FINANCIAL POLICY

Treatment Fees

Endodontic Exam/Diagnosis*	***$125.00***	Anterior Root Canal Treatment	$825.00	Anterior Root Canal ReTreatment	$1075.00
Endodontic Surgery	$1225.00	Bicuspid Root Canal Treatment	$1025.00	Bicuspid Root Canal ReTreatment	$1225.00
		Molar Root Canal Treatment	$1225.00	Molar Root Canal ReTreatment	$1450.00

*(*NOTE: Exam/Diagnosis fee will be charged in addition to the appropriate treatment fee)*

SS#_____ - ___ - _____ ** Patient's social security number is required for payment options 2 & 3.

If the patient is a minor, the legal guardian MUST provide his/her social security number for payment options 2 & 3.

PLEASE CHECK ONE PAYMENT OPTION

1. ___ Pay in full upon completion of treatment **(CASH, CHECK, VISA, MASTER CARD,DISCOVER and CARE Credit are accepted)**
2. ___ Provide all dental insurance information and pay the estimated co-payment upon completion of treatment**

   ****NOTE**: The co-payment is only an estimate calculated by limited information that is obtainable from your insurance company. The actual payment is subject to deductibles, maximums, and reasonable and customary adjustments, which is not always available information. Dental insurance is a contract between your employer and a dental insurance company. The benefits that you will receive are based on the terms of your contract that were negotiated between your employer and the dental insurance company and not this dental office.

3. ___ Pay a minimum of $300.00 upon initial treatment and a minimum of $75.00 monthly payments

DENTAL INSURANCE – *(most dental insurance companies consider this office out of network)*

Primary	**Secondary**
Name of Insured:____________	Name of Insured:____________
Relationship to patient:____________	Relationship to patient:____________
Insured's Birthdate:____________	Insured's Birthdate:____________
Identification/SS #:____________	Identification/SS #:____________
Employer:____________	Employer:____________
Insurance Company:____________	Insurance Company:____________
Group #:____________	Group #:____________
Ins. Phone:____________	Ins. Phone:____________
Ins. Co. Address:____________	Ins. Co. Address:____________
____________	____________

Is this visit related to an accident? Yes ☐ No ☐ Was this accident work related? Yes ☐ No ☐ Other ____________

Please describe nature of injury: ____________ Date of injury:________ Claim Number:__________

Insurance Company Handling the claim & Address: ____________

FINANCIAL / PRIVACY PRACTICES / CONSENT ACKNOWLEDGEMENT

_____ Initials **I understand that I am financially responsible for all applicable treatment fees whether or not paid by an insurance company.**

_____ Initials **I acknowledge that I have received a copy of this office's Notice of Privacy Practices.**

_____ Initials **From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, but not limited to, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.**

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment.

____________ ____________ ____________

{Please Print Name} *{Signature}* *{Date}*

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement / consent was not obtained because:

- ❑ Individual refused to sign acknowledgement /consent
- ❑ Other (Please Specify) ____________