

## OFFICE POLICIES

### **INSURANCE**

We are a dental specialty practice; therefore our fees will be higher than a general dental practice.

It is our pleasure to assist you with submission to your insurance company for any eligible reimbursement as per your individual plan, some procedure codes may not be covered by your dental plan. Upon completion of service we will generate and submit insurance forms on your behalf, copies will be provided to you. Please provide our office with your insurance information at your initial appointment so we can expedite any eligible reimbursements.

We are unable to predict what your plan coverage will be, it is the responsibility of the plan holder to get this information from your insurance company. Payment is due regardless of insurance coverage.

### **PAYMENT**

As the patient (or legal guardian) you are responsible for full payment of any services received on the day of service regardless of insurance coverage. We DO NOT accept payment from insurance companies. Full payment must be made to our office by the patient or guardian. Any insurance reimbursement will go directly to the plan holder.

### **CANCELLATION**

2 business days' notice is required to change or cancel your appointment. Failure to provide us with adequate notification will result in a \$100.00 fee.

### **PRIVACY**

We respect your privacy. The Health Information Act (HIA) establishes rules to protect the privacy of an individual's health information. We collect information in accordance to (s20) of HIA.

### **CONSENT**

I, the patient (or legal guardian), do consent to the procedures as determined necessary or advisable in the opinion of the doctor. I understand that root canal treatment (RCT) is a treatment to save a tooth which may otherwise require extraction. I understand that while RCT has a high degree of success; however it cannot be guaranteed.

Occasionally, a tooth which has received RCT may require an additional endodontic surgical procedure or even extraction.

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Patient / Legal Guardian Signature

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Date

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Patient / Legal Guardian Name (PRINT)

