LAS VEGAS ENDODONTICS

Informed Consent for Endodontic Treatment

PATIENT INFORMATION					
First Name		**Last Name**		**Birth Date**	

Please initial your understanding after reading each statement carefully.

_____ Endodontic treatment has a high degree of success. However, as with any medical or dental treatment there is no absolute guarantee of success for any length of time. Retreatment of teeth with previous root canal therapy will have lower success rate.

_____ As with dental treatment involving local anesthetic injections, risks from root canal therapy may include: swelling, bruising, pain, residual numbness, and spread of infection to other areas.

_____ The possibility exists that a root canal instrument can break during treatment. It may be retrieved or the doctor may elect to leave the instrument in place as a part of the root canal filling if he judges that attempts at retrieval would further weaken or damage the tooth.

_____ Perforation of the tooth and/or root canal can occur, which may require additional surgical corrective treatment or extraction.

_____ The purpose of endodontic treatment is to retain teeth that would otherwise be extracted.

_____ Existing porcelain crowns are subject to breakage during root canal treatment.

_____ Other treatment choices include: a) no treatment, b) waiting for more definitive symptoms, or c) tooth extraction. Risks involved in these choices may include pain, infections, swelling, tooth loss, and spread of infection to other areas.

_____ No warranty or guarantee of success can be given in root canal treatment.

_____ **The fee does not include a final filling, post, or crown on the tooth. You must return to your general dentist to complete the final restoration.**

_____ **I acknowledge that I am financially responsible for services rendered. Any balance remaining after insurance benefits have been received is my responsibility. Returned checks are subject to a $25.00 fee.**

_____ **A $35.00 charge will incur for any declined or missed payments in addition to financial charges on arranged payment plans.**

_____ **A $25.00 charge will incur for any missed appointments without a 24-hour cancellation (notification).**

_____ **Financial charges will accrue on accounts over 90 days old at the rate of 21% APR (1.75% per month).**

_____ **I agree to reimburse the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorney's fees, incurred in such collection efforts.**

As a courtesy to our patients, we can bill your dental insurance for you. All benefits will be subject to deductibles, plan limitations, eligibility at the time of service, and benefits available on the date of service.

We strive to obtain an accurate estimate of your benefits and co-payment; however, insurance is not a guarantee of payment. Terms of your plan determine payment of benefits.

FORM COMPLETION			
I have read the above information and have had the opportunity to ask questions. The above information has been explained to my satisfaction. By signing this, I hereby consent to the treatment.			
Signature of Patient, Parent or Guardian:		**Date:**	
IF PATIENT IS A MINOR			
Form signed by:		**Relationship to Patient:**	