ADVANCED SPECIALTY ANESTHESIA, LLC

REQUEST FOR ANESTHESIA SERVICES

Email to: referral@asasleep.com Fax: 785-422-5477

Referring Provider Office please complete below section:

Referring Office: _____ Sedation Date Requested: ____/____/____ or(TBD)To Be Determined

Reason for the Procedure: (***please circle***) Dental Caries, Accident/Injury Related, Other:_____

Estimated Treatment Time: (***please circle***) 1 hr. 90 min. 2 hr. 2 hr. 30 min. Other:_____

ASA will need a copy of the medical card, Patient Medical History, Patient Authorization and current Physical with this referral.

Patient Information

_____

First Name M.I. Last Name (Nickname)

_____

Home Address Apt. # City State Zip

_____

Cell Phone Work/Alternate Phone Ok to contact by Text message: Y / N

Date of Birth: ____/____/____ Age: _____ Sex: M F Preferred Language_____

Does patient reside in a facility/nursing home? Yes/No *Name of Facility & Phone*_____

Is the patient in Foster Care? Yes/No Foster Care name & Phone: _____

Parent/Guardian Information (patients 18 years of age or younger)

_____

First Name M.I. Last Name Relationship to Patient

_____

Home Address (if different from patient) Apt. # City State Zip

_____

Cell Phone Number Email Address

Medical Insurance Information -Please send copy of card

Insurance Company: _____

ID Number: _____ Group Number: _____

Phone Number (for Providers – located on back of card): _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Holder's SSN: _____

Name of Employer or Company that provides benefits: _____

_____ I give permission for Advanced Specialty Anesthesia, LLC, to leave a message regarding information relevant to anesthesia services.

Patient/Guardian Signature: _____ Date: _____

Permission signature by patient/guardian is valid for 1 year from signature date.

Advanced Specialty Anesthesia, LLC

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____

Patient/Parent/Guardian Name (print please)

give permission to the following medical doctors/specialists to release the requested protected health information to Advanced Specialty Anesthesia, LLC

In Regards To:

_____

Patient Name (print please) DOB

Primary Medical Doctor:	
Facility:	
Address:	
Telephone Number:	**Fax Number:**

Other Medical Doctor/Specialist:	
Facility:	
Address:	
Telephone Number:	**Fax Number:**

Other Medical Doctor/Specialist:	
Facility:	
Address:	
Telephone Number:	**Fax Number:**

Submit to: **Advanced Specialty Anesthesia, LLC**
1201 Wakarusa Drive, Suite A-3
Lawrence, Kansas 66049
Phone: (785) 856-6170
Fax: (785) 422-5477

☑ **History and Physical**

☑ **Medication List**

☑ **Laboratory Results**

_____

Patient/Parent/Guardian Signature Date

_____

Primary Telephone # Cell # Work #

Advanced Specialty
ANESTHESIA

Financial Policy

Thank you for choosing Advanced Specialty Anesthesia, LLC for your medical care. We appreciate that you have entrusted us with your anesthesia care and we are committed to providing you with the best patient care possible.

Insurance benefits and coverage options have become increasingly complex. We have developed this financial policy to help you better understand your responsibilities as a patient. We will do our best to assist you with understanding your costs and in answering questions related to submitting your insurance claim for reimbursement.

Anesthesia Cost: Our office estimates the patients out of pocket cost for scheduled surgeries and procedures. Please note this is only an estimate based on the treatment time from your Physician and the benefits verified by your Insurance company. Estimated cost is due prior to the day of surgery for unmet deductibles, co-insurance, co-pays and self-pay charges. Estimated cost may differ from final cost and you are responsible for all patient responsibility.

Insurance: We participate in most insurance plans; each plan has different benefits and financial obligations. Not all Insurance policies cover all services. You are responsible for the payment of services rendered regardless of insurance coverage. As a courtesy to our patients, for the plans we participate in, we will submit claims to your insurance carrier for you.

