Documents included

1.	Before and After Sedation Instructions	-	So that you know what to expect
2.	Medical questionnaire	-	For us to know if we can go ahead
3.	Consent form	-	We can not proceed without your signed consent
4.	Billing and Medical Aid details	-	For us to submit a claim or provide you with a receipt
5.	Fees	-	So that you don't get any nasty surprises in the post

Read, Sign and forward to info@sedation.co.za

Phone: 021 910 2193

Billing Sheet

Patient Information:

Surname: .....First name: ..... Title: .....

Date of birth: .....

Account Details (Person responsible for the account):

Surname: .....First name: ..... Title: .....

ID number: .....Employer: .....

Home address: .....

Postal address: .....

Contact Details: (Home)..... Work).....

(Cell)..... E-mail).....

Medical aid details (For Account purpose only):

Medical aid: ..... Plan : .....

Medical aid number:.....Dependent code.....

Main member: ..... Authorization number: .....

For office use only: Sedation

Dentist/Surgeon: Date:

Start time: End time: Total time:

Procedure code: ICD codes:

☐ Private Tariff

Paid in full: ☐

Deposit paid: ☐

Outstanding: ☐

Deposit amount:

Outstanding:

☐ Discounted Tariff

Method of payment

Cash ☐ Cheque ☐ EFT ☐ Credit card ☐ Debit card ☐ Edcon card ☐

☐ Medical aid claim

Consent form

I have been informed and declare the following:

1. I understand the basis of Sedation, the purpose of the procedure and the risks involved.
2. I understand that no guarantee can be given with regards to the results obtained.
3. I declare that I understand that all the aspects of sedation are explained on the website www.sedation.co.za and that I can request the sedationist to contact me if there are any concerns.
4. Unforeseen complications may arise during sedation that may require additional or different medications or treatment. I authorize the sedationist to treat such complications according to his professional judgment.
5. I will abide by the postoperative instructions. I have completed a medical history questionnaire and have declared all drugs that I have been taking the last 6 months.
6. I take note that I am strongly advised not to drive any motorized vehicle, work with power tools or enter into any legal contract until the following day.

Sharing of personal information:

I hereby give permission to the sedation practitioner sharing the necessary personal information with the appropriate medical aid, billing institutions or financial services to facilitate payment.

Terms and Conditions of Payment:

1. The sedation account rendered is completely independent from the accounts rendered by the hospital and surgeons.
2. I accept full and complete responsibility for settlement of the account and declare that I understand and has been informed of the fees to be charged.
3. I acknowledge that the practice charge private rates that might be more than medical aid rates.
4. I understand that it is my own responsibility to obtain authorization from my medical aid prior to the procedure if it was arranged to be claimed on my behalf.
5. I take note of the fact that, in the event of **non-payment of 90 days** my account will be handed over to an independent company for collection.
6. I understand that if the account is not settled, I will be liable for all costs involved in any legal proceedings regarding the recovery of debt.
7. I accept the fees charged by the practice. If my medical aid pays less than the claimed amount, I will be liable for the difference .
8. If I cancel the sedation within 48hours prior to my appointment ,without a legitimate medical reason, a cancellation fee will be charged.

I have read, understood and agree to the conditions mentioned above. I hereby give permission for sedation on myself/my dependent

.....	.....	.....
Name of Patient	Witness 1	Witness 2

.....
Signature of Patient/Guardian

.....
Date

Practitioner's declaration: I have explained to the patient/guardian/representative, the nature of the above procedure as well as the reasonably anticipated risks and complications. I was led to believe the patient/guardian/representative understands. I herewith declare that the patient has been adequately informed and consented.

