Maddox DENTISTRY

EXCELLENCE IN ORAL HEALTHCARE

Maddox Dentistry Dental Membership Plan

APPLICATION FORM

First Name _____ Last Name _____

Home Address _____

City _____ State _____ Zip Code _____

Phone _____ Date of Birth _____

E-Mail Address _____

PLEASE PICK YOUR PREFERENCE

☐ **BASIC MEMBERSHIP $47 per person per month ($564) or $533 if paid Annually**

Included: Any xrays required at preventive visits

2 Cleanings and 2 Exams (Including VelScope screening)

Fluoride treatments as needed

50% discount for sealant placement

15% discount on all other services (Orthodontic, Botox, and Dermal Filler services are excluded)

☐ **ENHANCED MEMBERSHIP $73 per person per month ($876) or $835 if paid Annually**

Included: Any xrays need at preventive visits

2 Cleanings and 2 Exams (Including VelScope screening) Fluoride treatments and sealants as needed

1 included Emergency visit with necessary xrays

20% discount on all other services, except as noted below

10% discount on Orthodontic, Botox, and Dermal Filler services

☐ **IDEAL MEMBERSHIP $101 per person per month ($1212) or $1145 if paid Annually**

Included: Any xrays needed at preventive visits

2 Cleanings and 2 Exams (Including VelScope screening) Fluoride treatments and sealants as needed

2 included Emergency Visits and necessary xrays

30% discount on all other services, except as noted below

15% discount on Orthodontic, Botox, and Dermal Filler services

Family membership discounts will be offered toward the children of existing members in good standing. First 2 memberships at regular fees. Each additional member will receive a 10% discount on their membership fee. For patients that are current with their membership plan, up to 12 month interest free in house financing will be offered for situations where treatment costs of $1000 or more are required.

CONTINUED OVERLEAF

Program Guidelines

1. This program is NOT insurance. The program is only offered to individuals and families not currently covered by a dental health/insurance plan or Medicaid. This plan is not subject to any Maximums, Deductibles, or Waiting Periods. [If a patient is found to be covered by a dental insurance plan that Maddox Dentistry is a participating provider for, membership is no longer valid and the insurance plan fees, payments, and deductibles apply.]
2. The program outlined herein is only valid at Maddox Dentistry and benefits are not transferrable to another dental or specialty practice. Membership benefits cannot be combined with any other offers or discounts. Payment arrangements for membership fees are due at time of enrollment and must be up to date to receive membership benefits. Payment arrangements for the patient's portion of services provided are due at the time of service.
3. Membership is for 1 year from time of enrollment and shall automatically renew on the anniversary date unless a written request to cancel is received 30 days prior to renewal. Membership fees, fees for services, and terms of agreement may be altered at the discretion of Maddox Dentistry at renewal. Any changes in this regard, including a notice of renewal, will be communicated with the member 30-60 days prior to renewal. Membership fees are non-refundable. In addition, no refunds will be given if a member does not use the plan, relocates, or obtains dental insurance coverage.
4. 48 hour notice is preferred, 24 hour notice required, if a member needs to cancel or reschedule an appointment. ***There is a $100 cancellation fee for each appointment that is missed or cancelled with less than 24 hours notice.*** *Three (3) "no-shows" or cancellations without 24 hour notice may lead to membership termination without refund.*

TERMS OF MEMBERSHIP (including treatment discounts) apply to services actually performed/received during the membership plan year. These terms do not apply to services diagnosed/treatment planned during a membership year that are performed later during a year for which a membership agreement has not been completed and payment arrangements made for. Regular fees shall apply to those services, unless membership participation is reconciled.

Application acceptance

Patient's Signature _____ Date _____

Witness Signature _____ Date _____

Witness name (PRINTED) _____

Maddox DENTISTRY
EXCELLENCE IN ORAL HEALTHCARE

1100 Rickard Road, Springfield, IL 62704
Phone: 217.546.4738 | info@maddoxdentistry.com
www.maddoxdentistry.com