Vela Dental Centers

FINANCIAL POLICY

We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile with respect to your budget. **Payment is due prior to the rendering of services.**

PAYMENT OPTIONS

Cash or check: We are pleased to accept cash and checks drawn on local banks for payment of all treatment.
Debit and Credit cards: For your convenience, we have made arrangements to accept payments by Visa, MasterCard, Discover, and American Express.

DENTAL INSURANCE

We will be happy to file your insurance paperwork for you; however, we cannot guarantee any estimate of coverage we receive from your insurance company. Because your insurance policy is an agreement between you and your insurance, we require that your portion of the treatment estimate be paid in full prior to completion of your treatment. You are ultimately responsible for all payment due.

PAYMENT PLAN

We offer and accept 3rd party financing for patients who prefer to make extended monthly payments. A simple credit application is filled out and credit is approved or denied. If you are interested in financing your dental care, please inform our front office team member and ask for an application.

CareCredit Making care possible...today. Springstone PATIENT FINANCING UNITED MEDICAL CREDIT

Please indicate if you are interested in applying for 3rd party financing. We may have a response today making your ability to receive treatment almost immediate.

CANCELLATION / RESCHEDULING

Patients who cancel / reschedule / no show for their appointment without 24 hour notice will NOT be reappointed for treatment and may only be seen on a "walk-in" basis or referred to another dental provider.

Our office strives to be efficient and punctual. Please keep your scheduled appointments. Thank you!

_____I am interested in applying for Patient Extended Financing.

_____ I am not interested in 3rd party financing at this time.

Signature _____ Date _____

Vela Dental Centers

GENERAL CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other health care providers involved in my treatment)
Obtaining payment from third party payers (e.g. my insurance company)
The day-to-day health care operations of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at anytime. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.

_____

Print Patient Name _____

Person Authorized to Consent_____ Relationship to Patient_____

Signature_____ Date _____

Office Staff Member _____ Date _____

Vela Dental Centers

GENERAL CONSENT FORM

Please read this form carefully. Should you have any questions, our team will be delighted to help you.

1. I hereby authorize and direct the dentists of the Vela Dental Centers and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (X-Rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.

2. Certain parts of the treatment may be performed by dental assistants and dental hygienists.

3. I also authorize the dentists and/or dental auxiliaries of the Vela Dental Centers to take and to use photographs, radiographs, other diagnostic materials, and treatment records for the purposes of advertising, teaching, research, and scientific publication and, in any such publication or use no patient will be identified by name.

4. I understand any and all diagnostic aids acquired in the office are the property of the doctor but copies are available upon request for a fee.

5. As a general (non-specialty) practice, the dental procedure(s) can include but not be limited to:
   - Oral Examination with or without radiographs.
   - Cleanings and the application of fluoride and sealants for preventive maintenance.
   - Treatment of diseased, or injured teeth with dental restorations, crowns, or root canal treatment.
   - Treatment of periodontal disease with scaling and root planning and other modalities.
   - Surgical procedures including extractions and placement of dental implants.
   - Replacement of missing teeth.
   - Treatment of habits and malposed (crooked) teeth with clear aligners and nightguards.
   - Analgesia or conscious sedation may be recommended or requested but is limited to availability.

6. The Vela Dental Centers is not responsible for previous dental treatment which may require replacing.

7. I realize that guarantees of results or absolute satisfaction are not always possible in dental health service. I understand that my compliance as a patient and full dental and medical history affect success.

8. I have answered all the questions about me or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all medical conditions, including allergies. I also understand if I or my dependent ever had any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment.

9. I authorize the Vela Dental Centers to forward a review of findings and/or any other dental information to the referring doctor (if such has been the referral source) or any other health care giver for his/her records, as well as any third parties such as insurance companies who may request information.

_____**Initial**

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