Office Financial Policy

In consideration of treatment by the doctor, I the undersigned, individually and as agent for the patient,, understand and agree, jointly and severally, to the following:

1) That the preceding information is correct to the best of my knowledge.

2) That I am responsible for all fees relative to the professional services rendered under this agreement, that this may include me, my family, or other individuals that I authorize, and that this agreement as it relates to my financial responsibility extends to all past, present, and future services rendered by the doctor and his staff to me, my family, or other individuals I may have authorized. I recognize that insurance is a contract between the patient and the insurance company, and I agree that I will pay all charges under this agreement regardless of my insurance coverage. I may terminate my responsibility under this agreement be paying my account in full and giving written notice to the doctor.

3) That I will pay all sums that are due and payable at the time of service. No oral agreements have been made and this agreement cannot be modified orally.

4) That I agree to pay interest at the rate of 18% annually on all balances over 90 days from the original due date, plus court costs, reasonable attorneys' fees , with or without suit, and a collection fee if my account is assigned to a collection agency.

_____

Parent/Guardian Signature

Date_____/_____/_____

New patient consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health care, Desert Endodontics, PC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Desert Endodontics PC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.
I further understand that Desert Endodontics PC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal regulations. Should Desert Endodontics PC change their notice, they will give a revised notice to the patient upon the next office visit.
I wish to have the following restrictions to the use or disclosure of my health information:_____
_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I fully understand and accept/decline the terms of this consent.

_____

Parent/Guardian Signature

Date_____/_____/_____

_____

FOR OFFICE USE ONLY
[ ] Consent received by _____on_____/_____/_____
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to patient's medical record on____/_____/_____

Desert Endodontics PC
Practice Limited to Endodontics
Informed Consent

This document, signed and dated is my consent for any dental treatment deemed necessary in an attempt to preserve my tooth with root canal therapy. This Document will allow the treating doctor to perform a diagnosis, administer local anesthesia or nitrous oxide, and perform root canal therapy and any necessary post-operative care needed.
Although root canal therapy has a very high degree of success, I have been informed that there are certain uncontrollable risks that can arise which will lead to further treatment being necessary. Some of these potential risks include, but are not limited to the following:

- Fracture of existing tooth structure, fillings, crowns and bridges may occur.
- Short term muscle and jaw pain.
- Temporary or permanent numbness of lip or face from anesthesia or surgery.
- Extremely calcified, curved or previously treated canals can increase the difficulty of treatment causing blockage, ledging, root perforation or broken instruments.
- Post-operative pain, swelling and /or infection.
- Overfills or underfills of gutta percha or sealer.

Multi-focal pain may require treatment of more than a single tooth to alleviate pain.

The other treatment, which could be necessary, include, but are not limited to the following: retreatment, surgery, root removal, or even extraction.

I also understand that there are alternatives to root canal therapy. I have been informed of having no treatment, extraction with no replacement, and extraction with replacement with a bridge, partial or implant.

I also understand that some teeth may have fracture in them, which can lead to eventual extraction of the tooth although they are not detectable at the time of treatment. Most fractures that are in the clinical crown of the tooth are easily restorable with root canal therapy and a full coverage crown restoration. Fractures that extend to the root portion of the tooth may or may not be detectable and can eventually lead to continued chewing pain and eventual extraction.

Once your root canal therapy has been completed, it is your responsibility to see your dentist in a timely manner and have the tooth restored. Failing to have the tooth restored in a timely manner could lead to recontamination of the root canal filling material and subsequent infection with the possible need for retreatment.

_____

Parent/Guardian Signature

Date_____/_____/_____