Northern Illinois Endodontics

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have viewed a copy of this office's Notice of Privacy Practices.

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this contract. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we may maintain. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, except where we have already made disclosures based on your prior consent.

Our office will communicate with you regarding your appointments. If necessary, we may contact you regarding your account balance. Should you not be able to take our phone call, we will leave a message regarding the necessary information. Your signature will allow us to leave the above messages on an answering machine, voice mail or with another person.

_____ _____

Signature of Patient or Guardian Date

PRIVACY WAIVER

I understand that my dental records may be transmitted electronically by fax or email and may be received in error by a third party. In the event that this should occur, I absolve Northern Illinois Endodontics of all liability. I give my consent to fax my records for the purposes of treatment, payment or healthcare operations and understand that I may withdraw this consent at anytime in writing.

_____ _____

Signature of Patient or Guardian Date

CONTINUED ON BACK

PAYMENT POLICY

Welcome to Northern Illinois Endodontics. Please read these payment policies and feel free to ask us any questions that you may have.
We participate in the following insurance plans: Delta Dental Premier, Guardian PPO, Cigna PPO, Aetna and Dental Health Alliance administered by Assurant. However, we will file your insurance as a courtesy to you. **It is your responsibility to provide us with a current, valid insurance card at the time of your visit.** A deposit will be required for treatment. We will bill you for any balance that remains after the insurance payment has been received. If you have any problems or questions concerning your insurance, please contact your insurance company. **Please understand that you, the patient, are ultimately responsible for payment for any endodontic services received.**
If you do not have dental insurance, payment is due at the time of your appointment. A fee of $25.00 will be charged for any checks returned for insufficient funds.
Statements are mailed on a monthly cycle. Payment is due by the first of the following month. A $10.00 late fee will be added to the past due accounts. If a payment still is not received by the first of the next month an additional $10.00 late fee will be charged. Delinquent accounts will be referred to a collection agency. When your account is referred to a collection agency a 25% agency fee will be added to the outstanding balance, plus additional court costs and attorney fees if needed.
I acknowledge full responsibility for the payment of such services and agree to pay for them, in full, **at or before completion,** unless other specific arrangements are made with the office manager. I authorize my insurance carrier to issue the dental benefits of my plan directly to this dental office. I also authorize the release of any information necessary to process my dental insurance.

Signature of Patient or Guardian Date

INFORMED CONSENT

I understand that my written informed consent is required to allow this office to take radiographs, conduct a thorough examination and provide treatment options.

Signature of Patient or Guardian Date

I also understand that Root Canal Therapy is a procedure to retain a tooth which may otherwise require extraction. Although Root Canal Therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Occasionally, a tooth that has had Root Canal Therapy may require retreatment, surgery, or even extraction. I also understand that **only** the Root Canal Therapy is to be performed at this office. The **permanent** (outside) **restoration** (filling, onlay, crown, etc.) will be done by my regular dentist. I authorize the doctor to administer anesthesia and perform root canal therapy as needed.

Signature of Patient or Guardian Date