SALMAN HUSSAIN D.M.D., INC.
DENTIST ANESTHESIOLOGIST ON CALL

FINANCIAL AGREEMENT FOR ANESTHESIA SERVICE RENDERED

Name of Patient: _____ Contact Number:_____

Surgery Date: _____ E-mail address: _____

Your dentist has ESTIMATED treatment time to be: _____ Hr _____Min.

Anesthesia fees are:

$ for the first hour
$ for every 15 minutes thereafter

Anesthesia time = Estimated dental surgery time + 45 minutes.

Anesthesia Fee Estimate…… _____

The anesthesia fee estimate is based upon the dentist estimated operating time which will vary with the surgical complexity, anesthesia preparatory time and patient's individual response to the anesthetic agents used (recovery).

On the day of scheduling 30 percent of the estimated anesthesia fees will be charged and is non-refundable. The remaining 70 percent of the anesthesia fees will be charged 48 business hours prior to the day of treatment. 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.

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 insurance company requires. If possible please bring an insurance claim form with you the day of surgery.

PLEASE INDICATE ANTICIPATED METHOD OF PAYMENT (CIRCLE ONE)

CHECK CASH VISA/MC FINANCING

I have read, understand and agree with the above ESTIMATE of fees.

_____ _____
Signature of Patient, Parent or Legal Guardian Date

_____
Name & Address