Parker River Dental

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Parker River Dental
Dental Membership Savings Plan Application Agreement

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ * _____ * ____ _____
Last First MI Preferred Name

Title: _____ **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* _____ **Prev. Visit:** _____ **Email Address:**

_____

Phone: _____ * _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ * _____
Address 1 Address 2

_____ * _____ * _____-____ *
City State Zip Code

Plan Choice: *

☐ Adult Plan (age 13 and older) ☐ Child Plan (age 13 and under) ☐ Perio Plan (age 14 and Older)

Plan runs 12 consecutive months from initial payment.

Select payment type, monthly payments required credit card on file. *

☐ Cash ☐ Check ☐ Credit Card

Card Holders name: * _____

Last 4 digits of card #: * _____

Expiration Date: * _____

Please select one of the following.

I understand and agree my credit card will be charged for the full amount of the dental plan(s) I selected. * ◯ Yes ◯ No

I understand and agree my credit card will be charged for the agreed upon incremental amounts for the dental plan(s) I selected. *

◯ Yes ◯ No

I have read and understand Parker River Dentals Dental Membership Plan stipulations. (Dental Plan stipulations available at bottom of application)
By signing below I am agreeing and acknowledging my understanding of the plan, what is covered and my financial responsibilities.

Signature _____ **Date** _____

Add additional plans for family members below.
Must reside in same household for 5% discount.
Dependents to age 26.

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Home Mobile Work Ext

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Address 1 Address 2

_____ _____ _____-____
City State Zip Code

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☐ Adult Plan (age 13 and older) ☐ Child Plan (age 13 and under) ☐ Perio Plan (age 14 and Older)

Plan runs 12 consecutive months from initial payment.

I understand and agree that the payment information provided above will apply to this family member as well. ◯ Yes ◯ No

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Dental Plan Savings Plan Stipulations

No refunds will be given in the event you terminate the membership plan prior to the end of the plan year.
Membership benefits are not transferable, have no cash value and may not be redeemed for cash.
This is not an insurance plan and is not subject to regulation by the state department of insurance.
Plan membership cannot be combined with current dental insurance plans.
No insurance claim will be filed for Members under this plan.
Membership fee may be adjusted annually.
Members are responsible for notifying dental practice of any address, credit card or contact changes.
Missed appointment fees/penalties are ineligible for the membership discount.
Total payment amount for additional dental services is due at the time services are provided. If full payment is not received at the time of service, fee discount will be void.
This plan is effective for treatment only by Parker River Dental. If you are referred to a specialist the discount will not apply.
Should there be dental treatment needed following any type of injury where a lawsuit is pending and therefore medical, disability or workman's comp type insurances are involved this discount plan cannot be used.
If you choose to extend your payment for treatment by paying with Care Credit the discount will be reduced by 10%.

*Major Restorative includes: Crowns, Bridges, Root Canals, Dentures
*Invisalign is not eligible for discount

Membership year starts from initial payment and runs for the following 12 consecutive months. Unused services do not roll over into the next 12 months. If you choose to pay monthly your credit card left on file will be charged automatically on the 1st of the month. If your credit card payment is denied, no services will be rendered until you are current on your payments.

Response Date: _____