E. Michael Feltman, D.D.S., M.S.D.
Scott E. Risser, D.D.S., M.S.D.
Specialists in root canal therapy

Endodontic Services, Inc.
Dental Arts Building
225 N. Notre Dame Avenue
Suite 2
South Bend, Indiana 46617
574-232-5866

117 S. Nappanee Street
Elkhart, Indiana 46514
574-295-7342

ENDODONTIC SERVICES

We look forward to making your visit pleasant. Our office and procedures have been designed to put you at ease and our staff members are devoted to your comfort. We truly care about your needs and hope you feel relaxed in our office.

Before beginning treatment, we will discuss your case with you in detail and answer all your questions. Any permanent filling or restoration required after endodontic therapy will be completed by your general dentist. If your general dentist specifically requests that we place a permanent filling, there will be an additional fee.

We want to make your dental care affordable. To help keep our fees as low as possible, payment on the day of your treatment is required. For your convenience, we accept cash, personal checks, VISA, and Mastercard. If you have unusual circumstances, please speak with the doctor or the receptionist PRIOR to your endodontic treatment to arrange a dental payment plan.

We strive to help patients maximize their dental plan benefits. To minimize your out-of-pocket expense at the time of your visit, we will submit for direct payment of your dental plan benefits. Please be aware that each dental plan independently determines their UCR maximum fee allowances for each type of service. For this reason, we ask patients with dental plan benefits to take care of an estimated 25% minimum co-payment, plus deductible (if applicable) on the day of treatment. Upon receipt of your company's dental plan payment, we will refund any credit or bill the balance to you. While dental plans offer assistance, they rarely cover the entire fee. Please understand that our services are provided to you, the patient, and not to your dental plan. Therefore, you, and not the dental plan, are responsible for the account.

Thank you for your effort to save your tooth. It is a wise decision and we are pleased to be a part of the effort.

AMERICAN ASSOCIATION OF ENDODONTISTS

SPECIALIST MEMBER

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ENDODONTIC SERVICES

You are here for an evaluation and possible treatment of a tooth with root canal therapy. Root canal therapy or endodontics is 95% successful and the cost of this treatment includes all pre-op diagnosis, root canal therapy and all post-op care.

Of the 5% that do not heal, follow-up treatment involving a small surgical procedure may be needed. This procedure will be an additional fee. Again, all diagnosis, treatment, and post op care for the surgery will be included in that particular fee.

Please feel free to talk with Dr. Feltman or Dr. Risser and their staff today during your appointment regarding any questions that you may have about the procedure, fees, payment arrangements, insurance questions, or appointments.

If you decide to initiate treatment today, your next scheduled visit is very important. Success of treatment is based on a timely conclusion. If you fail to keep your scheduled appointment time without giving 24 hours notice, a $45.00 fee will be added to your account.. PLEASE keep ALL scheduled visits.

SIGNATURE_____

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ENDODONTIC SERVICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosure of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my provate information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are boound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

SPECIALIST MEMBER

Please Print Entire form **NAME**_____ First Middle Last	Telephone Home_____ Work_____	Date	Chart Number
Patient's Address	City	State	Zip Code

Patient's Age	Date of Birth	Sex M ☐ F ☐	Marital Status ☐Single☐ Married☐ Separated ☐Divorced☐ Widow

Patient's Occupation	Patient's Employer and Address
Patient's So. Sec. No.	Patient's Physician
Who was the dentist that referred you to us?	How long have you been a patient of this dentist?
Have you ever been treated in our office before? ☐ No ☐ Yes	Are you close to using up your maximum insurance benefits for this year? ☐ Yes ☐ No

PERSON RESPONSIBLE FOR ACCOUNT – (FINANCIAL RESPONSIBILITY)

First Name and Middle Initial	Last Name	Date of Birth

Street Address	City	State	Zip Code

Home Phone	Social Security Number	Occupation

Employer	Address

City-State	Zip Code	Business Phone

FILL OUT ONLY IF YOU HAVE DENTAL INSURANCE

PRIMARY DENTAL INSURANCE INFORMATION		**FILL OUT ONLY IF YOU HAVE A SECONDARY DENTAL INSURANCE PLAN**	
Employees name who has the insurance coverage DOB_____	Social Security Number	Employees name who has the insurance coverage DOB_____	Social Security Number
Address		Address	
Name of Insurance Company		Name of Insurance Company	
Address		Address	
City, State, Zip		City, State, Zip	
Is this employee: ☐Hourly ☐Salaried ☐Other What percentage will this insurance company cover?		Is this employee: ☐Hourly ☐Salaried ☐Other What percentage will this insurance company cover?	
Group Number	Service Code	Group Number	Service Code
How is this employee related to the patient? ☐ Subscriber ☐ Spouse ☐ Dependant		How is this employee related to the patient? ☐ Subscriber ☐ Spouse ☐ Dependant	

