OFFICE PAYMENT POLICY

Payment for services rendered may be made by cash, check, credit card or a Care Credit account on the day of treatment. There will be a $35 fee for any check returned from the bank for non-payment.

INSURANCE INFORMATION

Our goal is to assist you in utilizing your insurance benefits. Dental Insurance plans vary widely in covered services. We encourage you to become familiar with your plan's exclusions, deductibles and co-payment. As a courtesy to you we will file your insurance promptly and request payment of your benefit to our office ("assignment of benefits").
We require payment at the time of service of fees not covered by your plan.
Dental Insurance plans reduce payment for some services based on plan provisions, restrictions, exclusions and waiting periods.
If Dr. Knox is not a participating provider with your insurance the payment provided may be reduced by your dental insurance and paid directly to you, which makes the entire balance due when treatment is rendered.
If we are unable to obtain reimbursement from your plan, you agree to accept responsibility for payment of any unpaid balance.
If the account becomes delinquent collection fees apply.
Please inform our office of any changes in coverage, employment or personal information.

I authorize Antonio L. Knox, D.D.S., to release any necessary information to my insurance carrier and authorize benefits to be paid directly to the office. I understand that I am responsible for any unpaid balance.

It is understood that risks are inherent with every medical/dental procedure. Please ask if are concerned what these risks might be for treatment that will be rendered.

PRIVACY PRACTICES

I consent to the use of my protected health information for the purposes of carrying out treatment, consultation with specialists and billing my insurance company on my behalf. This information will not be shared for any other purpose unless I direct you to do so. We do not typically receive substance use and mental health records which may have additional federal protections. In the event that we do receive them as part of a patient record, we will not disclose this information or pass this information along to any other entity. We will abide by 42 CFR Part 2 as it relates to these records.

NOTICE OF UPDATED PRIVACY PRACTICES

*We are required by federal and state law to maintain the privacy of your health information.
*You may request a copy of this notice at any time.
*We use and disclose health information about you for treatment, payment and healthcare Operations ONLY.

Treatment: We may use or disclose your health information to a physician, specialist, or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use your health information in quality assurance, training, certification licensing and credentialing activities. We must disclose your health information to you. We may disclose your health information to a family member or friend to the extent necessary to help with your healthcare

or with payment for your healthcare only if you agree that we may do so. In the event of an emergency we will disclose health information based upon our professional judgment only as directly relevant to your healthcare.

We do NOT use your health information for any marketing purposes.
We may use or disclose your health information as required to do so by law, such as in case where we believe that you are a possible victim of abuse, neglect or domestic violence.
We may use or disclose your health information to provide you with written appointment reminders via mail or electronic email.

Access: You have the right to view or obtain copies of your health information by written request. Reasonable costs will be charged for photocopying, staff time and postage.

Restriction: You have the right to restrict the use or disclosure of your health information.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your healthcare information you may file a complaint with the contact person, Denise Martin or Dr. Antonio Knox, or in writing to the U.S. Department of Health and Human Services.

*Your signature acknowledges your consent for the use of your personal information that may be used electronically. (ie: email, insurance claims)

Signature_____Date_____
(to be used as “signature on file” for insurance purposes)

Updated
January 29, 2026