

Samuel B. Burg, D.D.S.  
Rick J. Kleinsasser, D.D.S.  
Henry Y. Arakaki D.D.S.



### **-OFFICE POLICY-**

It is the desire of the doctors and staff of our office to supply dental education and dental care of the highest quality and with the greatest degree of care and gentleness. It is the policy of this office to help create and maintain your child's health, because oral health is necessary in order to maintain total health. If we work together, you as the parent, your child, and our dental team, we will have greater success in meeting this goal.

In that spirit, we ask that you help us care for your child by following these protocols:

- 1) Please show up on time for your appointments
- 2) If you find it necessary to change an appointment, please give us 24-48 hours notice so we can offer the time to another child in need of treatment. A missed or unused appointment time hurts the children of the practice much more than it hurts us.
- 3) We expect our patients to visit us every 6 months in order to maintain good dental health and to avoid emergencies.
- 4) We provide financial plan options for you to assist you in meeting your fiscal responsibilities as parents and expect you to honor the agreements you make with us.

### **-FINANCIAL POLICY-**

*Please refer to our financial option sheet for more details.*

At the onset of your child's treatment, we will provide you with an *estimate* of the total fees expected. Please understand that it will be an *estimate only*. Treatment sometimes changes for a variety of unforeseen reasons. When it comes to estimating insurance payments, we must also stress the word *estimate*, as insurance companies continue to surprise us at times. Your estimated portion is due in full the day of treatment.

If the insurance company pays more than expected, you will receive a refund. If they pay less than expected, a balance due will reflect on your monthly statement. Because we cannot guarantee your exact insurance coverage, there may be a balance remaining after insurance payment is received. Any account that extends over 90 days will be assessed a service charge of \$2.00 or 1.5%, whichever is greater, to the balance on your account each month. Legal action taken on any account deemed delinquent.

Your patient portion is due in full as treatment rendered. We gladly accept cash, personal checks, and most major credit cards. We also offer a monthly payment option for patients who qualify through Care Credit. Our staff can assist you with the application process.

---

I accept full financial responsibility for this account. I understand that any insurance estimate given to me by this office is not a guarantee of actual insurance payment or coverage. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon my dependents in this dental office. Any insurance claim not paid in full after 60 days will become my responsibility to pay at that time. I have read the above policy statement and agree to follow all requested stated.

Parent Signature: \_\_\_\_\_ Date signed: \_\_\_\_\_

**1430 E. Main Street, Suite 204, Santa Maria, CA. 93454, (805) 922-3530**