Ultra Endodontics

SPECIALISTS IN ROOT CANAL THERAPY & MICROSURGERY

Enrique Oltra, DDS, MSD

FINANCIAL POLICY

Your estimated cost for your consultation today is $_____

If treatment is recommended by the endodontist, your estimated cost for treatment will be $_____ and is due at your treatment appointment.

This includes the $186 for Fotona Laser and $39 for the final PA Xray.

If it is determined that you would need an interim CBCT scan between treatment appointments, there would be an additional cost of $70.00 for that service.

If your root canal is started but not completed, it will be billed as an incomplete root repair. Which costs **half of the root canal fee (plus all of the GentleWave or Laser fee if used).**

This can happen for cracked or calcified teeth that do not show signs of healing.

Other services will be rendered as needed and would be subject to the fee for that service.

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.

As a courtesy, we will file insurance claims for our patients. Please remember that dental insurance coverage is a contract between the patient and the insurance company. **Patients are ultimately responsible for their entire account.**

The full cost of the consultation or root canal fee will be collected at the time of service. We will file your insurance for you, and they will reimburse you directly what they cover for these services.

Our office offers a 2% discount for **cash or check** payments. We also take **Mastercard** and **Visa.** If you elect to use American Express or Discover, a 1.5% service fee applies. Please feel free to discuss any uncertainty regarding fees or insurance coverage with our patient care coordinator. Care Credit interest-free financing may be available to you.

I understand that if the final restoration (crown or filling following the root canal) is not done **within 2 months** following completion of treatment, and the root canal subsequently re-infects due to improper or lack of permanent restoration then I accept responsibility for the cost of retreatment of the root canal.

If my account becomes delinquent**,** I understand and agree that any charge which is unpaid shall be subject to a monthly interest charge of two percent (2%) and, should my account be assigned for collection, I will be responsible for all costs and an attorney's fee of thirty-three and one-third percent (33 1/3%) of all monies due. Open accounts must be paid within 90 days of treatment completion.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY. I authorize my insurance company to pay (assign) the dental benefits directly to this office or directly to myself (non-assigned).

Patient Name (Printed): _____

Signature of Patient (or Parent/Guardian): _____ Date:_____