

PATIENT'S NAME \_\_\_\_\_ SOCIAL SECURITY# \_\_\_\_\_

IF RESPONSIBLE PARTY IS NOT PATIENT, LIST BELOW PERSON RESPONSIBLE FOR ACCOUNT

NAME \_\_\_\_\_ RELATION TO PATIENT \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE/CELL \_\_\_\_\_

\_\_\_\_\_ WORK PHONE \_\_\_\_\_

NEAREST RELATIVE (NOT LIVING AT SAME ADDRESS AS PATIENT)

NAME \_\_\_\_\_ RELATION TO PATIENT \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_

**FEES**

Regarding the "usual and customary fee": The exact fee is determined by the number of canals involved and the degree of difficulty of the treatment. Retreatment of previously root canal treated teeth require more expertise and time. An additional fee will be charged. Fee does *not* include restoration or crown.

**Root Canal (Nonsurgical Endodontics) Treatment**

	<u>Standard Fees</u>	<u>Retreatment*</u>
Front Teeth	\$1075	\$1285
Bicuspid Teeth	\$1180	\$1400
Molar Teeth	\$1400	\$1600
Consultation/Diagnosis Only: Limited	\$125	
Complex	\$200	
Permanent Restoration of Access	\$175	* does not include fee for post
Bleach: Endodontic Treatment Here	\$200	removal (\$400) and/or perforation
Endodontic Treatment Elsewhere	\$350	repair (\$400)
Dental CT Scan	\$195	

**Apicoectomy (Surgical Endodontics) Treatment**

Apicoectomy (Surgical Endodontics) Treatment fees typically fall within the same range as root canal (Nonsurgical Endodontics) treatment, specified above.

**PAYMENT FOR TREATMENT IS DUE AT THE TIME SERVICES ARE RENDERED**

Method of Payment:  Cash  Check  MasterCard/Visa  Care Credit

**INSURANCE**

Because of the many differences in the way insurance claims are settled, we have set forth our office policy regarding payment of insurance claims.

1. Patients covered by Dental Insurance should remember that professional services are rendered and charged to you and not to the insurance company. Some insurance programs provide no coverage. Very few pay the entire charge. Most insurance companies do not cover retreatment of teeth that have previously had root canal treatment.
2. Insurance will be accepted under the condition that you provide us with dental information and are prepared to pay your percentage at the initial appointment.
3. Even though an insurance claim is filed, you will receive a statement each month if your account has a balance due. Our office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. You are responsible for payment of your account within the limits of our credit policy.
4. Due to the emergency nature of most endodontic procedures, pre-treatment estimates are not usually required by the insurance company.
5. Any overpayment paid directly to us by the insurance company will be returned to you promptly, via check, by our office.

I accept full financial responsibility for the treatment performed by the doctors in this office.

Signature \_\_\_\_\_ Date \_\_\_\_\_