OFFICE POLICIES

Kenyu Takamoto D.D.S.; M.S.D.
1811-156th Avenue N.E. Suite # 1
Bellevue, WA 98007

Welcome to our office! We would like to provide you the best treatment based on our knowledge, therefore, please read and understand the office policies, if you have questions please ask the receptionist.

FINANCIAL POLICY:
As a courtesy, we will bill the insurance company for you if we are provided with the necessary and accurate information. *This is **not** a guarantee of payment*. If in-accurate information provided and the second claim to your insurance company needed, there is a fee for processing and you may have to pay the fee.
Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. Accordingly, you are fully responsible for the service fees.
Co-payments are due at the time of each treatment. Please advise the receptionist of any changes that may affect your billing and physical conditions, i.e. employment, address, new medical/dental problem(s), or insurance coverage. If you are involved in third party litigation special arrangements may apply. Please see the office manager for further details.
Students and the patients with NO dental insurance should pay the full fees at the day of the services rendered.

CANCELLATIONS AND NO SHOWS:
If you need to change/cancel an appointment, please provide **48** *office hours* notice so that we may give another patient that opportunity to come in at that time. If the appointment is changed/cancelled less than **48** office hours or no show appointment, you are responsible for a minimum fee (US $**74.00**) plus additional fee depending on the time length of the appointment. We will not bill your insurance company for these fees (the fee is subject to change).

RETURNED CHECK POLICY:
Any check returned for NSF by your bank will be subject to an additional charge.

NON-DISCRIMINATION POLICY:
Admission to our clinic is non-discriminatory for service rendered, regardless of race, color, national origin, disability or age. All patients who come to our clinic for service are protected against discrimination.

PATIENT CONSENT AND RELEASE:
I understand that I am financially responsible for all charges for services rendered regardless of litigation, insurance reimbursement, or pending Labor & Industries claims. I understand that parent accompanying a minor for treatment will be responsible for payment. I authorized payment directly to release any necessary information requested by my insurance carrier and authorized payment directly to KENYU TAKAMOTO D.D.S.; M.S.D. for any benefits available under my insurance plan.

I hereby give Dr. Takamoto and the Associates permission to take photographs of me for the purposes of diagnosis, treatment and post-treatment comparison etc. to create safety and health training programs. I further grant permission for the photographs to be used and distributed in health educations including publication. I hereby release and discharge Dr. Takamoto and the Associates from any and all claims arising out of the use of the photographs, and/or any right that I may have.

I hereby consent to evaluation and treatment by my dentist.
I acknowledge that I have read and understand the office policies.
I acknowledge that I have received the Notice of Privacy Policy and I have been provided an opportunity to review the notice.
Signature: _____ Date: _____

Patient Signature (If minor, parent or guardian's signature)