JL ENDODONTICS

JL ENDODONTIC OFFICE POLICY AND CONSENT FORM

Please remember that we are here to serve you in a comfortable and professional atmosphere. Our goal is to provide you with the very best quality of endodontic care.

INSURANCE AND PAYMENT POLICIES

- WE DO NOT DIRECT BILL - FEES FOR SERVICES AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT.
- **For patients with dental insurance:**
    - Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
    - We will file your claim for you at no charge as a courtesy to you, but any and all ACCOUNT BALANCES are ultimately your responsibility, at the time of your appointment for treatment.
    - Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
- Please note, for your convenience, we accept Visa, MasterCard, and Debit.

OFFICE POLICES

- Your appointment time is set aside especially for you. We ask for the courtesy to the Doctor and to other patients that you keep your scheduled appointment. If you must change or miss an appointment, we require 24 hours' notice. Cancellations, last minute rescheduling or failure to show may result in a charge of $100, or no reappointment.
- Our office will provide confirmation calls. We ask that if we are unable to reach you, that you please contact us as soon as possible to confirm your appointment. Failure to do so may result in your appointment needing to be RESCHEDULED.
- We realize that many families are in a state of change. The policy in our office is that the parent who requests treatment for a child is responsible to us for all FEES incurred.

CONSENT

I have read and understand all the above information. The undersigned hereby authorizes Dr. Jeffrey M. Lo to perform these diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in the health or change in my medication, I will inform Dr. Jeffrey M. Lo at the next appointment.

Date: _____ Signature: _____

(Patient/Parent/Legal Guardian)

Turn Over

JL ENDODONTICS

CONSENT FOR ENDODONTIC THERAPY

Please review the following consent form. You will be required to sign this form prior to the initiation of treatment. Your signature does not commit you to treatment.

Occasionally, Dr. Lo will prescribe medication. Medication prescribed for discomfort and/or sedation may cause drowsiness, which can be increased by the use of alcohol or other drugs. We advise that you DO NOT operate a motor vehicle or any hazardous device while taking such medications. In addition, certain medications may cause allergic reactions, such as hives or intestinal discomfort. If any of these problems occur, call Dr. Lo immediately. It is the patient's responsibility to report any changes in his/her medical history to Dr. Lo.

I understand that root canal therapy is a procedure that retains a tooth, which may otherwise require extraction. As a specialty practice, this office performs only endodontic therapy and associated endodontic surgery. Although root canal therapy has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery, or even extraction. Following treatment, the tooth may be brittle and subject to fracture. A restoration (filling), crown, and/or post and core will be necessary to restore the tooth, and your general dentist will perform these procedures. During endodontic treatment, there is the possibility of instrument separation within root canals, perforations (extra openings), damage to bridges, existing fillings, crowns or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals, and fracturing of the tooth. Also, there are times when a minor surgical procedure may be indicated or when the tooth may not be amenable to endodontic treatment at all. Other treatment choices include no treatment, a waiting period for more definitive symptoms to develop, or tooth extraction. Risks involved in those choices might include, but are not limited to, pain, infection, swelling, loss of tooth, and infection to other areas.

I have read and fully understand the above statements in this consent form.

Furthermore, I give Dr. Jeffrey M. Lo my permission to take 35mm and/or digital photos of any procedure for purpose of completing my medical record and/or for patient education.

NOTE: All medical records will be kept strictly confidential.

Patient (print name) _____

Patient (signature) _____

Date _____

(If patient is under the age of 18, the signature of a parent or guardian is required)