MOUNDS VIEW FAMILY DENTAL

Mounds View Family Dental Savings Plan

In an effort to serve you in a new and different way, our office has created an in-office dental savings plan. This is a savings dental program, **not dental insurance**. This program is offered to our patients who do not have dental coverage, or patients who have used their dental insurance benefits for the year. Our dental savings plan is an alternative for families or individuals, who want excellent dental health coverage without the barriers of traditional dental insurance.

ENROLLMENT FEES:

- Individual: $399 per year
- Additional Family Members: $359 per year
- Dependents must be 21 years of age or younger.

Membership Benefits Include:

- All necessary x-rays including a full mouth series taken every 3-5 years
- Two Oral Examinations (D0120/D0150) per year
- One Emergency Limited Exam (D0140) per year
- Two Routine Oral Prophylaxis (D1110) cleanings
- Fluoride (D1206) treatments for children are limited to twice per calendar year, for members 18 years and younger only.

Modification regarding Periodontal Disease:

If you are diagnosed with periodontal disease, you will need Scaling and Root Planing ("deep" cleaning, D4341/D4342), followed by a periodontal maintenance (D4910) visit every 3 or 4 months. You will receive 20% off of the Scaling and Root Planing treatment, as well as each Periodontal Maintenance visit. **Note:** an oral prophylaxis cannot be completed once an individual has been diagnosed with periodontal disease.

Reduced Fees:

Dental services are offered at a price that is 20% less than the standard fee. Payments for services are due at the time services are rendered, and all payments are made directly to Mounds View Family Dental.

Program Limitations and Exclusions:

1. When Care Credit is applied, standards fees are reduced by 15% rather than the standard 20%.
2. Orthodontic and implant services are excluded from this dental plan.
3. The member is fully responsible for any dental lab fees, and no reduced fee will be given on those charges.
4. This plan does not cover damage, loss, or theft of any removable prosthetic devices or appliances.
5. This plan does not provide any medical coverage.
6. Yearly benefits do not roll over into the next year.
7. Plan benefits cannot be transferred to other members on the plan.
8. Annual membership fees are to be paid in full at the time of applying, and are **non-refundable** once services of any kind are rendered.
9. This dental plan cannot be combined with any other special offers, discounts, and/or insurances.
10. All payments are due at the time of service to receive the reduced rate of 20%. If payment is not received when services are rendered, then the member will be charged the office's standard fee.
11. Membership in the dental savings plan may be terminated if the member: misses multiple appointments, and/or fails to pay for dental services received.
12. Missed or broken appointments without 24 hour notice will result in a $50 charge per hour scheduled.
13. Reduced fees do not apply to any and all products that can be purchased at Mounds View Family Dental (i.e. Oral B toothbrush, MI Paste, Whitening products, e.t.c.).
14. This policy is valid for 12 months from the day the annual premium is paid.

By initialing below, I acknowledge that I have read, understand, and agree to the conditions above.

____________________ Initials   __________ Date

DR. SABRY M. SHARARA, DDS

5366 Edgewood Drive • Mounds View, MN 55112

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Agreement:

I hereby apply for membership in Mounds View Family Dental in Office Dental Savings Plan, for myself and all listed family members. I acknowledge that Mounds View Family Dental reserves the right to change membership fee and provisions of the Membership Agreement. I understand that payment of membership fees shall be deemed acceptance of the terms of Membership Agreement.

Applicant's Name ____ Date of Birth ______________

Additional Applicants

Spouse or Domestic Partner (First, Last)	Date of Birth Gender M F
Dependent Child (First, Last)	Date of Birth Gender M F
Dependent Child (First, Last)	Date of Birth Gender M F

I acknowledge and agree that by signing this application I signify my understanding of, and my agreement to be bound by the Terms and Conditions for the Mounds View Family Dental Savings Plan.

____ ________________
Applicant's Signature Date

Plan Renewal Date ________________

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