CENTER for DENTAL ANESTHESIA

FINANCIAL ARRANGEMENTS

In order to schedule a General Anesthesia Appointment, Payment is expected in full. (Overpayments will be refunded.) If for any reason the general anesthesia appointment is canceled without at least 2 weeks' notice, a, 20% non-refundable charge will be applied, this includes cancellation by the anesthesiologist due to failure to follow the pre-anesthesia instructions you have been given**.** Rescheduling due to unexpected illness or family emergency may require physician/pediatrician clearance, 20% fee will be credited (but not refunded) toward your next available appointment. Please read and follow all instructions. We require a valid credit card on file to collect any residual balance. Provided credit card information is proof of authorization to process any outstanding balance on the account .

We accept personal checks, Visa, MasterCard, Discover, and American Express.

We have partnered with several third party financing companies such as care credit, and lending club to offer you more flexible ways to finance your treatment**.** These companies offer outside financing at excellent rates. Please ask the front desk for details. Information will be provided to you and you can apply at your convenience.

Insurance Note: If a patient has insurance benefits that they feel may cover a portion of the cost, we can assist in obtaining a predetermination of these benefits. The following guidelines must be met in order to facilitate this:

- The patient must provide a picture ID, copy of the insurance card, and complete subscriber information to be kept on file.
- The predetermination of benefits must be in writing from the insurance company detailing the benefits and indicating assignment for payment has been made to the office.
- Patient must be able to allow approximately 4-6 weeks for the predetermination to be processed and returned to our office.
- Please be advised these estimates are subject to change, if for any reason your insurance does not pay as much as was estimated you will be responsible for the difference.

Your signature below acknowledges that these options have been explained to you, all questions pertaining directly to these options have been answered and you are aware of the office policies in order to schedule additional treatment. Your signature does not obligate you to any options or treatment.

_____ _____

Signature of Patient/Guardian Date

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Signature of Office Representative

A copy of this form was provided to the caretaker to forward to the patients guarantor.

Signature of Office Representative