Bogdan Popa, M.D.
Jon Bennett, D.O.

Coastal Anesthesia Consultants
218 8th Street,
Huntington Beach, CA 92648
www.dental-anesthesia.net

Specialists in Office-based Anesthesia
Diplomates, American Board of Anesthesiology

Dr. Popa - (714) 201-3804
Dr. Bennett - (714) 655-8719
Fax - (714) 908-7953

dental_anesthesia@yahoo.com

Agreement to Pay for Services to be rendered

Estimated Anesthesia Time: _____ **Estimated Fee: $_____**

I authorize one of the following physicians: **Dr. Bogdan Popa or Dr. Bennett** (depending on who will perform Anesthesia the day of my appointment), to place a **$500.00 deposit** upon scheduling my case. This reservation deposit will be applied to the anesthesia bill upon settlement.

I, _____, agree to directly pay one of the following physicians: Dr. Popa/Dr. Bennett (depending on who will perform Anesthesia the day of my appointment) the entire estimated fee for professional anesthesia services to be provided for me or my child on **_____month _____day, _____year**, in advance of the anesthesia care.

I understand that the anesthesia fee will be based on actual care time. This fee **is five hundred dollars per hour ($500.00/hr)**. Special handling of my anesthetic due to a request for either mask induction of general anesthesia or total intravenous general anesthesia, presence of co-existing medical problems, alcohol and drug abuse, or excessive anesthesia medication requirements, will incur a special handling, and/or additional medications charge.

It is necessary to allow for an additional **60 minutes for induction of anesthesia and recovery in addition to the actual length of the treatment itself**. Most patients are able to safely leave the office with their escort about 30 to 45 minutes after the procedure. I understand that anesthesia care will begin when the anesthesiologist starts monitoring and will end when I am ready to be discharged, and a responsible adult driver is present. I understand that the physicians named above charge a **minimum of $625.00 dollars**, regardless if the actual time of care is less. I agree that any difference from the estimated fee must be settled by cash, check or credit card prior to my discharge from the dentist's office.

Non-compliance with pre-operative instructions regarding ingestion of food, drink, tobacco use, or “recreational drug” use may also result in a loss of the reservation deposit or additional charges for special handling of my anesthetic. Arriving late to the treatment, or a discharge delay attributed to the untimely arrival of your driver will result in extra charges for the additional time. I understand that a **cancellation charge** equal to the reservation deposit may apply should I find it necessary to cancel or reschedule my

appointment without giving the physicians named above **at least five working days notice**, except in cases of documented acute illness. I am aware that it is imperative that I immediately **inform the above named physicians and my doctor or dentist of any change in health**. In cases of documented acute illness, **I will have 30 days in which to reschedule my appointment** without my reservation deposit becoming a cancellation fee.

Checks with insufficient funds will be subject to a $25.00 handling fee, and will be treated as an unpaid balance. I understand that any unpaid balance will be turned over to R.C. Mclean & Associates, Inc. (an anesthesia billing agency), and subject to finance charge at the maximum percentage permitted by law. After 60 days from the date of service, any outstanding balance may be subject to finance charges at the maximum rate permitted by law. I further understand that I may be liable for attorney and / or court costs incurred in the collection of a delinquent debt.

Insurance Information: If you wish to pursue reimbursement from your insurance company it is best to submit anesthesia related claims to your dental or medical insurance carrier after the procedure. For maximum reimbursement, we recommend that you have your insurance form professionally coded by our anesthesia billing agency specializing in coding, they will obtain and code an insurance form, and return it to you to submit to your insurance company. Our billing company charges an approximate $50.00 coding fee, which will be added to your bill upon request. Since insurance policies vary in coverage, deductible and annual limits, it should be understood that no guarantees can be made with respect to insurance company reimbursements for anesthesia services rendered. Many insurance carriers will not reimburse anesthesia services when rendered for dental surgery unless a patient has a coexisting medical condition, such as heart or lung disease, diabetes, or extreme anxiety. Please check with your insurance company representative if you have questions regarding your coverage. While your insurance company may cover a portion of the cost of anesthesia it is likely that you will have to pay out-of-pocket an amount in excess of your insurance reimbursement. Also, please note our physicians do not participate in Medi-Cal or Medicare, as neither will reimburse medications or supplies.

Signed: _____ Date: _____

Witness: _____ Date: _____

Please return all forms to your DENTIST'S OFFICE as soon as possible.

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CONSENT FOR ANESTHESIA

I hereby authorize and request that Dr. _____ perform the anesthesia as previously explained to me, and any other procedures that may be deemed necessary or advisable as a corollary to the planned anesthesia. I consent, authorize, and request the administration of such anesthetic by any route that is deemed suitable by the anesthesiologist, who is a member of Coastal Anesthesia Consultants. It is the understanding of the undersigned that the anesthesiologist will have full charge of the administration and maintenance of anesthesia for the duration of my procedure and for the care in the immediate postoperative period.

I have been informed and understand that occasionally there are complications of the anesthetic techniques and medications including but not limited to: pain, hematoma, numbness, infection, swelling, bleeding, bruising, nausea, vomiting, and allergic reaction. I further understand and accept the risk that complications may require hospitalization and may even result, in extremely rare cases, in death.

