Dr. Harvey Levy & Associates, P.C.
198 Thomas Johnson Drive, Suite 108, Frederick, MD 21702
Office: (301) 663-8300 Fax: (301) 682-3993 E-mail: appointments@drhlevyassoc.com

Personal Information

Patient's Name: ______________________ Nickname: __________
Last First MI Mr. Ms. Mrs. Dr.

Date of Birth: ___/___/_____ SSN: ___-___-____ ☐Single ☐Married ☐Child ☐Other

Home Address: ______________________________
Street City State Zip

Home Ph: (   ) ________ Cell Ph: (   ) ________ Work Ph: (   ) ________ Preferred #: ☐H ☐C ☐W

E-mail: ______________________ **Referred By:** ______________

Employer/School: ______________ **Occupation:** __________ How long there? ______

Work/School Address: ______________________________
Street City State Zip

Spouse's or Parent's Information

Name: ______________ Relation: __________ Ph: (   ) ________

Employer: ______________ Title: __________ How long there? ______

Name: ______________ Relation: __________ Ph: (   ) ________

Employer: ______________ Title: __________ How long there? ______

Emergency Contact

Name: ______________ Relation: __________ Ph: (   ) ________

Person financially responsible for account, if not yourself

Name: ______________ Relation: __________ Ph: (   ) ________

Address: ______________________________
Street City State Zip

Dental History

Most recent cleaning? ________ Most recent visit? ________ What was done? ________

Previous Dentist: ______________ City, State: ______________ Ph: (   ) ________

How often do you brush? ______ Floss? ______ Any additional hygiene aids? ________

Have you ever had any of the following conditions? Please circle "yes" or "no" for ALL

Y N Bleeding Gums	Y N Tired Jaws	Y N Periodontal (Gum) Treatment
Y N Tender/Swollen Gums	Y N Clenching Teeth	Y N Endodontic (Root Canal) Treatment
Y N Loose Teeth	Y N Burning Tongue	Y N Complicated Extraction
Y N Sensitive Teeth	Y N Sinus Conditions	Y N Crown (Cap) or Bridge
Y N Mouth Sores	Y N Fear of Dentistry	Y N Removable Dentures
Y N Pain in Mouth	Y N Sedation for Dental Work	Y N Dental Implants
Y N Ear Ache	Y N Orthodontic (Braces) Treatment	Y N Oral Habits ____________

Please describe any unusual dental experience: ______________________

Please list any medication you need to take prior to dental work: ______________________

Medical History

Last Visit to Physician:____________ Reason: ______________________________

Physician's Name:________________________ City, State:_____________________ Ph: ( ) __________

What drugs or medications are you taking now and why? ______________________________

Have you ever had any of the following conditions? Please circle "yes" or "no" for ALL

Y N Rheumatic Fever
Y N Heart Murmur/Condition
Y N Pacemaker/Other Device
Y N Prolonged Bleeding
Y N Herpes I or II
Y N AIDS/HIV
Y N High Blood Pressure
Y N Low Blood Pressure
Y N Cancer/Malignancy/Tumor
Y N Artificial Joint/Rod

Y N Deaf/Hard of Hearing
Y N Diabetes
Y N Epilepsy/Seizures
Y N Tuberculosis
Y N Hepatitis
☐ A ☐ B ☐ C ☐ D
Y N Radiation/Chemotherapy
Y N Mentally Challenged/Autistic/CP
Y N Nervous Problems/Psychiatric Care
Y N Major Surgery __________________
____

Y N Asthma
Y N Sleep Apnea
Allergic to:
Y N Aspirin
Y N Penicillin
Y N Codeine
Y N Novocaine
Y N Latex
Y N Other ____________________
____

Women: Are you currently pregnant? ________ If so, how many weeks? __________________

If you marked **YES** to any of the answers above, please explain: ______________________________

How much/often do you smoke?__________________________

What hospitalizations have you had in the past 5 years? ______________________________

Any other medical information the doctor should be aware of? ______________________________

Dental Insurance

Will you be using dental insurance? ________

Name of Dental Insurance Company: ______________________________

Patient Consent

I hereby consent to the treatment requested by me, including but not limited to the taking of photographs and dental radiographs for diagnostic, promotional and educational purposes, and the use of local anesthetics, relaxant medicines, physical restraints, laughing gas or a combination as required for completing treatment rendered. I understand that perfect results cannot be guaranteed. I certify that all the above information is true and correct to the best of my information, knowledge and belief.

______________________________(SEAL) ______________________
Patient's Signature (Parent/Guardian) Date

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OFFICE FINANCIAL AND INSURANCE POLICY

July 21, 2016

Thank you for choosing Dr. Harvey Levy & Associates, P.C., as your dental practice. We've been striving to keep our fees fair and reasonable since opening our doors in 1980. You assist that effort when you pay at the time of service.

This practice will make every effort, to the best of our knowledge and ability, to inform you of your treatment options and associated fee ranges.

PAYMENT

Payment is required at the time of service. To make payments convenient for you we accept cash, money order, debit card, check, all major credit cards, and third party financing through Care Credit.

DENTAL HEALTH CLUB

If you are not covered by an insurance plan, we offer discounted fees through our Dental Health Club. Terms are described in our Dental Health Club brochure dated 4/26/2016.

