FINANCIAL AGREEMENT FOR ANESTHESIA SERVICES

Patient Name _____ Date _____

Procedure _____

Estimated treatment time: _____
Estimated Anesthesia time:_____
Estimated anesthesia fee: _____

Anesthesia fees are:
$600.00 for the first hour
$125.00 for each additional 15 minutes (or portion thereof)

Anticipated method of payment: Cash Visa / MasterCard Check

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. 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 (if the anesthesia fees are paid in advance).

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.

I understand that if I fail to pay the anesthesia 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. There is a $25.00 returned check fee (the returned check fee and any additional fees must be paid in cash).

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

Print Patient's Name _____Phone _____

Print Parent/Guardian's Name _____Date _____

Signature_____

SPECIAL DENTAL CARE
"Anesthesia Powered Dentistry"