



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: <i>An initial 15-minute period of pre-dental procedure anesthesia</i> <i>A variable-length period of anesthesia during the dental procedure</i> <i>A final estimated 30-minute post-procedure monitored recovery</i>	
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
	<small>[Billed as a minimum of 2 ASA units (15-min increments) regardless of actual length]</small>
_____	<i>Total estimated length of anesthesia services</i>

Estimated Anesthesia Fees

Basic fee for initial hour and a half: <i>Billed as a minimum of \$750</i> Extended fee beyond initial hour and a half: <i>\$100 per additional 15-min. period of anesthesia or portion thereof</i>	
Basic minimum fee for anesthesia services	\$ 750
Extended anesthesia time (\$100 x _____ <i>Extended ASA units</i>)	\$ _____
Total amount of estimated anesthesia service fees	\$ _____
Less amount of non-refundable deposit due today	\$ _____
<i>Estimated balance due day of dental appointment</i>	\$ _____

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 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. 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: <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Care Credit <input type="checkbox"/> Credit Card <input type="checkbox"/> Other _____
Credit Card #: _____	Exp. Date: _____ / _____ 3-digit Code (on back of card) : _____ <small>(required)</small>
Billing Address: _____ <small>(required)</small>	Zip: _____
Agreement: Cardholder acknowledges responsibility to pay the <i>Non-refundable Deposit</i> and agrees to perform the obligations set forth in the <i>Cardholder's Agreement</i> with the issuer.	
Name on Card: _____ <small>(printed)</small>	Cardholder's Signature: _____ Date: _____