

BROWN

FINANCIAL AGREEMENT FOR ANESTHESIA SERVICES

PATIENT/ GUARDIAN INFORMATION

Name _____ Date: _____
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