

FINANCIAL POLICY

Dr. Henry A. Knowles, Jr. ~ 4318 Kelson Avenue ~ Marianna, FL 32446 ~ (850) 526-3939

To enable us to establish the best possible relationship with our patients, and to avoid misunderstandings in the future, we have established the following financial policy. Please read and sign. If you ever have any questions regarding your treatment or the costs involved, please feel free to speak to our administrative staff **BEFORE** any work is initiated.

- I. Payment is due at the time of service (the day of treatment). We are pleased to accept cash, check, Visa, Mastercard or Discover. For dentures and partials, one half (1/2) of the total cost is due the day the work is started (impressions taken). The balance IN FULL is due when the work is completed (the day of delivery for dentures/partial). {NOTE: THERE WILL BE A \$40.00 CHARGE FOR ALL RETURNED CHECKS}
- II. Treatment Discounts – If you would like to have your treatment fee discounted, you may do so by meeting the following criteria:
 - a. Treatment plan must exceed \$1000.00
 - b. Payment must be made IN FULL by cash on or before the day of treatment
 - c. A fee reduction of 5% will be given
- III. If you have an extensive treatment plan, we offer CARECREDIT Financing. This is a separate line of credit that does not affect the balances of your other credit cards. There is no annual fee. For your convenience we offer a one-year option with NO INTEREST. More details about applying for CARECREDIT are available from any employee.
- IV. Dental Insurance – If you or your family is covered by dental insurance, we will be happy to file your claims, PROVIDING you supply us with ALL of the necessary information. This includes, but is not limited to, a signed Dental Insurance Agreement form and your insurance card.

You are responsible for paying your deductible and co-payment the DAY OF SERVICE. If your insurance has not paid their portion within 60 days of your treatment, YOU will be responsible for payment in full. ANY amounts not covered by insurance are the PATIENT'S RESPONSIBILITY.

- V. Collections – Any balances owed by the patient and not paid in a timely manner may be subject to collections. An additional fee from the collection agency will be charged to the patient. The patient is responsible for payment of the additional fee.

I have read this financial policy and understand my patient responsibility. I UNDERSTAND I WILL BE EXPECTED TO PAY **TODAY** FOR TREATMENT PERFORMED.

Patient/Guardian Signature: _____ Date: _____
