test

Patient Name **Procedure Date**

Estimated Dental Procedure Minutes	Total Prepaid Fee	Deposit due at scheduling	Balance due prior to procedure
5	**$450**	$250	$200
10	**$525**	$250	$275
20	**$650**	$250	$400
40	**$850**	$250	$600
60	**$1050**	$250	$800
80	**$1350**	$250	$1100
100	**$1550**	$250	$1300
120	**$1800**	$250	$1550
140	**$2100**	$250	$1850
160	**$2350**	$250	$2100
180	**$2600**	$250	$2350
200	**$2900**	$250	$2650
220	**$3200**	$250	$2950
240	**$3500**	$250	$3250

Payment Policy:

- $250 Deposit is due at the time of scheduling. There is a $250 charge for patients who fail to keep the IV
  Sedation appointment without giving us a 24 hour notice.
- The card on file will be charged automatically for the balance 2 business days prior to the procedure date.
- On the day of the patient's procedure, you will be given a Superbill to file the anesthesia through your out of network benefits.
  Many medical insurance companies do not cover anesthesia services for office based dental care.
- Your dental treatment plan may change after treatment is begun. Charges for anesthesia services may be more or less than the estimated amount based on the final length of the procedure. The anesthesia charges may be more than initially estimated and **an additional payment by credit card is due at the**
  time of service. Any overpayments will be refunded automatically to you.
- We accept cashier's check, American Express, Discover, Visa, MasterCard, and Carecredit for payment in full 3 business days before the patient is treated. You can apply for Carecredit at www.carecredit.com
- I authorize PDAA to send me text messages via SMS texting regarding my child's anesthesia appointment and finances. I understand standard text message and data rates may apply.

• I understand that my health plan (**Tricare** and other plans) may impose a limit on balance billing by out of
network providers. I wish to waive any limit on balance billing and receive treatment from this out of network
provider.
• I understand that I am seeking the care of PDAA for a service that may not be covered by my insurance company. I understand that my insurance plan may not cover any part of the charges, costs or expenses related to Anesthesia services and I will be responsible for all charges incurred.

April 25, 2024

Dentist Name
Patient Last Name
Patient First Name
Patient Nickname
Address
State
Parent Name
Email address
Home Phone
I prefer to be contacted by:

Procedure Date
Patient DOB
Gender

City
Zip

Work Phone
Cell Phone

Order ID:
Redfin ID:

Today's Date April 25, 2024

Parent Name:

X _____

Signature Certificate

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This audit trail report provides a detailed record of the online activity and events recorded for this contract.