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.

• 1 Comprehensive New Patient Exam and 1 Periodic Exam (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 _____