SOUTH CALGARY ENDODONTICS

Informed Consent

PATIENT INFORMATION					
First Name		**Last Name**		**Birth Date**	

FINANCIAL RESPONSIBILITY

I assume full responsibility of the services rendered in this office, and agree to pay in full, at or before completion of treatment, unless other arrangements are agreed upon, in advance. To avoid misunderstanding regarding dental insurance, we wish our patients to know that ALL PROESSIONAL SERVICES ARE CHARGED DIRECTLY TO THE PATIENT and that PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES.

CONSENT FOR TREATMENT

I, the undersigned, being the patient, parent or guardian of the above minor patient, consent to undergo whatever endodontic treatment procedures are deemed necessary or advisable in the opinion of the doctor.

I understand that root canal therapy is an attempt to retain a tooth that may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment surgery, or even extraction. I further understand that the FINAL RESTORATION of the tooth (with a filling, inlay, crown etc.) will be done by my regular dentist AT AN ADDITIONAL FEE.

PRIVACY POLICY

It is our policy to keep all information you have provided to us confidential. Information you have provided us is used for diagnostic and billing/insurance purposes only. We will share and provide information on a need-to-know basis to insurance companies, your dentist or health care providers as part of the care we provide you. Please sign below to acknowledge and accept this privacy policy.

Please click on the hyperlink to obtain a copy: Privacy Policy

FORM COMPLETION			
Signature of Patient, Parent or Legal Guardian		**Date**	
IF PATIENT IS A MINOR			
Printed Name		**Relationship to Patient**	