Norman D. Knowles, D.M.D.
3760 20ts St., Ste. A
Vero Beach, FL 32960
772-778-0954

Patient Financial Policy

Our office is committed to providing you with the best possible dental care. In order to achieve this goal, we need your assistance and understanding of our financial policies. If you have any questions, please ask for assistance.

Patient Payments:

Our office offers several payment options. We accept cash, checks, Visa, MasterCard, Discover, American Express and Care Credit. Care Credit offers the flexibility of extended payment plans with either low or no interest. Please ask for an application if you would like to participate with Care Credit.

Dental Insurance:

Understanding your insurance coverage can be difficult at times. Our goal is to assist you in maximizing you insurance benefits. Since we work with many different companies, processing claims can be challenging since every policy is different. Your employer contracts with certain carriers to obtain benefits in the most cost efficient manner it can, so each policy and plan is different, and each plan can cover different things in varying amounts. Please thoroughly review your policy to become familiar with its exclusions, deductibles, co-payments and maximums. Dental insurance is a benefit provided by your employer meant to help defray *some* of your costs; it is NOT meant to cover all the treatment you may require.

Insurance Filing:

- As a *courtesy* to you, we will file your insurance claim requesting payment of your dental benefits for services rendered here utilizing current American Dental Association CDT guidelines for coding and filing.
- We will make every effort to advise you of your benefits to the best of our abilities.
- Should your insurance not issue payment within 30 days, we will file the claim(s) for a second time.

Our Expectations From You, The Policyholder:

1. Payment of fees not covered by your insurance plan at the time the service is rendered.
2. Please understand that your insurance plan is a contract between YOU and YOUR carrier. We have absolutely no leverage in obtaining payment from your carrier.
3. In order to contain costs, Insurance Companies may restrict payment for some services and use restricted fee schedules. Usual and Customary Rates (UCR) for some companies is not necessarily the same as usual and customary rates charged in our office, and some procedures may be restricted based on prior conditions or length of time the plan is in effect. Any and all restrictions by a particular plan are based on the premium paid by your employer, not on our fees or recommendations.
4. If your insurance company DOES NOT issue payment for services rendered within 60 days, you will be responsible forose charges.
5. From time to time, you may change employment or your carrier may change. We ask that you keep us informed of any changes in your coverage, employment, or status of any covered dependents.

Cancellation Policy:

In this economic environment, a 48 hour notice is needed in order to cancel or reschedule any existing appointments. Also if you are late for your appointment, the appointment may need to be rescheduled. That will count as a missed appointment. If you require antibiotic premedication and you forgot to take your premedication and we are unable to accommodate you, then it will also count as a missed appointment. So, please do not forget to take your **Antibiotic Premedication.** This will result in a $50.00 charge. The $50.00 will have to be paid prior to rescheduling of broken/canceled appointments. Any appointments for other account/family members will be canceled until the $50.00 charge is satisfied. No appointments for anyone on the account/family can be scheduled until the $50.00 is paid. The third occurrence will result in dismissal from the practice.

Thank you very much for your cooperation in helping us with your insurance coverage. Your dental well-being is our primary focus, but we would also like you to be comfortable in dealing with the financing of your dental care. Please ask us if you have any questions regarding treatment recommendations or fees.

I hereby authorize Dr. Norman Knowles to release to my insurance company and information acquired during my dental care that it may request, and I hereby authorize benefits to be paid directly to Dr. Knowles. I also understand that I am responsible for any unpaid balances.

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Patient Signature (or responsible party) **Date**