I have been fully advised of the proposed anesthetic techniques for me and accept the possible risks and dangers. The requested information I have provided preoperatively to the anesthesiologist regarding my medical history and family is truthful and complete to my knowledge. I acknowledge the receipt and understanding of both preoperative and postoperative anesthesia instructions.

I have had the opportunity to ask questions about my anesthesia and I am fully satisfied with the information that has been provided.

Signed _____ Date _____

Relationship to the patient _____

Witnessed by _____

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MEDICAL RECORDS RELEASE FORM

PATIENT'S NAME _____ DATE _____

DATE OF BIRTH _____ / _____ /_____ SOCIAL SECURITY ____ ____ ____

I hereby authorize (name of your doctor) _____ to release my medical records to (circle one) : Bogdan Popa, M.D. / Jon Bennett, D.O. / John Brazill, M.D. as they may pertain to my procedure and anesthesia. **These records may be faxed to:**

(714) 908-7953

Specific Test Results:

_____
_____
_____
_____
_____

Patient Signature: _____ DATE _____

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Transportation Arrangement Agreement

Name of Patient: _____ Appointment Date: _____

Pre-arrangements must be made for a responsible adult to accompany you home upon discharge from the office, and to stay with you postoperatively. Do not plan to drive a vehicle or operate potentially dangerous equipment for twenty-four (24) hours after your treatment. **You will not be allowed to leave the office by bus or taxi after anesthesia.** Failure to make these arrangements before your appointment may result in your anesthesia services and procedure being postponed at your expense. Please inform your driver that he or she will be expected to escort you from the office. Arriving late for your scheduled treatment, or a discharge delay attributed to the untimely arrival of your driver will result in extra charges for the additional time. If you are not already in possession of the preanesthesia
/ Post-anesthesia instruction form, it will be given to your driver upon discharge.

Driver's Name: _____ Contact Phone Number: _____

Cell phone: _____ Pager: _____

Time needed by driver to return to the doctor's or dentist's office: _____ minutes

Phone # where you may be reached after your appointment: _____

Please bring this completed and signed form with you on the day of your procedure.
Thank you for your cooperation.

Sincerely,
Coastal Anesthesia Consultants

Signed: _____ Date: _____
Patient Signature

Signed: _____ Date: _____
Witness Signature

Please return all forms to your DENTIST'S OFFICE as soon as possible.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices (the last page of the patient scheduling forms).

_____ _____ _____
Please print name Signature Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgement could not be obtained because:

❒ Individual refused to sign
❒ Communications barriers prohibited obtaining the acknowledgement.
❒ An emergency situation prevented us from obtaining acknowledgement.
❒ Other (Please Specify).

_____
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PRE-ANESTHESIA INSTRUCTIONS - ADULTS

Eating and drinking

The following eating and drinking instructions are extremely important to follow exactly as written to insure your safety under anesthesia. These are standard guidelines given to any patient having anesthesia and are meant to prevent the possibility of vomiting and aspirating vomit while sedated or groggy.

On the day of your appointment, you should not have any food to eat or liquids to drink at least **8 hours before the procedure**. Therefore, for example, if your appointment is at 8 a.m. the last food or drink you can have would be at 12:00 AM. It is very important that you do not suck on candy or chew gum within seven hours, or smoke within sixteen hours prior to your procedure. If you find it absolutely necessary, you may drink no more than one ounce of water up to four hours before your procedure

Transportation

Pre-arrangements should be made for a responsible adult to accompany you home upon discharge from the office.

Change in health status

If you have a change in health status before the appointment, for example, a cold, sore throat, cough, nausea or vomiting, or fever, please call your dentists' office as soon as possible so that we can contact you.

Medications

If you take any prescribed medication, please continue it on the day of the appointment. If it is an oral medication take it with a small sip of water. If it is an inhaler continue to use it at the regular time and bring it with you. If you are a diabetic or if you have other medical conditions such as high blood pressure and coronary artery disease we will discuss the exact medications you should take when we talk on the phone 1-2 days before your procedure.

Clothing

Wear comfortable, loose fitting clothes, a short sleeve shirt, and flat shoes on the day of your treatment. Please do not wear make-up, lotions, jewelry, or cosmetic hair products on the day of your treatment. Please try to void immediately before your anesthetic. To avoid potential embarrassment, we strongly recommend the use of "Depends" urinary incontinence products for patients with a weak bladder, or for dental treatments expected to last longer than 4 hours.

Questions

As we mentioned above, we will contact you one or two days before the scheduled procedure to answer any questions. If you have urgent concerns or questions that cannot wait, please contact us on our pager numbers. We will call you back as soon as we are able.

