METROPLEX
ENDODONTICS & MICROSURGERY, P.A.

**Financial Information Form**

**Welcome to our office!** We hope to make your visit with us as pleasant and comfortable as possible. We believe in keeping you well informed concerning your treatment, and your financial obligation to us. For this reason we have prepared this financial information form. **Please review our fees and choose the payment option that best suits your needs.** Should you have any questions, please speak with our receptionist **prior to treatment**, and we will do our best to help you. **Please sign and date this form.**

**Endodontic Fees:** *

| | |
|---|---|
| Examination..... | $ 106 |
| Radiograph..... | $ 20 |
| Anterior Root Canal..... (excluding final restoration) | $1050 - $1409 |
| Bicuspid Root Canal..... (excluding final restoration) | $1215 - $1542 |
| Molar Root Canal..... (excluding final restoration) | $1395 - $1723 |
| Nitrous Oxide..... | $ 98 |
| Oral Sedation..... | $ 223 |

*Additional fees may be charged for the following: restorations, obstruction removal, surgery, failed appointments, and for any other problems which may become apparent before, during, or after treatment.

***Our office charges a fee for all missed appointments with less than 24 hours notice**

**Patient signature**_____

**Payment options: check one please**

☐ **Check/Cash**- (5% discount with payment in full for root canal therapy only. Discount does not apply to exams or any patient requiring insurance assignment with our office.)

☐ **Major Credit Card**

☐ **I will apply for outside dental finance company *Care Credit* or *Dental Fee Plan**** (Speak with front desk for assistance) *Our office offers 3-6 months interest free payment plans through these outside finance companies.

☐ **Dental Insurance Assignment-** (I understand I will be responsible for a substantial portion of the fee **on the date of service** /prior to my insurance being billed. I will also be responsible for any charges my insurance does not cover)

**Date** _____

**ALL PATIENTS PLEASE READ AND SIGN THIS ACKNOWLEDGEMENT:**

**Acknowledgement of receipt of privacy practices:**

By signing this form you will consent to our use and disclosure of your health information to carry out (only) treatment, payment activities, and healthcare operations. You have a right to review our office **Notice of Privacy Practices** in the patient folder prior to signing consent. You will have the right to revoke this consent at any time by giving us written notice of your revocation by certified mail.

I, (print name)_____, have received a copy of this office's **Notice of Privacy Practices.** I understand that by signing this form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

**Patient signature**_____ **Date**_____

**Witness**_____