

Silver Spring Dental Arts

Dental Membership Plan

Last Name _____ First Name _____ MI _____

Home Address _____ City _____

State _____ Zip _____

Cell Phone (____) ____ - ____ Home Phone (____) ____ - ____

Work Phone (____) ____ - ____ Birthdate ____ / ____ / ____

Email Address _____

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 understand that membership is for one year from date of enrollment and it is my responsibility to schedule appointments and keep track of enrollment end date. I*

understand the dental office will do its best to accommodate me in getting an appointment, but I understand the dental office is booked out six(6) months in advance and it is my responsibility to call & schedule an appointment. I also understand there are no refunds.

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. I ALSO UNDERSTAND THAT WHEN A PAYMENT PLAN IS USED FROM A THIRD PARTY VENDOR (i.e. CARE CREDIT) THE AMOUNT OF THE DISCOUNT GIVEN DECREASES FROM 20% TO 10%.**
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
silverspringdentalarts@gmail.com**

_____ Office use only _____

Plan Choice (choose one): [] Gold Plan \$425 [] Purple Plan \$325 [] Perio Plan \$725