Selkirk
Dental Anesthesia

Patient Financial Agreement

Patient Name_____Birthdate_____Age_____

Gender_____ Address_____Apt#_____

City_____State_____ Phone #_____Email_____.

Parent or Gaurdian_____Birthdate_____Age_____
Phone #_____ Relationship to Patient_____.
Email Address_____

PAYER AGREEMENT:

- **We accept cash, money order, any credit card, and any debit card.**
- ***Charges for anesthesia have been explained to me and I had an opportunity to ask questions. Billing is done in 15-minute intervals, fractions of 15-minute intervals are always rounded up.***
- ***PAYMENT FOR ANESTHESIA IS DUE BEFORE THE DAY OF SERVICES BEING RENDERED.***
- **Any time over the estimated time of anesthesia services will be billed immediately after the procedure and due upon receipt of bill. If the actual anesthesia time required is less than the estimated time it is possible that a partial refund will be issued. Refunds are issued in pro-rated 15-minute intervals. *There may be a 2-hour minimum charge for anesthesia if office does not schedule multiple cases in one day.***
- **Selkirk Dental Anesthesia PLLC will attempt to bill insurance, however full payment from patient is required prior to the procedure. Selkirk Dental Anesthesia PLLC is out of network with ALL dental and medical insurances. We do not perform prior authorizations. There is no guarantee that insurance will approve reimbursement for anesthesia services. Any insurance reimbursement will be refunded to the original form of payment**
- **Any delinquent or accrued charges may be sent to collections.**

I have read, understand and agree to the payer agreement. I also understand that payment is due in full on the day of service. I also understand that this is an estimate and that the final price could change based on the length of the procedure.

Signed_____ Date_____
Time_____

MY ESTIMATED PRICE FOR ANESTHESIA SERVICES

Hourly Rate=$_____.00
Estimated length of procedure=_____(rounded to the nearest 15minutes)+60 minutes for setup and recovery from anesthesia=_____.

Total Estimated Amount Due BEFORE Day of Procedure=$_____.