



CHATHAM DENTAL ARTS DENTAL SAVINGS PROGRAM

Cost of plan \$400 per person.

Start Date: _____ End Date: _____

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 Chatham Dental Arts. This program

CANNOT be used with any other insurance or discount program including Care Credit.

NO REFUNDS of program's 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 rendered with cash or check. Any procedures not paid for on the date of service will be billed at the usual office fee.

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| • 1 Comprehensive exam and 1 Periodic exam OR 2 Periodic exams | 100% |
| • 1 Emergency Exam | 100% |
| • 4 Bitewing X-rays | 100% |
| • 1 Periapical X-ray in conjunction with Emergency Exam | 100% |
| • Full Mouth X-Rays (required for any new patient of the practice) | 50% |
| • Panoramic X-ray | 50% |
| • 2 Routine Dental Cleaning (in absence of Periodontal Disease) | 100% |
| • 2 Optional Fluoride Treatments | 100% |
| • Periodontal recall cleanings and Scaling and Root Planing | 15% |
| • Dental Sealants | 15% |
| • Dental Fillings including Core Buildups for Crowns | 15% |
| • Root Canals | 15% |
| • Extractions & ALL Oral Surgery Procedures | 15% |
| • Crowns, Bridges & Veneers | 15% |
| • ALL Dentures and Partials | 15% |
| • Implant Restorations | 15% |
| • Night Guards | 15% |
| • Products sold in office, not applicable to discount. | |

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

Patient Signature: _____ Date: _____

Patient Printed Name: _____

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