Richard J. Rauth D.D.S., M.S.
Practice Limited to Endodontics
1234 7th Street, Suite 3 ● Santa Monica, CA 90401● (310)393-9733 ● FAX (310)576-1383

INSURANCE CLAIM AGREEMENT FORM

I, _____, understand that the office of Richard J. Rauth D.D.S., M.S., is a fee-for-service office and that payment for services is due on the date of my appointment.

I understand that any insurance claims are sent as a courtesy and that it is my responsibility to follow up with my insurance company for any reimbursement not received by me within 3 months.

I also understand that Dr. Rauth's office is not responsible for following up with my claims or reimbursements being paid directly to me.

Patient Signature _____ Date _____

Richard J. Rauth D.D.S., M.S.
Practice Limited to Endodontics
1234 7th Street, Suite 3 ● Santa Monica, CA 90401● (310)393-9733 ● FAX (310)576-1383

HIPPA INFORMATION AND CONSENT FORM

PATIENT DETAILS

The Health Insurance Probability and Accountability Act (HIPPA) provides safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as a patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with our healthcare providers, laboratories, and health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree and abide by the confidentiality rules of HIPPA.

4. You understand and agree to inspections and review of documents which may include PHI by government agencies or insurance payers in the normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purpose of marketing or advertising of products, goods or services.

We agree to provide patients with the access to their records in accordance with state and federal laws.

7. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

8. You have the right to request restrictions in the use of your protected health information and to request the change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I,_____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature _____

Date _____

Richard J. Rauth D.D.S., M.S.
Practice Limited to Endodontics
1234 7th Street, Suite 3 ● Santa Monica, CA 90401● (310)393-9733 ● FAX (310)576-1383

Consent Form

Acknowledgment and Consent:

I, _____, have been informed about and understand the current condition of my tooth (teeth) that require(s) endodontic (root canal) therapy. I acknowledge dentistry is an exact science, but in no way does that imply success outcomes are 100% predictable. Therefore, no guarantees can be made regarding the outcome of a particular procedure because of a number of variables (we encourage you to ask questions if further explanation is necessary). While root canal therapy has an approximate success rate of 90%, various factors can influence both higher and lower success rates. Endodontic therapy is a treatment option aimed at saving a tooth that would otherwise need to be extracted.

I understand the consequences of electing "no treatment" be it root canal treatment, extraction, biopsy, or any other suggested treatment against medical advice can lead to worsening conditions, further infection, swelling, pain, tooth loss, and other systemic diseases and infections.

Possible Complications:

I am aware that root canal therapy may involve complications, including but not limited to:

- Post-operative soreness, swelling, bruising, and/or restricted jaw opening that may persist for several days.
- Breakage of an instrument inside the canal during treatment.
- Perforation of the root canal system with instruments, potentially requiring additional surgical treatment or resulting in the loss of the tooth.
- Possible removal of the treated tooth due to a fractured root (whether recently treated or long standing).
- Successful completion of the root canal procedure does not prevent future decay or fracture, which may result in tooth loss. Good oral hygiene and scheduling your periodic recall exams (no fee) are critical in the long-term health of the tooth. An endodontically treated tooth is less strong and more prone to fracture than a natural tooth without root canal treatment. * In most cases, a full crown is recommended after treatment to reduce the risk of fracture. **

Confirmation of Understanding:

By signing below, I certify that I understand the recommended treatment, the risks associated with the treatment, alternative treatments, and the risks of those alternatives, including the consequences of not undergoing any treatment. I have had the opportunity to ask questions and have received satisfactory answers.

Signature: _____ **Date:** _____

*Root canal-treated teeth are not more brittle than normal teeth; they are less strong due to the structural access required for the treatment, not a change in the bio-materials of the tooth.

**Every posterior tooth that has undergone root canal treatment should receive a full coverage restoration (crown). Typically, teeth requiring endodontic therapy have had extensive dental treatment and lack sufficient tooth structure, therefore the teeth are compromised and in a weakened condition. Cementing a full coverage crown after root canal treatment is the best way to enhance the tooth's survivability, success, and long-term health.

Richard J. Rauth D.D.S., M.S.
Practice Limited to Endodontics
1234 7th Street, Suite 3 ● Santa Monica, CA 90401● (310)393-9733 ● FAX (310)576-1383

Cancellation and No-Show Policy

Office hours are by appointment, and we do value your time. This office is a private practice dental office and not a dental "clinic". Appointment time is reserved for you alone. Where appropriate, we prefer to schedule longer appointments so we can complete as much needed dental treatment as possible during one appointment. We feel this type of scheduling will cause minimal disruption to your daily schedule and will provide efficiency in completing your dental care. When you make an appointment, please be sure that you will be able to keep it. Morning appointments may be best for more complicated procedures.

Emergencies and unforeseen patient treatment problems may arise, causing schedule changes. Emergencies are unexpected and seem to come at the most inconvenient times. If you have a dental emergency that needs immediate attention, we will always offer to see you at once. We expect that other patients, who might be slightly inconvenienced by this, will understand the situation. At some point, they may need the same courtesy too.

This office does call/e-mail and/or text to confirm your appointment depending on your preference. Please make note of any dental appointments we have scheduled in a place where you will easily be reminded. If you cannot make an appointment as scheduled, please notify the office as soon as possible. **Cancellations with less than 24-hour notice of your scheduled appointment is considered a no-show appointment and may be subjected to payment for reserving the doctor's time. At the doctor's discretion the broken appointment fee can range from $100 to the full fee of the scheduled endodontic treatment.**

If you have any questions about your appointment cancellation and no-show policy, please feel free to ask us.

Patient's Name (PRINT):_____

Patient/Guardian Signature:_____ **Date:**_____

Financial Responsibility

I,_____, understand that Dr. Richard Rauth's office is **Fee-For-Service**, which means the financial responsibility for payment of dental services provided in this office for myself, or my dependent, is mine. **I am aware payment in full is due at the time services are rendered, unless other arrangements have been made with Dr. Rauth.** I have been informed that if I have PPO Dental Insurance, a claim will be submitted, as a courtesy, for the benefits to be mailed directly to the subscriber. **Please inquire with the front desk about treatment financing.**

Patient/Guardian Signature:_____ **Date:**_____