Dr. Harvey Levy & Associates, P.C.
198 Thomas Johnson Drive, Suite 108, Frederick, MD 21702
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OFFICE FINANCIAL AND INSURANCE POLICY

6/15/2020

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. The terms on the Membership Enrollment you signed will govern the financial aspects of your agreement with us. No other discounts apply.

In the event you set up a payment plan with us to cover the Dental Health Club yearly membership, you'll be required to keep your credit card on file. Payments will be automatically drawn on pre-arranged dates. Your credit card information is secure and will not be stored in our office or on our computers.

INSURANCES

We fully cooperate with patients who are covered by dental insurance plans. Please check with your insurance company if Dr. Harvey Levy, Dr. David Somerville or Dr. Niraj Patel 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.

If you are covered by dental insurance the only additional discount that is applicable is the Senior Citizen Courtesy Adjustment.

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 COURTESY ADJUSTMENT

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

DISCOUNTS FOR COSTLY PROCEDURES

If your out-of-pocket expense for dental treatment on a given day is greater than $300 you may receive a 5% discount as long as payment in full is received on the day of service. This discount is also applicable if your co-pay from out-of-network insurance is greater than $300.This discount does NOT apply if you are:

- receiving a dental insurance write-off
- receiving a Dental Health Club discount
- using Care Credit for payment.

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.

Anesthesia and facility fees are billed directly by the facility. Any questions regarding insurance billing, co-pays or remaining balances should be directed to the facility and not our office.

OUTSTANDING ACCOUNTS

If an account is outstanding for more than thirty (30) days, interest at the rate of 6.0% per year may be added to the balance. If arrangements are not made with our accounts receivable specialist and the account is not cleared within sixty (60) days, we may proceed with legal action.

(CONTINUED ON BACK)

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.

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 may be charged to your account. Additional pro-rated fees of $60 per hour may apply if the missed appointment is longer than one hour.

RESCHEDULING OR RUNNING LATE

With pre-screening and social distancing requirements, it is crucial that you arrive on time for your appointment. Please call or text us ahead of time at 301-663-8300 if you are not feeling well or running late. Should your appointment need to be rescheduled, missed appointment fees may apply.

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.

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 06/15/2020 lrr