ENDODONTIC THERAPY | INFORMED CONSENT

I UNDERSTAND THAT ROOT CANAL TX | includes the possible inherent risks, but not limited to:

- The teeth treated may remain tender or even painful for a period of time, both during and after completed therapy. If pain is severe or swelling occurs, please call our office immediately. In some teeth, regular root canal therapy alone may not be sufficient. If the canals are blocked, excessively curved, inaccessible, inadvertent pulp chamber, root perforation, or if there is substantial infection in the bone around the tooth, additional oral surgery, including apicoectomy(s) and repairs or possibly extraction(s) may become necessary.
- Root canal treated teeth may become somewhat brittle and subject to cracking or fracturing. Unfortunately, "hairline" cracks can be invisible and undetectable. Causes of root fracture are trauma, inadequately protected teeth, cracking of the tooth, large fillings, improper bite, wear and tear, habitual grinding of teeth, etc. Root fractures after or prior to treatment, usually necessitates extraction. Crowning the tooth is the best prevention to avoid this problem from occurring, as it is advisable to do so ASAP. When we have placed a temporary filling (requested by your dentist or your insurance), your dentist will place the final filling. Crowns may also fracture or may need replacement by your general dentist.
- Root canal therapy is not always successful. Many factors influence success: adequate gum tissue attachment and bone support; oral hygiene; previous and present dental care; general health; absence of trauma; pre-existing undetectable root fractures. No matter how successfully a tooth may appear to be treated, there is the possibility of failure and consequent extraction.
- There are alternatives to root canal treatment. These alternatives include: no treatment, extraction, extraction followed by bridge placement or partial denture placement, and/or extraction followed by implant and individual crown placement.
- Because of the fragility and small diameter of root canals, instruments used to treat root canal may separate. This may in some instances necessitate either apical surgery or extraction of the tooth.

ADMINISTRATION OF LOCAL AGENTS | includes the possible inherent risks, but not limited to:

ANESTHETICS | Bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness may occur. I understand that occasionally needles break and may require surgical removal.
MEDICATIONS | Analgesics and/or antibiotics may need to be prescribed depending on symptoms and/or treatment findings. Prescription drugs must be taken according to instructions. Women on oral contraceptives must be aware that antibiotics cause these contraceptives to be ineffective. Other methods of contraception must be utilized during the treatment period.
IRRIGANTS | Irrigants are used to enhance tissue removal and to disinfect the tooth. Occasionally these Irrigants may enter the surrounding tissue or bone and can cause pain, swelling, inflammation and in rare cases, necrosis.

ONCE TREATMENT IS BEGUN | It is absolutely necessary that the root canal treatment is completed. One or more appointments may be required to complete treatment. It is a patient's responsibility to seek attention should any undue circumstances occur; and the patient must diligently follow any and all preoperative and/or postoperative instructions given to them.

INFORMED CONSENT | I have been given the opportunity to ask any questions regarding the nature and purpose of root canal treatment and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including risk of substantial harm, which may be associated with any phase of this treatment in hopes of obtaining the desired potential results, which may or may not be achieved. No promises or guarantees have been made to me concerning the results. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize the Doctor and/or his associates to render any treatment necessary and/or advisable to my dental condition(s), including any and all anesthetics and/or medications.

PATIENTS NAME (PLEASE PRINT)	SIGNATURE OF PATIENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE

ROCKY MTN ENDO | FINANCIAL AND INSURANCE POLICY

THE FACTS

- Please understand we are desirous to extend care to you and to work with you and any insurance coverage you may have. Professional services are rendered to the patient, and not to the insurance company. Thus, the insurance company is responsible to the patients, and the patient is responsible to the doctor. We cannot render service on the assumption that the charges will be paid for by an insurance company.
- For your convenience we will estimate the portion of your total fee that your dental insurance company will cover. This is just an estimate. After insurance benefits, you are responsible for any unpaid balance. We will ask you to bring the estimated uncovered portion of the total fees to be paid at the time of treatment.
- If you desire to know exactly what your insurance coverage will be, prior to treatment, then we can pre-determine or pre-authorize your benefits. However, this delays treatment 4-6 weeks, waiting for the insurance company to respond.
- Our policy requires a percentage of the fee to be paid at time of treatment if patient has Dental Insurance. Payment options include: Cash | Check | Visa | MasterCard | Discover | American Express |Care Credit. Full payment is required at time of treatment, if there are no insurance providers or if there have been no payment arrangements made with Rocky Mtn Endo.
- Unfortunately, trends show that insurance benefits will almost always be less than anticipated. Please understand that the amount of benefits to be derived under your particular policy is a pre-determined arrangement between your employer and the insurance company; we are unable to increase benefits beyond that which this agreement allows. You however are entitled to discuss employee benefits with your employer and make recommendations for change for a more competitive policy and provider.
- A finance charge of 1.5% per month will be added to your bill if payment has not been received within 60 days. This will allow adequate time for you to see that your insurance benefits have been paid to your satisfaction.
- Should collection become necessary, the responsible party agrees to pay an additional 40% per Utah UDA collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs. I also authorize my insurance company to make payment directly to the doctor for services rendered and agree to pay any uncovered balance. I hereby authorize release of information for insurance purposes.

Thank you for your understanding in this matter

PATIENT'S NAME (please print) | SIGNATURE | DATE

ROCKY MTN ENDO | HIPPA CONSENT

- **Purpose of Consent |** By signing this form, you will consent to our use and disclosure of you protected health information to carry out treatment, payment activities and healthcare operations.
- **Notice of Privacy Practice |** You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important maters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
- **Right to Revoke |** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed below. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent
- **Mary Kay Hayes | 801-942-8686 work | 801-942-7652 fax | mhayes@rockymtnendo.com**

- **Signature |** I, ______________________________, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

PATIENT'S NAME (please print) | SIGNATURE | DATE