Dentist Anesthesiologist

David E. Rogers, D.D.S.

Financial Agreement

______ I, (the Patient, Legal Guardian, or responsible party for patient this date) acknowledge full financial Responsibility for anesthesia services rendered the day of surgery.

______ I understand that by signing this document I am agreeing to pay Dr. David Rogers his full fee for anesthesia services at the time when treatment has been completed ($150 each 15 min **or any portion thereof**, with a 1 hour minimum.)

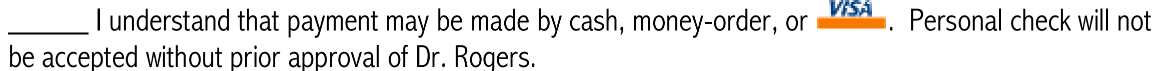
Estimated time for anesthesia/sedation _________ **Estimated fees** for services rendered $ __________

______I acknowledge that I have been informed that the estimated fees for this service may be more depending upon the surgical complexity, anesthesia preparatory time and the patient's individual response to the anesthetic agents used. I am prepared to pay these fees in full at the time services are rendered.

______ I understand that patient's failure to appear for their scheduled appointment without 48 hours notice or non-compliance with pre-operative instructions (no eating/drinking prior) will result in forfeiture of patient's deposit of $600 and an additional $600 deposit will be required to schedule the next appointment.

Deposit left in dental office: MC / Visa / cash ____________________________ exp date:_________
Email address : ____ (CVV #__ __ __)

______ I understand that my failure to pay these fees may result in my referral to a collection agency and or legal action.



______ I understand that payment may be made by cash, money-order, or MasterCard/VISA. Personal check will not be accepted without prior approval of Dr. Rogers.

______ Insurance reimbursement for dental anesthesia should NOT be assumed. Many insurance policies DO NOT pay for anesthesia services for dentistry. I understand that Dr. David E. Rogers, D.D.S., does not bill for insurance. Patients seeking reimbursement should check with their insurance company as to their benefits. Dr. Rogers can provide a receipt for services rendered upon patient's request.

I acknowledge that I have read and understand all the above-mentioned information.

Date: __________________________ Signed: ____

Relationship to patient: ___________________________

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