Silver Spring DENTAL ARTS

Discount Dental Plan Agreement

Last Name _____ First Name _____ MI _____

Home Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Birthdate _____/_____/_____ Email Address _____

Plan Choice (choose one): [ ] Gold Plan $249 [ ] Purple Plan $249 [ ] Perio Plan $269

Limitations & Exclusions

1. Demonstrated non-compliance with the recommended course of treatment.
2. Services which in the opinion of the attending dentist are neither necessary nor recommended for the patient's health.
3. Restorations, splints or other appliances used to increase vertical dimension or restore occlusion.
4. Any service you are referred out of the office for; Periodontics, endodontics, and oral surgery.
5. Congenital malformations, except congenital anomaly of a tooth or teeth covered from birth.
6. Dispensing of drugs not normally supplied in the dental office.
7. Hospital benefits for any dental procedure.
8. Loss or theft of dentures, bridges, or crowns.
9. Services for injuries or conditions which are covered under Workers' Compensation or Employer's Liability Laws.
10. Services that cannot be performed because of general health, physical or psychological limitations of the patient.
11. **If patient should become covered by a traditional dental plan this plan becomes null and void with no refund of fees.**

Please read and sign below:

I understand the benefits, limitations, exclusions and requirements of the Silver Spring Dental Arts Discount Dental Plan and I agree to the following:

1. I will remain in the plan and pay membership fees for a minimum of 12 months.
2. I understand this is a membership based discount plan, **NOT INSURANCE**, and is only valid for service performed at 12901 Tamarack Road, Silver Spring, MD 20904.
3. ***I UNDERSTAND THAT PAYMENT IN FULL IS DUE WHEN SERVICES ARE RENDERED.***
4. ***I UNDERSTAND PAYMENT FOR PROSTHODONTICS, CROWNS, AND CAST RESTORATIONS ARE DUE AT THE PREPARATION/IMPRESSION VISIT.*** Failure to comply WILL result in my being charged usual and customary fees for such services.
5. I agree to pay any and all costs in collecting all charges, including but not limited to attorney fees and court costs.

Signature_____ Date _____

Please remit to:
Silver Spring Dental Arts
12901 Tamarack Road
Silver Spring, MD 20904
phone (301)384-6776 fax (301) 384-6778
ssdainsurance@gmail.com