

JONATHAN A. LEVEY, D.D.S.
FAMILY DENTISTRY
(425)391-5511

INFORMATION POLICY ABOUT YOUR DENTAL SERVICES

Our office strives to maintain a high-quality, personal Dental Practice committed to excellence. Our goal is to involve you as an active participant in your dental care. In order for us to provide quality, efficient, care, we would like to share information with you about financing healthcare. We hope that by providing you the following information, we can prevent misunderstandings and that you will be comfortable discussing financial and insurance matters with us.

- We request that you pay in full at your first visit if you don't have dental insurance. If you have insurance, please pay that portion which insurance does not cover.
- We accept VISA, MASTERCARD and CARE CREDIT
- Remember that, if you have insurance, the insurance contract is between the patient and the insurance company. The patient is responsible for all account balances, even with insurance benefits. We will bill your insurance as a courtesy to you, but we cannot guarantee your benefits. We will only bill those insurance companies for which you provide written information to us prior to the treatment given. If your insurance provider informs us of benefits that you are entitled to, we will advise you of same. Any oral representation we make in good faith to you concerning your insurance is not binding on us and will not in any way or for any reason be considered a modification of this in writing.
- This information sheet is the full and final agreement between this office and you regarding your insurance and benefits, and may not be modified without a written agreement signed by you and this office.
- Within 30 days of service, the balance should be paid in full. Interest will be charged at 12% per year (1%per month) on balances over 90 days past due.
- Many insurance plans cover a certain percentage of the fees. Normally, the insurance company will cover the "usual and customary fees." These benefits are determined normally by how much your employer paid for the plan. Your insurance, as a result, may cover less than you thought they might have. Please be familiar with the benefits provided by your plan.
- The age of majority in this state is 18 years old. The parent that brings in the minor child is responsible for payment.
- Past due accounts will be sent to a collection agency at our discretion. We charge \$25.00 for checks returned due to insufficient funds.
- Broken appointments are charged a \$75.00 fee if a least 24 hours notice is not given.
- I understand credit information may be accessed in order to determine my credit worthiness. I understand that I am responsible for the entire balance of the account and that this office is extending credit to me.

I AGREE THAT I AM RESPONSIBLE FINANCIALLY FOR ALL BALANCES DUE.

Signature _____ Date _____

Printed Name _____

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

Jonathan A. Levey DDS
22725 SE 29th St.
Sammamish, WA. 98075
(425)-391-5511

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other

Patient Records Request Form

Jonathan A. Levey DDS
22725 SE 29th ST
Sammamish, WA 98075
Ph. 425-391-5511 / Fax. 425-391-4923

Name of Patient Whose Record is Requested _____

Date of Birth _____ Phone _____

Address _____ City/State/Zip _____

Please provide a copy of the record maintained by this provider/practice

The full health record maintained by this provider/practice

The health record for the following time frame: _____ through _____

A specific section of the health record as described below: _____

A summary of the information requested above is adequate to fulfill this request.

As permitted by federal and state law, I understand that a fee of _____ per page will be charged for copying the records along with a clerical fee of _____. In addition, a fee of _____ will be charged for any duplication of x-rays. I agree to pay this charge in full at the time I receive the copy of the record.

Signature of Patient _____

Signature of Authorized Personal Representative _____

Relationship to Patient _____

Date _____