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: [ ] **CO MEDICAID ID# _______________**

[ ] **SELF-PAY (Please complete Financial Agreement on page 2.)**

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: _____________

CarePoint Anesthesia Group, LLC
8301 East Prentice Avenue, Suite 215
Greenwood Village, CO 80111-2990
Tel: 720-606-4220 ; Fax: 720-606-4221
Email: info@carepointanesthesia.com
Website: https://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.

_______ For **Pediatric patients** (20 years and younger) with **TriCare** benefits, we require a minimum **payment of $750** (2 hours or less for anesthesia) **due 2 business days prior to your child's appointment.** Payment can be made through our website at ***www.carepointanesthesia.com***. Should the dental procedure exceed the allocated 2 hours, an additional **$90 per 15-minute increments** will be accessed. The remaining balance **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.

_______ A $300 NON-REFUNDABLE fee will be applied to your account in the event that this appointment is cancelled.

_______ Please fill out the TriCare form attached to this document. We reserve the right to cancel your child's appointment if this form is not received prior to the appointment.

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, LLC.

Parent/Legal Guardian Signature: ____ Date: ________________

Patient Name: __________________________________

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: ____________

Health Net Federal Services | TRICARE

REQUEST FOR NON-COVERED SERVICES

I am hereby requesting that the following services be provided to me by **CAREPOINT ANESTHESIA GROUP**.
(Provider Name)

Service(s) (List All)	Frequency Limitations	Proposed Date(s) of Service	Estimated Cost of Services
GENERAL ANESTHESIA (in conjunction with dental procedure)	1		$750.00

In making this request, I acknowledge that these services are not a benefit of my health coverage under TRICARE and that I will not receive the benefit of the TRICARE Hold Harmless Policy (defined below), which otherwise might apply to me. In addition, I acknowledge that if I have obtained services more frequently than authorized by TRICARE policy, I may be responsible for that professional service.

I also understand that if authorization for this care has been denied by TRICARE, or if reimbursement is denied upon submittal of a claim form, I may appeal the written notification of the denial issued by Health Net Federal Services, LLC/MHN Services.

Unless the decision to deny is overturned as the result of an appeal or dispute, I agree that I will be personally responsible for the payment IN FULL of the billed charges for these services.

Sponsor Name ____________________ Patient Name (Print) ____________________

Sponsor Social Security Number ____________________ Signature of Patient ____________________

Sponsor Address ____________________

TRICARE Hold Harmless Policy: A network provider may not require payment from the beneficiary for any excluded or excludable services that the beneficiary received from the network provider (i.e., the beneficiary will be held harmless) unless the beneficiary has been properly informed that the services are excluded or excludable and has agreed in advance in writing to pay for the services.

Privacy Act Statement:

In view of the fact that personal information is being requested from you, notice is hereby given as required by the Privacy Act of 1974. The information is requested and maintained under the authority of Chapter 55, Title 10, United States Code, Section 1101, Title 44, United States Code, and 41 Code of Federal Regulations 101-1100 et seq. The information is requested to establish or update information to control or process claims for payment. Routinely, the information will be used to determine eligibility for TRICARE benefits, review and approve medical care as TRICARE benefits, and to determine reasonable charges/costs of care to be cost-shared under TRICARE. Disclosure of the information is voluntary; however, failure to provide the information may result in denial of benefits.

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