Friendly Smile Membership Plan Contract:

Thank you for choosing our friendly smile membership plan. The purpose of this plan is to offer our patients, without dental insurance, a significant savings when the services are paid in advance. The membership plan is not insurance.

The term of the plan is 12 consecutive months. The plan automatically renews, on the anniversary of the inception date unless written notice is received, in our office, 45 days prior to renewal. The payment is a single renewing annual payment. ***Plan costs represent a 30-40% savings off our regular fees.***

Indiana law regarding membership programs, allows you to cancel and receive a full refund within 30 days of initial sign-up. After the grace period, the plan cannot be cancelled and no refunds will be given. ***Services that have been rendered, prior to cancellation***, will be collected and immediately due at our regular and customary office fees.

Plan benefits may be forfeited if the patient fails to cancel a scheduled re-care appointment within 48 hours of the appointment or fails to shows up for a scheduled appointment.

Benefits of Our Plan

No Deductible, No Waiting Period (Immediate Eligibility) No yearly maximum on services, No Treatment Exlusions.

Limitations and Exclusions

Participants cannot have additional dental insurance coverage. Services for injuries or conditions which are covered under Worker's Compensation or other insurance coverage are exempt from our plans. Services that cannot be performed because of the general health, physical, or psychological limitations of the patient are exempt.

Periodontal disease Limitation:

The benefits of this plan are provided to healthy patients who require routine cleanings only. Patients who develop periodontal or "Gum" disease may require a specialized treatment called scaling and root planing. Patients refer to this as a deep cleaning. Scaling and root planing is a therapeutic procedure that is typically administered with anesthetic and destroys harmful bacteria and removes hardened deposits below the gum line. A routine cleaning is a preventative and cosmetic procedure. If you require scaling and root planing, a 20% discount will be given off of our usual and customary fees.

[ ] Adult Plan - $300.00/Year (13 and over)

Regular Fee $550.00 | Save 250.00/ Per Year

2 Cleanings/ Per Year
2 Regular Exams/ Per Year
1 Set of BWX/ Per Year
1 Panorex/ 3 Years
1 Emergency Office Visit
Additional PA X-Rays/ As Needed

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[ ] Adult Plan (Periodontal Re-Care) - $550.00/Year (13 and over)

Regular Fee $850.00 | Save 300.00/ Per Year

2 Cleanings/ Per Year
2 Regular Exams/ Per Year
2 Additional Perio Cleaning Visits
1 Set of BWX/ Per Year
1 Panorex/ 3 Years
1 Emergency Office Visit
Additional PA X-Rays/ As Needed

[ ] Child Plan - $250.00/Year (Ages 3-12)

Regular Fee $570.00 | Save 320.00/ Per Year

2 Cleanings/ Per Year
2 Regular Exams/ Per Year
1 Set of BWX/ Per Year
1 Panorex/ 3 Years
1 Topical Flouride/ Per Year
1 Emergency Office Visit
Additional PA X-Rays/ As Needed

All Plans Include:

20% discount on routine dental services (***15% for Care Credit Users***)
15% discount on Orthodontics (***10% for Care Credit Users***)

For patients' new to the practice or individuals that have not been seen in the practice for over 2 year a one-time initial enrolment fee of $79.00 applies.

Plans cover routine PA/BXW X-rays. The Panolipse X-ray is taken every 3-5 years or for referral to specialists and is not covered under the plans. A 50% discount is offered to plan members for this X-ray.

Primary Member Registration:

Last Name_____ First _____ MI_____
Address:_____ City_____ ZipCode_____
Cell Phone #_____ DOB_____
Employer_____ Fee Amount
Driver's License#_____ _____
E-mail address _____

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Additional Members:

Full Name	Date of Birth	Relationship	Fee Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Credit Card Information

Cardholder Name: _____

Billing Address: _____

Credit Card Type: _____Visa _____ Mastercard _____ Discover _____ AmEx _____ Care Credit_____

HSA _____

Credit Card Number: _____ Expiration Date: _____

Card Identification Number (last 3 digits located on the back of the credit card): _____

Amount to Charge: $ _____ (USD)

I authorize Gillum Dentistry to charge the agreed amount listed above to my credit card provided herein. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Print Name, Sign and Date Below:

Name on Card: _____

Signature (Required): _____Dated: _____

Payment for discounted services are due at the time of service unless arranged in advanced. Prosthetic procedures such as crowns can be paid ½ at preparation day and ½ at seat or completion date. Failure to comply may result in my being charged usual and customary fees for such services. Procedures paid with Care Credit receive 15% discount on routine services and 10% on Orthodontics.

I agree to pay all costs in collecting all charges. Including but not limited to attorney fees and court costs

Print Name:_____

Signature (Required): _____ Date:_____

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