FINANCIAL AGREEMENT FOR ANESTHESIA SERVICES

Patient Name _____ Date _____

Procedure_____

Estimated Treatment time _____ **Estimated** Anesthesia fee _____

Anesthesia fees are:

$700.00 for the first hour (minimum)
$100.00 for each additional 15 minute increments
$450.00 Twilight Sedation

Please check method of payment and initial below:

□ Cash □ Debit □ Visa/Mastercard □ Discover □ Cashier's Check □ Care Credit

Card #_____

Expiration Date _____ 3 Digit code (back of card) _____

Name of cardholder _____ Phone # _____

Address of cardholder _____

***Social Security Number (required for personal checks) _____

_____The estimated anesthesia fee is based upon the dentist's estimate time for treatment as well as anesthesia preparatory time and the patient's individual response to the anesthetics used during recovery.

_____Payment for anesthesia services is due **two weeks prior** to the day of treatment. In the event the anesthesia time exceeds the above estimate, the patient is responsible for the additional charges at the end of the appointment. There is a **$300 non-refundable** cancellation and/or rescheduling fee once the anesthesia fees are collected. Any refunded deposit will be $700 **minus** the amount of any bank or credit card finance fees via written check.

_____Many insurance policies to do not pay for anesthesia services. Please check with your insurance company regarding your benefits. We will be happy to provide the appropriate billing codes as well as your receipt for the anesthesia services rendered. Please contact our office at 503-680-4406.

Personal Checks: If payment if made by personal check, a social security number is required. If you prefer not to provide your social security number, you may pay with the above methods of payment. There will be an additional fee of **$50** for all insufficient checks returned.

I have read this financial agreement, understand and agree with the above **estimate**. I authorize Dr. Sophia Tan, DDS to keep my information/signature on file and to charge my bank/credit card for anesthesia services rendered.

Print Patient's Name _____

Print Parent / Guardian's Name _____

Signature _____

Date _____ Phone _____