

**JAMES KODAMA D.D.S.**  
**19231 VICTORY BLVD.,#253**  
**RESEDA, CA 91335**  
**(818) 344-1393**

Patient's  
Name \_\_\_\_\_

### **FINANCIAL POLICY**

Thank you for choosing our office for your Orthodontic needs. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which must be reviewed and signed.

\*ACCOUNTS MUST BE CURRENT AT THE TIME OF SERVICE.

\*WE ACCEPT CASH, CHECK, VISA/MASTERCARD/DISCOVER

#### **REGARDING INSURANCE**

As a courtesy, our office will submit your insurance claim on your behalf. However, you are responsible for any amount not covered by your insurance company. We are not a party to that contract. If your insurance company does not pay their estimated portion, the outstanding balance is your responsibility.

#### **PAYMENT OPTIONS**

1. Payment-in-full with a 5% courtesy discount (3% if Credit Card used).
2. Monthly Payment Coupon Book. Late payments will be automatically billed to your Credit Card number, which will be kept on file.
3. Automatic Monthly Billing to Credit Card.

#### **MISSED APPOINTMENTS**

Unless canceled, at least 24 hours in advance, our policy is to charge \$20.00 for missed appointments. Please help us serve you better by keeping scheduled appointments.

#### **BROKEN/LOST ORTHODONTIC APPLIANCES**

Any broken or lost appliances, e.g. retainers or expanders, are subject to a replacement or repair fee that will be determined at time of service.

#### **RETURNED CHECKS**

A \$10.00 returned check fee will be billed for any returned checks.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

*I have read the Financial Policy. I understand and agree that:*

- *I understand my insurance policy is a contract between me and my insurance company.*
- *I understand that Dr. Kodama's dental office is not party to my insurance contract.*
- *I authorize that the payment from my insurance company due me be paid directly to Dr. Kodama's dental office.*
- *I understand if my insurance company does not pay their estimated portion, the outstanding balance is my responsibility.*
- *I understand that insurance is not a guarantee of payment to my account and that I am responsible for my account balance.*
- *I understand that job termination, changing of job, or changing insurance plans will result in my insurance stopping payments to my account, and I am responsible for any balance remaining in that account (Orthodontic insurance payments are pro-rated for the duration of treatment).*

X \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Patient or Parent/Legal Guardian