NJ ENDODONTICS OFFICE POLICY

APPOINTMENTS AND CANCELLATIONS: NJ ENDODONTICS requires **24 HOURS NOTICE** for any/all schedule changes. Repeated cancellations or missed appointments by THE PATIENT will result in a loss of future appointment privileges.

PAYMENT: Any/all co-payments and co-insurance are due at the time of service. Insurance claims will be submitted as a courtesy by NJ ENDODONTICS at the time treatment is completed. Any/all balances thereafter are the responsibility of THE PATIENT. Payments will be accepted via CASH, CHECK, VISA, MASTERCARD, DISCOVERY and/or AMEX.

PLEASE NOTE that any expenses quoted by NJ ENDODONTICS may only be an estimate. NJ ENDODONTICS is not responsible for any expenses quoted **IN ERROR** – THE PATIENT MUST VERIFY ANY/ALL EXPENSES WITH YOUR INSURANCE COMPANY.

If insurance claim payments are sent to YOU (and not directly to NEW JERSEY ENDODONTICS), YOU are then responsible for payments to NJ ENDODONTICS. THE PATIENT may forward the insurance claim payment to NJ ENDODONTICS with a copy of the insurance explanation of benefits -or- THE PATIENT may issue a personal check to NJ ENDODONTICS with a copy of the insurance explanation benefits.

If claims are not paid by the Insurance Company, then THE PATIENT will be billed out-of-pocket expenses for all services rendered. If YOU do not have insurance that NJ ENDODONTICS participates with, YOU will be responsible for payments in full for any and all services rendered.

By treating with NJ ENDODONTICS, it is implied that YOU understand any and all risks of and results from any and all treatment, whether said treatment is successful or not as clarified and explained to YOU by NJ ENDODONTICS. Should treatment provided be unsuccessful, payment for said services is still required by YOU and/or the insurance company you participate with.

It is YOUR responsibility to inform NJ ENDODONTICS of any updates or changes to any and all information.

I HAVE READ AND UNDERSTAND THE INFORMATION AND MY RESPONSIBILITIES AS STATED ABOVE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF ANY/ALL DENTAL TREATMENT NOT COVERED/PAID BY INSURANCE. I HAVE READ AND UNDERSTAND MY FINANCIAL OBLIGATION TO NEW JERSEY ENDODONTICS.

Patient Name (PRINT): _____

Patient/Guardian Signature: _____

Date: _____

- **NOTICE OF PRIVACY PRACTICES:** I consent to the use of my records and information to carry out treatment, payment activities, and healthcare operations as set forth by NJ ENDODONTICS' Privacy Policy.

- **MY SIGNATURE WILL ALSO SERVE AS A HIPAA DOCUMENT RELEASE, SHOULD I REQUEST THAT TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.**

_____ _____

NAME OF PATIENT (PRINT) **NAME OF GUARDIAN/LEGAL REPRESENTATIVE (PRINT)**

_____ _____

PATIENT/GUARDIAN SIGNATURE **RELATIONSHIP OF GUARDIAN/LEGAL REPRESENTATIVE**