

Anesthesia Scheduling Instructions for Dental Offices

1. Please give each patient a PDAA brochure

2. Complete Anesthesia Scheduling Forms

1. Anesthesia Fee Estimate form

- Fill out the top box.
- Have patient sign.

2. Anesthesia Scheduling form

- Fill in the Patient sections **or** attach a copy of your office's registration form.
- Fill in credit card information **or** send check to:
PDAA P.O. Box 2080 Palm Harbor, FL 34682-2080

➤ ****Medical History

- A medical history is not necessary for healthy patients
- "Red Flag patients"- (medical problems, special needs, medical allergies)
please send medical history from the patient's dental record

3. Email or Fax these forms to:

1. Anesthesia Fee Scheduling form
2. Anesthesia Estimate form (Signed)

If you have any questions, please contact:

Email: billing@pediatricseparation.com
P.O. Box 2080
Palm Harbor, FL 34682-2080
Phone: 813-545-9924 Fax: 866-773-3520

**Even if the patient is undecided about scheduling the procedure try to get all the forms filled out and placed in the chart for future use.*

Anesthesia Fee Estimate Form Fax to: 866-773-3520

Patient Name		Procedure Date	
Estimated Dental Procedure Minutes ✓	Prepaid Anesthesia Fee	Deposit due at scheduling	Balance due prior to procedure
5	\$450	\$250	\$200
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.
- Our financial office can help patients with medical insurance determine their out of network benefits. 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, however, PDAA is committed to fully assisting you with the pursuit of any potential reimbursement.
- 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 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.

Parent/Guardian or Patient signature

Date

Anesthesia Scheduling Form Fax to: 866-773-3520**Patient Information**

Dentist's name		Procedure Date	
Patient's Last Name		M	Date of Birth
		F	
Patient's First Name		Middle or Nickname	
Address			
City		State	Zip
Parents Name:			
Check preferred method of contact		Email address	
		Home Phone	
		Work Phone	
		Cell Phone	
Payment (Circle one): Visa MasterCard AmEx Discover Cashier's Check CareCredit			
Cardholder agrees to pay \$250 required at scheduling and balance of \$_____ to be charged 2-3 business days prior to procedure.			
There is a \$250 charge for patients who fail to keep the IV Sedation appointment without giving us a 24 hour notice			
<i>If you prefer the credit card information below can be given to our billing office directly over the phone Thank you</i>			
Exp. date	Security code	Card #	
Card Holder's Name			
Card Holder's Address- (if different than above)			
Card Holder's Signature			

If you have any questions, please contact our billing office:

Email: billing@pediatricседation.com

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