Connecticut Endodontics
Microsurgical Root Canal Specialists

Financial Policy

Patients are responsible for payment at the time treatment is performed. We accept cash, checks, Visa, Mastercard, American Express, and Care Credit. For those patients with insurance, we are pleased to assist you by filing your insurance claim for you.

Patients are responsible for paying, at the time of treatment, the fee amount that insurance benefits do not cover. This is often referred to as your "estimated copay". Please be reminded that this figure is only an estimate until the benefits, if any, are issued by your insurance company. You are responsible for payment regardless of your insurance company's arbitrary determination of benefits.

If your insurance company has not paid your account within 90 days, the balance will be transferred to your responsibility and will accrue interest at the rate of 18% APR.

Agreement and Informed Consent

_____ **I understand** that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be protected in accordance with federal HIPPA privacy law. I acknowledge that it is my responsibility to inform this office of any changes in my personal and insurance information.

_____ **I have been offered a copy of this office's Notice of Privacy Practices.**

_____ **I consent to the necessary diagnostic procedures** (including x-rays) to determine if root canal therapy is indicated. If root canal therapy is indicated, I will decide whether or not I wish treatment.

_____ **I understand root canal treatment is a** procedure to retain a tooth which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, and it cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery, or even extraction.

_____ **I understand that only the root canal treatment is to be performed at this office.** The permanent (outside) restoration (crown, filling, etc.) will be done by my regular dentist.

_____ **I acknowledge full responsibility for the payment** for such services and agree to pay for them, in full, in accordance with the current office financial policy, as detailed above, unless other specific arrangements are made with the office manager. I understand that my dental insurance carrier may pay less than the actual bill for services.

_____ **I authorized my insurance carrier to issue the dental benefits** of my plan directly to this dental office. I also authorize release of any information necessary to process dental insurance.

_____ **I understand that failure give 24 hour notice for appointment, cancellation will result in a $150 fee per appointment.**

_____ _____

Signature date

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Print name