Patient balance and payment arrangements: Balances that are billed to the patient are expected to be paid in full within 60 days of the first statement mailed. Failure to pay the account balance in full may result in the balance being placed with a collection agency and possible listing with the credit bureau(s).

CareCredit: We participate with CareCredit. You may be eligible to participate in short-term financing offers that enable you to make payments over six (6) or twelve (12) months with deferred interest. You are responsible for applying with CareCredit at their website; www.carecredit.com.

Cancellation Policy: If an appointment is not canceled at least five (5) business days in advance you will be charged our no show/cancellation fee of four hundred dollars ($400.00); this will not be covered by your insurance company and is non-refundable or transferrable to a future appointment.

Divorce decrees: This office is not a party to your divorce decree. The responsibility for minors rests with the accompanying adult.

We accept checks, Visa, Mastercard and CareCredit. A $20.00 fee is assessed for any returned checks.

I have read, understand, and agree to the above financial policy. I understand that charges not covered by my insurance company, as well as applicable co-pays, co-insurance and deductibles are my responsibility. I further agree, in order for you to service my account or to collect any amounts I may owe, your organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of your debt collection agency, may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Your organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of your debt collection agency may also contact me by sending text messages or emails, using any e-mail address I provide to you. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I have read this disclosure and agree that the Lender/Creditor, its ancillary providers, HIPAA business associates, vendors, and its debt collection agents may contact me as described above.

Patient Name:_____ Patient DOB:_____

X_____	X_____	X_____	X_____
Print Guarantor Name	Guarantor Signature	Guarantor SSN	Date

Advanced Specialty
ANESTHESIA

Pre-Anesthesia Health History *(to be filled out by parent/patient)*

Today's Date:_____

Patient Name:_____ DOB:_____ Height:_____ Weight_____

SURGICAL/ANESTHESIA HISTORY: ☐ None

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Is there any Family History of Anesthesia Complications? ☐ Yes ☐ No

If yes, please Explain:

_____

_____

HOSPITALIZATIONS: ☐ None

Has the patient ever been hospitalized? ☐ Yes ☐ No

If yes, please list reason, dates of hospitalization, and at which hospital they were admitted:

_____

_____

Has the patient visited the ER in the last 30 days? ☐ Yes ☐ No

If yes, please list reason, date, and at which hospital they were seen:

_____

Has the patient seen a specialist for any reason? ☐ Yes ☐ No

If yes, please list what specialty and when they were last seen:

_____

MEDICATIONS: ☐ None

Please list **ALL** medications, supplements, inhalers, and medications through a nebulizer (if you need more space, please write on the back):

Medication:	Reason:	Medication:	Reason:

ALLERGIES: ☐ None Please list any additional food and/or Medication allergies:

☐ Soy ☐ Latex Allergy:_____ Reaction:_____

☐ Eggs ☐ Iodine Allergy:_____ Reaction:_____

☐ Peanuts ☐ Tree nuts Allergy: _____ Reaction:_____

If yes to any of the above, please list reaction: _____

Has the patient been prescribed an epipen? ☐ Yes ☒ No

Advanced Specialty Anesthesia
Lawrence, KS 66049
(P) 785.856.6170, (F) 785.422.5477

PATIENT NAME: *DOB:*

PULMONARY (LUNGS) ☐ None
- ☐ Asthma/Reactive Airway Disease
- ☐ Recent Cold/Respiratory Infection
- ☐ Bronchitis/Pneumonia (last 6 weeks)
- ☐ Tuberculosis (☐ Latent ☐ Active)
- ☐ Chronic Cough
- ☐ RSV/Croup
- ☐ COPD/Emphysema
- ☐ Other: _____

CARDIAC (HEART) ☐ None
- ☐ Irregular Heartbeat
- ☐ Heart Murmur
- ☐ Congenital Abnormality
- ☐ Abnormal Heart Tests
- ☐ Chest pain/Palpitations
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Coronary Artery Disease
- ☐ Heart Attack (Date of occurrence:_____)
- ☐ Other: _____

