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

PATIENT FINANCIAL AGREEMENT AND CONSENT

Parent Name: ____ Account number:_________________

Patient Name: ____ Date: ___________________________

Total Balance for Treatment Plan: $__________________

At General Dentistry for Children and Teenagers, we have the following financial arrangements available. Please indicate your preferred option and sign the agreement below.

Taking great care of your children is our top priority. That's why, when it comes to talking about finances, we want everything to be as easy and clear as possible to avoid any chance of misunderstanding. With your child's well being as our focus, we strive to offer payment options that are as convenient as possible to assist you in your fiscal responsibility as a parent.

❑ **OPTION 1: Full Payment Courtesy:**
We offer a 5% bookkeeping reduction for all treatment that paid in full by cash or check before or at the time of service.

Balance Due: $ __________________ **Due Date**: __________

❑ **OPTION 2: Payment as Services are Rendered**
We gladly accept cash, personal checks, and most major credit cards. For payment with a credit card, please see the "Credit Card Authorization Form".

Balance Due:$ ___________________ **Due Date:** __________

❑ **OPTION 3: Payment Plan through Care Credit**
We offer a no-deposit, and no-annual-fee short and long-term payment plan option, through Care Credit, upon application approval. A member of our front office staff will gladly assist you with the application process. See attached "Credit for Dental Services Document".

Date:______________

❑ **OPTION 4: Insurance Coverage and one of the above Options for patient portion:**
We are happy to help our patients with dental benefits maximize their insurance benefits, and as a courtesy, we are happy to bill your dental insurance for services. We provide an estimate of the dental benefit plan coverage and require payment of the patient's portion in full at time of service. We file the claim with your dental benefit plan and receive reimbursement directly. Any unpaid balance upon receipt of payment from the dental benefit plan is the patient's responsibility. ***Please understand that it is up to you to confirm your child's eligibility, waiting periods, and benefits and that this office cannot guarantee your child's status in any of these areas.***

Estimate of Dental Benefits Plan Coverage: $________________ **Estimated Patient Portion Due**: $_____________ **Date:** ________

*(**Please note the dental benefit plan portion is an estimate. The contract for your insurance coverage is between you, your employer, and your insurance carrier. The patient is responsible for any unpaid balance upon receipt of payment from the dental benefit plan.)*

Authorization:
I, _______________________, understand my financial obligations as outlined above. The treatment plan and financial options have been explained to me and I have agreed to the terms of this agreement with General Dentistry for Children and Teenagers. This financial agreement will expire within 60 days from the date listed below.

____ ____________
Responsible Party Signature: Date:

____ ____________
Staff Member Signature: Date:

1430 E. Main Street ◆ Suite #204 ◆ Santa Maria, California 93454 ◆ (805) 922-3530