CarePoint
ANESTHESIA GROUP
A COMFORTABLE WAY TO A HEALTHY SMILE

8301 E Prentice Avenue, Suite 215
Greenwood Village, CO 80111-2990
Phone: (720) 606-4220 : Fax: (720) 606-4221

FINANCE POLICY AGREEMENT with TRICARE BENEFITS

For (Child's Name): _____ ***Scheduled Appointment:*** _____

The **CarePoint Anesthesia Group LLC**, hereinafter known as ("CarePoint"), is 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 child's care. We would like to advise you of your financial obligations. Please **initial** below that you have read, understood, and acknowledge this Finance Policy Agreement.

____ CarePoint is a "Fee-for-Service" company and is a separate entity from your dentist. All related fees, operative times and/or dental procedures are billed separately

____ Our fee for **Pediatric** (20 years and younger) patients with **TriCare** benefits is **$1,250** (2 hours or less of dental anesthesia). **Payment is due 2-business days prior to your child's scheduled appointment**. Should the dental procedure exceed the allocated 2 hours, an additional **$175 per 15-minute increments** will be assessed. The remaining balance will be charged to the card on file unless other special arrangement(s) 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. Payment(s) can be made through our website at ***https://carepointanesthesia.com***.

____ The attached TriCare "***Request for Non-Covered Services***" form must be completed and received by CarePoint prior to the scheduled appointment. Should we not receive the completed form as stated, we reserve the right to re-schedule and/or cancel your child's appointment.

____ We require a minimum of **2-business days** notification to cancel your child's appointment. A "**broken appointment"** fee of **$300** fee will be assessed should you cancel less than the required 2-business days notification. A "no call" or a "no show" status will be considered a "broken appointment" and the $300 fee will apply. This fee will be deducted from payment received by CarePoint.

____ We reserve the right to charge a $25 processing fee for any requested refunds. This fee will be deducted from payment received by CarePoint. The refund payment will be in the form of a bank issued check by JPMorgan Chase Bank, N.A.

ACKNOWLEDGEMENT

I, the undersigned, certify that I have read, understood, and acknowledge that I have retained a copy of this Finance Policy Agreement. I also understand and acknowledge my financial responsibility for the dental anesthesia services provided by CarePoint Anesthesia Group, LLC. By signing below, I authorize CarePoint to submit payment for any remaining balance due on or after the date of service. I can alternately provide my card information through CarePoint's website in the form of a payment.

Signature: _____ Relationship: _____ Date: _____
Parent/Legal Guardian to Patient

Credit Card Payment Authorization

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

Name: _____ Card Number: _____

Cardholder Signature: _____ Expiration: _____ CVV: _____ Billing Zip: _____

REQUEST FOR NON-COVERED SERVICES

I am hereby requesting that the following services be provided to me by CarePoint Anesthesia Group, LLC .
(Provider Name)

Service(s) (List All)	Frequency Limitations	Proposed Date(s) of Service	Estimated Cost of Services
Dental Anesthesia	1		$1,250 (2 hours or less)
Dental Anesthesia	1		$175 (per 15 mins increments)

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.

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

Date

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 3101, 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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NEW PATIENT INTAKE FORM
(with TriCare Insurance)

PATIENT INFORMATION

First Name: _____ Last Name: _____

Date of Birth: _____ Gender: M [ ] F [ ] **Weight (lbs.)**: _____ Height: _____

Dental Office Name: _____ Contact Number: _____

Dental Office Address: _____

Primary Physician Name: _____ Contact Number: _____

(If applicable) Specialist Physician Name: _____ Contact Number: _____

PARENT OR LEGAL GUARDIAN INFORMATION

Please check one.

Mother [ ] **Father** [ ] **Legal Guardian** [ ] **Other**: _____

Full Name: _____ Date of Birth: _____ Contact Number: _____

Street Address: _____ City: _____ State: ___ Zip: _____

Email Address: _____

PREGNANCY/NEONATAL HISTORY

1. Were there any complications during pregnancy or delivery? [ ] NO [ ] YES, reason(s): _____
   _____
2. Delivery: [ ] VAGINAL [ ] C-SECTION, reason(s): _____
3. Was your child premature? [ ] NO [ ] YES, born at number of weeks _____
4. Were there any complications during the newborn period? _____
   _____

INFANCY/CHILDHOOD/ADOLESCENCE MEDICAL HISTORY

1. Does your child have any allergies to drugs, supplements, or latex? [ ] NO [ ] YES, please select type of reaction(s): [ ] Rash [ ] Hives [ ] Emergency Room [ ] Other: _____
2. Has your child ever been hospitalized? [ ] NO [ ] YES, reason? _____
3. Has your child ever had surgery? [ ] NO [ ] YES, why/what for? _____
   _____
4. Has your child ever had general anesthesia? [ ] NO [ ] YES If so, any problems with anesthesia?
   _____

INFANCY/CHILDHOOD/ADOLESCENCE MEDICAL HISTORY (Cont'd.)

