

TREATMENT and FINANCIAL CONSENT FORM

Treatment:

- I understand that root canal treatment and the alternative(s) to root canal treatment will be explained to me by Dr. Rodney Brown or Dr. Robert Gatti prior to beginning any treatment.
- Possible risks and complications of root canal treatment include but are not limited to the following: pain; swelling of the gum, jaw or face; trismus (restricted jaw opening); temporary or permanent numbness of the gum, lip or face; infection of the jaw, face or other parts of the body; allergic or other serious or potentially life threatening adverse reactions to medications prescribed or materials used.
- In approximately 5-10% of cases, treatment does not succeed. If failure occurs, the treatment may have to be redone, root-end surgery may be required or the tooth may have to be extracted (taken out.) Small instruments may break during treatment, which may be left in the root or jaw or require surgery for removal. The root may be perforated with instruments which may require additional surgical corrective treatment or result in premature tooth loss or extraction. The tooth may be lost to progressive periodontal (gum) disease in the surrounding area. Another undiscovered tooth in the area may also require root canal treatment. The root of the tooth may break during or after treatment and the tooth will have to be extracted.
- I agree to take all medications prescribed and to promptly report any problems to the office by calling 785-843-8610.
- I understand that after root canal treatment my tooth will be brittle and must be protected against fracture by a crown (cap) or filling by my general dentist. If this is not done, there is a strong possibility that I will lose the tooth. If Dr. Brown or Dr. Gatti recommends, I agree to return in six (6) months for a recall visit so that the doctor can evaluate the root canal treatment and I agree to follow his recommendations at that time.

Financial:

- I understand that if I **do not** have dental insurance that I am responsible for **payment in full at time of treatment**. If I **do** have dental insurance, I am responsible for my **estimated portion in full at time of treatment**.
- No warranty or guarantee of success has been or can be given in root canal treatment. I acknowledge full responsibility for the payment of such services. I agree that no refund is due if the tooth is lost prematurely or if other complications occur.
- While the staff will make their best attempt to get accurate benefit information, I understand that any balance due after insurance pays (due to: under estimation, having met insurance plan maximum for year or for procedures not covered by insurance, etc) or for accounts for which insurance has not paid within 60 days of treatment, that this balance is my responsibility and is due in full **at that time**. **Effective, 7/1/2010, if balance is not paid within 90 days of service date, finance charges will accrue with an annual rate of 12% compounded monthly.**

I have read and fully understand the above statements on this "Treatment and Financial Consent" form. I hereby consent to the required treatment to be performed by Dr. Rodney Brown or Dr. Robert Gatti and to these financial stipulations.

Signed: _____ Date: _____
(Patient, Parent or Guardian)

Updates: _____

