FINANCIAL AGREEMENT FOR ANESTHESIA SERVICE RENDERED

Name of Patient:_____ Contact Number: _____

Surgery Date: _____ E-mail address: _____

The anesthesia fee is based upon the dentist estimated operating time which will vary with the surgical complexity, anesthesia preparatory time and patient's recovery time.

There is a One Hour minimum charge and for every 15 Minute increments thereafter.

A deposit of $500.00 is required to schedule your sedation appointment. Your dentist's office may obtain, process and facilitate payment (Visa/MC/Amex only) on behalf of Dr. Sandhu/Dental Anesthesia Associates, PLLC. We require a valid credit card on file to collect any residual balance. The provided Credit Card information is proof of your authorization to process outstanding unpaid payment or charges or in case a cancellation policy is applied.

If the anesthesia time exceeds the estimate, the patient will be responsible for the additional charges. If the anesthesia time is less than the estimate, the patient will receive a prorated refund.

Cancellation/Rescheduling Policy

If the patient does not appear on time or failed to keep the scheduled appointment time as agreed, a non- refundable charge of $500.00 will be applied. If the procedure is cancelled due to patient not following the fasting, eating or drinking restrictions, A non-refundable charge of $500.00 will be applied. Rescheduling due to unexpected illness or family emergency may require a physician/pediatrician clearance. The $500.00 fee will be credited (but NOT refunded) toward your next available appointment.

INSURANCE INFORMATION

It is important that reimbursement for the anesthesia fee by dental or medical insurance programs NOT be assumed. Many insurance policies do not pay for anesthesia services for dentistry. Please check with your insurance company representative as to the benefits included. We will be delighted to fill out for you any forms which your submission to insurance company. If possible please bring an insurance claim form with you the day of surgery.

I have read and understand the above information. I agree to accept these terms and conditions. Please return this form to your dentist's office.

_____ _____

Signature of Patient, Parent or Legal Guardian Date