Dr. Michael Kaiser
Apex Endodontics
20631 Kuykendahl Rd
P: 281-655-0603
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Spring, TX 77379

Office Policy and Consent

If we **only** provide Endodontic Evaluation (Limited Evaluation, Consultation):

This consists of an examination and testing, discussing the likelihood of maintaining the tooth and treatment options available to you. Payment is due at the time of service.

If we provide Treatment:

Those without dental insurance: Fifty percent of the total will be required when we begin treatment and the balance due upon completion of treatment. If we complete treatment in a single visit, payment is due at the time of service.

Those with dental insurance: We will estimate the portion your insurance is going to pay and we will bill your insurance for you. The remaining portion for the cost of the treatment is required at time of service. *Please keep in mind however, insurance companies routinely indicate that coverage verification does not guarantee payment and any portion not covered by the insurance company is the responsibility of the patient.*

▶ If your insurance pays **more** than the estimated amount, a refund check from this office will be mailed within 1 month from the date payment is received in this office. We usually batch them at the end of the month.

▶ If your insurance pays **less** than the estimated amount, you will receive a statement from this office. We usually do not send monthly statements so prompt attention is greatly appreciated! NOTE: *If your insurance company does not reimburse us after 2 submissions, you will be responsible for the remainder of the balance since we were unable to collect from them.*

CONSENT

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Patient (Print Name) _____

Patient (Signature _____

Date _____

(If patient is under the age of 18, the signature of a parent or guardian is required.)