Healthy Smiles Membership Plan Agreement

(Not an Insurance Plan)

Responsible Party Information

First Name: _____Last Name:_____

Home Address: _____

City:_____State: _____ Zip Code: _____

Cell Phone #: _____Date of Birth: _____/_____/_____

E-mail Address: _____

The Healthy Smiles Membership Plan(s) you have selected for provider of service:

Dr Evy Guerrero

Investment	Age	Service	Total Children Enrolling
☐ **Plan 1 $320**	**≤2 yrs**	• 2 Exams • 2 Cleanings* • 2 Emergency Exams • X-rays • Intra-oral photos • 40% off sealants, courtesy repair within first 3 months after placement • 10% off fillings, extractions, crowns, space maintainers (if made in-office), pulpotomy, IPC, silver nitrate, fillings for cosmetic reasons, fillings as a result of dental injury • 20% OFF frenectomy surgery	
☐ **Plan 2 $340**	**3 yrs**	• Everything in plan 1 plus • 20% OFF nitrous gas	
☐ **Plan 3 $440**	**4-12 yrs**	• Everything in plan 1 plus • Panoramic X-ray • 20% OFF nitrous gas	
☐ **Plan 4 $460**	**13-18 yrs**	• Everything in plan 1 plus • Panoramic X-ray • 20% OFF nitrous gas • 50% OFF whitening tray fabrication + free whitening gel at each visit	

***For children who cooperate**

Name:_____**Date of Birth:** _____/_____/_____

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Name:_____**Date of Birth:** _____/_____/_____

Name:_____**Date of Birth:** _____/_____/_____

➢ **Does the patient have an active insurance plan? (Check one) No_____ Yes_____**

If Yes: I understand I cannot use my insurance plan benefits in conjunction with the membership plan. I understand I cannot request Green Apple Pediatric Dentistry to complete insurance claim forms on my behalf. I understand that if I obtain insurance benefits in the future, I can cancel my membership benefits with a written request, however a refund will not be issued for the membership plan fee. _____

Payment Details: <u>Full fees are due at the time of enrollment.</u> Payment options: ☐ Cash ☐ Credit Card

Credit Card Information: Visa Mastercard Discover

Cardholder Name: _____

Card Number: _____Exp Date: _____Security Code:_____

By signing below, I acknowledge that I have reviewed, understand, and agree to the terms and conditions of the Healthy Smiles Membership Plan. I authorize this dental office to process my payment as listed in this Agreement.

Signature of Responsible Party: _____Date: _____

FOR OFFICE USE ONLY: EFFECTIVE DATES: ____/____/_____ TO ____/____/____ ☐ Membership Activated

By _____Date: _____Initials_____

Membership Plan Terms and conditions. Please initial all items to acknowledge.

1. This is NOT a dental insurance product, rather a savings plan. It cannot be used in conjunction with any other plan, dental insurance, other discounts, or other special offers.This plan is only valid at Green Apple Pediatric Dentistry. Care from other providers or specialists is not included. Plan fees are subject to change without notice. _____
2. For families who have one or more children who are current patients at our practice, there MUST be a ZERO balance on the account individually and for the entire family account. _____
3. The plan is not retro-active and will become effective on the date of enrollment. _____
4. It is the responsible party's responsibility to utilize the services included in this agreement for the members within the plan year limit. No refunds will be given for any unused benefits during the member's 12 month membership plan benefit period. Any unused benefits will not be carried over or refunded. The plan is non-transferable. _____
5. If we are unable to process a responsible party's credit card, the Healthy Smiles Membership Plan is VOID until payment is made and payment for any performed procedures will be due immediately. Any scheduled future appointments will be canceled and cannot be rescheduled until the account is in good standing. ____
6. In exchange for the care provided under this plan, the responsible party agrees to pay all balances in full for the covered member at the time of treatment. If treatment is not paid in FULL at the time of service, any % discount is void and will be billed at our usual and customary fees. _____
7. There is no discount available for general anesthesia, braces, space maintainers made by a lab, fixed, or removable appliance therapy._____
8. Care Credit **cannot** be utilized for payment of any plans. If care credit is used for dental procedures that have a percent discount off, the total discount given will be reduced to only 5% off. _____
9. The member has the right to opt out of the plan for a full refund within 30 days of enrollment as long as no dental procedures have been rendered. If the member had any visits within these first 30 days, including on the date of enrollment, NO refund will be given. _____
10. No refund will be issued if the member is released/dismissed from the dental office and/or if the family decides to change dental home or home relocation after the first 30 days of active membership._____
11. Services are based upon a plan year. The full membership fees are due on the date of enrollment and eligibility will begin at that time remaining active for one year. Your membership can be renewed at the end of each plan year. _____
12. **Important:** We are an appointment based practice. If appointments are broken without a 48 hour notice before your scheduled time or you fail to show for your appointment, a cancellation fee of $50 will be charged to your account per child member and must be paid before the next visit. _____
13. No membership card will be given. Your membership's effective date will be registered on file in the member's electronic file. _____