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.

As a courtesy of our patients if you arrive more than 10 minutes late to your appointment you may be asked to reschedule your appointment.
We reserve a time specifically for you. We do ask for 48 hours' notice, otherwise $50 cancellation fee will be assessed to your account

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 understand this office has no control over the response of the insurance companies. To avoid finance, charge your payment will be due within 30 days after the insurance claim has processed. Dr. Silva feels that to wait more than 90 days to be reimbursed for services completed is not only unreasonable, but unfair to the practice.

If this account is turned over to an attorney or collections agency, in addition to all sums owing, the patient agrees to pay all collections costs, attorney's fees.

Your signature below indicates that you understand and agree to the policies above and you give authorization for all future work performed and that you authorize payment for dental benefits from the appropriate insurance companies to Dr. Silva for services and treatment rendered.

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.