

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 regarding any questions **prior to treatment.**

Your ESTIMATED copayments for today will be:

Eval	
Treatment	
Build-Up	
MISC. Charges	

Examination:	\$ 88.00 - \$ 172.00
Radiographs:	\$ 34.00
Anterior:	\$ 940.00
Bicuspid:	\$1,207.00
Molar:	\$1,444.00

*Addi

tional 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.

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 and 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 us in making a claim on your behalf, please make sure all dental insurance information is provided prior to treatment.

Payments 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. We also **DO NOT** file claims with medical insurance carriers in the event of dental trauma or file secondary insurance.

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 treatment completion. If payment is not received in 30 days the responsible party will be billed regardless of any pending insurance claim. Our office does not provide pay-out schedules 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 a small claims suit 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 will 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* database. If your check is declined please call 800-366-2425 for information.

Signature of Patient or Guarantor

Date