Dr. Jay Patel
Tel: 732-986-3690 | Fax: 732-601-4865
Email: info@dentsed.com

DENTAL SEDATION SERVICES

Appointment & Fee Policy

Patient Name:	Service Location:
DOB:	Date of Procedure:

Thank you for choosing DENTAL SEDATION SERVICES for your dental appointment. The following information will help you understand our pre-anesthesia policies and financial agreement.

DEPOSIT:
A non-refundable deposit of $ 350.00 will be collected to secure your appointment, cover pre-anesthesia consultations, and day of preparation. Your deposit must be received within 24 hours from scheduling your appointment to secure your appointment date and time. An appointment with NO DEPOSIT may be forfeited. Your deposit will be applied towards your final invoice balance. You may pay deposit ONLINE or by PHONE.

FEE:
We will provide an estimate for the anesthesia bill based on your dentist's anticipated working time and your particular anesthetic induction and recovery. Your personal consultation with the anesthesiologist, pre-operative clearances, full anesthesia care, medications, and recovery are all covered by your final invoice. The fee schedule is as follows:

$ _____ per 15 minutes of anesthesia time

PAYMENT:
Full payment of your anesthesia invoice will be collected at the conclusion of your appointment. We accept CASH, CHECK, and CREDIT CARD (Visa, MasterCard, and AMEX).
In the event of a defaulted payment, the patient will be held responsible for any costs associated with collection, including but not limited to: attorney fees, collection fees, and interest (3% per month for bills overdue by 30 days).

INSURANCE:
Although we do not participate with any insurances, we will provide all necessary paperwork to assist you in submitting your anesthesia claim to obtain any reimbursement to your benefit. Reimbursement is NOT GUARANTEED. It is the patient's responsibility to verify benefits. I hereby authorize the doctor to release any relevant information to my insurance carrier.

ESTIMATE:
I understand the following is an estimate of my anesthesia invoice. This estimate is based on the dentist's anticipated working time and an estimated induction and recovery from anesthesia. A final invoice will be furnished for me at the conclusion of my treatment.

Estimated anesthesia time:	
Estimated anesthesia fee:	

I, _____, have read and understand the terms and agreement set forth.

Signature:	Print Name:	Date: