



SMILE MEMBER PLAN

Dental savings for healthy smiles

COLLEGE HILL DENTAL



Please return completed agreement and payment to the following:



Mail to: College Hill Dental: 2400 Willamette St, Eugene, OR 97405
541-485-0272 | office@mygreat.dentist | www.mygreat.dentist

Plan Terms and Conditions:

- This is **NOT** dental insurance, rather a savings plan. This savings plan cannot be used in conjunction with dental insurance or other discounts. This plan is only valid at this dental office. Care from other providers or specialists is not included. Plan fees are subject to change.
- If you are a current patient enrolling in the Smile Member Plan, your account MUST have a ZERO balance.
- This plan is not retro-active and will become effective on the date of enrollment.
- Registration fee of \$50 is waived for first time enrollment but applied for re-enrollment if lapse in coverage occurs.
- It is the member's responsibility to utilize the services included in this agreement within their plan year limit. Any unused benefits will not be carried over or refunded. This plan is nontransferable.
- It is the patient's responsibility to inform College Hill Dental of changes in billing information due to expired credit/debit cards, etc. Expired cards are not a valid reason for non-payment. If we are unable to process a member's credit card, the Smile Member Plan is VOID until payment is made. Any unused benefits during this time are relinquished. Any scheduled future appointments will be canceled and cannot be rescheduled until account is in good standing.
- In exchange for the care provided under this plan, the covered member agrees to pay all balances in full at the time of treatment. If treatment is not paid in FULL at the time of service, the 15% discount is void. If paying for treatment using CareCredit, the discount offered on treatment will be 10%.
- The member has the right to opt out of the plan for a full refund within 30 days of enrollment as long as treatment has not started. If ANY treatment has been performed or if 30 days from enrollment have lapsed, NO refund will be given. The member will be responsible for paying the remaining balance regardless of services rendered.
- Services are based upon a plan year. The full membership dues, plus registration fee if applicable, are due on the date of enrollment and eligibility will begin at that time, remaining active for one year. There are no waiting periods. Your membership can be renewed at the end of each plan year.
- Should you need to change an appointment, we ask that you provide us with a minimum of two business days notice.



Child[†]
\$299



Adult
\$379



Perio*
\$588

What is the Smile Member Plan?

The Smile Member Plan is a membership-based dental savings plan that provides the quality care you deserve at a price you can afford. Members pay an annual fee to receive regular exams, cleanings, and X-rays along with access to significantly reduced rates on all other restorative and cosmetic dental procedures performed in our office. Plus, the plan offers many benefits including no annual caps, no limits, and no waiting periods. This provides for quick access to the care you need!

Our plan is designed to provide greater access to quality dental care at an affordable price.

- No** yearly maximums
- No** deductibles
- No** claim forms
- No** frequencies
- No** pre-authorization requirements
- No** preexisting condition limitations
- No** one will be denied coverage
- No** waiting periods (immediate eligibility)

CHILD & ADULT PLANS:

- Up to 2 exams, routine cleanings, and necessary X-rays
- 1 Emergency Care Visit - exam and necessary X-rays
- Oral cancer screening
- Up to 2 fluoride treatments when indicated
- \$200 off sleep apnea appliance
- Full mouth whitening - only \$149
- 15% discount on all other dental treatment

PERIO PLAN:

- Up to 4 perio maintenance cleanings (as needed), 2 exams, and necessary X-rays
- 1 Emergency Care Visit - exam and necessary X-rays
- Oral cancer screening
- Up to 2 fluoride treatments when indicated
- \$200 off sleep apnea appliance
- Full mouth whitening - only \$149
- 15% discount on all other dental treatment

Program Exclusions & Limitations

This is a savings plan, not dental insurance. It cannot be combined with any other insurance. It is only valid at this dental office; care from other providers and specialists is not included. Plan fees are subject to change. For complete details, see Plan Agreement or Plan Terms and Conditions.

[†] Children 13 or younger

* If periodontal infection is present, a periodontal plan may be required at an additional charge.

SMILE MEMBER PLAN AGREEMENT

Responsible Party Information:

First Name: _____ Last Name: _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Date of Birth: ____/____/____
Email: _____

Your Smile Member Plan Includes:

- **Child & Adult Plans** - Up to 2 exams, routine cleanings, and necessary X-rays
- **Perio Plan** - Up to 4 perio maintenance cleanings (as needed), 2 exams, and necessary X-rays
- 1 Emergency Care Visit - exam and necessary X-rays
- Oral cancer screening
- Up to 2 fluoride treatments when indicated
- \$200 off sleep apnea appliance
- Full mouth whitening - only \$149
- 15% discount on all other dental treatment

Enrollee Information:

Name: _____ Date of Birth: ____/____/____
Name: _____ Date of Birth: ____/____/____
Name: _____ Date of Birth: ____/____/____
Name: _____ Date of Birth: ____/____/____
Name: _____ Date of Birth: ____/____/____

Pricing

Children (ages 13 and under) - \$299/person
Adults (ages 14 and over) - \$379/person
Perio Plan - \$588/person
Registration Fee - \$50 (waived for first time enrollment, applied for re-enrollment if lapse in coverage occurs)

TOTAL CHILDREN ENROLLING: _____
TOTAL ADULTS ENROLLING: _____
TOTAL ADULTS ENROLLING: _____

Payment Options:

Cash Check Credit Card Monthly: Credit Card Only - Processed 1st of each month or following business day until remaining balance paid (next 2 months)

Credit Card Information:

Visa MasterCard Discover American Express

Cardholder Name: _____
Card Number: _____ Expiration Date: ____/____ Security Code: _____

By signing below, I acknowledge that I have reviewed, understand, and agree to the terms and conditions of the Smile Member Plan. I authorize College Hill Dental to process my payment as listed in this agreement.

Signature of responsible party: _____ Date: _____

FOR OFFICE USE ONLY: EFFECTIVE DATES: ____/____/____ TO ____/____/____