ENDODONTIC SPECIALISTS of Wisconsin, S.C.

OFFICE POLICY

David W. Belardi, D.D.S.
Bruce R. Hilt, D.D.S.
Richard F. Urbanczyk, D.D.S.
F. Kris Olsen, D.D.S.
Sam R. Gharib, D.M.D.
Brian D. Watkins, D.D.S.
Cody J. Nelson, D.M.D.
Verne F. Reed, D.M.D.

Appointment times are approximate only, because each patient requires and receives individualized attention by the doctor and his staff for whatever time period that may be necessary. The doctor, as a specialist, is, also, confronted with many emergency cases during the day which often delay his schedule. No time clocks are punched when a human health care service is being rendered. Please try to understand if you are asked to wait for the doctor.

Accurate medical histories and a signed consent are required before any work can proceed. The medical history is important for the doctor so that he can tailor his treatment to you dental and physical needs.

It is your responsibility to know what coverage your insurance provides in the area of Endodontics (Root Canal Therapy). **The doctor and his staff are not and cannot be knowledgeable about the coverages of the dozens of health care plans presented for claims.** Medicare does not cover endodontic treatment. Read your policy and know its provisions, as well as its exclusions. You are encouraged to discuss fees with the staff prior to treatment to avoid any misunderstandings.

Our office will assist you in filling your health care claims with your insurance carrier. **However, you are personally responsible for all fees for services provided, not your insurance company.** The insurance company has a contract with you or your employer and not with the doctor. **All fees not covered by your dental or health care plan will be billed directly to you for payment.**

INFORMED CONSENT: The surgical procedure _____
has been explained to me. I give Dr. _____ and /or associates my consent to perform the surgery and other procedures that are necessitated during the course of the planned operation. I understand there may be side effects in connection with these procedures. These include swelling, infection, tingling or permanent numbness of the lips, tongue, gums, or face, post operative bleeding, and discomfort. It is also possible to loosen or damage adjacent teeth and fillings and displace teeth or roots into the sinus.

I agree to the use of local anesthetic, sedation, or analgesia depending on the judgement of the endodontist and that there are risks in the use of any anesthetic agent. I understand that I am not to operate any vehicle or hazardous devices or drink alcoholic beverages until fully recovered from anesthetic.

_____ _____
Signature of Patient, Parent or Guardian Date

_____ _____
Signature of Endodontist Date

_____ _____
Signature of Witness Date

In general, we ask that payment for services be made by the first visit. **Patients with dental insurance should realize the insurance programs generally pay only a percentage of the average dental fees for this area. Our practice is exclusively endodontics, our fees may be higher than the average since the cases we see are more than average difficulty and therefore insurance coverage may be slightly less.** Insurance payment will be made directly to the office **and the patient is responsible for any balance. 18% APR interest is added to all account balances over 60 days.**

If you have any concerns about payment, please feel free to discuss them with the doctor.

I am aware of the fees for the services that are being provided by the doctor or doctors of Endodontic Specialists of Wisconsin, S.C. in the amount of $_____.

Past Due accounts will be responsible for all costs associated with trying to collect a debt including a $20 collection fee and all court costs and reasonable attorney fees. A broken appointment fee of $175.00 will be added for any appointment that is cancelled with less than 24 hours notice.

Date: _____ _____
Patient Signature