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. 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 my 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 913-305-5121.

- 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. 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 the time of service.** If I **do** have dental insurance, I am responsible for my **estimated portion in full at the time of service.**

- 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 procedures not covered by insurance, ect.) or for my accounts for which insurance had not paid within 60 days of treatment, that this balance is my responsibility and is due in full **at that time. Effective, 07/01/2010, 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. Robert Gatti and to these financial stipulations.

Signed:_____ **Date:**_____

Patient, Parent or Guardian

Updates:_____

LEGENDS ENDODONTICS, LLC
9501 State Avenue, Ste 5
Kansas City, Kansas 66111
913-305-5121

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Legends Endodontics, LLC to use and/or disclose certain protected health information (PHI) about me to the following family member(s) and/or friends: **Please indicate relationship and any necessary telephone #'s.**

1) _____ 2)_____
3)_____ 4) _____
5)_____ 6)_____

This authorization/disclosure is provided so that I can make an informed decision whether to allow release of information. This authorization permits Legends Endodontics to use and/or disclose any individually identifiable health information about me pertaining to my treatment or to obtain payment for the services provided me. In addition, I can be contacted at the following places and receive messages for the following purposes: **Indicate by Y (yes) or N (no) for each #/email listed.**

Contact Numbers:	Appt Confirmation	Treatment	Financial/Accounting
Cell:_____	___	___	____
Home:_____	___	___	____
Work:_____	___	___	____
Email*:_____	___	___	____

* If I agree that the dental practice may communicate with me electronically at the above email address, I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I am responsible for providing any updates to my email address and I can withdraw my consent to electronic communication by calling: 913-305-5121. I also understand that this risk may also apply to unencrypted emails sent to any healthcare providers related to my treatment.

I was given an opportunity to read and/or take with me a written copy of Legends Endodontics' Notice of Privacy Practices. I do not have to sign this authorization in order to receive treatment from Legends Endodontics, LLC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorixation, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My revocation must be submitted to the Privacy Officer at Legends Endodontics, LLC.

Signed by:_____ Date: _____

Please Print the following:

Patient's Name: _____

Parent/Legal Guardian (if applicable) : _____