Sweet Dreams, LLC

Office-based Anesthesia Services

Rev. Jan 2018

Financial Information and Agreement

Patient Name _____ (First Last) Age _____ Birth Date _____ Sex _____

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

Parent/Guardian Name _____ Birth Date _____ Phone # _____
(If Patient is a Minor)

Relationship to Patient _____ Email _____

Dental Insurance Company _____ Insurance ID # _____

Policy Holder's Name _____ Birth Date _____ Phone # _____

Address _____ Apt. # _____ City _____ State_____ Zip _____
(If different from above)

Relationship to Patient _____ 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 ___ RJL ___ CA _____ CC _____ CK _____ Source: _____

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

Times: _____ to _____ Total Minutes: _____

Dx. Codes: K02.62 K02.63 K04.01 K04.02 K04.6 Other: _____ P1 P2 P3 Reason: _____

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

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

Notes: _____

KIDS TOWN PEDIATRIC DENTISTRY
IN OFFICE I.V. SEDATION

Your child will be having dental procedures done with I.V. sedation by a Certified-Registered Nurse Anesthetist. Please have your child wear loose fitting clothing. **Bring only the child being treated and a parent.** Please be advised that due to the nature and age of the children we are treating we cannot guarantee the time we schedule your child to be the actual time we start treatment. Once your child is asleep, if additional x-rays are needed we will take them. Any additional work needed will be taken care of while your child is asleep, so that he/she does not have to return for an additional I.V. sedation visit. Please be prepared to wait patiently so we can care for all our patients in the same manner that your child will be cared for. You are welcome to call our office prior to leaving your home to see if we are on schedule. **DO NOT ALLOW YOUR CHILD TO EAT OR DRINK ANYTHING AFTER MIDNIGHT,** if your child does eat or drink **ANYTHING** we will reschedule your appointment due to safety issues.

Your **estimated** fee for the I.V. sedation should be$_____
This fee is paid to the anestheologist and is a separate fee from your dental co-pay. A $100.00 deposit is required to schedule the appointment. The deposit is NON REFUNDABLE if you do not show up for the appointment, or if you cancel without 24-hour notice. **Payment in full is due on the date of service with cash or credit/debit cards NO CHECKS ARE ACCEPTED**

You will receive a claim form from the anesthetist for the I.V. sedation fee that you can submit to your medical/dental insurance for reimbursement. No copies of this insurance form are kept, please do not mail out your original. You may call your insurance company to see if they will cover this procedure. Ask if they cover I.V. sedation done in a dental office by an anesthesiologist, and tell them the child's age. They may ask you for the dental codes they are D9223 and D9243. **Knowing your insurance coverage is your responsibility.**

Because it is **your** insurance **you** are ultimately responsible for knowing and executing the requirements of your insurance. We strongly suggest you contact your insurance company to verify your coverage and benefits. **NO insurance will guarantee and exact payment.** Please keep in mind that all insurances relay a disclaimer that states they are only giving general information when we call to check your benefits. **ALL QUOTES GIVEN TO YOU ARE ESTIMATES AND NOT A SET COST FOR COPAYS**

ESTIMATED dental fees $_____
ESTIMATED dental co-pay $_____
I agree to pay my dental co-pay in full on the date of service.

Signature:_____ Date:_____

If you have any questions or concerns feel free to contact us.
801-217-3359 or 801-779-2900

KIDS TOWN PEDIATRIC DENTISTRY

ROY OFFICE- 3540 W 6000 S #200, ROY, UT 84067
PH: 801-217-3359
LAYTON OFFICE- 2940 N CHURCH STREET #301, LAYTON, UT 84040
PH: 801-779-2900
SYRACUSE OFFICE – 780 S 2000 W Bldg F-2, SYRACUSE, UT 84075
PH: 801-776-8176

I.V. SEDATION NON-REFUNDABLE DEPOSIT

PATIENT NAME: _____

PARENT OR GUARDIAN: _____

Your child is scheduled to have dental treatment done under I.V. sedation in our office with a Certified Registered Nurse Anesthetist. A $100.00 non-refundable deposit is required at the time of scheduling for the sedation appointment to hold your child's spot on our schedule.

We do not charge your card until the day of treatment, the information taken is only a deposit to hold your child's spot on our schedule.

However, if you **do not** show to the appointment, **break or reschedule** your appointment with less than 48 hours' notice you will be charged a $100.00 fee for the expenses that we may have incurred to hold your child's appointment time on our schedule.

