

STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of. This includes issues relating to your treatment, payment, and our dental care operations. Your personal health information will never be otherwise given to anyone - even family members - without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

Patient Rights!

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at Drs. Levin, Leff and Pollock. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

STANLEY M. LEVIN, D.D.S.
GARY S. LEFF, D.D.S.
RICHARD M. POLLOCK, D.M.D., LTD
BRUCE T. SALLEN, D.M.D.
MICHAEL R. PICHARDO, D.D.S.
JASON J. SETLOCK, D.D.S.
TU-QUYNH BAO NGUYEN, D.D.S.

PRACTICE LIMITED TO ENDODONTICS

311 PARK AVENUE
FALLS CHURCH, VA 22046

BURKE PROFESSIONAL CNTR
8987 HERSAND DR
BURKE, VA 22015

11710 PLAZA AMERICA DR
SUITE 150
RESTON, VA 20190

3801 N. FAIRFAX
SUITE 40
ARLINGTON, VA 22203

I acknowledge receipt of the "statement of privacy practices" from
Drs. Levin, Leff & Pollock.

Patient: _____

Signature: _____

Date: _____

DRS. LEVIN LEFF & POLLOCK, LTD.

COPAYMENT REQUIRED AT THE TIME

SERVICES ARE RENDERED

THANK YOU

LEVIN, LEFF & POLLOCK, LTD

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FINANCIAL POLICY

A Guaranteed form of payment **in full** must be received by the time services are rendered. For your convenience, we have made the following list of options available to you. Please check the method of payment that best suits you. You may choose more than one option:

- Cash
- Personal Check
We will need a copy of a current driver's license from the payor. There is a \$35.00 charge for all checks that are returned to Levin, Leff & Pollock & their associates unpaid
- Credit Card
We accept VISA, MASTERCARD, AMERICAN EXPRESS and DISCOVER
- American General Financial
This is an "Instant Credit" option for those with solid credit rating. We have applications in our office and will explain the program to you.
- Assignment of Dental Benefits through your Insurance Carrier
We will accept the assignment of dental benefits upon your signed authorization. We will do our best to provide you with an ESTIMATE of your co-payment. However, benefit payments cannot always be precisely determined in advance. ESTIMATED co-payments are due at the time services are rendered. If your insurance has not paid within 90 days of submission, you will be responsible for the amount due.

FOR THOSE CARRYING PLANS WITH WHICH THIS OFFICE PARTICIPATES:
Exact patient co-payments are ultimately determined by the insurance carrier by an EXPLANATION OF BENEFITS. Any final balance they determine is still due on your part will be billed to you. If after 90 days there is still an outstanding balance due from insurance, this balance will become YOUR responsibility.

IF YOU DO CARRY A PARTICIPATING PLAN:

Any balance that remains unpaid by your carrier is also your responsibility and due upon receipt of your EXPLANATION OF BENEFITS.

I agree to pay interest on any past due balance at the rate of 1.5% per month on the delinquent balance which is an Annual Percentage Rate (APR) of 18%. I further agree to pay for all reasonable costs of collection, including but not limited to attorney fees, court costs and collection fees (33.3% of unpaid balance) incurred by this office to recover my unpaid balance.

Signature of Responsible Party _____ Date _____

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FALLS CHURCH, VA 22046 8987 HERSAND DR SUITE 150 SUITE 40
BURKE, VA 22015 RESTON, VA 20190 ARLINGTON, VA 22203

PATIENT EASY PAY CONSENT

In order to provide guarantee of payment for service provided, it is the policy of this office to request a credit card signature on file. Please review the authorization below and provide the necessary information.

I authorize Levin, Leff & Pollock LTD to keep my signature on file as a guarantee of payment and to charge my credit card account for the balance of charges not covered by insurance after I have satisfied by estimated co-payment.

Patient Name: _____

Cardholder Name: _____

Cardholder Street Address: _____

City: _____ State: _____ Zip: _____

Card #: _____ Exp. Date: _____

VISA _____ MASTER CARD _____ AMER EXPRESS _____ DISCOVER _____

Cardholder Signature: _____ Date: _____

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PRACTICE LIMITED TO ENDODONTICS
PERMISSION FOR ENDODONTIC TREATMENT

This constitutes my written consent for Drs. Levin, Leff & Pollock, Ltd. to perform any necessary dental procedure(s) as indicated by their examination during root canal therapy such as occlusal adjustment, canal preparation by post, perforation repair or special instructions from the referring general dentist. With this consent form I have been informed and understand that there are certain inherent and potential risks in any treatment procedure. These include swelling, bruising, discomfort, infection, permanent numbness or tingling of the lips and/or jaw. Fractures of existing restorations, the tooth, and/or instruments used to perform the treatment may occur. Additionally, variations in canal shape and size may complicate treatment and result in a perforation (hole) in the root or a root canal filling that is less than desirable.

If you are taking or have ever taken oral or intravenously administered bisphosphonates (Fosomax, Boniva, Actonel, Skelid, Didronel, Aredia, Zometa or Bonefos) to treat osteoporosis, Paget's disease or cancer, you are at risk of developing osteonecrosis of the jaw for surgical procedures such as extractions and surgical endodontic therapy (root amputation or apicoectomy). Osteonecrosis is death of bone which can occur from loss of blood supply or inability of the bone to regrow. The risk of developing osteonecrosis is higher if you are over 65 years old, take intravenously administered bisphosphonates, have periodontal disease, take oral glucocorticoids for chronic conditions.

Initials ____ I understand that although root canal therapy has a high degree of success, it is still a biological procedure, and that success cannot be guaranteed. Occasionally a tooth which has had a root canal may require further treatment, surgery or even extraction.

I have been advised of possible alternative methods to endodontic treatment which are extraction or no treatment and of possible or adverse results from these alternative treatments.

I understand that the permanent restoration (filling or crown) will be done by my general dentist following the root canal therapy unless I have been referred additionally to this office for this procedure.

SIGNATURE _____ DATE _____ DRS INIT ____
(PATIENT/GUARDIAN)