TULSA ENDODONTIC ASSOCIATES

Informed Consent For Treatment

I understand that root canal therapy is an attempt to save a tooth, which would otherwise be extracted. Although root canal treatment has a high rate of success, it cannot be guaranteed. Occasionally a tooth which has had a root canal may require retreatment, surgery or even extraction. Possible complications of root canal treatment include but are not limited to; 1) procedural difficulties due to calcified, severely curved or previously treated canals 2) instrument breakage 3) fracture of tooth structure or root 4) breaking or chipping of porcelain crowns of fillings 5) persistent numbness following treatment and 6) continued swelling and/or discomfort. **Upon completion of my root canal treatment in this office I am to return to my general dentist for restorative care needed to protect my tooth.**

We would like you to know our policy regarding fees. Fees vary with the number of pulp canals and the complexity of treatment; as is listed on this consent form. Payment for services is due at the time of treatment. Our fees for services are the same for all patients, whether or not they have dental insurance.

Self pay patients: Our treatment is provided on the basis that the full fee for service will be paid by you on the date of service.

Dental insured patients: As a convenience to you, our office will submit charges to your insurance carrier, but you are responsible for our estimated percentage of charges at the time of service. If your insurance company does not pay their estimated portion, you are responsible for any and all remaining balances. You will have 30 days from the date of notification of balances to pay in full. We urge you to be fully aware of the provisions of your policy since few insurance companies cover the entire fee. Please know that "usual and customary" allowable charges are not the same as actual charges. Estimates given by our office are not exact valuations and insurance may not pay us as estimated. You are responsible for any portion disputed, denied, reaming, or unpaid by your carrier.

Check Method of Payment:

- ☐ CASH
- ☐ CHECK/DEBIT
- ☐ MASTER CHARGE/VISA
- ☐ AMERICAN EXPRESS
- ☐ DISCOVER CARD
- ☐ CARE CREDIT

Signature: _____ Date: _____

INSURANCE INFORMATION:

Dental Ins. Company: _____

Insured Name: _____

Relationship to Patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I may refuse to sign this acknowledgement.
I have received a copy of Tulsa Endodontic Associates' Notice of Privacy Practices

Signature: _____ Date: _____