

Name _____

Chart # _____

FEE SCHEDULE AND PAYMENT OPTION FORM

Thank you for selecting our office for your endodontic treatment. Please review our fee schedule. **Fees are due upon completion of treatment.** Please speak with the office staff if you have any questions **prior** to treatment.

Your estimated Copayments for today will be:

Eval	See Treatment Proposal
Treatment	
Build-Up	
MISC. Charges	

Endodontic Fees*:	
Examination:	\$103.00 - 197.00
Radiographs:	\$36.00
Anterior:	\$1257.00
Bicuspid:	\$1383.00
Molar:	\$1648.00

Ins Coordinator _____ Patient _____

**Additional fees will be charged for the following complications: calcified canals, curved roots, retreatments, seating of a post, post removal, build-ups, microsurgery, and other problems which may become apparent before, during or after treatment.*

Your estimated Copayments for today will be:

This fee range for complications pertaining to your treatment is: \$200 to \$450

DENTAL INSURANCE COVERAGE

Filing a Claim

Our office may accept your insurance in order to assist you with the financial aspect of treatment. Any co-payment calculated by our office is an **estimate** that is based on the information provided to us by your dental insurance provider and our past experience with that insurance provider. Co-payments are not based on percentages allowed by your dental insurance provider, but the cost of treatment, deductible, benefits, calendar year maximum. If for any reason we are unable to verify dental benefits with your provider, we respectfully request that **full payment be made at the time of service**. To better assist you in making a claim on your behalf, please make sure all dental insurance information is provided prior to treatment.

Payment will be due in full at the time of treatment for any insurance plan that does not provide for assignment of benefits to this office. Under no circumstances do we participate with Safeguard insurance. We also DO NOT file claims with medical insurance carriers in the event of dental trauma.

Payments

Payment for services rendered is your responsibility, and we appreciate your assistance in making sure that your dental insurance provider pays all benefits due promptly.

Please note that payment from your insurance provider must be received in our office within 30 days of the completion of your treatment. If payment is not received in that time the responsible party will be billed regardless of any pending insurance claim. Our office does not provide billing service, and all co-payments are due in full at the completion of treatment. Any balance not paid after 90 days runs the risk of having small claims filed in an attempt to collect the debt.

If you are paying by check, you agree to permit us to present your check via TeleCheck an electronic payment service that will draft your account electronically. If we receive a payment on your account via mail we may also process your check via TeleCheck. If for any reason TeleCheck declines to accept your check, an alternate form of payment is required. Telecheck approvals are based on information in TeleCheck's files. If your check is declined please call 800-366-2425 for information regarding the transaction.

Thank you for your cooperation.

Signature of Patient or Guarantor

Date