FINANCIAL POLICY

The following is a description of our financial policy that you are asked to read and sign prior to your evaluation and treatment.

FOR PATIENTS WITH DENTAL INSURANCE: Please have your correct dental insurance card available for us to photocopy, so we will be able to confirm your dental benefit coverage. We will provide you with an **ESTIMATE** for your co-payment amount and expect that ESTIMATED PORTION TO BE PAID TODAY. Any delay in obtaining sufficient information may result in consultation and/or treatment to be rescheduled. If we cannot confirm your dental benefits, we will ask for full payment. Once provided with the correct information, we can then file the insurance for your reimbursement. However, this does not absolve you of the full responsibility for the charges. The estimate provided by our office is to be considered as a guideline only until the final insurance payment is received and your account reconciled. ***Ultimately, you are responsible for knowing your insurance benefits and coverage.***

FOR PATIENTS WITHOUT DENTAL INSURANCE: If you currently do not have dental insurance, we can provide you with an estimate of the charges prior to your initial consultation by the endodontist. The estimate may vary depending upon the final diagnosis and type of treatment rendered. The FULL BALANCE IS EXPECTED TO BE PAID TODAY.

There is no assurance of success that has been or can be given in root canal therapy. There is always the possibility that further treatment may be necessary, which may result in additional charges. In signing below, you acknowledge full responsibility for the payment of all necessary services on the date treatment is started. Your signature authorizes your insurance carrier to pay the dental benefits directly to our office and allows us to release any information to your insurance carrier that is necessary to process your dental insurance claim.

A fee of $100.00 will be charged for a NO-SHOW or FAILED appointment or an appointment that is canceled or rescheduled with less than 24 hours notice.

I have read, understand, and agree to the above financial policy.

Signature of Patient and/or Responsible Party:_____

Date:_____

Would you like to discuss costs and/or co-payments? _____Yes _____No

Please indicate the desired method of payment:

_____Dental Insurance and Co-payment

_____Cash or Check

_____Credit Card (MasterCard, Visa, Discover, or American Express)