Northern Lights Dental Anesthesia, LLC
P: (907) 268-3109 F: (907) 331-0216
www.NorthernLightsDentalAnesthesia.com
nlda@northernlightsdentalanesthesia.com

Financial Agreement for Anesthesia Services

Patient Name_____ DOB _____ Date _____

E-mail _____ Contact Number _____

Your dentist has estimated treatment time to be: _____ hour(s) _____minutes

The estimate anesthesia fee includes pre-operative examination, 15 minutes to put the patient to sleep and 15 minutes for recovery. The anesthesiologist will be actively monitoring the patient in the operatory room for the full duration of the dental procedure.

If the patient fails to reschedule an appointment 24 hours in advance or fails to arrive for the dental appointment, you will be responsible for a $500 deposit. If you become sick, please call us as soon as possible.

Estimated Treatment time: _____
Estimated Anesthesia time: _____
Estimated Anesthesia fee: _____

Anesthesia fees are:

$1,150.00 for the first hour
$250.00 for each additional 15 minutes (or portion thereof)

Anticipated method of payment: Cash Visa / MasterCard / Discover CareCredit

The estimated anesthesia fee is based upon the dentist's estimate of treatment time, anesthesia preparatory time, and the average patient's response to the anesthetic used.

Payment for anesthesia services is due in full on the day of treatment. In the event anesthesia time exceeds the estimate, you are responsible for the additional charges. However, if the anesthesia time is less than the estimate, you will be charged less than the estimated fee. Should the estimate be paid in advance, you will receive a prorated refund.

Many insurance policies do not pay for anesthesia services for dentistry. Please check with your insurance company regarding your benefits. We will be happy to provide a receipt for the anesthesia services.

I understand that if I fail to pay the anesthesia fees, or failure to pay the balance in the event of a financial arrangement, I will be charged an interest of 18% APR and will be liable for all the collection charges and or court fees.

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

Print Patient's Name _____ Phone _____

Print Parent/Guardian's Name _____ Date _____

Signature _____

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Anesthesia Fee Schedule and Services

By discussing your needs with us, an anesthetic plan is individually created to suit your specific goals. Some specific services that we commonly provide are:

1. **Intravenous Mild sedation**: the patient is awake through the entire experience with medications given to help control anxiety and pain.
2. **Intravenous Moderate Sedation**: the patient is at a depressed level of consciousness but remains easily arousable.
3. **Intravenous Deep Sedation**: the patient's level of consciousness if very depressed and the patient is not easily arousable.
4. **General Anesthesia**: the patient is unconscious throughout the procedure and is not arousable until the end of the procedure.

The anesthesia fee includes dentist's time plus 15 minutes to put the patient to sleep and 15 minutes for recovery. Payment is due in full at the time of service, either by cash, care credit, or credit card.

Dentist's Time	Total Anesthesia Time	Anesthesia Fee
30 minutes	1 hour	$1,150
45 minutes	1 hour 15 minutes	$1,400
1 hour	1 Hour 30 minutes	$1,650
1 hour 15 minutes	1 Hour 45 minutes	$1,900
1 hour 30 minutes	2 Hours	$2,150
1 hour 45 minutes	2 Hours 15 minutes	$2,400
2 hours	2 Hours 30 minutes	$2,650
2 hours 15 minutes	2 Hours 45 minutes	$2,900
2 hours 30 minutes	3 Hours	$3,150
2 hours 45 minutes	3 Hours 15 minutes	$3,400
3 hours	3 Hours 30 minutes	$3,650

Northern Lights Dental Anesthesia - Credit Card Authorization

Date of Treatment: _____
Patient's Name: _____
Patient's Birthdate: _____

I have reviewed the financial agreement and the anesthesia fee schedule. I understand that the estimated fees are estimations based on probable treatment times and I understand that the fees may change based on actual treatment times. I authorize Northern Lights Dental Anesthesia, LLC to charge my credit card for the fees according to the time spent providing anesthesia.

Signature of Card Holder _____ **Date _____**
(Day of Treatment)

To help us better assist you, if you plan on submitting for reimbursement to your MEDICAL insurance please provide the following information:

Insurance Company _____

Subscriber Name _____ Subscriber DOB _____

ID # _____ Group # _____

Employer _____

Insurance Company Phone Number _____

Claims Address (on back of card) _____

Credit Card Information

Payment Method**:** ☐Cash ☐Check ☐ Credit Card ☐CareCredit

If **Care Credit**, please select promotion:

No Interest if paid in full within the promotion period: ☐ 6 Months ☐ 12 Months

Reduced APR and fixed monthly payments required until payed in full ☐36 Months ☐48 Months ☐60 Months

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Name on Card _____

Credit Card Number _____

Expiration Date _____

Security Code _____

Billing Address_____

E-mail for Credit Card Receipt _____