Providence Dentistry Dental Savings Program

Start Date: ________________ End Date: ________________

Cost of plan is $299.00 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. **This 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 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 that if I do not use my plan it does not roll past the end date.

Discounted Fees must be paid for at the time 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 100%
- 1 Emergency Exam 100%
- 4 Bitewing X-Rays (Cavity Detecting) 100%
- Periapical x-ray series 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 and Core Build Ups 20%
- Root Canals 20%
- Extractions/Oral Surgery 20%
- Crowns, Bridges, and Veneers 20%

- Dentures 20%
- Implants 20%
- Mouth Guards 20%
- Orthodontics 20%

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

Patient Signature: ________________________________ Date: _____________

Patient Printed Name: _____________________________