CAREPOINT ANESTHESIA GROUP, LLC
A Comfortable Way To A Healthy Smile
8301 E Prentice Avenue, Suite 215
Greenwood Village, CO 80111
Tel: 720-606-4220 : Fax: 720-606-4221
info@carepointanesthesia.com
www.carepointanesthesia.com

Registration

PATIENT INFORMATION:

Patient Name: ____

Date of Birth: _____/_____/________ Weight (LBS): __________ M [ ] F [ ]

Name of dental office:______________________________ Appointment Date: ____/____/______

RESPONSIBLE PARTY:

Name: ______________________________________ Relationship to Patient: ____________

Phone: ____________________________ Secondary phone:__________________________

Email: ____

Mailing Address: ____

PAYMENT INFORMATION: [ ] **Self-Pay** [ ] **Colorado Medicaid** State ID #: ____________

PRE-OPERATIVE (FASTING) GUIDELINES

Appointments Before 11:59 AM

- Nothing to eat or drink beginning **8** hours prior to anesthesia
- May take medication at least 2 hours prior with a SMALL sip of water

Appointments After 11:59 AM

- Nothing to eat or drink beginning **8** hours prior to anesthesia
- May drink water or Sprite ONLY up until 4 hours prior to anesthesia
- May take medication at least 2 hours prior with a SMALL sip of water

Please contact CarePoint at (720) 606-4220 or info@carepointanesthesia.com to complete your registration.

I certify that:

- ***I have read and understand the fasting guidelines.***
- ***CarePoint may communicate patient information using the contact information listed above.***

Patient/Legal Guardian Signature: ________________________________ Date: ____________

Please continue to page 2 – Financial Policy

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Financial Policy

Welcome to CarePoint Anesthesia Group! We are dedicated to providing specialized anesthesia services in the familiar and comfortable environment of your dentist's office, bringing a tailored and personal touch to your care. We would also like to inform you of your financial obligations. The following is our company's financial policy:

Payment for Services:

_____ CarePoint is a "Fee-for-Service" company and payment is due at the time services are rendered.

_____ CarePoint is a completely separate entity from your dentist. All related fees, operative times and/or orders are charged and billed separately.

_____ CarePoint requires a non-refundable deposit at the time of scheduling which will be applied to your total. Deposits can be made through our website at www.carepointanesthesia.com. The remaining balance is due on the date of service. This will be charged to the card on file unless other arrangements have been made.

- **Pediatric Fee** (20 years and younger): $950 minimum for 2 hours or less; $150 for each additional 15 minute increments. This includes a $300 pediatric deposit.
- **Adult Fee** (21 years and older): $600 minimum for 1 hour or less; $150 for each additional 15 minute increments. This includes a $500 adult deposit.

_____ CarePoint accepts all major credit cards, debit cards, Health Savings Account (HSA) cards, flex spending cards, CareCredit (6 months term), cash, money orders or checks for our services.

If You Have Insurance:

- CarePoint does **NOT ACCEPT** private insurances and **only accepts Colorado Medicaid.** Upon request, we can provide you with a *reimbursement* claim form that you may submit directly to your insurance company. We do not guarantee that you will receive reimbursement from your insurance company. Please contact your insurance company directly for any questions regarding your coverage, their payment policies, and reimbursement procedures.

I certify that I have read, understood, and acknowledge receipt of a copy of the above Financial Policy. I also understand and acknowledge my financial responsibility for the anesthesia services provided by CarePoint Anesthesia Group.

Patient/Legal Guardian Signature: ____ Date: ________________

Patient Name: ____ Date of Service:______________

CREDIT CARD PAYMENT AUTHORIZATION

By signing below, you authorize CarePoint to submit payment for any remaining balance due on or after the date of service.

Please check: [ ] Visa [ ] MC [ ] AMEX [ ] Discover [ ] CareCredit (6 month term)

Cardholder Name: ____

Card Number: ____ Expiration Date: _____/_____

Billing Address: ____

Cardholder Signature: ____ Date: ________________

******Alternatively, card information can be provided through our website in the form of a deposit.***