POST-ANESTHESIA INSTRUCTIONS - ADULTS

Pre-arrangements should be made for a responsible adult to accompany you home upon discharge from the office. You will not be allowed to leave the office by bus or taxi after anesthesia. You should plan to have a responsible adult stay with you until the next day. Do not plan to drive a vehicle or operate potentially dangerous equipment for twenty-four (24) hours after your treatment. Muscle aches and a sore throat similar to a mild flu may occur. It is also not uncommon to have mild dark bleeding or clots from one or both nostrils following dental surgery. This is nothing to be alarmed about, and will normally disappear in 24 to 36 hours. Your mouth and tongue may be numb following the dental treatment, resulting in a sensation of a foreign body or "lump" in your throat. This is perfectly normal, and will disappear in a few hours. Post-operative pain medication is the responsibility of the doctor or dentist. The first drink should be plain water, then fruit juice or Gator-Aide. Avoid soft drinks at first. Drink only small quantities of beverages during the first hour. After the first hour, you may eat small portions of food, as tolerated (preferably soft, bland and not hot). No alcoholic beverages for 24 hours. NO SMOKING for 24 hours. Pain medication on an empty stomach often causes nausea. If persistent nausea and vomiting, difficulty breathing, fever in excess of 101.5 degrees within the first 4 hours, tenderness and or redness near the IV site develops, or for any other anesthesia related concern developing within the first 24 hours, please call us at the numbers provided above. For all other matters, such as postoperative pain medication and wound or bleeding concerns, please contact your doctor or dentist.

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PRE-ANESTHESIA PEDIATRIC INSTRUCTIONS

Eating and drinking

The following eating and drinking instructions are extremely important to follow exactly as written to insure the safety of your child under anesthesia. These are standard guidelines given to any patient having anesthesia and are meant to prevent the possibility of vomiting and aspirating vomit while sedated or groggy.

On the day of your appointment, your child should not have any food or milk within 6 hours of the procedure. He or she may have *water, Gatorade, apple juice, Jell-O, frozen fruit juice popsicles* **up to 2 hours before the time of the appointment**. **No liquids (including water) within 2 hours of the appointment**. Therefore, for example, if your appointment is at 10:00 a.m. the last food or milk your child can have would be at 4:00 in the morning (not very practical) but he or she can have clear liquids until 8:00 a.m. If your appointment is at 1:30 p.m., your child can have food and milk until 7:30 a.m. and clear liquids until 11:30 a.m.
If your child is **breast-feeding**, the last feeding can be **3 hours before** the appointment.

Change in health status

If your child has a change in health status before the appointment, for example, a cold, sore throat, cough, nausea or vomiting, or fever, please call your dentists' office as soon as possible so that we can contact you and determine if it is safe to proceed with the anesthetic or if we need to reschedule.

Medications

If your child takes any prescribed medication, please continue it on the day of the appointment. If it is an oral medication, let your child take it with a small sip of water. If it is an inhaler, have your child use it at their regular time. If your child is an insulin dependent diabetic, a pre procedure consultation with me will be arranged.

Clothing

We recommend loose fitting, and easy to put on clothes for your child on the day of the dental procedure. The shirt layer closest to the skin should be short sleeved. If your child has a favorite blanket, please bring it. Many children under the age of 6 years urinate in their pants as they are waking up from the sedation. So, please bring a 'pull-up' if your child is 4 years old or younger or a change of clothes.

Questions

We will contact you one or two days before the scheduled procedure to answer any questions. If you have urgent concerns or questions that cannot wait, please contact us on our pager numbers. We will call you back as soon as we are able.

POST-ANESTHESIA INSTRUCTIONS - PEDIATRIC

Eating and drinking

Do not give your child anything to eat or drink in the car on the way home. They have a higher risk of vomiting in the car after anesthesia. As soon as you get home your child can have some clear liquids to drink. For the first hour give them only the clear liquids i.e., popsicles, water, soup, apple juice, etc. The first meal can be offered one hour or so after you get home and should consist of soft foods only, requiring minimal chewing. If your child is not hungry for the first several hours, do not force him or her to eat but do encourage plenty of fluid intake. If your child has nausea or vomiting for more than 2 hours after the procedure, please call us on at the numbers provided above.

Physical Activity

Please do not leave your child alone for the first 4 to 5 hours after you get home. He or she could easily fall if they try to walk on their own while recovering from the effects of the anesthetic medications. It is a good idea for your child to take it easy the first day, especially avoiding activities that require balance and coordination. For example, your child should not be bicycle riding, climbing trees, playing on the jungle gym, etc. Occasionally a child will develop a bright red color in their face a few hours after the anesthetic. This is not an allergic reaction and usually occurs if the child has been overly active after the anesthesia and a bit dehydrated. It is self limited and usually goes away in a few hours. If this occurs in your child and you have any concerns, feel free to contact us.

Pain Control

If your child complains of any discomfort in their mouth when you are home, give them an appropriate dose of children’s Tylenol or Motrin. These medications are usually adequate for pain control after dental treatment.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect Dec, 25th 2005, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you, or to obtain a pre-authorization by your insurance company for your anesthetic.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend

or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or 'patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact Information listed at the end of this Notice. We will charge you a reasonable costbased fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.75 for each page, $20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee, Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of Instances In which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003, If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location. and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended,) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices, or have questions or concerns, please contact us. See the contact information in the opposite side.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact Information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way If you choose to file a complaint with us or with the U.S. Department of Health and Human Services.