Insurance /Fee Agreement

I authorize payment of dental benefits directly to Cypress Endodontics. I also authorize the release of any information relating to this claim, in order for the claim to be processed and paid. I understand that Cypress Endodontics will file my insurance as a courtesy, but I am responsible for any balance not covered by my insurance. I am responsible for the balance on my account after 90 days, even if insurance has not paid at that point. For any account, which remains unpaid after 90 days, we reserve the right to charge late fees on the unpaid balance until paid in full in the amount of 1.5% per month. If no payment is received or payment plan arranged within 90 days after first balance statement, we also reserve the right to turn this account over to the collection agency. Any fees involved with collection agency or attorney will be patient's responsibility.

Signature:_____ **Date:**_____

Office Policy Agreement

At the outset, we will try to advise you that the expected outcome (prognosis), the number of appointments anticipated and what you may reasonably expect from the treatment.

The problem of missed appointments hurts everyone. Firstly and most importantly, it delays and may prevent proper treatment of your root canal. Secondly, by reserving your appointment time, others in need of treatment must be delayed or turned away. Unfortunately, if you fail to appear for your scheduled appointment, there will be a rescheduling charge of $35.00.

Endodontic Information and Consent Form

Endodontic (Root Canal) Treatment, Endodontic Surgery, Anesthetics, and Medications

We would like our patients to be informed about the various procedures involved in endodontic treatment and have their consent before starting treatment. Endodontic (root canal) treatment is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by conservative root canal treatment, or, when needed, endodontic surgery. The following discusses possible risks that may occur from endodontic treatment and other treatment choices.

General Risks

Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections. These complications include: swelling; sensitivity; bleeding; pain; infection; numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is transient (temporary) but on infrequent occasions may be permanent; reactions to injections; changes to occlusion (biting); jaw muscle cramps and spasms; temporomandibular (jaw) joint difficulty; loosening of teeth; referred pain to ear, neck, and head; vomiting; allergic reactions; delayed healing; sinus perforations; and treatment failure.

Risks More Specific to Endodontic (Root Canal) Treatment

The risks include the possibility of instruments broken within the canals; perforations (extra openings) of the crown or root of the tooth; damage to bridges, existing fillings, crowns, or porcelain veneers; loss of tooth structure in gaining access to canals; and cracked teeth. During treatment, complications may be discovered which make treatment impossible, or which may require dental surgery. These complications may include blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), splits or fractures of teeth.

Medications

Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives, or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effects.

Alternative Treatments

These treatments include no treatment, waiting for more definite development of symptoms, and tooth extractions. Risks involved in the choices might include pain, infection, swelling, loss of teeth, and infection of other areas.

Ozone Therapy

I am consenting for Cypress Endodontics/Dr. Vi Ho to incorporate ozone therapy into my treatments.

_____ _____

Patient/Parent/Guardian Signature Date

Consent

I hereby authorize Cypress Endodontics/Dr. Vi Ho or designated staff to take x-rays, 3D imaging (CBCT), study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis.

Also, I, the undersigned, being the patient (parent or guardian of minor patient) consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. I also understand that upon completion of the root canal treatment in this office, I shall return to my general family dentist for a permanent restoration of the tooth involved, such as a crown, cap, jacket, onlay, or filling. I understand that root canal treatment is an attempt to save a tooth which may otherwise require extraction. Although root canal treatment has a high degree of success, it cannot be guaranteed. Occasionally, a tooth which has had root canal treatment may require retreatment, surgery, or even extraction.

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Patient/Parent/Guardian Name (Print) Witness