JINSOO KIM, DDS
DENTIST ANESTHESIOLOGIST

FINANCIAL AGREEMENT FOR ANESTHESIA SERVICES

THIS AGREEMENT made by and between the undersigned PATIENT/PARENT/GUARDIAN and Jinsoo Kim, D.D.S.

Patient Name _____ Parent/Guardian Name_____
Your dentist has **ESTIMATED** his/her treatment time to be: _____
Anesthesia time is approximately treatment time plus 30 minutes: _____
Anesthesia fees are:
$400.00 for the first hour
$100.00 for every 15 minutes thereafter (or portion thereof)
Anesthesia Fee Estimate: (**$600.00 minimum**) $ _____

The anesthesia fee estimate is based upon the dentist's estimated operating time, which will vary with the surgical complexity, anesthesia preparatory time and patient's individual response to the anesthetic agents used.

Payment for anesthesia services is due ***the day of treatment***. If the anesthesia time exceeds the estimate, the Patient/Parent/Guardian will be responsible for the additional charges. If the anesthesia time is less than the estimate, the Patient/Parent/Guardian will receive a prorated refund. A non-refundable deposit may be required at the time the appointment is made. This will be applied to your final bill.

It is important that reimbursement for the anesthesia fee by dental or medical insurance programs **NOT** be assumed. Many insurance policies do ***not*** pay for anesthesia services for dentistry. Please check with your insurance company representative as to the benefits included. We will be happy to supply you with a receipt to attach to your insurance forms, so that you may be reimbursed by your insurance carrier. I hereby authorize my doctor to release any information requested by my insurance carrier. I hereby declare and affirm that the patient is NOT a Tricare beneficiary.

Patient/Parent/Guardian shall be in default of this Agreement if the Patient/Parent/Guardian fails to pay, in full, the cost of services rendered under this Agreement on the date of treatment. If the Patient/Parent/Guardian is in default of this Agreement, any and all unpaid portions of fees owed shall bear interest at the maximum rate allowed by law, compounded monthly, until collected from the date of treatment. Any deposits will be nonrefundable and forfeited if not given 48 hours notice prior to cancellation.

In the event the Patient/Parent/Guardian fails and/or refuses to make payment for services rendered under this Agreement and is in default of this Agreement, the Patient/Parent/Guardian shall be responsible for all **ACTUAL** costs, attorney fees and interest incurred by Dr. Kim in the collection of the debt accumulated under this Agreement.

Patient/Parent/Guardian hereby consents and agrees that if the Patient/Parent/Guardian is in default of the payments required herein, Dr. Kim may file a legal claim in Dallas County, Texas, rather than the county in which the Patient/Parent/Guardian is located, and further that proper venue in all disputes between the parties hereto shall be in Dallas County, Texas. This Agreement will be governed by the laws of the State of Texas. This Agreement constitutes the entire agreement by the parties and supersedes any written or oral agreement of the parties prior to the date hereof. Amendments to this Agreement may only be made in writing and signed by the parties.

Please indicate anticipated method of payment:
(PLEASE NOTE THAT CREDIT CARD PAYMENTS ARE SUBJECT TO A 3% FEE)
Cash Cashier's Check Visa Mastercard

I have read, understand and agree with the above ESTIMATE of fees.

_____ _____
Patient, Parent or Guardian Date