EPIONE Dental Anesthesiology
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BROWN

FINANCIAL AGREEMENT FOR ANESTHESIA SERVICES

PATIENT/ GUARDIAN INFORMATION

Date:___________________________
Name____Date of Birth:___________________________
Address:____ City:____________________ State:_______ ZIP:_____________
Home phone number:_______________________ Cell number:________________________ Email:___________________________
Age:________ Gender:________Occupation:____ SSN:__________________________
Procedure:____ Date:_________________________
Facility;____

The anesthesia estimated fee is based upon the dentist estimated operating time which will vary with the procedural complexity, anesthesia induction time and patients individual response to the anesthetics including recovery. Payment for anesthesia services is due the day of the treatment. If the anesthesia time exceeds the estimated time, the patient will be responsible for additional charges. However if anesthesia time is less than estimated time, the patient will receive the prorated refund.

ESTIMATED TREATMENT TIME: ____
ESTIMATED ANESTHESIA TIME: ____

ANESTHESIA FEE INCLUDES INDUCTION AND RECOVERY PERIOD

ANESTHESIA FEE:	$	for the first 30 minutes
	$	for each additional 15 minutes or portion thereof
ANESTHESIA SET UP FEE:	$	
TOTAL ANESTHESIA FEE:	$	

Many insurance companies do not reimburse patients for anesthesia services for dental procedures. Please check with your insurance company regarding your benefits. We will assist you in filling out of any forms your insurance carrier requires. If it is possible, please bring all your insurance claim forms with you the day of the procedure.

ANTICIPATED METHOD OF PAYMENT

CASH CHECK VISA/ MC/ AMEX CARE CREDIT FINANCING

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

Patient name	Patient signature	Date
Guardian name	Guardian signature	Date
Witness name	Witness signature	Date