CENTER FOR ENDODONTIC CARE FINANCIAL POLICY

Name:_____

IF YOU HAVE ***DENTAL*** INSURANCE...Please select ONE of the following:

- ***OPTION 1:*** _____ *(*If option 1 is selected, and someone other than non-minor patient is assuming financial responsibility for payment of this treatment, a Financial Responsibility Agreement must be completed.)*
- I (or Guarantor*) will make a down payment today:
  - Non-surgical root canal procedures - 25% of treatment fees
  - Surgical procedures - 50% of treatment fees
  - Two insurances - Normally $0. Please let us know if your annual benefits have been used or procedure(s) will not be covered.
  - If an estimate or pre-determination of benefits was obtained, we will collect the estimated patient portion.
  - Nitrous, bone grafts & 3D scans - Most insurance plans do not cover these, so we will collect in full for these services.
- I will leave a form of payment on file (VISA, Master Card, Discover, American Express, checking account or Care Credit).
- After my insurance pays its portion, Center for Endodontic Care will notify me of any remaining balance and the due date (25 days from statement date) on which my form of payment on file will be charged. I may choose to pay by a different method prior to the due date. **If a refund is due**, this credit will be issued promptly, via credit/debit card or check, depending on my down payment method.

OPTION 2: _____ I (or Guarantor) will pay my fee in full at the time of service. If my insurance company pays the office directly, I understand that I will be issued a refund of my credit balance via credit/debit card or check, depending on my payment method today.

Responsibility: As the patient, it is ultimately your responsibility to know your insurance benefits and for payment to our office. Insurance plans vary vastly & coverage often depends on if you see an in or out-of-network provider. Until we receive the Explanation of Benefits from your insurance company, we do not know the amount covered by your insurance.

MY CONSULTATION AND TREATMENT FEES:

Consultation		Treatment	
Consultation	$ 95.00	Root Canal Treatment _____	$_____
3D Scan	$300.00	GentleWave Materials Fee (when used**)	$ 89.00
3D Scan Discount	-$150.00	Nitrous Oxide (optional):	$ 100.00
TOTAL W/3D Scan	**$245.00**	Other: _____	$_____
TOTAL W/O 3D Scan	**$ 95.00**	Other: _____	$_____

Miscellaneous Fees: **Returned check** - $35; **Late payment** - $20 on account balances of $400 or less; $35 on balances over $400. **Missed appointment** (no show or cancellation with less than one business day's prior notice) - $50.

** **GENTLEWAVE PROCEDURE:** Please review the following information and ask your doctor any questions you may have.

Center for Endodontic Care is very excited to offer the GentleWave procedure to patients. This state-of-the-art technology offers superior cleaning and disinfection of the root canal system, using a minimally invasive protocol, which allows for maximum preservation of tooth and root structure. Because GentleWave is cutting edge technology, I understand that there is not yet a specific procedure code for billing my dental insurance plan and that my insurance will not pay for this procedure. If my doctor recommends that my tooth is a suitable candidate for the GentleWave procedure, I give my informed consent to pay the GentleWave Materials Fee at the time of service.

Initial: _____

MY SIGNATURE BELOW INDICATES THAT I HAVE READ AND UNDERSTAND MY TREATMENT FEES ABOVE; THAT I CONSENT TO TREATMENT; AND I WILL BE RESPONSIBLE FOR PAYMENT OF THESE FEES.

Signature: _____ _____

Patient (or Guardian if patient is a minor) Date

I would like a copy of this form? **Yes**___ No ___ Copy provided to patient: _____ _____

Patient initials Date