NEUROLOGIC (BRAIN) ☐ None
- ☐ Seizures (date of last seizure :_____)
- ☐ Paralysis/Muscle Weakness
- ☐ Hydrocephalus
- ☐ Fainting/Dizziness
- ☐ Other:_____

ENDOCRINE: ☐ None
- ☐ Diabetes (Date of last A1C:_____ Result:_____)
- ☐ Thyroid Disorder
- ☐ Adrenal Disorder
- ☐ Metabolic Disorder
- ☐ Other:_____

PSYCHOSOCIAL: ☐ None
- ☐ Developmental Delay
- ☐ Autism
- ☐ Intellectual Disability/MR
- ☐ ADD/ADHD
- ☐ Depression/Anxiety
- ☐ Other:_____

EAR, NOSE, THROAT ☐ None
- ☐ Enlarged Tonsils/Adenoids
- ☐ Sleep Apnea (pauses or gasps in breathing during sleep)
- ☐ Recent Strep or Throat infection
- ☐ Snoring
- ☐ Difficulty Swallowing
- ☐ Other:_____

STOMACH, LIVER, KIDNEYS ☐ None
- ☐ Acid Reflux/GERD
- ☐ Chronic Nausea and/or Vomiting
- ☐ Hiatal Hernia
- ☐ Feeding Tube/PEG tube
- ☐ Hepatitis A, B, or C
- ☐ Chronic Kidney Disease
- ☐ Fatty Liver Disease
- ☐ Cirrhosis of the Liver
- ☐ Other:_____

MUSCULOSKELETAL ☐ None
- ☐ Cerebral Palsy
- ☐ Scoliosis
- ☐ Arthritis
- ☐ Muscular Dystrophy
- ☐ CVA/Stroke/TIA (date of occurrence :_____)
- ☐ Chronic Headaches/Migraines
- ☐ Other:_____

BLOOD DISORDERS: ☐ None
- ☐ Anemia
- ☐ Bleeding/Clotting Problems (including family history)
- ☐ Easy Bruising
- ☐ Sickle Cell
- ☐ HIV/AIDS
- ☐ Cancer (Type:_____)
  Date of Diagnosis:_____
- ☐ Other:_____

GENETIC DISORDERS: ☐ None
- ☐ Angleman's Syndrome
- ☐ Fragile X
- ☐ Down's Syndrome
- ☐ DiGeorge Syndrome
- ☐ Wolf-Parkinson-White Syndrome
- ☐ Turner's /Klinefelter Syndrome
- ☐ Other: _____

Are there any other diagnoses or pertinent medical information you feel we need to be aware of?

Advanced Specialty Anesthesia
Lawrence, KS 66049
(P) 785.856.6170, (F) 785.422.5477

If yes, please explain:

_____
_____
_____
_____

MEDICAL RECORDS RELEASE DISCLOSURE:

I acknowledge, and hereby consent to the release of all medical records to Advanced Specialty Anesthesia. Medical information will be requested only if pertinent to planning and care associated with requested anesthesia services for mine or my child's upcoming dental or surgical procedure. The following are authorized to disclose information:

Patient Name:_____ **DOB:**_____

Primary Care Physician:_____ **Phone Number:**_____

Facility Name:_____ **Fax Number:**_____

Specialist Physician:_____ **Phone Number:**_____

Facility Name:_____ **Fax Number:**_____

Specialist Physician:_____ **Phone Number:**_____

Facility Name:_____ **Fax Number:**_____

Patient/Parent Signature:	Print Name/Relationship to Patient:	Date:

REQUEST FOR ANESTHESIA SERVICES
MOBILE ANESTHESIA CARE
8717 W. 110th St. Suite 600 Overland Park, KS 66210
Division of Anesthesia Associates of Kansas City, PC

