# TROY FAMILY DENTAL
## Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

All patients must complete our Information and Insurance form before being seen by the doctor.

- Payment Due At The Time Of Service
- We Accept Cash, Checks and Credit Cards
  (VISA, MasterCard, Discover & American Express)
- Monthly Payment Plans (with approval)

**Regarding Insurance**

We have accepted assignment of dental benefits. However, we do require payment of deductibles and any portion not paid by insurance by one of the options listed above. You are responsible for any remaining balance whether your insurance company pays or not. We cannot bill your insurance unless you give us complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid in full within 90 days, the balance becomes due and payable. Delinquent accounts will bear interest at a rate of 1% per month (12% annually) on the unpaid balance.

(Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney fees and collection expense. All delinquent accounts bear interest at legal rate.)

**Usual and Customary Rates / Maximum Allowable Benefit**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for treatment regardless of any insurance company's arbitrary determination of usual and customary or maximum allowable benefits.

**Minor Patients**

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment at the time of treatment or by one of the other options listed above.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to the Financial Policy.

______________________________________ __________________
Signature of Patient or Responsible Party Date