Office Guidelines and Privacy Policy

APPOINTMENT POLICY;

Our office prides itself on running on time. We respect your time and hope that you will do the same for us. A minimum charge will be made for a failed or cancelled appointment without 24 hour notification. Once an appointment is made, please remember that this time has been especially reserved for you.

FINANCIAL POLICY;

For those patients who do not have insurance coverage, fees are due at the time of service. If you anticipate any problems, please contact our office prior to any treatment.
For those patients that do have dental insurance, we would be pleased to submit dental information for you to your insurance company. You are responsible for your estimated share at the time of treatment. Please realize that we are not a party to the agreement between you and your insurance carrier, and that you are responsible for any amount that they do not pay.
We offer many payment options: Cash, Check, Visa and MasterCard.
We also have available Care Credit: an outside payment plan that offers no interest/low interest options.
Please see our receptionist if you have any questions.

PRIVACY POLICY NOTICE;

Please review the following and sign below:
In connection with the medical service that I am receiving from Dr. Levine, I authorize the office to disclose any information concerning my medical/dental treatment, including copies of my records, to:
-any third party payer covering the medical/dental services of the patient;
-other health care professionals and institutions involved in the delivery of health care to the patient;
-the proponent of any legally sufficient subpoena, or in response to a court order;
-employees and agents of our practice, to the degree necessary to facilitate the provision of health care services and payment for such services;
-pharmacies; and
-other parties as otherwise required by law.

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given access to the physician's privacy notice and that I have had the opportunity to place special restrictions upon the consent hereby given:

Special Restrictions: (if any)_____

This consent is valid from the date executed until revoked in writing by the patient.

Signed_____ Date___/_____/_____

Privacy director's signature_____