TOWSON ENDODONTICS

Practice Limited to Endodontics & Microsurgery

515 E Joppa Road, Suite 106
Towson, MD 21286
BRENDA K. RICHARDSON, D.D.S., P.A.
PETER H. LUCAS, D.D.S.

CONSENT FOR ENDODONTIC THERAPY

I hereby request and authorize Brenda K. Richardson, D.D.S., or Peter H. Lucas, D.D.S. to perform dental treatment consisting of consultation, x-rays, and/or endodontic (root canal) services. I understand that root canal therapy is a procedure to retain a tooth, which may otherwise require extraction. Root canal therapy is usually successful, but occasionally is not. If it is not, retreatment, endodontic surgery, or extraction may be required. It has been explained to me and I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted. Factors which may affect the result include, but are not limited to: curved root structure, cracked or split roots, narrow or calcified root canal spaces, additional untreated root canal systems, broken or separated root canal instruments within the root canals, or the failure to return to your family dentist promptly to have the tooth permanently restored.

During treatment there is the possibility of damage to existing restorations including porcelain crowns or bridges. Complications of root canal therapy and injection of local anesthesia may include swelling, discomfort, trismus (restricted jaw opening), infection, bleeding, sinus involvement, and temporary or permanent numbness or tingling of the lip. I understand that it is my responsibility to report any symptoms to the endodontist immediately. In addition, antibiotics may inhibit the effectiveness of birth control pills.

Our office is dedicated to providing you with the most current technology and procedures available to ensure you the highest standard of care possible. In many cases this standard of care is well above what is expected by most insurance companies. An example of this is the use by our office of a surgical microscope. It has become essential in treating difficult cases, retreating failed root canals and all endodontic surgeries.

I understand that it is possible that some of the procedures I require may not be covered under my insurance plan and that I will be financially responsible for them. I understand and agree that, at my request, the doctor will answer any questions concerning this advanced level of care and their associated fees which I agree to pay, yet will not be submitted to my insurance company for payment coverage. If I desire, I may request a written statement of these fees prior to any treatment.

There is a $50.00 charge per ½ hour for missed appointments not canceled 24 hours in advance.

PLEASE CHOOSE METHOD OF PAYMENT FOR YOUR COPAYMENT DUE TODAY

_____ CASH/CHECK: Total payment by **cash** or **check** at the time service is completed

_____ CHARGE: Total amount charged to **MASTERCARD, VISA, DISCOVER OR CARE CREDIT**

_____ INSURANCE: I accept full and total responsibility for providing correct insurance information. If I provide incorrect information or do not understand the terms of my insurance plan, it is my responsibility and not that of Dr. Richardson, D.D.S. and Dr. Lucas, D.D.S., to provide correct insurance information and understand my plan's benefits. We will gladly submit insurance forms for you. I hereby authorize payment directly to Dr. Richardson the group benefits otherwise payable to me. If I assign my benefits to Dr. Richardson, a payment of 25% of the total is due by the time treatment is completed, subject to refund of all overpayment by insurance. I understand and agree that I am completely responsible for full payment despite the fact that I may have insurance. I also understand and agree that I am responsible for providing the Doctors with the information necessary to submit a claim to my insurance company. If my insurance plan should change or terminate, I will notify the office immediately and provide them with the new information. Failure to do so will exonerate Drs. Richardson and Lucas of any obligation to file an insurance claim on my behalf.

There is no FINANCE CHARGE when bills are paid when due. Bills are due upon receipt. There will be a $35.00 return check fee for each returned check. A LATE PAYMENT CHARGE is imposed only if the balance is not paid 10 (ten) days after the statement due date. The LATE PAYMENT CHARGE is $15.00 (fifteen dollars) per month or 1.5% per month, which is an annual rate of 18% (eighteen percent) per year. *If it becomes necessary to send my account to collection, I understand and agree that I will pay for all collection costs, including but not limited to agency fees, court costs, the cost of a private process server (if utilized) and reasonable attorney's fees.*

SIGNATURE: _____ DATE: _____

PLEASE SIGN & DATE *BOTH* SIDES

Brenda K. Richardson, D.D.S., P.A
Peter H. Lucas D.D.S.
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Microsurgery

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I have received and/or was offered a copy of this office's Notice of Privacy Practices

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgment
- ❑ An emergency situation prevented us from obtaining acknowledgment
- ❑ Other (please specify)

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