CITRUS ENDODONTICS

ENDODONTIC CONSENT AND HIPPA AUTHORIZATION

We would like our patients to be informed about the various procedures involved in endodontic therapy and have their consent before starting treatment. Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by root canal therapy or endodontic surgery. The following discusses possible risks that may occur from endodontic treatment and other treatment choices.

RISKS: The risks include: the possibility of instruments separated within the root canals; perforations (extra openings) of the crown or root of the tooth; damage to bridges, existing fillings, crowns, or porcelain veneers; loss of tooth structure in gaining access to canals; paresthesia (or permanent numbness); and cracked or fractured teeth. During the treatment complications may be discovered which make treatment impossible, which may require dental surgery, or may incur increased out of pocket expenses. These complications may include: blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), or splits or fractures of the teeth.

MEDICATIONS: Prescribed medications, the use of nitrous oxide (laughing gas), and other drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effects.

OTHER TREATMENT OPTIONS: These include no treatment (waiting for more definite development of symptoms) or tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infection to other areas.

OUR PAYMENT POLICY

The best patient-doctor relationships are maintained when there is a complete understanding of the treatment rendered and the fee. Please feel free to discuss the treatment or the fee with us at any time.

Our Payment Policy is as follows: Payment due on day of treatment. Primary insurance will be filed as a courtesy at patient's request. The patient is responsible for any insurance co-payment and deductible amounts at the time of service. The patient will also be responsible for any related collection costs that pertain to the collection of this debt and interest on past due accounts.

When endodontic therapy is complete, your tooth will require a permanent restoration. The endodontic fee does not include this service. Your referring general dentist will render this service which is mandatory for the preservation of your tooth and the success of the root canal therapy.

CONSENT: I, the undersigned, being the patient (parent or guardian of minor patient) consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. **I also understand that upon completion of root canal therapy in this office I shall return to my general family dentist for a permanent restoration of the tooth involved. This permanent restoration (crown, onlay or composite/resin filling) must be completed within 30 days to prevent reinfection or fracture of the tooth.**

I agree to be responsible for all charges for dental services not paid by my dental benefit plan, unless Citrus Endodontics has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I authorize payment directly to my doctor.

I authorize my doctor to retrieve and send all pertinent information to my general dentist. I authorize use of this form on all submissions. I understand no information from my dental records will be released to anyone outside this office without my written permission.

"I have read and understand the Citrus Endodontics Endodontic Consent and Authorization for the Use or Disclosure of Health Information and I hereby consent to treatment."

X Signature of the responsible party _____ Date_____