Armen A. Hartoonian, DMD, MSD, Inc.
Practice Limited to Microscopic Endodontics
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Financial Policy

We would like to provide you information about our office financial policy. Unlike your regular dentist, as a specialty practice, we may only see you as our patient for one treatment visit. Therefore, we require payment from you at the time services are rendered. For your convenience, we accept cash, check, and major credit cards. As a courtesy, if you have dental insurance we will bill your carrier, provide documentation, claim forms, radiographs, treatment narratives, and accept assignment of benefits. Our office manager/financial coordinator is an expert in maximizing your insurance benefits. She will be happy to answer any questions concerning your dental coverage. **Your estimated co-payment is only an estimate given to us by your insurance carrier.** Dental insurance carriers vary greatly in the benefits they provide. The coverage could be anywhere from zero to 100% and can change with or without notice. Your insurance is a legal contact between you and your insurance carrier. As healthcare providers we are not a party to that contract, therefore we have no say or influence on benefits it provides. **Please be advised that our office cannot guarantee payment from your insurance carrier.**

I, understand and accept full financial responsibility for endodontic treatment and related services provided for me by Dr. Hartoonian. **I understand that my co-payment is only an estimate and partial or full payment for my treatment(s) is not guaranteed by my insurance carrier.**

Endodontic Informed Consent

I understand that the goal of endodontic (root canal) treatment is to retain a tooth that may otherwise require extraction. Although endodontic therapy has a high degree of clinical success, it is a dental-biological procedure whose results cannot be guaranteed. Occasionally endodontic treatment may fail necessitating re-treatment, apicoectomy, root resection, or extraction. I have been informed of possible alternative methods of treatment including no treatment at all.

I have been informed about inherent and potential treatment risks including but not limited to the following. Swelling, sensitivity, pain, infection, bleeding, transient numbness and/or tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth which occasionally may be permanent, reactions to injections of anesthetic solutions and prescribed medications, changes in the occlusion, jaw muscle cramps and spasms, TMJ difficulty, facture/loosening of crowns and bridges, referred pain, delayed healing, sinus perforations and separated instruments.

I understand that occasionally a surgical procedure called apicoectomy would be necessary to achieve optimum healing following endodontic treatment. This procedure is indicated when the root canal system cannot be cleaned and sealed in its entire length because of anatomic complexities, severe calcification, separated instruments, blockage or ledging from the previous endodontic therapy. Cyst formations and persistent bacterial infection in the periapical region which do not respond to the routine endodontic treatment are also indications for apicoectomy/retrograde. The need for this procedure cannot be verified by radiographs alone and decision is made on case-by-case basis. **The fee for apicoectomy surgery is not included in root canal treatment or re-treatment fee.**

I understand that a permanent restoration placed by my regular dentist, within few days (2-14 days), is important for long-term success of endodontic treatment. Failure to do so will result in the fracture of the crown of the tooth, recontamination of the root canal space by oral bacteria and possible loss of the tooth.

I hereby authorize Dr. Hartoonian and his clinical staff to perform the endodontic treatment(s) necessary to save my tooth.

Patient's signature ..... Date .....

Doctor's signature ..... Date .....

Witness's signature ..... Date .....