REGISTRATION FORM

PATIENT INFORMATION:

Last Name: _____ First Name: _____

Date of Birth: _____ Gender: M [ ] F [ ] Weight (LBS): _____ Height: _____

Name of Dental Office: _____ Appointment Date: _____

RESPONSIBLE PARTY:

Name: _____ Relationship to Patient: _____

Tel/Cell: _____ Email: _____

Mailing Address: _____

PAYMENT INFORMATION: **[ ] SELF-PAY (Please complete the Financial Agreement on page 2.)**
[ ] MEDICAID ID #_____

PRE-OPERATIVE (FASTING) GUIDELINES

Appointments **BEFORE** 11:00 AM:

- Nothing to eat after midnight the night before
- May take medication with a SMALL sip of water, 2 hours prior to anesthesia

Appointments **AFTER** 11:00 AM:

- Nothing to eat **8** hours prior to anesthesia
- May drink water, apple juice or Sprite only up until 4 hours prior to anesthesia
- May take medication with a SMALL sip of water, 2 hours prior to anesthesia

I certify that:

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

Parent/Legal Guardian Signature: _____ Date: _____

8301 East Prentice Avenue, Suite 215
Greenwood Village, Colorado 80111-2990
Tel: 720-606-4220 ; Fax: 720-606-4221
Email: info@carepointanesthesia.com
www.carepointanesthesia.com

FINANCIAL AGREEMENT

Welcome to CarePoint Anesthesia Group! We are dedicated to providing specialized anesthesia services to 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:

FINANCE POLICY: Please **initial** below that you have read, understood, and acknowledge our financial policy.

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

_____ CarePoint is a completely separate entity from your dentist and that 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 ***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**. We accept all major credit cards, debit cards, Health Savings Account (HSA), flex spending cards, CareCredit (6-months term), cash, money orders, or checks for our services.

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

_____ I acknowledge that any cost of service not paid for or covered by Medicaid, is my financial responsibility.

IF YOU HAVE INSURANCE: CarePoint Anesthesia Group is "out of network" and we do **NOT ACCEPT** private insurances. We **only accept Colorado Medicaid**. Upon request and only when your account is paid-in-full, 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.

Parent/Legal Guardian Signature: _____ Date: _____

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

Please check: [ ] **VISA** [ ] **MC** [ ] **AMEX** [ ] **DISCOVER** [ ] **CARE CREDIT** (6-Months Term)

Cardholder Name: _____

Card Number: _____ Expiration Date: ____/____ CVV: _____

Cardholder Signature: _____ Billing Zip Code: _____