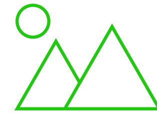
Pediatric (13 years and Under) Financial Agreement for Anesthesia Services



Mountain Dental Anesthesia

Please be aware that anesthesia and dental services are provided by two independent entities with separate fees. Mountain Dental Anesthesia is contracted with Colorado Medicaid. The fees for patients not covered by medicaid are listed below. Fees are based on time estimates provided by the dentist which takes into account the surgical and anesthetic complexity of the case.

Anesthesia fees

- For services lasting *less than or up to 2 hours* $950.00
- For service lasting *over 2 hours* $600.00/hour billed in 15 minute increments
- Deposit $300

Payment

Full payment can be made with cash or major credit/debit card on the day of surgery. Checks will NOT be accepted. Extensive attempts will be made to collect unpaid balances. Failure by the patient to pay outstanding claims will be submitted to a collections attorney for processing.

Insurance Reimbursement

If Mountain Dental Anesthesia is not contracted with your medical or dental insurance company, reimbursement for anesthetic services will be provided **directly to you**. Upon completion of anesthesia, the anesthesiologist will provide you with an itemized receipt for submittal for reimbursement. It is **your responsibility** to submit this to your insurance company. Please note that insurance company reimbursement allowances, if any, may not cover the entire cost for these anesthesia services. Should this be an important factor, please take a few minutes prior to scheduling this appointment to contact both your dental and medical insurance carriers to inquire about your particular coverage.

Notice for patients covered by TRICARE (United Concordia Dental):

Mountain Dental Anesthesia is a not a contracted provider for TRICARE (United Concordia Dental). This waiver allows a non-network (non-contracted) provider to collect billed charges for services denied as “non-covered” from a TRICARE beneficiary when the beneficiary has agreed, in advance, in writing, to waive his or her balance-billing protection.

I acknowledge that I am signing this statement voluntarily, and that it is not being signed under duress or after services have already been provided. I understand that by signing this form, I will be fully responsible for the total billed charge(s) for any services denied as a non-covered and listed above and will pay the provider this amount, regardless of any payment or non-payment made by TRICARE. I also understand that it is my choice to have these services at a future date and time by this provider who is not a participant in the TRICARE program.

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

Print Patient’s Name: ____ Phone: ____________________

Print Parent/Guardian’s Name: ______________________________ Date: _____________________________

Email Address for receipt: ____

Signature: ____

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