NORTHSIDE ENDODONTICS, P.C.

Authorization and informed consent for endodontic therapy

Patient name:

We recommend the following endodontic treatment:

I authorize the endodontist to perform the above procedures.

I further authorize the administration of medications and anesthetics, performance of diagnostic procedures, and such additional services that may be deemed necessary, understanding that risks are involved.

Possible alternative methods of treatment include the following: surgical procedures, or tooth removal. The advantages or disadvantages of each have been discussed. I have been advised that I may also choose to decline treatment at this time and understand the risks in not having treatment include, but are not limited to: pain, swelling, infections, increased bone loss, or loss of the tooth.

I also understand the following:

1. Root Canal therapy(endodontics) is performed to retain teeth that would otherwise have to be extracted. We recommend endodontic treatment only when we feel there is a reasonable chance for success. Treatment is usually completed in 1 or 2 visits. Every effort will be made to provide for your comfort and well-being.

2. Endodontics as with any branch of medicine or dentistry, is not an exact science. Therefore, no guarantee of treatment success can be given or implied. If the case is not successful, the treatment may have to be redone, a surgical procedure required, or the tooth extracted.

3. Cases started in other offices or retreatment cases are usually more difficult and may have a different outcome than expected under optimal conditions.

4. It may be necessary to alter the tooth structure or remove the restoration of the tooth being treated.

5. Possible complications of treatment include, but are not limited to the following:
   a. Unusual circumstances which cannot be detected prior to beginning treatment, for example, blocked canal, calcified canal.
   b. Swelling, soreness, infection, muscle spasm, or discoloration of the adjacent soft or hard tissues.
   c. Fractures of the crown or root of the tooth or restoration.
   d. Fragmentation of the root canal instruments during treatment.
   e. Perforation of the root with instruments
   f. Complications following anesthesia (hematoma, paresthesia, allergy, increased heart rate, etc.)
   g. Complications following surgery (paresthesia, infection, swelling, bruising.)
   h. Additional unknown or unspecified problems, the explanation for and the responsibility of which cannot be given or assumed.

6. Treatment will be performed in accordance with generally accepted methods of endodontic practice. Included in the therapy will be the taking of a minimal number of x-rays as dictated by the course of treatment.

7. I have truthfully completed a history of my health and included any allergies that I am aware of.

I certify that I have read and fully understand the above information and AUTHORIZATION AND INFORMED CONSENT and that all of my questions have been answered in a satisfactory manner.

X_____ _____ _____

Signature (patient or legal guardian) ***witness*** ***date***

NORTHSIDE ENDODONTICS, P.C.

Financial Policy

Patient name:

We recommend the following endodontic treatment:

Fee: $ **Estimated** Patient Responsibility: $

All fees quoted are due at the time of service. In case of broken appointments or short notice cancellation, less than 48 hours, an additional fee may be charged.

Once endodontic therapy is completed, you must contact your general dentist for the placement of a permanent restoration (filling, crown, etc.). This service is not included in our fee.

We will be happy to submit your insurance claims. All estimated out of pocket patient responsibility is based on the information received from the primary insurance coverage, only if the patient has coverage. Insurance agreements are between the carriers and their subscribers. All allowances are determined through the policy chosen by the patient and/or patient's employer. **Any balance left after insurance responds, the patient (guarantor) is required to pay.** (In some cases, payment arrangements can be made.)

Accounts not paid within terms are subject to an 8% APR finance charge. In the event of default in payment you will be responsible for all fees and costs associated with the collection procedure including but not limited to billing costs, interest fees, collection fees, lawyer's fee and court costs.

We accept Cash, Checks, American Express, Discover, Visa, Master Card and Care Credit. A $25 fee will be charged for checks returned for insufficient funds.

I have read and understand the above information.

I authorize my insurance company to pay benefits directly to Northside Endodontics, P.C.

x_____ _____ _____

Signature(patient/guarantor) ***witness*** ***date***