EPIONE Dental Anesthesiology
Jana Sabo DDS

p 206.787.0883 f 866.736.6256
www.epioneDA.com

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:	$	

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