Jeffrey P. Fisher, DDS

"Anesthesia for Little People"

Financial Agreement for Pediatric Dental Anesthesia

(For patients under 12 years of age)

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

Name of Parent/Guardian: _____ 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 $850* **Extended fee for service beyond the initial hour and a half**: *$100 per additional 15-min. period of anesthesia or portion thereof*	
Basic minimum fee for anesthesia services	$ 850
Extended anesthesia time ($100 x ____ *Extended ASA units*)	$ _____
Total amount of estimated anesthesia services fee	$ _____
Less amount of non-refundable deposit due today	$ _____
Estimated balance due day of dental appointment	$ _____

I (parent / legal guardian of patient) 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 child's 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 $350*** is required before your child's anesthesia appointment will be confirmed. If you fail to appear in a timely manner for your child's appointment or if you fail to comply with the instructions requiring that your child ***not be allowed to eat or drink for eight hours prior to his/her scheduled appointment***, your child's appointment will be canceled and you will forfeit the $350 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. I understand that 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, understand, and agree to the above financial arrangements.

Signed:_____ Printed Name: _____ Date:_____

Payment of Deposit

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