**Aloha Dental Care**

**Aloha Dental Care Abides by the Privacy Practices adapted by Federal and State Laws.** This document is Acknowledgement of our Office Policies and Privacy Policy. If you would like a copy of the Privacy Policy please notify a member of our staff.

**Please notify the office staff of any changes** to insurance or personal information such as address, phone numbers, employment and or change in health status as soon as the change occurs.

**A 24 Hour notice is required for all broken appointments. A $100.00 per hour fee will be assessed without proper notification.** Our office strives to see one patient at a time during their scheduled appointment time. We arevery conscience of our patient's time and strive to keep our patient's appointments on time. **If you are more than 15 minutes late** for your appointment it is possible that treatment will not be performed and may need to be re-appointed, and or partially performed when warranted.

**Insurance Policy:** Our staff will be happy to go over your dental benefits with you, however, **we strongly urge our patients to do their part in understanding their dental insurance policies.** From time to time your dental insurance may change, usually at the beginning of the year, but this change could occur at any time. Please let us know if your dental insurance changes. Please remember that our office only can keep track of what you use in our office. Please inform us of any treatment that you have at another dental office or specialist. You may run out of benefits without our knowledge, this can greatly affect our estimate of co-pay. We will do our best to estimate your co-pay at the time of service. Insurance is billed as a courtesy to our patients, it is only estimation. I understand that I am responsible for all fees regardless of insurance coverage.

**I authorize the use of my signature on all insurance submissions.**

**Payments and or Co-payments** are due at the time of service. This includes all co-pays, co-insurance, and deductibles. If a minor is brought in for treatment, the adult seeking the treatment is responsible for payment regardless of who carries the insurance policy or who has custody. For your convenience we accept cash, check, Care Credit, and all major credit cards.

I have read, understand, and accept the **Privacy Policy, Office and Insurance Policies** of

**Aloha Dental Care**

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**Print Name** (If Minor child print name of child and relationship to child)

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**Signature of Patient or Guardian if minor child**

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**Date**

**For Office Use Only:**

We attempted to obtain written acknowledgement of receipt of our privacy policy and office policy, but acknowledgement could not be obtained because: ( ) Individual refused to sign ( ) Communication barriers prevented obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining the acknowledgement

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Action Taken:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_