RAMBOD KAMRAVA, D.D.S.
PRACTICE LIMITED TO ENDODONTICS
5400 BALBOA BLVD., SUITE 327
ENCINO, CA 91316
818-981-8115

Endodontics is a specialty in the field of dentistry dealing with root canal related procedures. You have been referred to our office to receive root canal treatment, or for an evaluation to determine if a root canal procedure is required. Endodontic procedures enable most teeth to be saved that would otherwise be lost. Our fees have been established according to the complexity of the evaluation and treatment required.

If you have insurance coverage we are happy to extend the courtesy of filling out the necessary forms to see that you receive full benefits of your coverage: however, ***we cannot and do not guarantee any estimated coverage. You are responsible for the full cost of the treatment.*** Problems with regards to eligibility, allowance, fees and/or coverage by your insurance company are your responsibility and will require you to contact your insurance company directly. You may wish to complain to your company's benefits representative should your benefits be less than you expect. ***Your credit card will be charged if:***

1. ***there is a remaining balance after receipt of your insurance payment.***
2. ***the insurance information provided is incorrect.***
3. ***payment is not received from your insurance company within 60 days from the date of service.***

If you do not have insurance the full fee is due at the time of service.

If you do have insurance, please choose the payment option most comfortable for you:

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover ☐ Care Credit

Card # _____

Expiration date_____CID#_____

Name on Card _____

I authorize Rambod Kamrava, DDS to charge my credit card for endodontic treatment provided. I agree not to dispute charges applied to my credit card for the endodontic treatment that was provided.

Signature _____ Date _____

If you have insurance

I hereby authorize any Provider, Insurer or other Organization to release any information regarding the dental history, treatment, or benefits payable for this claim to the Plan Administrator or its authorized agent for the purpose of determining benefits payable.

Signature_____

I hereby authorize payment directly to Rambod Kamrava, DDS for services rendered.

Signature_____