IF YOUR CHILD IS SCHEDULED TO HAVE AN I.V. PROCEDURE DONE ON A MONDAY YOU MUST CALL AND CANCEL YOUR APPOINTMENT BY 3:00 PM THE THRUSDAY BEFORE TO AVOID BEING CHARGED AN EARLY CANCELATION FEE

We will call 1 week prior to the appointment to remind you the appointment is coming up, we require this to be confirmed with us so that we may arrange our schedule according to age, we will then call the business day before the appointment to give you an exact time and any pre-op instructions.

I certify that I have read the above and understand this policy. I agree to pay the $100.00 non-refundable deposit if I fail to keep my child's scheduled appointment or cancel within 48 hours.

_____ _____
Signature of Parent or Legal Guardian Date

CARD TYPE: VISA ☐ MCA ☐ DISCOVER ☐ AMEX ☐

Card #: _____

Expiration: _____ Security Code: _____

Amount: $_____ if appointment is kept and

Amount: $_____ if appointment is a no-show, broken or canceled without

Pre-Anesthesia Instructions

1. Fasting before surgery helps prevent nausea and vomiting and keep the patient safe during surgery. The patient may eat a light breakfast 6 hours before, nurse 5 hours before, and drink small amounts of clear liquids (water, apple juice, Gatorade or have a Popsicle) 4 hours before their scheduled time of arrival. Failure to comply will be cause for your case to be rescheduled and deposits forfeited.
2. Take any medicines as instructed with only a sip of water. Bring diabetic testing supplies and insulin; bring any inhalers prescribed for asthma with you.
3. Bathe before your scheduled appointment.
4. Remove any and all jewelry, contact lenses, and makeup.
5. Wear loose, short-sleeved clothing.
6. Arrange girls' long hair in pigtails. (Ponytails and loose hair make head positioning more difficult.)
7. Arrive 10 minutes prior to your scheduled time, use the restroom, get weighed, and finish filling out all paper work.
8. Be prepared or make arrangements to pay for anesthesia.
9. If the patient becomes ill, develops a cough or sore throat, or has a temperature over 100.0 degrees, notify the dentist as soon as possible to reschedule your appointment.
10. Parents, please refrain from bringing other children to the office on the day of surgery. Your child needs your complete attention. You will not be allowed to be with your child in the room where the dentistry is being performed. Please remain in the waiting area until you are invited to be with your child in the recovery room.
11. Please refrain from planning other activities close to your dental appointment as you may be asked to arrive one to two hours earlier or later to accommodate last minute changes in the day's schedule.

Post-Anesthesia Instructions

1. Go home and rest. The patient may be dizzy or blurry-eyed for two to three hours after you return home. Children should be closely observed and not allowed to walk until balance is stable.
2. Do not drive or perform any rigorous activities or make important cognitive decisions for 24 hours after anesthesia. Children may attend school or other activities the day following anesthesia.
3. Begin eating and drinking as tolerated. Start with water, clear juices, Popsicles, or Gatorade for the first two hours. Advance to soft foods such as gelatin, yogurt, or pudding for the next two hours and then advance to a regular diet if not nauseated.
4. Understand that normally the patient may be dizzy, sleepy, or sick to their stomach for two to four hours after anesthesia.
5. Call the dentist if any of the following occurs: uncontrolled bleeding, swelling, excessive pain, fever greater than 100 degrees, nausea or vomiting for more than 2 hours, sleepiness or dizziness lasting more than 6 hours, rash or flushed skin worsening with time, or dehydration.
6. Call 911 or go to the nearest hospital emergency room if the patient exhibits slow, shallow breathing or difficulty with breathing or swallowing or if patient is difficult to arouse.

☐ Pain medicine in the Ibuprofen family (Toradol) was given to the patient at _____. You may give Tylenol (Acetaminophen) after 3-4 hours or Motrin (Ibuprofen) in 6 hours. You may repeat these medicines every 6 hours as needed or every 3-4 hours if alternating between the two different medicines for one to two days.

Royce Bartholomew, CRNA 801-372-1888, James Benson, CRNA 801-505-2541,
Ben Rabe, CRNA 801-540-0115, Ryan Larsen, CRNA 801-628-3923

KIDS TOWN PEDIATRIC DENTISTRY

CONSENT FOR SEDATION

The following information is provided to help make you better informed so you may give or withhold consent for the procedure indicated. It is NOT meant to scare or alarm you. Please read this consent form carefully and ask about anything you do not understand.

