



# Providence Dentistry Dental Savings Program

Start Date \_\_\_\_\_

End Date \_\_\_\_\_

**The cost of the plan is \$329.00 per person for a 12-month period.**

I understand all exclusions and limitations of this plan, this program is not a dental insurance plan.

This is a discounted dental fee program. This plan is only honored at Providence Dentistry. ***The program cannot be used with any other insurance or discount program, including Care Credit.***

No Refunds of program payments will be issued at any time if participants decide to stop using the program for any reason.

Benefits may not be transferred to other patients.

***The plan expires one year from the date of enrollment. I understand if I do not use my plan, it does not roll past the end date.***

**Discounted Fees must be paid at the time services are rendered. Any procedures not paid for on the date of service will be billed at the usual office fee.**

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|--|----------------------------|
| • 1 Comprehensive New Patient Exam and 1 Periodic Exam<br>(Existing patients renewing will receive 2 periodic exams) | 100%                       |
| • 1 Emergency Exam   | 100%                       |
| • 4 Bitewing x-rays (cavity detecting)   | 100%                       |
| • Periapical x-ray   | 100%                       |
| • Full Mouth x-ray series  | 50%                        |
| • Panoramic x-ray  | 50%                        |
| • CT Scan  | 50%                        |
| • Dental Cleaning 2X1 year (Prophy and/or Perio Maintenance)   | 100%                       |
| • Scaling and root planing for periodontal disease   | 20%                        |
| • 2 Fluoride Treatments  | 100%                       |
| • Oral Cancer Screenings   | 100%                       |
| • Additional Cleaning within 12—month time frame   | 20%                        |
| • Dental Sealants  | 20%                        |
| • Dental Fillings & Core Build Ups   | 20%                        |
| • Root Canals  | 20%                        |
| • Extractions/Oral Surgery   | 20%                        |
| • Crown, Bridges & Veneers   | 20%                        |
| • Dentures   | 20%                        |
| • Implants   | 20%                        |
| • Mouth Guards   | 20%                        |
| • Orthodontics   | Not applicable to discount |
| • Bleaching Gel  | Not applicable to discount |
| • Nitrous Oxide (Laughing Gas)   | Not applicable to discount |
| • Arestin  | Not applicable to discount |

I understand and agree to the above terms of the dental saving program.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Printed Name \_\_\_\_\_