PLEASE FAX TO **1-855-284-4131** (SECURE & HIPPA COMPLIANT FAX LINE)

FINANCIAL POLICY:

ADULT PATIENT FEE:

$700 for the 1st hour of sedation and $500 per hour after.

(The anesthesia time starts 10 minutes after the appointment time or when the patient arrives in the procedure suite and ends when the patient is adequately recovered for discharge home.)

SCHEDULING INFORMATION:

Patient Name: ____ Birthdate: ____________________ Age: ___________

Phone #: ____

Procedure: ____

Estimated Procedure Time: __________________________ Procedure Date: _____________________________________

PAYMENT AUTHORIZATION:

_______ Check Amt. $________________________________ (payable to **Texas Elite Anesthesia**)

_______ Cash Amt. $________________________________

_______ Credit Card: **Visa MC AMEX Discover CareCredit (Circle one)**

Full name on Credit Card: ____

Credit Card #: ____

Expiration Date: __________________________ CVV Code_________________ Billing Zip Code: _____________________

Email (for payment receipt): ____

I hereby agree to pay the **full balance of the anesthesia fee** upon completion of the anesthesia service. I authorize **Texas Elite Anesthesia** to charge any balance that is due on the referenced credit card above. I have read, fully understand, and accept this financial policy.

Signature of Patient or Responsible Party Date / Time