5. Has anyone in your family had problems with general anesthesia? [ ] NO [ ] YES If so, what problems?

   _____

6. Has your child ever been treated for or diagnosed with any of the following conditions?

	YES	NO	WHEN	MEDICINE / TREATMENT
Heart Diseases				
* Heart Murmur				
* High Blood Pressure				
* Irregular Heart Beat				
* Congenital Heart Defect				
* Other Heart Problems				
Lung Diseases:				
* Wheezing / Bronchiolitis				
* Asthma				
* Pneumonia				
* Obstructive Sleep Apnea				
* Other Lung Problems				
Other Medical Conditions:				
* Diabetes				
* Kidney Disease				
* Seasonal Allergies / Eczema				
* GERD / Ulcer / Hernia				
* Recurrent Ear Infection				
* Seizure Disorder				
* Psychiatric Condition				
* Genetic Syndrome				
* Learning Disability				
* Anemia				

Please list any other medical conditions: _____

_____

_____

_____

_____

***** PRE-OPERATIVE GUIDELINES *****

- **Absolutely NOTHING TO EAT or DRINK 8 hours before your scheduled appointment time, unless discussed with your anesthesia provider.** (Your child's appointment time will be given to you by the dental office.)

***** IMPORTANT NOTIFICATION *****

A Parent or a Legal Guardian must be present and remain at the dental office during the time of service.

HIPAA AND OUR PRIVACY POLICIES

*(The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") addresses the manner in which a Patient's individual health information may be used or disclosed by Covered Entities (as defined in HIPAA) and other individuals and entities, such as a Provider. For more information regarding your rights under HIPAA, please visit their site at **https://hhs.gov/ocr/privacy**.)*

Please initial below that you have read, understood, and acknowledge the following:

— I give CarePoint permission to communicate with me via email, text messaging, and to my cellular devices.

— I understand that I have the option of accessing and/or viewing the Notice of Privacy Practices online at **https://carepointanesthesia.com** or have a printed copy provided to me.

— If needed, I hereby request and give my authorization to my child's medical providers to release his/her medical history records to CarePoint. I also understand that I can revoke this permission at any time.

— I understand that I am giving my permission to CarePoint the use and disclosure of my child's protected health information in order to carry out the dental anesthesia treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke this permission at any time.

ACKNOWLEDGEMENT

I, the undersigned, certify that I have read the above pre-operative guidelines and that the above information is complete and accurate to the best of my knowledge. I understand that providing incomplete or inaccurate information may negatively influence my child's treatment and treatment results.

Signature: _____ Relationship: _____ Date: _____
Parent/Legal Guardian to Patient

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CONSENT FOR DENTAL ANESTHESIA SERVICES

The following is provided to inform patients about having treatment under dental anesthesia. The information is not presented to make you more apprehensive, but rather to enable you to better understand the risks and benefits involved with anesthetic treatments.

For (Child's Name): _____ ***Scheduled Appointment***: _____

I, the undersigned, hereby authorize and request any doctor represented with CarePoint to administer anesthesia to my child as previously discussed with me. I understand and agree that procedures not talked about, but deemed necessary for my child's well-being may be performed to supplement the planned anesthesia. It has been explained to me that all types of anesthesia, although safe, involve some risks and no guarantees can be made concerning results. Serious complications are very rare. The following are complications that may be associated with the anesthetic treatment:

Common Complications:
- Pain and/or bruising at the IV site
- Sore throat and/or hoarseness
- Muscle aches
- Nausea and/or vomiting

Rare Complications:
- Heart injury
- Brain damage or death

Uncommon Complications:
- Headaches
- Injuries to lips, teeth, mouth or throat from airway instruments or devices
- Unexpected drug reaction
- Infection at intravenous site and veins nearby
- Bleeding/injury in the nose due to passage of a breathing tube
- Lung infection
- Eye injury or infection
- Weakness in breathing after awakening
- Nerve Damage

- Alternative options to deep sedation/general anesthesia have been discussed with me and may include the use of local anesthesia with nitrous oxide sedation or local anesthesia alone.
- I confirm that my child (the patient) **had nothing to eat or drink 8 hours prior** to their scheduled appointment time.
- I certify that to my knowledge that my child (the patient) is not pregnant or trying to become pregnant.
- I have read and agree to the HIPAA Notice of Privacy Practices posted on CarePoint's website ***https://carepointanesthesia.com***.

ACKNOWLEDGEMENT

I, the undersigned, consent to the anesthesia deemed appropriate by my child's anesthesiologist. I acknowledge that I have read this form or had it read to me and that I understand the risks, alternatives, and expected results of the anesthetic plan of care.

Signature: _____ Relationship: _____ Date: _____
Parent/Legal Guardian to Patient