Scheduling/Pre-Op: 913-428-2939
Account/Benefit Team: 913-428-2934
913-428-2927
Email: machelp@aakc.com

Patient: (PLEASE PRINT)

Last Name: _____ First Name: _____

Date of Birth: _____/_____/_____ Gender: ❑ Female ❑ Male Nickname: _____

Responsible Party/Legal Guardian: **Parent present with child at dental/surgical consultation**

Last Name: _____ First Name: _____

Address: _____ City: _____ State:_____ Zip:_____

Preferred Contact #: (_____) _____-_____ Relationship to Patient: _____ ❑ Cell ❑ Home ❑ Work

Alternate Contact #: (_____) _____-_____ Relationship to Patient: _____ ❑ Cell ❑ Home ❑ Work

E-mail Address: _____ **Preferred Method of Communication**: ❑ Phone ❑ Text ❑ Email

❑ **Child lives at address above** Primary Language: ❑ English ❑ Spanish ❑ Other_____

Medical Insurance: ❑ No Medical Insurance **Dental Insurance Not Applicable**

Primary ***Medical*** Insurance: _____

Policy Number: _____

Group Number: _____

Customer Service #:_____

Claim Address:_____

Employer: _____

Policy Holder's Name: _____

Policy Holder Date of Birth: _____

Policy Holder's SSN: _____

Relationship to Patient: _____

Secondary ***Medical*** Insurance: _____

Policy Number: _____

Group Number: _____

Customer Service #:_____

Claim Address: _____

Employer: _____

Policy Holder's Name: _____

Policy Holder Date of Birth: _____

Policy Holder's SSN: _____

Relationship to Patient: _____

Financial/Education Acknowledgement (*Sign below*):

I have been provided with the following MAC educational forms (Financial FAQ & Preparing for Surgery)

I'm aware that I am responsible for a Mobile Care Fee. This fee includes items and services not included as part of the professional physician's fees, such as specialty nursing care, all emergency equipment/supplies, and patient comfort /care items. A MAC representative will inform me if this fee applies to me.

I give permission for Mobile Anesthesia Care/Anesthesia Associates of Kansas City, P.C. to contact me via **phone, text or email** to provide information relevant to anesthesia services for my child. I authorize the release of any information concerning my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize all payment of insurance benefits directly to the physician. I understand that I am responsible for any fees not covered by insurance.

Responsible Party /Legal Guardian Signature:_____ Date: _____/_____/_____

DENTIST/SURGEON OFFICE: Fax all completed forms to 913-428-2784

Requesting Dentist/Surgeon: _____ Proposed Procedure Date: _____ or **TBD**

Estimated Procedure Time: _____ hr _____min (surgeon time only) **Dental Down Payment**: ❑ Yes, _____

Please forward all below as part of patient consultation

_____Request for Anesthesia Form _____Pre-Anesthesia Health History Form _____Copy of Medical Insurance Card(s)

_____Treatment Plan/Procedure Codes _____Letter of Medical Necessity _____ Medical/Dental Notes (as available)

Pediatric Pre-Anesthesia Health History

Patient Name:_____ **M / F**

DOB:_____/_____/_____ **HT:**____**ft**_____**in.** **WT:** _____ **lbs / kg**

Allergies: ☐ **None**

- ☐ Medication:_____ Reaction:_____
- ☐ Medication:_____ Reaction:_____
- ☐ Food:_____ Reaction:_____
- ☐ Food:_____ Reaction:_____
- ☐ Other:_____ Reaction:_____

Current Medications: ☐ **None**

Medication Name	Dose	# times per day

Previous surgeries/procedures WITH anesthesia? ☐ **None**

Surgery	Date

- ☐ The child had complications after having anesthesia
- → Complication:_____
- ☐ Immediate family history of **severe** complications with anesthesia
- → Who and What:_____
- ☐ Family history of Malignant hyperthermia or Pseudocholinesterase deficiency
- → Who and What: _____

