GENERAL COSMETIC AND
HOSPITAL DENTISTRY

1441 KAPIOLANI BLVD. SUITE 408
HONOLULU, HI 96814

PHONE: (808) 946-0442

OFFICE POLICIES

Welcome to **Dr. Kevin K.L Ching's Dental Office**. Our mission is to deliver the finest comprehensive treatment available today and we want it performed to your satisfaction. Please feel free to review our office policies. If there's any question or comment let us know.

APPOINTMENT POLICY

We reserved your appointment very carefully so you will receive the doctor or hygeniest's full attention. Should you require changing your appointment it could take several weeks before another one is available. We ask that you call us directly so we can reschedule with you personally rather than leaving a message on the answering machine.

Please give us 24 hours in advance to cancel or reschedule an appointment to avoid a $25 cancellation fee.

INSURANCE POLICY:

Our agreement for service is with you, our patient not with the insurance company, however, we do accept assignment of benefits as a courtesy.

We **do participate with all Delta Dental Insurances and Hawaii Dental Service**. We will accept "Assignment of benefits" with United Concordia, Metlife, Aetna, Blue Cross/Blue Shield, Guardian and any other private insurances. However, we **do not participate with HMAA, SUMMERLIN, ALOHA CARE, QUEST, HMO & all HMSA.** At the time of service payment is due in full for all non participating insurances mention above. But, we will help you maximize your insurance by filling all of your claims. For any reason your insurance denies your claims, it is your responsibility to pay for those services in full.

PAYMENT OPTIONS

NOTE: ALL CO-PAYMENT ARE DUE AT THE TIME OF SERVICE!

1. Cash or Check
2. Visa Card/Master Card/Discover Card
3. Care Credit Card (Application may obtain in our office)
4. Monthly Payment Arrangement (in office payment arrangement)

BILLING

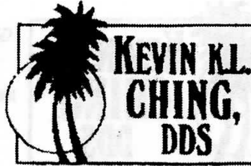
Each month you will received a statement of your account including all current charges regardless of insurance coverages. As insurance payments are received we will credit them to your account. If you believed that there is a discrepancy in your account let us know right away so that we can do an adjustment. All charges are your responsibility and we request to pay it in full.

REFERRALS:

We are pleased that you have chosen our office to give you a healthy and attractive smile. Our door is always open to newcomers. We would be pleased to serve your family and friends.

____________________ ____________________

Signature *Date*



Acknowledgement of Receipt of Notice of Privacy Practices

I ,______________________ have read and agree with the Acknowledgement of Receipt of Notice of Privacy Practices.

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Please Print Name

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Signature

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Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign.
- Communication barrier prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.
- Other (please specify).

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Dental Office Signature______________ Date: __________

7/2002