ENDODONTIC ASSOCIATES, P.A.

FINANCIAL POLICY

Endodontic Associates, P.A. is committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

The fee for root canal treatment in this office is based upon the complexity of the tooth which is to be treated. All fees will be quoted prior to the start of treatment.

It is our policy of this office that the full fee for treatment be paid on the day of treatment. We accept cash, checks, MasterCard, Visa, or Discover.

In those cases where the cost of the treatment is covered by an insurance company, we will gladly submit to your insurance company for you, providing that you have supplied us with complete insurance information or a dental insurance card. Please sign the assignment of benefits below. We charge what is usual and customary for our area. You must realize, however, that your insurance company is a contract between you, your employer and the insurance company. We are not a party to that contract. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Because most insurance companies do not cover 100% of the charges, we do require a 20-30% deposit on the day of treatment.

We realize that temporary financial problems may affect timely payments of your account. If such problems do arise we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us. We are here to help.

I have read and understand the Endodontic Associates Financial Policy. Regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

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Signature of responsible party Date

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and request my insurance company to pay directly to the Doctor the amount due on my claim for services rendered to me or my dependent.

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Signature of responsible party Date