Private Insurance Dental Plan

The Dental Suite

Initial Visit	Treatment	Regular Cost	Plan Cost
	Full set of X-Rays	$154	
	Cleaning	$106	(all 3 services)
	Exam	$60	
		$320	$150

Beginning 30 days or more after the initial visit, $40 will be due/debited from a checking or savings account each month in order to remain active in the program ($30 for children 13 years of age and younger). Must be renewed annually. *For each patient that you refer* to us, who remains active in the practice, *a discount will be given.*

Subsequent hygiene visits (i.e. two Dental Cleanings, four bitewing X-Rays, one examination, one cancer screening and one application of child fluoride) will be covered by the monthly debit.

All restorative treatment performed (i.e. fillings, crowns, veneers, root canals, etc…) will be done at a **40% discount**. Unlike conventional insurance plans, there will be *no deductible* to be paid, there will be no limits placed on restorative treatment in a given year, and there will be no waiting period before treatment can be started. Cosmetic procedures are also covered under this plan.

Fees of some common procedures and the cost savings:

Treatment	Regular Cost	Plan Cost
One Surface Filling	$214	$128
Two Surface Filling	$270	$162
Crown	$1295	$777
Molar Root Canal	$1200	$720
Professional In-Office Whitening	$450	$270

In January of each subsequent year, all fees and plan costs will adjust relative to the Consumer Price Index change from January of the previous year.

Although all who wish to enter the program will be accepted, it is at our discretion to dismiss patients from the practice and void this plan for repeatedly cancelling or missing appointments and non-payment. If one opts out of or is dismissed from this plan, reentry may not be granted. A 60 day written notice is required for termination of the plan, after the 60 days your depository information will be cleared from our ACH Debits and will no longer be charged.

Any dental treatment received outside of our office (i.e. referrals to an orthodontist, oral surgeon, endodontist, periodontist, etc.) will not be discounted through this plan. On occasions that outside labs are needed for the fabrication of crowns, bridges and dentures, costs will be passed on to and paid by the patient. Estimates for these costs will be presented beforehand with the treatment plan.

I, ______________________________ , have read and understand the conditions of the dental plan laid out above. My signature below acknowledges my agreement to the terms and denotes my participation.

X____ X ____

Patient Name (Please Print) Signature of Patient, Parent or Guardian Date