Todd P. Roth, DMD
Todd P. Roth, DMD, P.C.
Practice Limited to Endodontics

Office Payment Policy

The best patient-doctor relationships are maintained when there is a complete understanding of the treatment rendered and the fee. To avoid misunderstandings concerning payment of the account, please note that payment is required in full on **the day of service. We do not send monthly statements.** In the event an account is turned over for collection, the patient responsible for the account agrees to pay any attorney's fees, court costs and any other reasonable costs of collection, and I agree to waive my right of exemption under the laws of the State of Alabama and any other state.

If you have dental insurance this office will be happy to submit any forms for you, however you are required to provide your insurance card and information at the time of service. Please be aware that most insurance companies do not provide full coverage for Endodontic therapy and in some cases may provide no coverage for certain procedures. Our office will provide you with an **estimate** of your insurance company's benefit. This estimate will be based on information obtained through communication with the company and/or prior experiences with them. There is no way to insure that this estimate will be accurate.

We ask that you pay any and all co-payments and charges for procedures not covered at the time of service. **The patient, not the insurance company, is responsible for payment of fees to this office. If payment from your insurance company has not been received within 45 days from the date of service, you will be required to pay the entire balance due on your account.** This form authorizes your insurance carrier to issue the dental benefits of your plan directly to this office and to release any information necessary to process your dental insurance.

I will pay my estimated portion due today by: cash _____ check _____ (A $30 NSF fee will apply to all returned checks)

credit card _____ CareCredit _____

Only root canal treatment is to be performed at this office. When your Endodontic therapy is completed **your tooth will require a permanent Restoration (crown, filling, etc.).** My fee does not include this service. Your referring dentist will render this service which is mandatory for the preservation of your tooth and to prevent reinfection. It is your responsibility to contact your dentist within 2 weeks to have this service completed.

*AGREEMENT TO PAY: The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including any/all collection agency fees, (33.33%), attorney fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state.

*EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE: You agree, in order for us to service your account or to collect monies you may owe, Todd P. Roth, DMD, P.C. and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I have read this disclosure and agree that Todd P. Roth, DMD, P.C., its employees and/or agents may contact me as described above.

Patient or Guardian signature _____ Date _____