INSURANCES

We fully cooperate with patients who are covered by insurance plans. Please check with your insurance company if Dr. Harvey Levy, Dr. David Somerville, Dr. Niraj Patel or Dr. Sunanda Bhushan is on your list of providers. Please read your policy carefully and become familiar with its benefits and limitations.

It is important that you understand that in most cases your insurance is designed to reduce your cost, NOT eliminate it completely. You are ultimately responsible for the full amount of your bill, regardless of your insurance coverage.

All patients who have insurance are expected to pay 100% of their deductible and co-payment at the time of service. Any difference will be billed or refunded after the insurance payment has been received.

DUAL INSURANCES

If you have dual insurance and correct information is provided to our office, we will be happy to submit to your second insurance after your first insurance has paid its portion.

SENIOR CITIZEN DISCOUNT

Patients 65 or over may claim a 5% Senior Citizen discount on payments made on the day of service. This discount does not apply to members of our Dental Health Club.

DISCOUNTS FOR COSTLY PROCEDURES

If you pay 100% of your uninsured portion on the day of service, or pay 100% of the uninsured portion of your entire treatment plan on the first day of service, the following discounts apply:

- Payments made with cash, money order, debit card or check will receive a 5% discount for charges over $300 or 10% for charges over $1000.
- Payments made with a credit card will receive a 3% discount for charges over $300 or 8% for charges over $1000.

These discounts do not apply to members of our Dental Health Club or to patients using Care Credit.

DOWN PAYMENTS FOR APPLIANCES

At the start of cases requiring appliances (bridges, crowns, dentures etc.) we require a down payment of at least 50% of your anticipated portion of the treatment, to cover the lab fee, with the remaining patient portion due at delivery.

OPERATING ROOM AND OFF-SITE CASES

All estimated fees and co-payments must be paid one week prior to the treatment date. The senior citizen and other discounts are applicable as stated above.

OUTSTANDING ACCOUNTS

If an account is outstanding for more than thirty (30) days, interest at the rate of 18.0% per year will be added to the balance. If the account is not cleared within sixty (60) days, we will proceed with legal action.

If legal action has to be initiated to collect overdue balances, you become responsible for all attorney and court fees.

Patients who have made arrangements under a prior financial policy and who are still carrying balances may NOT add to their existing balances. Any new work must be C.O.D. (cash on delivery of service) in addition to monthly payments on the old balances.

(Continued on back)

Date: ________________ Initials: _______

RETURNED CHECKS

Any check returned to our office is subject to an additional clerical fee of $39.00. Immediate remittance of the amount due plus the clerical fee, in the form of cash, money order, or credit card, is expected. Failure to do so in 30 days will result in the outstanding account being charged an interest rate of 18.0% per year.

MISSED APPOINTMENTS

When time has been reserved for you and you do not keep your appointment (or fail to contact the office 24 hours prior to the appointment to cancel), a minimum overhead fee of $60 will be charged to your account. Additional pro-rated fees of $60 per hour will apply if the missed appointment is longer than one hour.

REQUESTS FOR X-RAYS

All requests to send a copy of x-rays to the dentist of your choice must be received in writing (by HIPAA law, originals remain property of the permanent record). Please allow one week for processing and note that a pre-paid handling fee of $35 is required.

QUESTIONS OR CONCERNS

If, at any time, you have a question about this policy or your account, please do not hesitate to contact one of our Front Desk Coordinators for assistance. We are pleased to be your dental provider, and thank you for your cooperation.

I have read the above policy (front and back) and agree to be bound by these terms.

___________________ ____________ ____ __________________________ (SEAL)

(My Name, Printed) (My Signature) (Today's Date)

GUARANTOR OR OTHER RESPONSIBLE PERSON:

I have read the policy (front and back). I agree to accept all financial responsibility for: ________________________________

(Patient's Name)

___________________ ____________ ____ __________________________ (SEAL)

(My Name, Printed) (My Signature) (Today's Date)

Last revised 9/1/16 lrr

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Communication Authorization

Patient's Name: ______________________________ Date of Birth: ____/____/____
Last First MI

I, ______________________________, (☐ Patient ☐ Parent/Guardian) give permission to

Dr. Harvey Levy and Associates, P.C. to discuss the following:

☐ Diagnosis, prognosis and/or treatment information

☐ Scheduling information

☐ Billing information

☐ Other (please specify): ______________________________

with the following people:

______________________________ Relation: ______________ Ph: (____) __________

______________________________ Relation: ______________ Ph: (____) __________

______________________________ Relation: ______________ Ph: (____) __________

I also authorize Dr. Harvey Levy and Associates, P.C. to:

☐ Leave messages on my cell voicemail

☐ Leave messages on my home answering machine

☐ Leave messages on my work answering machine/voicemail

☐ Send e-mails and/or text messages (may opt-out at any time after receiving initial e-mail or text)

☐ Leave messages with members of my household

Consent for Use and Disclosure of Health Information - HIPAA

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Lena Rotenberg
Telephone: (301) 663-8300 **Fax:** (301) 682-3993
E-mail: hipaa@drhlevyassoc.com
Address: 198 Thomas Johnson Drive, Suite 108, Frederick, MD 21702

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

______________________________(SEAL) ______________

Patient/Parent/Guardian's Signature Date

Dental Claim Form

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HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

19. Student Status ☐FTS ☐PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)

33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44) | 44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) – | 52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hearby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56A. Provider Specialty Code

57. Phone Number ( ) – | 58. Additional Provider ID