

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I HAVE REVIEWED AND AGREED TO THE CONTENT OF THE NOTICE OF PRIVACY PRACTICE FOR LAKE OCONEE ENDODONTICS. I UNDERSTAND THAT A COPY IS AVAILABLE TO ME UPON REQUEST.

Date: ____/____/____

Patient or Patient's Guardian Signature

FINANCIAL POLICY

Payment for services is due at the time services are rendered.

*If your check is returned for any reason, you agree to pay a service fee of \$30 and your check will be electronically re-presented for payment.

*In the event a decision is made to refer any or all of your account balance to an outside collection agency, a 50% collection fee will be charged to the patient. Should this decision be made by Lake Oconee Endodontics, I have been informed prior to services being rendered.

FOR ALL PROCEDURES LESS THAN \$200, WE REQUIRE 100% PAYMENT AT THE TIME OF SERVICE.

Lake Oconee Endodontics has a \$50 No Show fee for appointments cancelled without 24 hour notice.

Date: ____/____/____

Patient or Patient's Guardian Signature

AUTHORIZATION AND RELEASE

I authorize my dentist to release any information including the diagnosis records of any treatment or examination to me or my child during the period of such dental care to third party payors, my general dentist practitioner, and any dental specialist.

CONSENT FOR ENDODONTIC TREATMENT

I understand root canal treatment 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. I, undersigned, have been informed that I require an endodontic procedure (root canal treatment) and that I fully understand the following:

- *Failure to follow this recommendation will most likely result in: a.) the loss of the tooth b.) bone destruction due to an abscess c.) possible systemic (affecting the whole body) infection.*
- *A certain percentage (5-10%) of root canals fail, and they may require re-treatment, periapical surgery, or even extraction.*
- *During instrumentation of the tooth an instrument may separate and lodge permanently in tooth, or an instrument may perforate the root wall. Although this is rarely occurs, such an occurrence could cause the failure of the root canal and the loss of the tooth.*
- *When making an access (opening) through an existing crown or placing a rubber dam clamp, damage could occur and a new crown would be necessary after endodontic therapy.*
- *Successful completion of the root canal procedure does not prevent future decay or fracture.*
- *Temporary fillings are usually placed in the tooth immediately after root canal treatment. Teeth which have had a root canal treatment will require a permanent (outside) restoration. This may involve a filling or more extensive restoration work (pins, post, crown build-up, crown) depending on the clinical status of the tooth.*

I understand that a series of appointments will be necessary to complete the root canal therapy, as well as other appointments for restoration. I am also aware that I may have continuing temporary symptoms throughout the treatment. Those symptoms may include: *swelling, drainage, pain, fever, infection, and numbness*. There are risks involved in administration of anesthetics, analgesics (pain medication) and antibiotics. I will inform the Doctor of any previous side effects or allergies.

NOTE: Antibiotics may decrease the effectiveness of birth control medication. Additional methods of birth control should be used while on antibiotics.

Date: ____/____/____

Patient or Patient's Guardian Signature

New Patient