2025 Office Loyalty Plan

Thank you for your interest and confidence in our Office Loyalty Program. The Office Loyalty Program (OLP) allows us to reward existing and new patients for their dedicated support of our practice by offering substantial savings for you and your family

We offer the following benefits included in each package:

- (2) Routine Cleanings
- (3) Examinations (Comprehensive, Periodic, Limited, or Consultations)
- All Recommended and Necessary X-rays
- (2) Desensitizing and Fluoride Applications

- 15 % off accepted in-office treatment

  - Referrals for specialty treatment are excluded from the plan. Examples may include:
    - Endodontic/Root Canal Referrals
    - IV Sedation/Oral Surgery Referrals
    - Pediatric Referrals
    - Biopsy/Pathology Referrals

- Office fees are considered reasonable and customary by most dental industry and insurance standards. Any changes to our office fee schedule will be posted 30 days prior to effective date as a notification on our website and in office

- Renewal of the OLP before expiration ensures previous yearly cost and fee schedule to help our patients maximize savings regardless of inflation or external cost factors

The costs of the Office Loyalty Plan are the following for activation during 2025:

Individual - $535 *Couple* - $945
Family of 3 - $1325 *Family of 4* - $ 1695

- Each additional child may be added for $335 per twelve-month active period

121 W Woodlawn Ave
Hastings, MI 49058
269-948-2244

3636 Kraft Ave SE
Grand Rapids, MI 49512
616-988-4494

Email our office at
Goledental@gmail.com

2025 Office Loyalty Plan Disclaimers & Acknowledgement

The following are the agreed upon terms and conditions of the Office Loyalty Program for 2025:

_____ I understand that the Loyalty program is a Twelve (12) month Dental Service Agreement with the providers of Gole Dental Group PC with a start date upon acceptance of both parties.

_____ I understand the plan is non-transferable and non-refundable

_____ The OLP is available to be used at either Gole Dental Group location during regular business hours. After hour visits may be approved in advance by the treating doctor.

_____ I understand the providers of Gole Dental Group are not in network with any insurance company. Any charges for treatment rendered will be my responsibility. Gole Dental Group will submit claims on my behalf. Any benefits I have with my insurance plan will be paid directly to the plan subscriber

_____ I understand I may renew the plan before expiration to lock in the 2025 fee schedule for only one additional year. Subsequent renewal or activation will be for the prevailing cost and fee schedule upon re-activation

_____ I acknowledge that I must pay for the Office Loyalty Plan out of pocket. We will not bill your insurance company directly for the unapplied credit of the Office Loyalty Plan. Claims can be submitted for reimbursement with my insurance carrier after treatment is rendered and paid directly to the subscriber

_____ Failure to maintain appointments or complete payment according to the terms of the agreement, may result in forfeiture or inactivation of the Office Loyalty Program agreement. I understand I am responsible to make a reasonable effort to notify the office 48 hours in advance if I need to cancel or change an appointment that was scheduled in person, over the phone, or online.

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2025 Office Loyalty Plan Financial Consent

Please indicate the plan you want to activate:

The costs of the Office Loyalty Plan are the following for activation during 2025:

Individual - $535 *Couple* - $945

Family of 3 - $1325 *Family of 4* - $ 1695

- Each additional child may be added for $335 per twelve-month active period

The total cost of the Office Loyalty Plan will be: $_____

*** The plan must be paid in full before the 15% discount treatment plan discount is applied ***

- A minimum 50% deposit is required for acceptance and activation
- The OLP will need to be paid within Three (3) months of acceptance

$_____ Paid in full or $_____ Deposit w/ monthly payments of $_____

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)

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