SJS Endodontics
& Microsurgery

Steven J. Schmoldt, DDS
Diplomate – American Board of Endodontists

10 Forest Ave, Ste 201
(920) 933-5332

Patient: Tooth: #

Estimate for treatment/services provided $ _____

The complexity and type of tooth determines the fees charged for endodontic treatment. The estimate above is based upon information provided from your general dentist. Once your unique treatment needs are determined, we will provide you with an exact amount of fees for service.

Patients with dental benefits:

- You are responsible for any co-payment amounts at the time of service.
- You are responsible for any deductibles that are not yet met.
- You are responsible for any amounts over your yearly contracted benefit amount.
  For example, if your total annual benefit is $1000 and you have already submitted $1000 of claims, you will be responsible for 100% of treatment cost.
- You are responsible for knowing the rules and regulations of your dental insurance policy.
  For example, not all dental or endodontic procedures are a covered benefit in all dental benefit plans.

Patients without dental benefits:

- You are responsible for payment in full at time of service. If your endodontist recommends that your treatment be divided into 2 appointments, you may pay 50% at the first appointment and 50% at the completion of treatment.
- You will receive a 5% discount on treatment provided if payment is made in full by cash or check at the initiation of treatment.

Upon signing this document, you are electing to assign benefits to be paid directly to the office and authorize release of information relating to your insurance claim.

_____ I will pay one third of the estimated total fee (,) which will be due upon initiation of treatment. Upon receipt of the insurance benefits, my account will be credited. If an overpayment occurs, I will be notified and will remit the balance due within 30 days or be subject to fees incurred from collection efforts. Any overpayment will be promptly refunded to me.

Remember that you are ultimately responsible for any and all charges incurred in this practice regarding your treatment. It is your legal responsibility to pay any balance which is not paid by your insurance company at time of service. Your signature on this document indicates that you agree to this. If your account with SJS Endodontics becomes delinquent, you are responsible for paying all costs associated with the collection procedure, and we may report the status and payment history of your account to credit reporting agencies.

I have read and understand the SJS Endodontics & Microsurgery financial policy, and I consent to the terms.

Patient's Name **Date**

_____
Patient/Legal Guardian Signature

If you have any questions about this payment policy, please contact our Office Manager at 920-933-5332.