Financial Agreement with DENTISTHESIA

Patient Name: _____ Service Location / Dental Office: _____

Name of person financially responsible: (print) _____ Relationship: _____

Email: _____ Contact Phone #: (_____) _____-_____ Appointment Date: _____

Fee Schedule: First Hour of Anesthesia: $750.00 Every additional 15 minutes: $125.00

Preoperative Time (15 min) + Surgery Time (To Be Determined) + Recovery Time (15 min) = Total Anesthesia Time

Surgery Time 1 hour	Total Anesthesia Time (Minimum Time: 1 hour 30 minutes)	Anesthesia Fee (Minimum Fee: $1000.00)
1 hour 15 minutes	1 hour 45 minutes	$1125.00
1 hour 30 minutes	2 hours	$1250.00
1 hour 45 minutes	2 hours 15 minutes	$1375.00
2 hours	2 hours 30 minutes	$1500.00
2 hours 15 minutes	2 hours 45 minutes	$1675.00
2 hours 30 minutes	3 hours	$1800.00
2 hours 45 minutes or more	(Each additional 15 minutes hereafter adds $200.00)	TBD

Estimated Fee: (Completed by Dentist/Surgeon)

Estimated Surgery Time _____ + 30 minutes = Estimated Total Anesthesia Time (See Estimated Anesthesia Fee Above) $_____

Balance due in order to reserve Appointment: $_____

I, the undersigned, acknowledge full financial responsibility for the payment of anesthesia services provided by Dentisthesia. I understand that by signing this document, I am agreeing to pay the full fee for anesthesia services prior to time services are rendered. I understand that the estimated total anesthesia fee quoted above is only an estimate. The balance due on the day on the appointment may or may not be adjusted according to the actual total anesthesia time. Anesthesia time begins when the patient is sedated and ends when recovered and discharged to a responsible adult.

Due to the extensive time, effort and coordination between the dentist and anesthesiologist necessary in scheduling an appointment, balance in **FULL** is required before the anesthesia appointment can be confirmed. This is to make certain the patient complies with the instructions given prior to the anesthesia appointment, and to reserve the time of the dentist and the anesthesiologist. If anesthesia services cannot be performed or administered as planned because the patient did not appear at the agreed time or failure to follow the preoperative instructions, the **payment is forfeited**.

It is important that reimbursement for the anesthesia fee by dental and/or medical insurance not be assumed. In general, insurance **does not** pay for anesthesia services. Please contact your insurance carrier to determine whether coverage is provided for your appointment. Upon request, an anesthesia statement of services will be provided to submit to your insurance carrier.

Cancellation: In case of illness, the appointment must be re-scheduled within 6 weeks, or the anesthesia fee will become a cancellation fee. Non-compliance with the pre-procedural instructions, specifically eating and drinking will result in cancellation of the case, and the payment completely forfeited.

Payment Information:

Method of Payment: We accept Cash, MasterCard, Visa, American Express and Discover. (Please circle one)

Name of person financially responsible: (print) _____ Relationship:_____

Cardholder Name: (print) _____ Billing Zip Code: _____ Exp Date: _____

Credit Card Number: _____Security Code on back of card: _____

By signing this form I am authorizing Dentisthesia to charge my credit card. Should my credit card be rejected or denied by the credit card company for any reason, I understand that I must pay Dentisthesia the amounts owed and hereby agree to make full payment. I agree to the remittance of deposit and anesthesia fees, cancellation policies and rescheduling policies. **I have read, fully understand and agree to the estimation of fees, terms and conditions of this financial agreement.**

Signature: _____ Print:_____Date: _____