Sweet Dreams, LLC

Office-based Anesthesia Services

Rev. Jan. 2016

Financial Information and Agreement

Patient Name _____ Age _____ Birth Date _____Sex _____

Address _____ Apt. # ____ City _____ State _____ Zip _____

Insured's Name _____ Birth Date _____ Phone # _____

Address _____ Apt. # _____ City _____ State _____ Zip _____
(*If Different From Above*)

Dental Insurance Company _____ Insurance ID # _____

Employer _____

PAYER AGREEMENT:

- *Payment for Anesthesia is required on the day of service.*
- *Anesthesia charges are $75.00 for each 15 minutes. There will be a one-hour minimum charge on all cases.*
- *Sweet Dreams does not accept any checks.*
- *Medicaid insurance is accepted only when it is the primary insurance.*
- *I give permission for Sweet Dreams to process agreed insurance claims and receive payment for covered anesthesia services.*
- *A receipt will be supplied to facilitate sending claims to my insurance companies.*
- *Any reimbursements from other insurance companies sent directly to Sweet Dreams will be mailed to me or credited to my dental office account as soon as they are received.*
- *Any delinquent or accrued charges may be sent to collections and will incur an additional 33.33% collection fee.*

I have read, understand, and agree to the above *Payer Agreement*.

Signed: _____ Date _____

For Office Use Only: RBB ___ JKB ___BCR ___ BVB ___ CA _____ CC _____ CK _____ Source: _____

Date: _____ Dentist: _____ Amount Billed: $_____ Amount Collected: $_____

Times: _____ to _____ Total Minutes: _____

Dx. Codes: K02.62 K02.63 K04.0 K04.6 Other: _____ P1 P2 P3 Reason: _____

Insurance Co.: _____PA # _____ UHIN Submission Date: _____

Insurance Reimb: $_____ Date: _____ S.D. Reimb. Check # _____ Amount: $_____ Date: _____

Notes: _____
