GCFDental Plan

RESPONSIBLE PARTY INFORMATION

OFFICE USE ONLY	
INITIALS:	DATE:

FULL NAME	DATE	DATE OF BIRTH
ADDRESS	CITY	ZIP
EMAIL	PHONE	ALT PHONE

FAMILY INFORMATION

PLEASE WRITE PATIENT'S FULL NAME AND CHECK THE APPROPRIATE BOX FOR ADULT, CHILD AGE 6-21, OR CHILD AGE 3-6. CHILDREN UNDER 3 ARE INCLUDED IN THE PLAN AT NO COST. CHILDREN MUST BE LEGAL DEPENDENTS OF THE RESPONSIBLE PARTY NAMED ABOVE.

PATIENT NAME	ADULT	CHILD 6-21	CHILD 3-6	DATE OF BIRTH
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
TOTAL				TOTAL AMOUNT DUE
COST	x $309	x $239	x $119	

PAYMENT INFORMATION

SELECT ONE: ☐ CASH ☐ CHECK ☐ CREDIT CARD ☐ CHARGE MY CARD ON FILE EACH MONTH*

NAME ON CARD	TYPE OF CARD	
CARD NUMBER	EXP DATE	CVV
ADDRESS	CITY	ZIP

THE GCFDENTAL PLAN IS NOT INSURANCE. IT IS A MEMBERSHIP BENEFITS PLAN. THE FEES OUTLINED IN THE GCFDENTAL PLAN ARE NON-REFUNDABLE. ALL PLAN FEES ARE DUE AT THE TIME OF ENROLLMENT. AN ADDITIONAL FEE MAY BE CHARGED FOR ANY MISSED, CANCELLED, OR BROKEN APPOINTMENT WITHOUT 24 HOURS PRIOR NOTICE. THIS PLAN IS NON-TRANSFERABLE BY PATIENT. THIS PLAN DOES NOT COVER ANY CURRENT TREATMENT IN PROCESS OR RE-TREATMENT. THIS PLAN CANNOT BE COMBINED WITH ANY OTHER INSURANCE OR DISCOUNT. FAILURE TO COMPLY WITH THE TERMS OF THE PLAN MAY RESULT IN TERMINATION OF THE PLAN AND FORFEITURE OF FEES PAID. GRUNDY CENTER FAMILY DENTAL RESERVES THE RIGHT TO REFUSE TREATMENT AND/OR TERMINATE THE PATIENT'S PARTICIPATION IN THIS PLAN WITHOUT NOTICE OR REFUND IF THE PATIENT'S ACCOUNT BECOMES DELINQUENT OR PATIENT IS NON-COMPLIANT. THIS PLAN MAY BE MODIFIED, AMENDED, OR CANCELLED AT ANYTIME. ACCEPTANCE OF DEPENDENTS AND OTHER FAMILY MEMBERS IS ULTIMATELY SUBJECT TO DR. WEAVER'S APPROVAL. *FOR AUTOMATIC MONTHLY/QUARTERLY PAYMENTS ON CREDIT CARD, SEPARATE AUTHORIZATION FORM MUST BE SIGNED. AUTOMATIC PAYMENTS WILL CONTINUE UNLESS WRITTEN NOTICE OF CANCELLATION IS GIVEN TO GCFD THIRTY DAYS IN ADVANCE.

PATIENT SIGNATURE	DATE