

## FINANCIAL AGREEMENT AND POLICIES FOR ANESTHESIA SERVICES

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Procedure \_\_\_\_\_

**Estimated** treatment time: \_\_\_\_\_

**Estimated** anesthesia fee: \_\_\_\_\_

Anesthesia fees are:

Anticipated method of payment (**circle one**):

Cash   Debit   Visa / Mastercard   Care Credit (a 10% charge will be added)

The estimated anesthesia fee is based upon the dentist's estimate of treatment time, anesthesia preparatory time and the patient's response to the anesthetic used.

Payment for anesthesia services is due the day of treatment, unless otherwise arranged. In the event anesthesia time exceeds the estimate, the patient is responsible for the additional charges. However, if the anesthesia time is less than the estimate, the patient will receive a prorated refund.

Many insurance policies do not pay for anesthesia services for dentistry. Please check with your insurance company regarding your benefits. We will be happy to provide a receipt for the anesthesia services.

A nonrefundable deposit of \$500 may be collected prior to the date of the scheduled treatment. This deposit is credited toward the total anesthesia fee. Cancellation of the scheduled appointment less than 48 hours prior will result in the loss of this deposit or you will be charged a cancellation fee of \$500.

I understand that if I fail to pay the fees (a returned check or failure to pay the balance in the event of a financial arrangement), I will be charged an interest of 18% APR and will be liable for all the collection charges and or court fees.

I have read, understand and agree with the above **estimate** of fees and policies.

Print Patient's Name \_\_\_\_\_ Phone \_\_\_\_\_

Print Parent/Guardian's Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_