Levie Family Dentistry

- **All Patients Please Sign:** Any balance due beyond 60 days from the date of service will be assessed a monthly fee. Any court/attorney's/ collection fees will be the responsibility of the person whose signature appears below. Also, all returned checks will have a $25.00 fee assessed. A dishonored check must be paid by one of the following: cash, cashier's check, money order, Discover, MasterCard, or Visa within seven business days of notification of the dishonored check.

Signature: _____ Date_____

- **All Patient's with Dental Insurance Please Initial the Following:** As a service to our patients, we will file your insurance claim. We accept most major plans involving direct reimbursement. In the event your insurance company has not paid all or part of the claim within 30 days, you will be responsible for the full balance due. You agree to pay the balance in full within 10 days from the date of the statement you receive. Any monies paid to this office by your insurance company after you have paid your balance in full will be reimbursed to you in a timely manner.

Please Initial: _____

- **All Patients Please Print Name and Sign:** I_____ have
  Please Print Name

  received a copy of this office's Notice of Privacy Practices.

Signature: _____ Date_____

Section Below For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___Individual refused to sign ___Communication barriers prohibited obtaining the acknowledgement

___An emergency situation prevented us from obtaining acknowledgement ___Other