GREENVILLE ENDODONTICS

PRACTICE LIMITED TO ENDODONTICS

870 CLEVELAND STREET #2-B
GREENVILLE, SC 29601

3115 B BRUSHY CREEK ROAD
GREER, SC 29650

TELEPHONE 864-233-4874
FAX 864-233-4868

Welcome to our office. We appreciate the confidence that your dentist has placed in us by referring you for endodontic treatment. Our goal is to provide you with the highest quality of endodontic treatment in a caring and professional manner. We will do everything possible to achieve this goal. Please understand that payment of your bill is considered a part of your treatment. We believe that patients appreciate being informed of our business policy prior to treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

PAYMENT OPTIONS, (please check your option for payment):

I. **If appointment is for consultation only, payment is due at time of service.**

II. **Patients Without Dental Insurance:**
Full payment due at time of service.

III. **Patients with Dental Insurance (two options):**

_____A. Insurance benefits assigned to patient:
Patient makes full payment at time of service; insurance is filed and benefits are assigned to patient.

_____B. Insurance benefits assigned to doctor's office:
Patient pays 50% of the fee at time of service. Patient also presents credit card authorization or post-dated check to cover the remaining 50%, which will be returned to the patient if the insurance pays within 45 days. If the insurance does not pay in full within 45 days, the credit card authorization or post-dated check will be placed into effect. Any overpayment by the insurance company will be promptly refunded to the patient.

X_____ Date_____
Signature of Patient or Responsible Party

REGARDING INSURANCE

Your insurance is a contract between you and your insurance company. We will be happy to assist you in filing insurance claims; however, You are responsible for full payment regardless of the outcome.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Below is a list of our fees:

Diagnostic Exam / Radiographs	$145
3D Scan X-ray	$300
Anterior	$1330
Bicuspid	$1430
Molar	$1530
Bleaching of Discolored Teeth	$300
Re-treatment	$200 additional
Post-removal	$200
Calcium Hydroxide Medication Replacement	$250

MINOR PATIENTS

An adult must accompany a minor, and the parents (or guardian of the minor) are responsible for full payment. A minor is considered to be anyone under the age of eighteen.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.