PAYMENT EXPLANATION

Our office policy requires that a portion of your bill be paid when treatment is started and the balance must be paid by the time treatment is completed, which is usually the second appointment. Please advise our receptionist if other arrangements are necessary, BEFORE SEEING THE DOCTOR. We accept cash, personal checks on local banks, money orders, Visa Mastercard. Charges not paid within 30 days will have a service charge of 1.5& per month (Annual Rate 18%) added to the past due balance on each monthly statement thereafter.

I agree to be responsible for any charges not paid by my insurance company.

_____ _____

DATE Signature of Patient or (Parent or Guardian of Minor)

CONSENT FORM

PATIENTS NAME_____
Last First Initial Date of Birth

I hereby authorize_____
DOCTOR'S NAME

And whomever he may designate as his assistants, to perform upon me the following operation and or procedures:

I request and authorize him to do whatever he deems advisable if any unforeseen condition arises in the course of these designated operations and or procedures calling, in their judgment, for procedures in addition to or different from those now contemplated.

I consent to the above treatment after having been advised of the risks, advantages and disadvantages of the treatments and consequences if this treatment were withheld.

I further consent to administration of local or general anesthesia, antibiotics, analgesics or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response (e.g., allergic reactions), cardiac arrest, and aspiration, and thrombophlebitis (e.g. irritation and swelling of a vein), pain, discoloration and injury to blood vessels and nerves which may be caused by injections of any medication or drugs.

I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include post-operative bleeding, swelling or bruising, discomfort, stiff jaws, loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g., numbness in mouth and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw which might require extensive surgery for removal.

I realize that in spite of the possible complications and risks, my contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation of procedure.

I have provided as accurate and complete a medical and personal history as possible including those antibiotics, drugs, medications and foods to which I am allergic. I will follow any and all instructions as explained and directed to me and permit prescribed diagnostic procedures.

I have had the opportunity to ask questions and receive answers to and responsive explanations for, all questions about my medical condition, contemplated and alternative treatment and procedures, prior to signing this form.

Patient or Guardian's Signature _____ Date _____

Dentist's Signature _____ Date _____

Witness's Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES
(DENTAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to you protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

PATIENT'S MEDICAL HISTORY

Yes	No	
☐	☐	Are you in good health?
☐	☐	Are you under a physician's care?
☐	☐	Are you subject to prolonged bleeding?
☐	☐	Have you ever had major surgery?
☐	☐	Have you been hospitalized in the last five years?
☐	☐	Are you pregnant? What month?_____
☐	☐	Do you have or been told you had TMJ(temporo-mandibular joint) syndrome?
☐	☐	Have you ever been treated for TMJ?
☐	☐	Do your jaws ever lock?
		Are you allergic or had an unusual reaction to.....
☐	☐	penicillin
☐	☐	novocaine
☐	☐	aspirin
☐	☐	codiene
☐	☐	valium
☐	☐	barbiturates
☐	☐	demerol
☐	☐	nitrous oxide
☐	☐	other _____
☐	☐	Are you taking any medications now?
		List them _____
		_____
		_____
		_____

Check any of the following which you have had or presently have...

- Aids or A/R/C ☐
- Heart Condition ☐
- Heart Pacemaker ☐
- Heart Angina ☐
- Heart Attack (coronary) ☐
- Heart Murmur ☐
- Congenital Heart Disease ☐
- Heart Surgery ☐
- Rheumatic Fever ☐
- Diabetes ☐
- Hepatitis ☐
- Ulcers ☐
- Stroke ☐
- Anemia ☐
- Asthma ☐
- Epilepsy ☐
- Glaucoma ☐
- Tuberculosis ☐
- Venereal Disease ☐
- Herpes ☐
- Fainting Spells ☐
- Kidney Trouble ☐
- Radiation Therapy ☐
- Psychiatric Treatment ☐
- Blood Disorders ☐
- Respiratory or Lung Disease ☐
- High Blood Pressure ☐

any other health Problems? _____

RECENT DENTAL HISTORY

(please check appropriate boxes)

I am here for treatment of:

☐ present pain ☐ past pain ☐ abscess

My dentist said I need:

☐ root canal ☐ consultation ☐ other (please describe) _____

For my problem I am presently taking:

☐ antibiotics ☐ pain pills ☐ other _____

Signature of Patient or (parent/guardian of minor)_____ Date_____