CONSENT FOR ENDODONTIC TREATMENT AT VALLEY ENDODONTICS

I, the undersigned, (being the patient, parent or guardian) after evaluation and discussion with the doctor, consent to the performing of procedures decided to be necessary or advisable. I understand that upon completion of the root canal therapy I shall return to my referring dentist for a permanent restoration of the tooth. I understand that root canal treatment is an attempt to save a tooth that may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure and cannot be guaranteed. Occasionally a tooth that has had root canal therapy may require retreatment, surgery or even extraction.

Patient/Guardian Signature:

_____Date:_____

FINANCIAL POLICY

ALL PATIENTS:

Payment is due at time of service. We accept cash, check, Visa, MasterCard, Amex, and Discover. We also offer "monthly payment plans" through Care Credit. You may apply on line or in our office at www.carecredit.com.

Late Fees: you may incur a $10 late fee for overdue billing.
NSF CHECKS: there will be a $24 charge to your account for NSF check

PATIENTS WITH INSURANCE:

As a courtesy to our patients we check insurance coverage prior to treatment to give you the best estimate of your financial obligation.

I understand that my dental insurance will only pay a portion of the cost of my treatment, and that the amount may differ from the original estimate we receive from the insurance company. If they pay a lesser amount, I will receive a statement to that effect and it will be my responsibility to pay the difference. If they pay more, I will be sent a refund in the amount overpaid.

If the insurance company does not make payment by ninety days after the forms are sent in, I will assume immediate responsibility for the payment and deal with the insurance company myself.

Patient/Guardian
Signature _____Date: _____