Hours Office Fee

Any office visit that is after-hours or not during business hours will be subjected to a fee not inclusive of the treatment rendered. Please confirm the amount to be collected at the time of visit. This fee may not be covered by all plans so will be collected at the time of visit.

(Please initial) _____

By signing below, you are agreeing to and understand the above financial agreement and you acknowledge that as a patient and/or guarantor you are responsible for any charges incurred and agree to pay them as required within 30 days of receiving your billing statement. I understand and agree that all services rendered to me, my dependents, or others assigned by me to my account are charged directly to me. I further understand that I am personally responsible for payment, including any amount not covered by my insurance. Late fees of $25 per month and/or finance charges can be applied to all past due amounts at the rate of 1.5% per month (18% annual rate). Should the fees for the professional services not be paid in accordance with the provisions herein, reasonable attorney's fees, collection fees or finance charges will be added. ALL fees may be subjected to change without notice.

Signature: _____ Date:_____

Print Name: _____ DOB: _____

Pure Smiles Hawaii, LLC
4211 Waialae Avenue Suite 501
Honolulu, HI 96816
(808)735-3455
(808)450-2679(fax)