We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

APPOINTMENTS: Because we reserve 1-2 hours for your exclusive use, we require 24 hours notice if you are unable to keep a scheduled appointment. Failure to notify our office of a cancellation will result in a $150.00 broken appointment fee.

PAYMENT: Payment is due in full at the time services are rendered. We accept cash, personal check, Care Credit, Visa and Master Card. If payment is not made within thirty days of the office visit, interest of 1.5% per month (18% per year) will be incurred. All balances are due in full within 60 days of service, regardless of insurance company arrangements. Accounts not settled by 60 days **will be** forwarded to our collection agency. When sent to collection an additional 35 percent will be added to the unpaid balance, and any legal and court fees incurred will be the patients responsibility. There will be a $50.00 fee for any returned checks or disputes for credit card payments made.

INSURANCE: As a courtesy, this office provides a computer generated insurance form upon the completion of each visit. You must realize that your insurance is a contract between your employer, and the insurance company. We are not a party to that contract. Furthermore, not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will not cover. You will be responsible for any fees or deductibles not covered by your current insurance carrier. Please refer to your personal policy for this information.

We must emphasize that as a dental care provider, our relationship is with you, not your insurance company. All charges are your responsibility from the date the services are rendered. This office realizes that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us before services are rendered for assistance in the proper management of your account.

If you have any questions about the above information or any uncertainty, PLEASE do not hesitate to ask us. The staff is here to help you.

I _____understand and agree to the above on _____
(Patient Signature) (DATE)

INFORMED CONSENT FOR ENDODONTICS (ROOT CANAL THERAPY)

Endodontic (root canal) therapy is an attempt to save a tooth that has pulpal disease, which would otherwise be removed. This is usually accomplished by using non-surgical procedures but on occasion surgery is necessary.

ALTERNATE CHOICES TO ROOT CANAL THERAPY: Other treatment choices include: no treatment, waiting for more definitive symptoms to develop or even tooth extraction. Risks involved in these choices might include pain, swelling, loss of teeth, and infection to other areas.

GENERAL RISKS: Resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics, and injections included (but not limited to) complications which may result in swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, which may be transient but on infrequent occasions may be permanent; reactions to injections; changes in occlusion (bite); jaw muscle cramps and spasms; temporomandibular jaw (joint) difficulty; loosening of teeth; referred pain to ear, neck, and head, nausea, vomiting; allergic reactions; delayed healing, sinus perforations and treatment failures.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY: The risks include the possibility of instrument parts separating within the root canals; perforations (extra openings) of the crown or root of the tooth; damage to bridges, existing fillings, crowns or porcelain veneers, loss of tooth structure in gaining access to canals, or cracked teeth. During treatment, complications may be discovered which make treatment impossible, or which may require dental surgery. These complications may include: blocked canals due to fillings or prior treatment, natural calcifications, previously broken instruments, unusually curved roots, periodontal disease (gum disease) and/or splits or fractures of the teeth.

PRESCRIBED MEDICATIONS: Some medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs). If prescribed, it is not advisable to operate any vehicle or hazardous device until you have recovered from their effects.

CONSENT: I, the undersigned, being the patient (parent or guardian of a minor patient) consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. I also understand that upon completion of the root canal therapy in this office I shall return to my dentist for a “permanent” (outside) restoration of the tooth involved such as a crown (“cap”), jacket, onlay, or filling. I realize that check-up x-rays should be taken at prescribed intervals by my dentist or the treating endodontist.

I understand that root canal treatment is an attempt to save a tooth, which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth, which has had root canal therapy, may require retreatment, surgery or even extraction. I have carefully read the above statements, my questions have been answered to my satisfaction, and I give my consent to the procedure.

Signature of Patient or Guardian:_____ Date:_____
Signature of Witness:_____ Date:_____
Signature of Doctor:_____ Date:_____