With regards to my child, I voluntarily request Dr. Brett Packham or Dr. Renn Veater, and/or such associates as they may designate to utilize the following sedative agents, which are deemed necessary or advised to facilitate the rendering of necessary dental treatment:

☐ Diazepam (Valium) Oral

☐ Midazolam (Versed) Nasal

☐ Midazolam (Versed) Oral

☐ Oral Sedation: Chloral Hydrate, Meperidine (Demerol), and Hydroxyzine (Oral)

☐ IV or General Anesthesia administered by a Certified Registered Nurse Anesthetist, Dental Anesthesiologist, or Anesthesiologist either in the office or Primary Children's Medical Center

Factors that need to be considered when administering sedative drugs included the child's medical history, previous reaction to drugs, age, weight, behavior of the child and the expected treatment. With regards to aforementioned variables, some children may exhibit mild sedation while others may become profoundly sedated, which may affect the ability to successfully complete treatment. I have been advised that though good results are expected, the possibility of continued poor behavior and/or complications could occur which could not be accurately anticipated. Therefore, there can be NO guarantee, expressed or implemented, to the effectiveness of the proposed sedative procedure.

Although their occurrence is extremely rare, some risks are known to be associated with the proposed sedative drugs and anesthesia including but not limited to: nausea, vomiting, allergic reactions, breathing problems, brain damage, stroke, heart attack, paralysis, and loss of organ function. Although extremely unlikely, complications may also require hospitalization and even result in death.

I certify that I have read the above and understand this form. I have been given an opportunity to ask questions about my child's treatment and that all my questions have been answered in a satisfactory manner and I believe that I have sufficient information to give this consent.

_____ _____

Signature Date

Sweet Dreams, LLC

Office-based Anesthesia Services

Rev. January 2018

PATIENT INFORMATION

Complete this section. Please print.

Date_____ Name _____ Age_____ Birthday _____ Sex _____

Weight _____ lbs. Allergies to Medicines _____ Medications taken routinely _____

Proposed Procedure _____ Dentist _____

Previous Anesthetics/Surgeries _____ Anesthetic Complications _____

Is there a history of anesthesia problems in your family? _____

Has the patient experienced any of the following: (Check appropriate spaces)?

☐ Large Tonsils	☐ High Blood Pressure	☐ Kidney Disease	☐ Tuberculosis
☐ Snoring/Sleep Apnea	☐ Irregular Heart Beat	☐ Diabetes/Hypoglycemia	☐ Cancer/HIV
☐ Shortness of Breath/Asthma	☐ Rheumatic Fever/Murmur	☐ Liver Disease/Hepatitis	☐ Bleeding Disorders
☐ Exposure to Smoking	☐ Heart Attack/Chest Pain	☐ Thyroid Problems	☐ Alcohol Abuse
☐ Chronic Cough	☐ Stroke/Blood Clots	☐ Numbness/Paralysis	☐ Substance Abuse
☐ Hiatal Hernia/Reflux	☐ Epilepsy/Seizures	☐ Headaches ☐ Other _____	

Any loose, cracked, or chipped teeth? _____ Any dentures or dental appliances? _____ Glasses/Contact Lenses? _____
Disabilities/Restrictions/Preferences _____
Do you or any member of your family have any concerns or questions about anesthesia? _____

Consent for Anesthesia: I give my consent for anesthesia to be provided as requested by my dentist. I certify that I have read, understand, and have fully complied with the pre-anesthesia instructions and intend to fully follow the post-anesthesia instructions. I understand that there are certain risks associated with anesthesia. Although rare, patients can suffer allergic reactions, circulatory or respiratory failure, organ damage, nerve damage, brain damage, or even death. If the patient requires transport to or treatment at another facility, I understand that I am financially responsible for the costs incurred. I understand that my questions and concerns will be addressed by my dentist or anesthetist.

Signed: _____ Relationship _____ Date _____

PRE-OP PHYSICAL EVALUATION

To be completed by anesthetist.

NPO Since _____ Spo2 _____ HR _____ RR _____
HEENT _____ Temp. _____
ASA Airway Classification I II III
ASA Anesthesia Risk Class I II III E
Comments _____

Cardiovascular _____
Respiratory _____
Neuro/Endocrine _____
Extremities/Skin _____

Anesthetic Plan: ____ I/M / IV Sedation. Plan and risks discussed with pt./s.o., questions answered, accepted by pt/s.o. ____

Signed _____ Date _____ Time _____

Post Operative Note: _____

Signed _____ Date _____ Time _____
