Cedar Rapids Endodontics PC

Informed Consent

I understand Root Canal Therapy is a procedure to retain a tooth which may otherwise require extraction. Although Root Canal Treatment has a very high degree of clinical success, it is **still a biological procedure so it cannot be guaranteed**. Occasionally, a tooth which has had Root Canal Treatment may require retreatment, apicoectomy surgery, or extraction.

I understand that only the Root Canal Treatment is to be performed at this office. After Root Canal Treatment is completed a temporary restoration is placed. The permanent (crown, alloy, etc.) will be done by my general dentist.

You must be informed of possible risks of the procedure, no matter how remote the possibility of those risks. Some risks associated with the procedures include, fracture or loss of tooth, continued pain, infection, swelling, bleeding, trismus, discoloration, the need for additional treatment, difficulty with diagnosis, inability to diagnose all crown or root fractures, paresthesia (numbness), separated instruments, overextension of filling materials, inability to negotiate all canals, damage to your present restoration.

If you are prescribed a medication, some risks may include: allergic reactions (rash, itching, and swelling), gastrointestinal problems (nausea, vomiting, and diarrhea), cardiovascular problems (shortness of breath) and neurologic (drowsiness).

Initial _____

Authorization for Exam and/or Treatment

I authorize the Endodontist, and their designated staff, to perform an oral examination for the purpose of diagnosis. I authorize the Endodontist to perform the necessary Root Canal Treatment if indicated. Furthermore, I authorize the taking of x-rays required as a necessary part of this examination for diagnosis and/or treatment.

Initial_____

Financial Agreement

Methods of Payment: **Cash, Check, MasterCard, Visa, Discover, American Express, CareCredit, Insurance**.

Self-Payment/No Insurance: If you have no insurance **the fee is to be paid in full on the day treatment is rendered**. There is a 6% discount for balances paid in full day of treatment.

Dental Insurance: We will assist you in submitting your dental insurance. However, your insurance contract is between you, and your employer, and the insurance company. **As a courtesy to you, we will file your insurance. We ask that your estimated out of pocket and deductible be paid at the time of service (at least 20%). Not all services are a covered benefit with all insurance contracts.** Please remember **you are responsible for all charges** incurred. If there is a remaining balance due after receipt of insurance payment, we will send you a statement. I realize that I am financially responsible for all charges regardless of insurance coverage. I hereby authorize payment of my insurance benefits directly to the office of Cedar Rapids Endodontics, PC.

A bookkeeping fee of 18% annually, will be added to all account balances over 120 days. Also a bookkeeping fee of $25 will be applied to all returned checks.

For an estimate of today's charges, please speak to one of our staff members in reception.

I have read and understand the informed consent, exam/treatment authorization and the terms of the financial agreement. I realize that I am financially responsible for all charges.

Patient or Responsible/Guardian's signature Date staff initials