Birth/Genetic: ☐ **N/A**

- ☐ Patient Adopted
- ☐ Premature (less than 36 weeks gestation) _____ weeks
- ☐ NICU admit due to_____
- ☐ Syndrome:_____
- ☐ Chromosome Deletion/Duplication:_____

Cardiac: ☐ **N/A**

- ☐ Congenital abnormality:_____
- ☐ Any/all other cardiac conditions followed by cardiology
  - ☐ Condition:_____
  - ☐ Last cardiology visit:_____
  - ☐ Next required follow up in _____ months

Respiratory: ☐ **N/A**

- ☐ Asthma-date of last flare up:_____
- ☐ Recent Bronchitis/Pneumonia-date diagnosed:_____
- ☐ Recent Croup-date diagnosed:_____
- ☐ Recent RSV-date diagnosed:_____
- ☐ TB (Tuberculosis)
- ☐ Cystic Fibrosis

Ears/Nose/Throat: ☐ **N/A**

- ☐ Large tonsils required to be followed by Doctor
- ☐ Gasping, pausing, apnea, with nightly snoring
- ☐ Frequent bloody noses
- ☐ Narrow Airway
- ☐ Difficulty swallowing

Hematology/Oncology/Other: ☐ **N/A**

- ☐ Anemia (requiring treatment)
- ☐ Bleeding Disorder:_____
- ☐ MRSA or other infectious disease:_____
- ☐ Sickle Cell Disease (not trait)
- ☐ Cancer:_____
- ☐ Family History of ANY bleeding disorder:_____

GI/GU: ☐ **N/A**

- ☐ GERD/acid reflux (currently)
- ☐ Hiatal hernia
- ☐ G-tube-reason for placement:_____
- ☐ Hepatitis/Liver transplant

Endocrine/Metabolic: ☐ **N/A**

- ☐ Diabetes-Type 1 / Type 2
- ☐ Hypothyroid/Hyperthyroid (circle if applicable)
- ☐ Kidney Transplant
- ☐ Metabolic Syndrome:_____

Neurological/Musculoskeletal: ☐ **N/A**

- ☐ Seizures/Epilepsy-date of last seizure:_____
- ☐ Cerebral Palsy
- ☐ Muscular Dystrophy
- ☐ Low muscle tone/Paralysis
  - ☐ Where:_____
- ☐ Scoliosis-type:_____
- ☐ Neuromuscular disease:_____

Psychosocial/Social: ☐ **N/A**

- ☐ Developmental Delay:_____
- ☐ ADD/ADHD
- ☐ Autism
- ☐ The child is in care/custody of anyone other than parent
- ☐ The child is exposed to second hand smoke
- ☐ The child is currently breastfeeding

I understand that withholding any information about my child's health could jeopardize his/her safety. Therefore, I have reviewed the above medical health history carefully and have answered all questions truthfully and to the best of my knowledge. I hereby give permission to Mobile Anesthesia Care, to discuss and request necessary medical records from any physician/facility named below.

Primary Care Physician:_____

Hospital/Other:_____

Parent/Guardian Signature:_____

Printed Name:_____

Date:_____ **Relationship:**_____

REM ANESTHESIA

Preliminary Intake Form

Patient Information

Name_____
DOB_____ Gender_____
Address_____
City_____State_____Zip+4_____

Responsible Party Information and/or Emergency Contact (if not the same)

Name_____
Address_____
City_____State_____Zip+4_____
Mobile Phone_____
Email_____

PLEASE ATTACH A LEGIBLE COPY OF THE FRONT AND BACK OF THE MEDICAL INSURANCE CARD
Primary _____. Name of Insured _____ DOB of Insured_____

Secondary_____. Name of Insured_____ DOB of Insured_____

Confirm if the patient is covered under any other Medical Insurance. Esp. if they only show Medicaid
Insureds address if different than the Patient _____

