Joseph B. Suffridge, D.D.S., P.A.
Practice Limited to Endodontics
707 W. Faulkner
El Dorado, AR 71730
419 Highway 5 North
Benton, AR 72019

FEE SCHEDULE AND PAYMENT OPTION FORM

Thank you for selecting our office for your endodontic treatment. Please review our fee schedule. **All patients, please complete BOTH parts A and B below**. Please speak with our Financial Coordinator, prior to treatment, if you have any questions.

A.

Endodontic Fees:

Consultation	$95–150	
Nitrous Oxide	$65	
Post and Core	$250	
Core Build up	$175	
Root Canals:	Anterior:	$830
	Premolar:	$940
	Molar:	$1,095
Retreatment:	Anterior:	$910
	Premolar:	$1,040
	Molar:	$1,295

Payment Options:
Please write your initials by the option that is best for you.

Check_____ MasterCard_____

Cash_____ Visa_____

Care Credit*_____ (balances of $350 or more)
If you are a first-time Care Credit user, please notify the front desk.

Additional Fees could be charged for the following: calcified canals, curved roots, retreatments, post removal, microsurgery and any problems which may become apparent before, during or after treatment.

Dental Insurance Coverage Information
Filing A Claim

As a courtesy to our patients, we will be happy to complete and file the necessary forms for your claim. If your insurance company is Blue Cross Blue Shield, they will not pay us directly so you will be responsible for all fees and Blue Cross Blue Shield will reimburse you. With all dental insurance, your coverage is a contract between you and your insurance carrier. All fees charged are ultimately your responsibility if not paid by your insurance company. Any questions regarding your reimbursement should be directed to your insurance company.

Either fill out below or give insurance card to front desk.

B.

Primary Insurance

Ins. Co._____
Ins. Group #_____
Ins. Phone #_____
Employer_____
Subscriber Name_____
Subscriber ID #_____
Birthdate_____
Soc. Sec._____

Secondary Insurance

Ins. Co._____
Ins. Group #_____
Ins. Phone #_____
Employer_____
Subscriber Name_____
Subscriber ID #_____
Birthdate_____
Soc. Sec._____

Should this matter be turned over to collections, all costs, including reasonable collection fees, attorney fees, and court cost incurred by Joseph B. Suffridge, D.D.S., P.A. shall be borne by the undersigned.

You are financially responsible for all services rendered at the time of your appointment.

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Signature of Patient **Date**

If under the age of 18, signatures must be by parent or guardian.