Dr. Mark D. Sueoka DDS
Financial Policy

Welcome to the practice of Dr. Mark D. Sueoka DDS. We ask that you read and sign our financial policy prior to any treatment. To avoid misunderstandings, please ask us if you have any questions about out policy.

Payment for Service: Our policy requires payment for services at the time services is provided. If special arrangements are needed, please discuss those arrangements with our business manager prior to treatment.

Method of Payment: Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express, Debit, and Care Credit.

Insurance: As a courtesy, we will verify your insurance benefits, estimate your approximate co-insurance (The amount you owe at the time of your appointment), and file your insurance claims. To do this we must have complete and accurate information from you.

1. Verification of benefits is not a guarantee of payment by your insurance company. Final determination is made by your insurance company at the time the claim is received.
2. An insurance estimate is not a guarantee that your insurance will pay exactly as estimated. Your insurance company determines the amount paid when they receive the claim. We will of course, do all we can to make sure your estimate is as accurate as possible.
3. You are responsible for payment of estimated co-insurance, deductible, co-pay or non-covered services at the time of service. We will file all claims with your insurance company.
4. To determine exactly what amount will be covered by insurance, we can request a predetermination or a pretreatment by your insurance carrier. This request may take up to four to six weeks to be processed by the insurance company.
5. All charges you incur are your responsibility. Your insurance is a contract between you and your insurance company. You are responsible for payment whether or not your insurance pays.
6. We ask that you sign this form and any necessary documents that may be required by your insurance company.
7. Insurance payments are ordinarily received within 30-60 days from the time of filing.
   If your insurance company has not paid within 60 days, we ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim has been denied, you will be responsible for the full amount at that time.

Non-Insured: If you do not have insurance, or our office is not a participating provider with your insurance plan, full payment is due at the time of service. When possible, we will work with any insurance plans we do not participate with on an out-of – network basis.

Patients with Medicare: We have opted out of the Medicare program, therefore, we cannot submit any claims on you behalf, nor can you. Should you decide to be seen at our office, you will be responsible for any charges at the time of service.

Patients with Medicaid: We are not providers of Medicaid, you will be responsible for your bill.

Returned Checks: Returned checks will be subject to a $25.00 fee. We do not accept temporary checks. All checks are subject to approval through an automated check clearing house.

Collection Fees: If it becomes necessary for our office to enlist a collection service, and or legal assistance, you will be responsible for any collection or legal fees incurred.

Minor Patients: The parent or guardian accompanying a minor is responsible for the payment of services. Regardless of insurance coverage, young adults (age 18 and over) are legally responsible for their accounts unless a parent accompanies them to the initial appointment and signs this financial agreement.

Divorced Parents: The parent who brings the child to the appointment is deemed responsible for payment, regardless of who provides insurance coverage. Our office will not become involved in disputes over which parent is the responsible billing party.

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my benefits directly to Mark D. Sueoka, DDS.

Patients Name: ______________________ Date: ______________

Signature of Patient or Guardian/Parent: ______________________