Financial Policy for Cedar Rapids Endodontics, PC

Methods of Payment: **Cash, Check, MasterCard, Visa, Discover, and American Express.**
We offer financing/payments thru Care Credit or UICCU

Dental Insurance: We ask that your **estimated out of pocket be paid at the time of service**. We will assist you in submitting your dental insurance. However, your insurance contract is between you, and your employer, and the insurance company. Not all services are a covered benefit with insurance contracts. It is a method of reimbursement to the patient for fees paid, not a substitute for payment. **As a courtesy to you, we will file your insurance.** If there is a remaining balance due after receipt of insurance payment, we will send you a statement.

No Dental Insurance: Payment in full is expected at the time of treatment. We offer **Care Credit** and **UICCU Financing** for those in need of a payment plan.

Estimated Charge: _____ Estimated out of pocket due today: _____

I hereby authorize payment of my insurance benefits directly to the office of Cedar Rapids Endodontics, PC. I realize that I am financially responsible for all charges regardless of insurance coverage.

I have read and understand the above information and the terms of the financial agreement.

X _____

Patient or Responsible/Guardian's signature Date staff initials

A brief explanation of root canal treatment including some of the risks.

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 that can occur with the procedures includes: difficulty with diagnosis, inability to diagnose all crown or root fractures, inability to negotiate all canals due to calcification of the root canal space, numbness, separated instruments, overextension of filling materials, loss of tooth. Pain, infection, swelling, trismus (spasm of the jaw muscles, causing the mouth to remain tightly closed) following treatment can occur. Over the counter pain meds (Ibuprofen/Tylenol) can be taken or an antibiotic and/or narcotic may be prescribed. Possible risks: allergic reaction (hives/rash), stomach issues, cardiovascular problems and possible drowsiness.

***Authorization for Exam:** I authorize the Endodontist, and their designated staff, to perform an oral examination for the purpose of diagnosis. I also authorize the taking of x-rays required as a necessary part of this examination for diagnosis and/or treatment. **Initial _____**

To be signed in operatory after diagnosis.

I, _____ HEREBY CONSENT TO ROOT CANAL TREATMENT

ON TOOTH # _____

Patient/Parent or Guardian Signature _____

Endodontist _____ Date _____