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KEVIN P. CUNNINGHAM, D.D.S., L.L.C.
Practice Limited to Endodontics
11900 West 87th Street Parkway, Suite 160
Lenexa, Kansas 66215

Our Financial Policy

Thank you for selecting Kevin P. Cunningham, D.D.S., L.L.C. for your Endodontic care. We are committed to your treatment being successful. In order to do so, we have prepared a statement of our Financial Policy. We require that you read, agree to, and sign it prior to any treatment.

Our office accepts numerous insurance plans. Every plan is different. It is up to you to know the exact requirements of your insurance plan. In order for us to file insurance claims on your behalf, you must present proper proof of insurance at the time of your visit. If you are not able to provide proof of insurance or you do not have the required referral form you must either pay in full at the time of service or you may choose to reschedule your visit.

Insurance benefits are based on a contract between your employer and the insurance company. Your benefits have been set according to your contract terms, and we must follow those terms exactly. Please do not ask us to provide services outside those terms, or to file your claims in any other manner, as we cannot do so. Some benefits are based on usual and customary fees charged by all dentists in the community, not just specialists. We will be more than happy to file your primary and secondary coverage insurance. However, if your insurance hasn't responded within 45 days, full and prompt payment will be expected from you.

The fee for an examination, diagnosis, and treatment planning is usually less than $100. The fee for a root canal treatment is usually between $700 and $1300 depending on tooth location and difficulty. Additional fees may be charged for, calcified canals, curved roots, retreating existing root canals, post placement or removal, microsurgery, after hours, emergency or for other problems which may become apparent before, during or after treatment. Fees do not include final fillings or crowns placed by your referring dentist. Please understand that payment of your bill is considered a part of your treatment. Full payment (less estimated insurance benefit) is due at time of service.

Please **circle** which method of payment you prefer:

Cash
Check (Verified electronically through TeleCheck)
Mastercard, Visa, or Debit Card

No warranty or guarantee of success has been or can be given in root canal treatment. No refund is due if you lose the tooth or if complications occur. By signing below you acknowledge full responsibility for the payment of our services at or before completion of treatment unless you make arrangements with our staff. A late payment charge may be assessed on any late payments in accordance with the terms of agreement. Your signature also authorizes your insurance carrier to pay the dental benefits of your plan directly to us and lets us release any information necessary to process your dental insurance claim.

I have read, understand, and agree to the above Financial Policy.

Patient or Responsible Party _____ Date _____

Co-Responsible Party _____ Date _____