MUTUAL UNDERSTANDING/CONSENT FOR TREATMENT

I, the undersigned, after consulting with the doctor, consent to whatever procedure may be decided upon to be necessary or advisable in the opinion of the doctor.

I understand that root canal treatment is an attempt to save a tooth which otherwise requires extraction. Elective root canal therapy may be performed to provide space to anchor a final restoration and/or crown when insufficient tooth structure remains or to relieve excessive sensitivity to temperatures or as an adjunct to other specialty treatment. Although root canal therapy has a high degree of success, it is still a biological procedure, so success cannot be guaranteed or warranted. Occasionally, a tooth that has had a root canal may require retreatment, surgery or even extraction.

It will be explained to me that there are certain inherent and potential risks in any treatment or procedure, including extraction and/or dental implant placement which may be alternative treatments instead of root canal therapy. I understand that the following may be potential risks of root canal treatment and/or surgery: numbness and/or a tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, which is transient but on infrequent occasions may be permanent; treatment failure; complications resulting from the risks of dental instruments (broken instruments, perforation of the tooth, root or sinus). If the doctor is required to drill through a crown for treatment, there is a risk of the crown breaking and/or falling off. If this occurs, expenses involved in the replacement of the crown will be the responsibility of the patient.

Swelling or discomfort may be experienced after treatment by some patients. There is no way to predict this. Prescriptions for pain killers and/or antibiotics will be provided if needed.

I will have an opportunity to question the doctor concerning the nature of treatment, the inherent risks of the treatment and the alternatives to this treatment.

I also understand that only the root canal will be done in this office. The permanent (outside) restoration (filling and/or crown) needs to be done by my regular dentist within a maximum of an 8-week period.

I also acknowledge full responsibility for the payment of such services and agree to pay for them in full, at or before the completion of treatment, unless other specific arrangements are made with this office.

Signed_____ Date_____

Parental Permission_____

FINANCIAL /INSURANCE INFORMATION

Thank you for choosing Elite Endodontics for your endodontic needs. Dental treatment carries with it special cost considerations. We realize that these can be unexpected and are sensitive to this fact. The following information may prove helpful.

For patients with insurance:
Dental insurance is a contract between you and your insurance company. As a service to you we will try to ***estimate***, if possible, what amount your insurance plan will cover for the treatment needed and file a claim on your behalf. This may vary depending upon any deductibles, insurance maximum, limitations or UCR's that may apply. Ultimately, it is your responsibility to determine what benefits your company will provide. We will request payment for your estimated portion at the time of service. Once insurance has paid their portion, if there is a balance on your account, a statement will be sent or a refund check will be issued if an overpayment has been made.

For patients without dental insurance:
Payment is due at the time of service. We accept VISA, MasterCard, Amex, Discover, Care Credit, cash or check. If this is not possible, a payment plan may be arranged with our financial coordinator. There will be a $20.00 late fee assessed per month for all past due accounts. There will also be a $35 fee assessed for checks returned with insufficient funds.

Past due accounts:
If your balance is not paid in a timely manner, we reserve the right to forward your account to an outside collection agency or attorney. All fees assessed by the agency or attorney will be charged to you and become part of your outstanding balance. *The parent/guardian who consents to dental care of a minor or a patient that is not legally competent is legally responsible for payment of all charges. We cannot send statements to other persons.*

I have read this information and have had an opportunity to discuss any financial concerns with the financial coordinator. I understand and agree to comply with these policies.

Signature_____ Date_____