Neighborhood Dental SAVINGS PROGRAM

Select a program: ☐ Individual Child ☐ Single ☐ Dual ☐ Family

Please answer all questions or indicate "not applicable"

PERSONAL INFORMATION

First Name: _____ Last Name: _____

Birthday: _____

Mailing Address: _____

Street Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Email Address: _____

SPOUSE'S/PARTNER'S PERSONAL INFORMATION

First Name: _____ Last Name: _____

Birthday: _____

Cell Phone: _____

Email Address: _____

CHILDREN

First Name: _____ Last Name: _____

First Name: _____ Last Name: _____

First Name: _____ Last Name: _____

First Name: _____ Last Name: _____

First Name: _____ Last Name: _____

Member Signature Date

Parent or Guardian Signature (if child is under 18) Date

After the initial term of the one (1) year contract, this agreement shall be deemed renewed automatically each year for an additional one (1) year period, unless canceled via email or a phone call within thirty (30) days of the current term expiration date. You will receive an email 45 days and 30 days in advance of your contract end date. At that time, if you want to cancel your auto-enrollment, please respond to the email or call the clinic directly. If you forget to respond/cancel, we can refund you in full as long as no benefits have been used for that renewal period.

A recurring payment authorization form is required to be completed.

DENTAL SAVINGS PLAN AUTO-RENEWAL

AUTOMATIC PAYMENT DISCLOSURE

This form outlines your agreement with Neighborhood Dental, in which you authorize us to process electronic payments from the credit card, debit card, or bank account provided below. You will be automatically charged the annual Dental Savings Plan contract renewal fee on the start date listed below. Payments will continue annually until the end date has been satisfied or your contract has been cancelled at your request. You will receive renewal information 45 days prior to your renewal date. If there are changes to the fees, you will be notified at this time. If you wish to cancel your contract, you must provide a written notification (30) days before to your current term renewal date. Please provide Neighborhood Dental with a minimum 48 hour notice, should you need to edit a payment for any reason. If you are unable to fulfill the agreement, it will be your reasonability to contact Neighborhood Dental to discuss alternate payment options. You will not receive any further correspondence from Neighborhood Dental regarding these payments if your account remains in good standing. A receipt for payments completed will be available upon request.

Patient Name:

Last 4 digits of Card/Bank Account:

Renewal Start Date:

Plan Selected: ☐ CHILD ☐ SINGLE ADULT ☐ DUAL ☐ FAMILY

*how many family members on plan:

Patient Signature (Parent/Guardian if under age of 18):

Date:

Card Holder/Bank Account Authorizing Signature:

Date:

Neighborhood Dental SAVINGS PROGRAM

Neighborhood Dental Savings Program is a **one (1) year contract**, starting from the date of the signed contract between the patient and Neighborhood Dental. Our dental savings program is designed to provide access to affordable, quality dental care.

DENTAL BENEFITS INCLUDE:

- **Two Dental Prophylaxsis/Cleanings** (Adult Prophy, Perio Maintenance, or Child Prophy)
- **Two Exams: Comprehensive** (new patient), **Periodic** (recare), **Limited** (emergency)
- **Annual Radiographs** (Bitewings; Full Mouth Series or Panoramic Radiograph if necessary)
- **Two Fluoride Treatments**

*****ALL OTHER SERVICES OFFERED AT NEIGHBORHOOD DENTAL ARE DISCOUNTED 15% OFF*****

COST:

- **Individual Child** (Age 13 and Younger) **= $315**
- **Single** (Age 14 and Older) **= $425**
- **Dual** (Married Couple) **= $750**
- **Family** (Three Members or More)
  - **1st Member = $375**
  - **2nd Member = $350**
  - **3rd Member = $325**
  - **Additonal Members = $300 each**

EXCLUSIONS AND LIMITATIONS:

- This contract is only for services performed by a staff member of Neighborhood Dental.
- This contract does not replace, eliminate, or modify any other contract with Neighborhood Dental.
- This contract does not give discounts on services already rendered.
- Family plans are limited to families of 3 people or more.
- Family members must live in the same household as the contract holder (unless attending college), are limited to immediate family members (parents and children), and are included in the family option up the age of 20.
- Maximum allowed discount off any single procedure is $500.
- Payment must be made at time of service.
- Cannot be used or combined with any other discount or promotion.
- No refunds of premiums will be issued at any time if participant decides not to utilize plan.

Neighborhood Dental

Dental Savings Plan Financial Policy

Our Dental Savings Plan is an alternative to traditional dental insurance- designed to save you pain, time, and money. It's a great way to get the care you need with the savings you want. The Dental Savings Plan cannot be used or combined with any other insurance, discount or promotion. No refunds of premiums will be issued at any time if participants decide not to utilize the plan. **Neighborhood Dental has partnered with our top Specialist Referrals to accept our Dental Savings Plan discount. Ask a team member for the Specialist information today!*

Your Dental Savings Plan includes 100% coverage on the following: Comprehensive/Periodic Exams (two per year), Bitewing X-Rays (one per year), Full Mouth Series X-Rays/Panorex (one every 3 years), Preventative or Periodontal Maintenance Cleanings (two per year), Fluoride (two per year- no age limit), and Oral Cancer Screenings (two per year). All other services offered at Neighborhood Dental are discounted 15% off up to $500 per procedure.

Full payment must be paid at the time of service. We accept cash, personal checks, money orders, Mastercard, Visa, HSA, American Express, and Discover. If a personal check is returned for non-sufficient funds (NSF), you may be charged a collection fee. You will, also, be required to pay with either cash or credit card for any future visits. We do have financing options available through CareCredit and Cherry Finance (upon approval).

In the case that you have an unpaid balance, we will attempt to reach you to collect. In the event that we are unsuccessful, we may place your account with a collections agency. Upon placement, we will add a minimum fee of 24% to the total balance to cover the cost of collections fees, litigation costs, and any other additional fees that may occur.

As a result of your unpaid balance being sent to collections, your Dental Savings Plan contract will be voided. If you choose to participate in the Dental Savings Plan, again, your balance must be paid in full and no longer in collections. You will need to purchase a new Dental Savings Plan and will not have access to any benefits that were available from your previous plan.

Appointments are reserved exclusively for you. Some appointments may require a non-refundable deposit to hold your dental reservation. Your deposit will apply to your estimated patient portion, if completed as scheduled. The clinic requires a notice of at least one (1) business day if the patient is unable to keep the reserved appointment time. We will attempt to contact you prior to your appointment to confirm your reservation. If an appointment is not confirmed within one business day of the appointment, the appointment may be canceled or rescheduled. **You may be charged for missed appointments or cancellations with less than 1 business day's notice. If a patient "no-shows" or an appointment is "short-notice canceled" for three appointments, we will move you to a same-day-only scheduling list.** As a benefit to you, our valued patient, we may offer to move your appointment to an earlier time if an opening should arise.

In the case of separated or divorced parents of minors, who are responsible for a portion of the cost of a child(ren)'s treatment: The parent who brings the child to the appointment is responsible for paying the patient portion on the day of service.

☐ I have read and understand this financial and cancellation policy.

Patient _____ Date _____

Patient/Guardian Signature _____ Date _____