NON-SURGICAL ENDODONTIC TREATMENT AND FINANCIAL CONSENT

1. Root canal therapy is treatment or retreatment performed to retain a tooth that might otherwise require extraction. Other treatment options include no treatment, waiting for more definitive symptoms to develop, or tooth extraction.

2. I understand the process of endodontic treatment requires taking x-rays, administering local anesthetic, placing a rubber dam, and performing the treatment itself: opening, cleaning, shaping, placing the permanent material called gutta purcha, and a temporary filling. For the long-term success of this treatment, a permanent restoration is required.

3. During root canal therapy certain procedural complications can occur including, but not limited to: alteration of sensation (numbness), separated (broken) instruments, perforation of the crown and/or root that may or may not involve medicament(s) and/or solvents, and damage to restorations.

4. Treatment complications may be discovered which make treatment impossible, or which require dental surgery. These complications may include blocked canals due to fillings or prior treatment, natural calcifications, curved roots, periodontal (gum) disease, and splits/fractures of the teeth.

5. Local anesthetics will be used during root canal therapy. Some common side effects include pain, swelling, and bruising. Other rare side effects may include convulsions, weakness, allergic reactions, persistent numbness, stiffness in the jaw joint(s) or muscle (trismus), and injury to blood vessels.

6. Although root canal therapy has a high degree of success, it is still a biological procedure and as such, cannot be guaranteed or warranted. Some teeth that have had root canal therapy may require retreatment, surgery, or even extraction.

7. I understand the root canal treatment performed in this office will be done by an *Endodontic Specialist* and the permanent restoration (filling, crown, etc.) will be done by my general (family) dentist.

8. Fees incurred for additional treatment by another dentist or physician is the responsibility of the patient.

9. Financial Agreement with Central Florida Endodontics:

   Tooth number(s) & Treatment: _____ ESTIMATED FEE: _____

   Insurance or Discount Plan: _____ ESTIMATED Co-Payment: _____

   In-network insurance will be verified, estimated copays calculated and collected, and the claim will be submitted for payment with the assignment of payment to our office. After the insurance processes the remaining balance is payable immediately and credits will be promptly refunded. Unpaid balances older than sixty days are sent to collections. Any additional fees incurred by our practice to collect payment will be the responsibility of the patient, including but not limited to check fees, bank fees, collection fees, court costs, attorney fees.

   As a courtesy, out-of-network insurance will be verified for coverage and assignment of benefits. If assignment to provider is allowed, we will calculate an estimated copay and submit the claim on your behalf. Otherwise, the patient will pay out-of-pocket and self-submit for reimbursement.

   If the insurance does not allow out-of-network benefits, such as an HMO, Medicaid, and Medicare, the patient will pay out-of-pocket and not be eligible for direct reimbursement from their insurance.

   All my questions have been answered by the doctor and I understand the above statements. I hereby give my consent to the performance of endodontic therapy on the tooth or teeth listed above. I further give my consent to the administration of medications, anesthetics, drugs, and services deemed necessary to treat my endodontic problem. I attest the accuracy of the information provided on my health history form.

Patient Name Printed: _____

Patient/Parent Signature: _____ Date: _____