CENTER FOR ENDODONTIC CARE
FINANCIAL POLICY

If you have questions regarding the following information, please ask one of our team members.

- **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.
- **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 24 hours prior notice) - $50. **Payment plan billing charge** - $3 per payment.

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

OPTION 1: _____

- 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.
- *** NOTE: 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.*

- OR -

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.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ AND UNDERSTAND THE INFORMATION REGARDING THE FINANCIAL POLICY ABOVE, AND THAT I WILL BE RESPONSIBLE FOR PAYMENT OF FEES.

Signature: ____ ____________________

Patient (or Guardian if patient is a minor) Date

MY CONSULTATION AND TREATMENT FEES:

Consultation		**Treatment**	
Consultation	$____________	Root Canal Treatment ________________	$____________
3D Scan	$____________	Nitrous Oxide	$____________
Other ______________	$____________	Other: ___________________________	$____________
Other ______________	$____________	Other: ___________________________	$____________
TOTAL	**$____________**	**TOTAL**	**$____________**

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