.....	.....
Practitioners Signature	Date

Medical Questionnaire

Name: _____ **Contact number:** _____

Date of planned procedure: _____ **Dentist/Surgeon** _____

Age _____ **Height:** _____ **Weight:** _____ **Sex:** _____

	Yes	No	*PLEASE PROVIDE DETAILS IF YES:*
1. Did any family member had an anaesthetic related complication?	○	○	
2. Are you allergic to any medication, food (eg. Eggs, Soya, Peanuts) or substance?	○	○	
3. Any problems with the birth process?	○	○	
4. Premature birth?	○	○	
5. Might you be pregnant?	○	○	
6. Are you breastfeeding?	○	○	
7. Cardiovascular: Do you suffer from			
a. High blood pressure?	○	○	
b. Heart failure or shortness of breath with lying down?	○	○	
c. Heart valve lesions/ palpitations or irregular heart rate?	○	○	
d. Ischemic heart disease/ angina / stents or bypass?	○	○	
e. Do you become short of breath when walking?	○	○	
8. Respiratory: Do you suffer from/or			
a. Snore and/ sleep apnoea?	○	○	
b. Asthma, or other lung disease?	○	○	
c. Had flu/chest infection in the last 4 weeks?	○	○	
d. Do you smoke/how much?	○	○	
9. Central nervous system: Do you suffer from			
a. Epilepsy?	○	○	
b. Depression or psychosis?	○	○	
c. ADHD/hyperactivity?	○	○	
d. Autism?	○	○	
e. Ever had a stroke or cerebral event like TIA or bleed?	○	○	
10. Endocrine: Do you suffer from			
a. Diabetes?	○	○	
b. Thyroid problems?	○	○	
c. Porphyria?	○	○	
d. On steroid therapy?	○	○	
11. Liver			
a. Any liver disease, hepatitis etc.?	○	○	
b. History of jaundice?	○	○	
c. Do you drink more than 7 alcoholic beverages/week?	○	○	
12. Kidneys			
a. Do you suffer from any kidney or bladder disease?	○	○	
13. Blood disorders			
a. Anaemia, sickle cell disorder, thalassemia, etc.?	○	○	
b. Bleeding disorder or previous abnormal bleeding with extractions, surgery or trauma?			
14. Drugs			
a. Do you take any medication? (Including herbal)	○	○	
b. Have you had any adverse/unpleasant reactions to anaesthetics in the past or or a failed sedation?	○	○	

If there is anything you would like to discuss, but prefer not to write it down, please do not hesitate to contact your treating doctor.

I have completed the above questionnaire to the best of my knowledge and did not withhold any information.

....

Signature Date

Pre & Post Sedation Instructions

Pre Sedation Instructions

1) **Please arrive at least 30 minutes before your scheduled appointment**.

2) ***You/your child are not allowed to eat or drink anything for at least 6 hours prior to the procedure.***

3) Please ensure that you **empty your/ your child's bladder** before the procedure.

4) ***Children: You need to apply an EMLA patch (obtainable from any pharmacy) over the largest vein on top of your child's right hand and on the inside of his/her right arm where the arm bend) - 1 to 2 hours before the procedure (If unable to obtain an EMLA patch, please inform the doctor). The EMLA patch numbs the skin so that your child doesn't feel the injection!***

5) You/your child will need responsible **adult supervision** after the procedure for up to 6 hours. Please arrange this in advance. Uber is not seen as a suitable escort if you come alone. Sedation will not be provided without the availability of an escort home.

Feeling sick/unwell?

In order to practice safe sedation it is important to note that under certain circumstances we might need to reschedule.

To avoid any inconvenience, please read below.

If you/your child have any 2 or more of the following symptoms, please let us know for possible rescheduling:

1. Sore throat
2. Sneezing
3. Coughing
4. Temperature>38degrees
5. Malaise/Fatigue/Body pains
6. Nasal congestion/ runny nose

Post Sedation Instructions

1) Complete recovery can take up to 12hours(usually only 2-3hours)
2) Nausea and vomiting can occur, although very seldom.
3) You may eat and drink soon after the procedure as directed by your doctor.
4) You should not drive a vehicle or operate machinery for 12 to 24 hours after the operation, preferably not until the next day.
5) Do not sign any legal or other documents until the next day.
6) Do not take alcohol, herbal agents or home remedies for at least 6 hours.
7) Children should not be left alone for at least 2-3 hours after the procedure.

Fees

1) All our practices charge private fees. The fees will differ between the different practices. The office will provide you with the necessary tariff information for each practice.
2) Some practices will claim in full or partially from your medical aid, but will not take responsibility for non payment.
3) There is no universal “medical aid” fee. All medical aids pay different amounts for the same service.
4) If your medical aid pays less than the rate charged, you will be liable for the difference.
5) If for what ever reason your medical aid does not pay, you will be liable for the full amount.
6) You should check with your medical aid if you are covered and for what amount. It remains your responsibility.
7) Fees are time based and are calculated as follows: 15min setup time + time from entering the procedure room until awake enough to be moved to the general reception area.
8) Fee consists of

    Clinical fee(doctors time and expertise)

    Medicine and disposables used during procedure

Sedation codes if applying for authorization

ICD 10 codes: Usually K02.1 / K08.1 for dental procedures

Codes for other procedures will differ and can be obtained from your surgeon

Sedation Procedure codes:

1461	Dental procedure / Other procedures will have a different code (Obtained from your surgeon)
0020	Sedation outside a hospital theatre
0151	Pre-anaesthetic assessment
0034	Head/neck or shoulder modifier
0036/0023	Sedation/ anaesthetic time
0007	The use of own monitoring equipment
0201	The drugs and consumables used during the sedation.