

PATIENT'S NAME _____ SOCIAL SECURITY # _____

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

NAME _____ RELATION TO PATIENT _____

ADDRESS _____ HOME PHONE _____

_____ WORK PHONE _____

NEAREST RELATIVE (NOT LIVING AT SAME ADDRESS AS PATIENT) Pager/Mobile # _____

NAME _____ RELATION TO PATIENT _____

ADDRESS _____ HOME PHONE _____

_____ WORK PHONE _____

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	\$700-\$850	\$750-\$950
Bicuspid Teeth	\$800-\$950	\$950-\$1,100
Molar Teeth	\$1,000-\$1,250	\$1,100-\$1,400
Consultation/Diagnosis Only: Limited	\$50	
Complex	\$75-\$150	* does not include fee for post removal and/or perforation repair

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

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. Most companies require that work be completed before insurance forms are submitted.
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 by the insurance company, if paid directly to us, will be returned to you promptly by our office.

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

Insurance Co. _____

Group/Policy # _____

Signature _____

I hereby authorize & request payment directly to the doctor.

Date _____

Signature _____