FINANCIAL POLICY, ESTIMATE, AND INFORMED CONSENT FOR TREATMENT

Full payment / co-payment is required at the time of service. Our office accepts cash, checks, and major credit cards (MC, VISA, DISC, AMEX). A payment plan requiring a major credit card and short, five-minute pre-approval process is also available. **If you wish to apply for the payment plan please inform our receptionist prior to treatment**.

Estimation of Fees: Exam: **$95.00** X-rays: **$30.00** Endodontic Retreatment _____

Root Canal Treatment _____ Endodontic Surgery _____

For patients with dental insurance it is important to note that, in most cases, your dental insurance is an agreement between you, your employer, and your insurance company. As a courtesy to patients with verifiable benefits, our office will accept only your *estimated* co-payment at the time of service and bill the dental insurance company for the balance. A standard co-payment of 50% of the total fees will be required when an insurance company fails to provide adequate information for more accurate estimation of benefits. **Any unpaid balance will be transferred to the patient 45 days after insurance claim submission.** A small number of insurance companies send the check directly to the patient. Patients with these dental insurances must pay in full, and our office will submit the insurance claim and the insurance check will be mailed directly to the patient.

Informed Consent for Treatment

TREATMENT PLAN: _____ PROGNOSIS: _____

The procedure(s) necessary to treat the condition(s) have been explained to me. I have been informed of possible alternative methods of treatment, including **extraction**, **postponement**, and **no treatment at all**. I understand that a tooth that has had root canal treatment or surgery sometimes requires **re-treatment**, **additional surgery**, or **extraction**.

I understand that the following may be **inherent or potential risks for the treatment I will receive**: Swelling; sensitivity; bleeding; pain; infection; numbness and/or tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is transient but on infrequent occasions may be permanent; temporomandibular joint difficulty; loosening of teeth, crowns, or bridges; referred pain to ear, neck and head; delayed healing; sinus perforations; treatment failure; complications resulting from the use of dental instruments (**broken instruments – perforation of tooth, root, sinus**), medications, anesthetics and injections; discoloration of the face; reactions to medications causing drowsiness and lack of coordination; and **antibiotics may inhibit the effectiveness of birth control pills**.

The most common complications include (but are not limited to) instrument breakage inside the tooth, inability to negotiate canals due to prior treatment or calcification, perforation to the outside of the tooth, irreparable damage to the existing crown or restoration, cracking or fracturing of the root, crown, or porcelain (existing crown), and recession of gums at the necks of the teeth.

I understand that **medications administered or prescribed** may cause nausea, vomiting, allergic reactions, drowsiness, un-coordination, and impairment of motor and cognitive skills. Use of other drugs or alcohol with prescribed medications may result in detrimental side effects or interactions. I may be unable to operate any vehicle or hazardous device when under the influence of some prescribed medications.

I understand that **permanent restoration of my treated tooth** is necessary within 6 weeks of the completion of my treatment. I realize that this **is not** included in the endodontic fee, is my responsibility, and **failure to have the permanent restoration placed by my dentist may lead to failure of the root canal treatment.** I understand that it is not within the domain of my endodontist to perform this service.

It has been explained to me and I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted. All of my questions have been answered, and I have carefully read and understand the above information. This form does not necessarily reflect the entire discussion I had with the doctor regarding proposed treatment. I give my consent to Dr. Rybicki and any other agents or employees of Novi Endodontics to perform the above procedure(s). I also consent to the anonymous use of any slides, photographs, x-rays, and reports of my case for publication, presentation, or educational purposes.

I have reviewed the treatment plan and fees. I understand that I am responsible for all charges for dental services and materials. To the extent permitted under applicable law, I authorize the release of any information relating to this claim.

SIGNATURE OF PATIENT / PARENT _____ DATE _____

WITNESS SIGNATURE _____ DATE _____