Providence Dentistry Dental Savings Program

Start Date _____ End Date _____

Cost of the plan is $329.00 per person

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 programs payments will be issued at any time if participants decide to stop making use of the program for any reason.

Benefits may not be transferred to other patients

Plan expires one year to 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 for at the time of services are rendered. Any procedures not paid for on the date of service will be billed at the usual office fee.

• 1 Comprehensive and 1 Annual Exam (Unless renewing of which you get 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 (absence of Periodontal disease) 2X1 year	100%
• 2 Fluoride Treatments	100%
• Oral Cancer Screenings	100%
• Additional Cleaning (Prophy and Periodontal)	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 20%
- Bleaching Gel Not applicable to discount
- Nitrous Oxide (Laughing Gas) Not applicable to discount
- Arestin Not applicable to discount
- Orthodontic Treatment Not applicable to discount

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

Patient Signature _____Date _____

Patient Printed Name _____