**Endodontics of Colorado**

**FINANCIAL STATEMENT**

***PLEASE READ***

**Fees and Payments:**

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and **is not a substitute for payment**. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge**. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance company.**

Upon your request**, an estimate (not a guarantee)** will be quoted to you based on the complexity of treatment after a complete endodontic evaluation and prior to starting any treatment. **Payment is due at time of service.** If you have any questions, please ask. I authorize the dentist to release any information including the diagnosis and the records of any examination or treatment rendered to me during the period of such dental care to third party payers and /or other health practices. I authorize my insurance carrier to pay any dental benefits on my plan directly to this office**. I agree to be responsible for payment of all services rendered on my behalf or my dependent. If the account is referred to an attorney, or suit filed to collect any sum I owe, I agree to pay cost, collection of charges, and reasonable attorney fees.**

X _____

Patient / Legal Guardian Signature & Date

**ACKNOWLEDGEMENT OF REQUIRED CARE:**

I authorize a report to be sent to my (family) dentist following each important visit and that **I return to my (family) dentist for a permanent restoration after the root canal is completed.**

X _____

Patient / Legal Guardian Signature & Date