PLEASE COMPLETE RELEASE OF PROTECTED HEALTH INFORMATION FORM

Referring Office Name _____

Patient Arrival Time (30 minutes prior to appointment time) _____

Estimated Treatment Time_____

REMANESTHESIA.CARE INFO@REMREST.CARE

FINANCE 913.609.0399 MEDICAL 913.609.0980 913.904.0841

Request for Release Protected Health Information

REM Anesthesia, PLLC
7111 W 151st St, Suite 139
Overland Park, KS 66223

Patient Information
Name_____
DOB_____
Address_____
Timeframe_____

On behalf of the patient identified above, REM Anesthesia, PLLC requests disclosure of the Protected Health Information (PHI) identified below from the following facility or health care provider ("hereinafter the Disclosing Provider"):

Disclosing Provider(s)

1. Name_____
   Address_____
   Phone_____
   Fax_____
   Email_____

2. Name_____
   Address_____
   Phone_____
   Fax_____
   Email_____

3. Name_____
   Address_____
   Phone_____
   Fax_____
   Email_____

The information is being released for REM Anesthesia to provide in-office intravenous sedation for dental procedures.

REM Anesthesia requests disclosure of the following type of medical records:

History and Physical

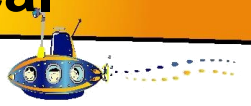
This document does not request certain types of information that are subject to special protections under federal and Kansas law (including 42 C.F.R. 164.508, 42 C.F.R. Part 2, K.S.A. 65-5601 et seq., K.S.A. 59-29b79 and K.S.A. 65-6001 et seq.) and Disclosing Provider shall not disclose such information.

Patient Authorization:
I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that I may refuse to sign this authorization. My treatment, payment enrollment, or eligibility for benefits may not be conditioned on signing this authorization. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. This Request will remain in effect for one year from the date of my signature below unless an earlier date in noted here: _____ or an alternative termination occurrence or event is noted here: _____.

_____	_____	_____
Patient or Surrogate Signature	Relationship (if applicable)	Date / Time

LeBlanc & Associates
DENTISTRY FOR CHILDREN

History & Physical



Patient Name: _____ DOB: _____

Informant: _____ Relationship: _____

Date: ____/____/____ Time: _____ hours

Primary Care Physician: _____ Referring Hospital/Physician: _____

Chief Complaint: _____

History of Present Illness: _____

_____

Past Medical/Surgical History: _____

_____

Review Of Systems

	See HPI	Negative
HEENT: _____	❑ ___	❑
Pulmonary: _____	❑ ___	❑
Cardiovascular: _____	❑ ___	❑
Gastrointestinal: _____	❑ ___	❑
Genitourinary/Reproductive: LMP __/__/__ _____ ❑ Premenarchal	❑ ___	❑
Bone/Skin/Joint: _____	❑ ___	❑
Neurologic: _____	❑ ___	❑
Endocrine: _____	❑ ___	❑
Psychological: _____	❑ ___	❑
Smoking/Drugs/Alcohol Use/Abuse: _____	❑ ___	❑

Allergies: ❑ NKA

Allergy: _____ Type of Reaction: _____

Allergy: _____ Type of Reaction: _____

Medications/Herbal Preparations/Dietary Supplements: _____

_____ ❑ None

Growth & Development

Parental Perception: ❑ Advanced ❑ On Time ❑ Slow/Delayed

School Age: Name of School: _____

Grade: _____ Retained?: ❑ No ❑ Yes

PhysicalExam

Wt: _____ kg Ht: _____ cm HC: _____ cm T: _____ °C P: _____ R: _____ BP: _____/_____

General: _____

HEENT: _____

Neck/Lymphatics: _____

LeBlanc & Associates – Surgery Department
8226 Mission Rd. Prairie Village, KS 66208. 913.583.5325
Email: surgery@kidsmilekc.com Fax 913.378-9611

