ADVANCED DENTISTRY of COLLEGEVILLE

NELLY SILVA, DMD

CREATING BEAUTIFUL, HEALTHY SMILES THAT LAST A LIFETIME.

WELCOME TO OUR PRACTICE!

Thank you for choosing our office today! We pride ourselves in having our patient's brag that we provided much more than any other dentist then they visited. We understand your concerns and try to make your stay with us as comfortable as possible. We listen to you and openly encourage good communication. Please advise us of your personal needs and how we can make your stay more pleasant. We hope that you enjoy your visit with us today and come back often. Thank you for allowing us to provide you with quality dental care tailored to your needs.

Appointment Cancellation Policy:

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an **Appointment Cancellation Policy** that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office **48 hours** notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of **$25-100** or **percentage of the treatment cost** will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled without the payment of this fee.

Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the **$25-100** cancellation fee will be charged.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

YOUR HELP IS GREATLY APPRECIATED!

Please provide us with the correct insurance information so that we can submit your insurance claims timely fashion. Because of the number of insurance plans, and frequency of changes, the insurance information is the patient's responsibility. We require all financial arrangements to be completed before treatment begins, so that together we can provide the best possible care without misunderstandings.

The patient is responsible for any part of the bill not covered by insurance. If a balance remains unpaid after 3 months, billing will then be directed to your immediate attention. We will do everything possible to get reimbursement form your insurance company, but please

HIPPA COMPLIANCE

We are fully HIPPA compliant to protect your personal health information. By signing below, you acknowledge that you have read the Office Privacy Policy Notice.

In case you do not agree to sign this acknowledgement, you must indicate why you declined to do so.

LIMITED POWER OF ATTORNEY

The dental Office is authorized to fill out and/or to assist me to complete all insurance forms pertaining to services rendered. This Dental Office is also authorized to sign insurance forms when payment is due if I am not present at the time of the completion of the form.

Responsibility and Consent Statement

I hereby authorize and request the performance of Dental Services for myself or for ___age___.

I also give my consent to any necessary dental procedures, medications, or anesthetics to be administered by the attending physician or by the supervised staff for diagnostic purposes or dental treatment. I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage.