ENDODONTIC ASSOCIATES, LLC

TREATMENT INFORMATION AND CONSENT

Patient name: _____. We want you to be informed about root canal procedures before you consent to treatment here. Please review these possible risks and complications, which - however rare - can occur from endodontic treatment choices. *Risks include, but are not limited to*:

Local anesthetic risks include allergic reactions, rapid heart beat, lightheadedness, fainting, swelling, bruising, or jaw muscle cramps and jaw joint difficulties. Prolonged numbness and tingling, although rare, may be permanent in some cases. Please avoid eating until the local anesthetic has worn off.

Common side effects from medications include nausea and stomach upsets, allergic reactions such as swelling or itching. Prescription medications may cause drowsiness, lack of awareness, poor coordination or poor judgment. Do not consume alcohol or other drugs because they may increase these effects. Do not work or operate any vehicle, automobile or hazardous device until fully recovered from the effects of the medications.

Non-surgical endodontic risks include discoloration of the tooth, localized swelling, loosening of existing fillings, crowns or bridges, fracture of porcelain veneers, loss of supporting tooth structure, cracked roots, sinus perforation or treatment failure.

During treatment, complications may arise or be discovered which make completion of the root canal impossible and which require extraction or surgery. These include extremely curved roots, periodontal (gum) disease, fractures, instruments broken in the canals, root perforations, canals blocked by prior fillings or by natural calcification. Also, after even routine treatment, problems of swelling, pain or lack of healing may require retreatment, surgery or extraction of the treated tooth.

Surgical endodontic risks include possible swelling and pain (which may be severe), secondary infection, loosening of the tooth, possibility of osteonecrosis of the jaw if taking osteoporosis medication, bleeding or facial bruising. Sinus perforations, although rare, may require additional surgery by an oral surgeon. There may be restricted mouth opening for several days / weeks and gum recession if there is injury to the supporting tissues. Stretching the corners of the mouth may cause cracking or bruising. A risk of lower jaw surgery is numbness or tingling in the chin, lip, cheek, gums, and /or tongue, which may persist for several weeks or months, in rare instances, permanently.

Treatment choices other than root canal include no treatment at all, extraction or waiting for more definite symptoms to develop. The risks for these choices include severe pain or swelling, serious infection that may involve other areas, premature loss of teeth, malocclusion or premature loss of bone.

Restoration. Root canal is not the final step in your treatment. To maintain the tooth, you need to continue good oral hygiene and see your general dentist for a permanent restoration such as a cap or crown. Avoid chewing on the root canal treated tooth until you see your general dentist for your restoration. Restorations are not covered in this disclosure or in any financial estimates given for services here.

Consent. I have read and understand this information and have had an opportunity to have my questions answered before signing. I know that although root canal treatment has a high success rate, success is not guaranteed. Root canal treated teeth may require retreatment, surgery or even extraction - and subsequent service will involve additional fees.

I know that a perfect result cannot be guaranteed and that treatment results are not guaranteed.
I read and understand English, and by signing, I consent to the treatment plan.

_____

(Patient, Parent or Guardian) (Date) (Witnessed by)

ENDODONTIC ASSOCIATES, LLC

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Thank you very much for taking the time to review our HIPAA Notice of Privacy Practice. It explains how we are carefully using your health information and how you can get access to and control your protected health information.

As we have done in the past, we will continue to remind you of your scheduled appointments. These reminders may be telephone reminders, telephone messages or postcards. If you do not wish to receive these reminders or if you have any questions please let us know.

Please sign below to agree that you hereby consent and acknowledge your agreement to the terms set forth in the HIPAA information form and any subsequent changes in office policy and that you understand that this consent shall remain in force from this time forward.

INSURANCE RELEASE / FINANCIAL POLICY

1. I AUTHORIZE DISCLOSURE OF INFORMATION RELATED TO PROFESSOINAL SERVICES RECEIVED. I UNDERSTAND THAT ELIGIBILITY IS NOT A GUARANTEE OF PAYMENTAND THAT SOME FEES MAY NOT BE COVERED AT ALL.

2. I agree to abide by the provisions of my plan for determination of eligibility and fees.

3. Services are rendered to patients. *We accept assignment of benefits as a courtesy, but the patient is responsible for all fees not paid by insurance*.

4. Any payment made prior to the final billing is a DEPOSIT. I will pay in full any balance remaining after the insurance claim clears.

5. If I am not covered by any dental insurance, I will pay in full upon completion.

6. If I default in making payments for my services, and my account is assigned to a collection agency, I authorize release for any information requested by the collection agency.

PLEASE ACKNOWLEDGE THAT YOU HAVE READ THE HIPAA NOTICE, INSURANCE RELEASE AND FINANCIAL POLICY BY SIGNING BELOW:

Date _____

Print Patient Name _____

Signature of patient X_____
(Parent / Guardian if patient is a minor)

(If minor) name and relationship to patient _____

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