PERIODONTAL SPECIALISTS OF HAWAII
Edmund A. Cassella D.M.D., L.L.C.
Allison P. Tran D.D.S., L.L.C.
Chestine Guevarra Toth, D.M.D., L.L.C.

Financial Policy

Welcome to our office.

Payments for services rendered are due at the time of treatment. For your convenience, the following payment options are available:

1. Cash or Check.
2. Mastercard, VISA, American Express or DISCOVER.
3. Care Credit- a dental financing company that is administered by Synchrony Bank, offering monthly payments. (12-18 months no interest)

We are participating providers with HDS, HMSA, HMAA, United Concordia, Delta and MetLife. We will process claims for all insurance carriers as a courtesy to our patients. In order for us to participate with insurance carriers, discounted fees, thereby giving our patients the lowest fees possible, we cannot extend credit on the remaining balance (patient portion) of services rendered. Therefore, the patient portion (after INS for participating carriers) **will be due at the time of treatment.**

Any remaining balance after all insurance payments are received will be the responsibility of the patient/responsible party.

I understand that insurance coverage is **estimated** and my actual indemnity may be less. I understand that that I, the patient, am responsible for all amounts not covered by my insurance carrier. Year to Date Used Benefits and Remaining Deductible amounts are not affected until the procedure is completed and are not used in the determination of benefits.

I understand that I am responsible for all fees due for services rendered by either Dr. Edmund A. Cassella or Dr. Allison P. Tran or Dr. Chestine Guevarra Toth regardless of third party coverage and will pay for my treatment by any one or a combination of the options noted above.

I understand that if I am unable to attend a scheduled appointment with Dr. Cassella, Dr. Tran or Dr. Guevarra Toth, I will give a minimum of 24-48 hours notice or I will be charged a cancellation fee or $25.00.

I have read and understand the above.

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Print Patient Name Print Name of Responsible Party

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Signature of Patient or Responsible Party Date