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Welcome to our office. Root canal (endodontic) therapy is an elective procedure. The purpose of root canal therapy is to save the damaged or infected tooth. The nerve in the tooth usually has been affected by bacteria, trauma, or nerve exposure. We recommend endodontic therapy only when we believe it will be successful. Occasionally teeth have undetectable cracks which may eventually lead to the loss of the tooth even after root canal therapy. Please ask about any phase of treatment.

FINANCIAL POLICY

IF YOU HAVE DENTAL INSURANCE:

Our office does NOT subscribe to most insurance companies. We are, however, contracted with Delta Dental Premier and Aetna PPO. As a courtesy to you, one of our Financial Coordinators will contact your insurance company to obtain an *estimate* of your insurance benefits. This information will be provided to you prior to or at your first appointment at our office. You will be responsible for a portion of your fee at your first appointment. You will also be responsible for any remaining balance not covered by your insurance. If your insurance pays more than we anticipate, a refund will be sent to you. If your dental insurance is **Federal Blue Cross Blue Shield**, please see below.

*****Due to an increased number of patients not meeting their financial obligations to this office, a credit card number will need to be left with us for any balance after your insurance has paid. We will send you written notification regarding the amount and date that charges will be applied to your credit card. Your credit card number will be destroyed after the balance is paid in full.**

If you are not comfortable leaving your credit card number with us, you may pay in full at time of service. For your convenience, cash, check, VISA, Master Card, Discover and Care Credit are accepted.***

IF YOU DO NOT HAVE DENTAL INSURANCE, OR YOU HAVE, FEDERAL BLUE CROSS BLUE SHIELD:

Payment of fees will be due at the time of service. For your convenience, cash, check, VISA, Master Card, Discover and *Care Credit, are accepted. **Federal Blue Cross Blue Shield will not pay our office directly.** As a result, we require payment in full at the time of service. As a courtesy to our patients, we will submit your dental claim to your insurance company and your insurance company will pay you directly.

CARE CREDIT:

Care Credit is a flexible patient payment program specifically designed for healthcare expenses. Care Credit lets you complete your procedure immediately and then pay for it over time with monthly payments. No interest is applied if the balance is paid within the specified time period (typically 6 months). In addition, Care Credit is a revolving credit line for additional treatment or add-on charges with no need to reapply. Please speak with one of our receptionists, **before treatment**, if you are interested in applying for this service.

If you have further questions regarding financial policies, please do not hesitate to ask one of our receptionists.

FEE SCHEDULE

Fees for endodontic services vary; they are dependent on the complexity of the root canal system of the tooth. Peri-apical x-rays, follow-up appointments, and a one-year check up appointment are included in all treatment fees.

Patient Name (Please Print/Type): _____

Date (Please Print/Type): _____

Please check one of the following:

_____ **I authorize this office to charge ANY balance to my credit/debit card after my insurance pays without being notified.**

_____ **I authorize this office to charge my credit/debit card any balance after my insurance pays, but I would like to be notified in writing if the amount is over \$_____.**

_____ **I will pay my fee in full at the time of service, with cash, check, Visa, Master Card, Discover, or Care Credit. (If your insurance company pays our office directly, we will reimburse you accordingly.)**

****PATIENT SIGNATURE:** _____ Date: _____
(or Guardian)

*Your signature indicates that you have read and understand the above information provided to you and that you will be responsible for payment of fees the day of service.

*Acknowledgement of Receipt of Notice of Privacy Practices: I have received a copy of Endodontic Specialists of the Rockies Notice of Privacy Practices.

****PATIENT SIGNATURE:** _____ Date: _____
(or Guardian) *You may refuse to sign this acknowledgement*

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign

___ Communication barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please Specify) _____