History & Physical

Patient Name: _____

Lungs: _____

Breasts/Tanner Stage: _____

Cardiovascular/Pulses: _____ ❑ N/A

Abdomen: _____

Rectal: _____ ❑ N/A

Genitalia/Tanner Stage: _____ ❑ N/A

Trunk: _____

Extremities: _____

Skin: _____

Neurological:_____

Other: _____

Laboratory/Radiology/Ancillary Results: _____

_____

_____ ❑ None

Assessment/Plan:_____

_____

_____

Child cleared for in office IV sedation YES_____ NO_____

Physician Signature / Title: _____ Date: ___/___/___

I M P O R T A N T! !

The attached "History and Physical" form must be dated within 12 months of your child's IV sedation appointment. UNLESS THIS EXAM IS COMPLETED AND SENT TO OUR OFFICE PRIOR TO APPOINTMENT, YOUR APPOINTMENT WILL BE CANCELLED. You need to use the attached form only. This is VERY IMPORTANT. Please do not neglect this or your child's appointment will have to be rescheduled.

LeBlanc & Associates – Surgery Department
8226 Mission Rd. Prairie Village, KS 66208. 913.583.5325
Email: surgery@kidsmilekc.com Fax 913.378-9611

In-Office Sedation Information

SCHEDULING/APPOINTMENT INFORMATION

- Please fill out packet in its entirety and return back to a LeBlanc & Associates office or email to our surgery coordinator at surgery@kidsmilekc.com along with a front and back copy of your child's **medical** insurance card.

- **PHYSICAL:**
  - A copy of your child's health history and physical exam dated within 12 months of the scheduled procedure must be turned in at least one week prior to the appointment. Failure to provide your child's physical could result in a cancellation. Physicals can be faxed by your pediatrician's office to (913)378-9611.
  - ***Please contact our surgery coordinator with any questions or concerns regarding the physical (913)583-5325.**
  - Our surgery coordinator will forward the physical to the anesthesia group. A Pre-Op nurse from the anesthesia group will reach out to the provided number to discuss pre-op and eating and drinking instructions a few days prior to appointment. If they do not speak to you, your child's appointment will be removed from the schedule.

- **PRE-OP INSTRUCTIONS:**

  Appointment time between 7:00 am – 11:59 am
  - **Nothing to eat or drink after midnight**.
  - **No** gum, candy, ice chips.
  - **No** brushing teeth or bathing morning of appointment. (toothpaste acts like food on the stomach under anesthesia)
  - **No** school or daycare.
  - Clean out the car seat the night before to assure nothing has fallen down into it that the child could put in their mouth.

  Appointment time 12:00 pm and after:
  - Light breakfast must be **completely finished** by 6:00 am. Light breakfast: cereal, toast or yogurt. **Nothing heavy on stomach -** so **NO** meat, potatoes, pancakes, or waffles.
  - **Water only** (and nothing added to water) until 9:00 am
  - **No** brushing teeth or bathing the morning of appointment. (toothpaste acts like food on the stomach under anesthesia)
  - **No** school or daycare.
  - Clean out the car seat the night before to assure nothing has fallen down into it that the child could put in their mouth.

PAYMENT

- ***Please note that LeBlanc & Associates and the anesthesia group are separate entities. You will be billed separately for the dental treatment portion and the sedation portion. It is your responsibility to pay for services day of or set up financial arrangements.**

- **SEDATION PAYMENT:** Once the anesthesia group has contacted your medical insurance for coverage details, they will contact you directly to discuss payment options. The anesthesia group requires the discussed payment for sedation 10 days prior to the appointment.

- **DENTAL TREATMENT PAYMENT:** LeBlanc & Associates will bill the dental treatment to the provided dental insurance. We will provide a treatment plan with a cost **estimate** at the consultation. Please expect to pay your estimated patient portion or set up a payment plan on date of service. If treatment changes on the date of service, a new estimate will be provided to you.

X

PARENT SIGNATURE DATE