HIGHLAND PARK
ENDODONTICS

Practice Limited to Endodontics
7001 PRESTON ROAD, SUITE 301-A
DALLAS, TEXAS 75205
214.528.ROOT (7668)

OFFICE POLICY

Welcome to our office!

We are committed to provide the best possible endodontic treatment to you. In addition, we are devoted to making your visit comfortable, relaxed, and pleasant. We care about our patients and hope you will have a great office experience. Before beginning treatment, your doctor will examine and evaluate your tooth/teeth, then discuss with you diagnosis, recommended treatment, treatment options, and prognosis. You will have an opportunity to ask questions regarding recommended treatment and make an informed decision.

We accept cash, checks, VISA, MasterCard, Discover and Care Credit
***** Payments are due in full prior to completion of all treatment*****

INFORMED CONSENT

I consent to the necessary diagnostic procedures (including x-rays) to determine if root canal (endodontic) therapy is indicated. If endodontic therapy is indicated, I will decide whether or not I wish treatment. I understand that root canal therapy is a procedure to retain a tooth which will otherwise require extraction. There is a high degree of clinical success but it is still a biological procedure and cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery, or extraction. I also understand that only the root canal therapy is to be performed at this office and permanent restoration will be done by my family dentist. **It is my responsibility to return to my family dentist for crown fabrication.** I am also aware that my porcelain fused-to-metal crown may fracture if the root canal is accessed through the crown. I consent to allow Highland Park Endodontics to contact any and all entities who may have information essential to my treatment including my physician, medical facilities, pharmacies, and family if needed. I also accept full responsibility for the payment of such services and agree to pay for them in full before the completion of treatment. I understand that although Highland Park Endodontics is accepting certain insurance plans, **I am ultimately responsible for the costs incurred**. I authorize release of any information necessary to process dental insurance on my behalf for my reimbursement. **I understand that my dental insurance is a contract between the patient and the insurance company. Highland Park Endodontics has no control over the insurance company's method of payment or amount of payment.**

Signature _____ Date_____
Parent, Guardian or Agent must sign for patients under 18