Endodontic Associates
Practice Limited to Endodontics

# FINANCIAL POLICY

As specialists in the practice of endodontics (root canal therapy), we are committed to providing you with the highest level of care. Unlike other dental services, our treatment is usually completed in one or two visits. Therefore, payment for services rendered is expected when your treatment is completed. If we are able to complete root canal therapy in one visit, the fee for that service is due at that time. If you are required to return to our office for a second visit in order to complete your root canal, payment for the entire treatment may be divided equally between the visits.

If you provide our office with complete dental insurance information, we will gladly inquire on your behalf to verify what benefits may be applied to your fee for our services. If your insurance benefits entitle you to a reduced fee or provide for payment to our office (except for deductible or co-payment), your portion of the balance is expected at the time of service. Our office will then submit your claim to your insurance company on your behalf for reimbursement. All co-payments are estimates until payment is received from the insurance company, any portion not covered will be the patient's responsibility. **We are not responsible for any misquotes by either our office or your insurance company. Please keep in mind that dental insurance is a contract between you and your insurance company.** Therefore, if we do not receive payment from your insurance company within 30 days, the unpaid balance of your account becomes your responsibility. We will assess a monthly late fee of 1.5% on any outstanding accounts.

A 33% collection and/or legal fee(s) required to collect fees due Endodontic Associates will be borne by the undersigned.

We understand that occasional errors may occur in the processing of insurance claims. If you believe that an error regarding your account has occurred, please do not hesitate to contact our office. We will make every effort to rectify the problem in the timeliest manner possible.

Your referral to our office indicates the confidence that your general dentist has in us for providing you with the best of care possible for this type of dental service. It is important to realize that your general dentist may participate with insurance companies other than those with whom we participate.

Your signature below indicates that you have read this statement and that you understand your responsibilities regarding payment prior to the initiation of any treatment by the doctors in our practice.

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**Print Name** **Signature (SEAL)** **Date**