Great Lakes Family Dentistry

Larry Grzegorzewski, D.D.S.

Patient Financial Agreement Form

Patient Name: ____

(Parent or Guardian) ____

Person responsible for account ____

Method of Payment

Please check one of the following:

_____ Payment in full at each appointment

_____ Co-payment in full at each appointment

_____ Credit Card

_____ Care Credit/Dental Fee plan for extended payment plan options

I understand that I am responsible for **all** fees incurred for my dental treatment. Most insurance plans are payment assistance plans; they are not designed to cover the entire cost of treatment. I understand that my dental insurance carrier may pay less than the actual bill for services. I hereby authorize Great Lakes Family Dentistry to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information listed is correct to the best of my knowledge.

***Any account balance over 60 days will incur a 1.5% finance charge. Additional charges may occur if the account is turned over for collection.**

Signature of Responsible Party

X____ Date: _______________________

State Driver's License Number: ____

____ Adult Patient _____ Parent _____ Spouse _____ Guardian