CARE ENDODONTICS, P.C.
Practice Limited to Endodontics

1. **I understand that I am completely responsible for the full cost of the <u>EVALUATION AND ROOT CANAL TREATMENT</u> performed in this office, and that if I have dental insurance, my co-payment is expected to be paid before root canal treatment has been completed. (Please be advised that the <u>EVALUATION</u> is Not Included in the co-payment fee.)**

2. **I understand that dental insurance is my responsibility and regardless of what I have been quoted as the amount of my dental benefits, I am still responsible for the TOTAL cost of dental treatment.**

3. **I understand, as a courtesy to me, that an ESTIMATE of my dental costs are based upon the most accurate information provided by my Insurance Company, but I am ultimately responsible for the total costs of my dental treatment.**

4. I understand that all of the information about my dental insurance must be given or made available to Care Endodontics, P.C., if I expect my dental insurance to cover its portion of my treatment.

5. I understand that a monthly finance charge of 1.5% will be added to any unpaid balance and that I will be fully responsible for any collection fees if my unpaid balance has been turned over to a collection agency or attorney.

6. I understand that I am responsible for calling this office in advance if I cannot keep my scheduled dental appointment.

7. I understand that if I arrive 15 minutes past my scheduled appointment, I might have to wait that day for treatment or be rescheduled for another day.

8. I understand that I will be held responsible for any damages caused to the office or equipment by me or anyone accompanying me.

9. I understand that I may not eat or drink in the waiting room.

10. **My signature below affirms that I understand and agree to the conditions listed above and that I acknowledge the Receipt of Privacy Practices.**

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Patient Signature (Parent of Minor) Date

CONSENT FOR ROOT CANAL TREATMENT

I (print name), ________________________________hereby authorize Dr. Carrington to perform root canal treatment on the following tooth/teeth.

I understand or will have explained to me that having root canal treatment performed on me could cause post-treatment pain and even swelling. In addition, some complications or adverse reactions to treatment could occur, such as numb lip, heart problems, heart palpitations, or even cardiac arrest. Although these risks are very unlikely, they do exist if I am taking medications that affect my heart and other vital organs or if my health is compromised in any way.

I understand or will have explained to me that there are alternatives to treatment if I chose not to have root canal treatment done. Such treatments include extraction of the tooth/teeth and placing an implant, partial denture, fixed bridge, full denture, or receive nothing.

I understand or will have explained to me that many factors may contribute to the success of root canal treatment, which cannot be determined in advance. Therefore, in some cases, treatment may have to be discontinued before completion, or treatment may fail following treatment. Some of the factors that adversely affect the success of root canal treatment could be my resistance to infection; the location and /or shape of infected canals to be treated in my tooth; root fracture of the root canal treated tooth; poor periodontal health of the root canal treated tooth; having a broken instrument lodged in the canal(s); or, not having the tooth promptly restored (crowned) by my general dentist.

I understand or will have explained to me that should root canal treatment have to be discontinued before completion, other procedures may be necessary to save the tooth or it may have to be extracted. In addition, during and following treatment, I may contact Care Endodontics, P.C. if I have questions or if I experience any unexpected reaction to treatment.

I acknowledge that there are no guarantees or warranties for success in having root canal treatment performed on me, and that I will be given the opportunity to ask or discuss any questions regarding my root canal treatment.

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Patient's Signature

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If minor, parent/guardian signature

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Witness Date

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Doctor's Signature