Jeffrey P. Fisher, DDS

"Anesthesia for Dentistry"

Financial Agreement for Dental Anesthesia

(For patients12 years of age and older)

Patient's Name: _____ Scheduled Date of Procedure: _____

Financial Guarantor: _____ Dentist's Name: _____

Estimated Anesthesia Time

Estimated anesthesia time is the sum of the following: *An initial 15-minute period of pre-dental procedure anesthesia* *A variable-length period of anesthesia during the dental procedure* *A final estimated 30-minute post-procedure monitored recovery*	
15 min.	Initial anesthesia time prior to dental procedure
_____	Length of time estimated by dentist for procedure
30 min.	Estimated post-procedure monitored recovery time [Billed as a minimum of 2 *ASA units* (15-min increments) regardless of actual length]
_____	***Total estimated length of anesthesia services***

Estimated Anesthesia Fees

Basic fee for initial hour and a half: *Billed as a minimum of $1,100* **Extended fee beyond initial hour and a half:** *$100 per additional 15-min. period of anesthesia or portion thereof*	
Basic minimum fee for anesthesia services	$ 1,100
Extended anesthesia time ($100 x ___ *Extended ASA units*)	$ _____
Total amount of estimated anesthesia service fees	$ _____
Less amount of non-refundable deposit due today	$ _____
Estimated balance due day of dental appointment	$ _____

I acknowledge full financial responsibility for the payment of anesthesia services provided by Dr. Jeffrey P. Fisher. I understand that by signing this document, I am agreeing to pay his full fee for anesthesia services at the time services are rendered. I understand that the procedure time quoted above by my dentist is ***ONLY AN ESTIMATE.*** If the procedure takes less than the estimated time, I will be charged a fee based on the total length of anesthesia services. If the length of the procedure exceeds the estimated time, I will be responsible for the additional fee involved based on the guidelines above. Any balance not paid in full on the day of service without prior arrangements will accrue a 1% per month service charge until paid in full.

Due to the extensive time, effort, and coordination between dentist and anesthesiologist necessary in scheduling an appointment, a ***NON-REFUNDABLE DEPOSIT of $500*** is required before your anesthesia appointment will be confirmed. If you fail to appear in a timely manner for your appointment or if you fail to comply with the instructions requiring that you ***not eat or drink for eight hours*** *prior to your scheduled appointment*, your appointment will be canceled and you will forfeit the $500 deposit. Payment may be made using cash, money order, check, or credit card. A $75 fee will be charged for any checks returned un-payable.

~ IMPORTANT NOTICE ~

Insurance reimbursement for dental anesthesia should not be assumed. Many insurance policies do not pay for anesthesia services related to dentistry. Dr. Jeffrey P. Fisher **does not** bill an insurance company on behalf of the insured. If you plan to seek reimbursement for anesthesia fees, check directly with your insurance carrier regarding covered benefits.

I have read the above estimates and explanations. I understand and agree to the financial arrangements as indicated above.

Signed:_____ Printed Name: _____ Date:_____

Payment of Deposit

Amount: $ _____ Payment Method: ☐ Cash ☐ Check ☐ Credit Card ☐ Care Credit ☐ Other _____

Credit Card #: _____ Exp. Date: _____ /_____ 3-digit Code **(on back of card) :** _____
(required)

Billing Address: _____ Zip: _____
(required)

Agreement: Cardholder acknowledges responsibility to pay the *Non-refundable Deposit* and agrees to perform the obligations set forth in the *Cardholder's Agreement* with the issuer.

Name on Card: _____ Cardholder's Signature: _____ Date: _____
(printed)