DENTAL SOUTH
Family Dentistry

630 THIRTY-SIXTH ST. SW
Grand Rapids, MI 49509
(616)538-9020 • (616)538-5353

OUR FINANCIAL AGREEMENT

Thank you for choosing our office for your dental needs. Dental treatment is an excellent investment in an individual's overall health and quality of life. Financial considerations should not be an obstacle to obtaining this important care. To assist you in choosing the method of payment that is best for your situation, we have several financing options available.

Your **estimated** copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Your **estimated** copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Our practice accepts cash, personal checks, MasterCard, Visa, American Express, and Discover. Third party, extended payment financing is available upon request and approval.

For our patients with dental insurance we are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage. Payment for your estimated portion is due and payable at time of service. **The insurance relationship constitutes an agreement between the carrier and the patient. As such, we can make no guarantee of estimated coverage or payment. Because we cannot guarantee your exact insurance coverage, there may be a balance remaining after insurance payment is received. We ask that you pay this balance upon receipt of invoice.**

Insurance payments ordinarily are received within 30–60 days from the time of billing. **If your insurance company has not made payment to our practice within 60 days, we will ask you to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company.**

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

Patient (or Responsible Party) Signature: _____Date: _____

ATTENDANCE AGREEMENT

When you schedule an appointment for your dental treatment, please understand that **we reserve that time only for you**. We let you choose a time that is most convenient in your schedule. **You are responsible for keeping the appointment that you reserved**. If something happens that will prevent you from being here, it is **your responsibility** to let us know no less than **48** hours in advance for a single appointment, and no less than **72** hours in advance for a family appointment (more than one family member scheduled on the same day) to allow us to fill the opening. If you fail to provide required notification a charge may be made for the time reserved.

We at Dental South promise to respect your time by honoring your appointment time and seating you as promptly as we can. We expect that you will respect our time as well.

Patient (or Responsible Party) Signature: _____Date: _____

PETER A. GARCHOW, D.D.S.