Joseph V. Baldassano D.D.S., M.S.D., L.L.C.
Practice Limited to Endodontics
Diplomate of the American Board of Endodontics

OFFICE FINANCIAL POLICY

Welcome and thank you for choosing this Endodontic office for your specialty care. The major objective of this office is to provide you with the highest quality and most progressive Endodontic dental care available today. The following information is to inform you of our office's financial policy which we request you read and then sign below.

A. Due to the short term treatment relationship at this office, payment is expected at the time of treatment. For your convenience, in addition to cash and checks, we will accept Visa, MasterCard, and Discover credit cards.

B. Consultation and examination fees are due in full at the time of the visit. An estimate will be provided at this appointment for the fee of any future treatment (Root Canal Therapy or Endodontic Surgery).

C. Balance is due in full at the completion of treatment, unless the root canal therapy is divided over two appointments: One half of the total fee is due at the first visit, and the balance is due in full at the completion of treatment. The fee will not increase EXCEPT if surgical intervention becomes necessary.

D. The fee for all surgical procedures is due in full the day the surgery is performed.

E. Endodontic therapy and any fees incurred in this office do not include the permanent filling or crown which is done by your general family dentist immediately following endodontic therapy. Please be sure to schedule an appointment within one month, with him/her following our treatment. If your tooth fractures any time after root canal therapy, retreatment or surgery is completed, no refund or reimbursement is due or owed to you the patient. Additionally, should Root Canal Therapy or Retreatment Root Canal Therapy be completed, in our office, and then, at a later date, be determined by your Family/General dentist that the completed tooth can now no longer be repaired and need removal, no refund or reimbursement is due or owed to you the patient.

F. Dental insurance is accepted and benefits utilized by the covered patient in the following manner: please provide all your necessary patient information, sign and date the form. This office will complete the treating doctor's section and it will be signed and dated by the attending doctor. The form will be mailed with reimbursement going directly to the home of the insured patient. Occasionally, on your behalf, an electronic/internet e-mail may be sent to you the patient, your doctor and or your insurance company. This office does not handle any insurance payments or collections. Any attorney, court and or collection fees are the responsibility of the patient.

I have read, understand and agree to this financial/office policy. I also consent to the release of any of my dental treatment records to insurance companies, employer insurance groups or health plans in order to obtain reimbursement on my behalf. In addition, I consent to the release of my endodontic treatment information, related x-rays, and/or video images to my referring dentist via mail, fax and or e-mail.

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Patient Signature Date