RANDOLPH ENDODONTICS/ORTHODONTICS
512 A East Randolph Road, Silver Spring, MD 20904
Phone: 301-384-9800 Fax: 301-384-9877

INFORMED CONSENT FOR ROOT CANAL TREATMENT

1. Root canal treatment is a procedure intended to save teeth that otherwise may need to be extracted (pulled).
2. Root canals are performed on teeth which are infected, teeth with large fillings, teeth which are in an improper position, or teeth which the nerve, if left untreated, will cause pain or an abscess.
3. The root canal procedure does **not** include the tooth restoration (permanent filling or crown) which must be completed or risk of complications and loss of the tooth will be increased.
4. In addition to the usual risks associated with routine dental work, some of the common risks associated with root canal procedures include:
    a. Damage to existing crown and fillings necessary to open the tooth to complete the root canal procedure.
    b. Pain, swelling, and infection; muscle tenderness.
    c. Complications:
        1. Breakage of fine instruments, such as root canal files
        2. Calcifications in the nerve which block the treatment process
        3. Cervical, furcal or root perforations
        4. Incomplete or excessive filling material.
    d. Incomplete healing of the infection requiring surgery (a separate procedure).
    e. Cracked roots or poor healing which could cause loss of the tooth.

    (Not all teeth have the same degree of risk. Please ask the doctor if you have any question about your case)
5. The alternatives to treatment include no treatment or extraction of the tooth.
6. It is your responsibility to have the tooth restored after root canal treatment. An appointment with your General Dentist for the crown/restoration is necessary.
7. I authorize Randolph Endodontics/Orthodontics to communicate with and send x-rays to the referring doctor and my insurance company regarding consultation and treatment rendered at this office.

I have read the above conditions of treatment and agree to their content.

_____
Patient's Signature (Parent or Guardian if a minor)

_____
Date

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FINANCIAL POLICIES

I understand that Randolph Endodontics/Orthodontics is filing my insurance claim as a **Courtesy** to **primary insurance only**. I understand that obtaining payment by my insurance company is ultimately my responsibility. Preauthorization by your insurance company is not a guarantee of the quoted benefit. Insurance companies do not guarantee benefits until the claim is received. I also understand that I am responsible for any co-payment and/or billable charges that are **not covered** and/or **denied** by my insurance company. I understand that I will receive a bill for all outstanding charges 30-45 days after the date on which I received services regardless of the submitted insurance claim status. A 1.5% finance charge per month will be added to my existing account balance. The expected insurance participation is my full responsibility. After 60 days, the account will automatically be handed over to a collection agency. I am aware that, in the event of default, the office will add 30% to any balance owed and **all** costs involved in collection, including, but not limited to, court cost, attorney fees, administrative fees and returned check charges. There is a $45 fee for broken appointments. Cancellation of appointments must be done 48 hours in advance. A $45 fee for bounced checks also applies.

I certify that the information I have reported with regard to my insurance coverage is correct and I authorize the release of any information relating to any claim for benefits, in order to process any claim for benefits. Furthermore, I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing.

_____
Patient's Signature (Parent or Guardian if a minor)

_____
Date