Dental Savings Plan

Our Dental Savings Plan is a one (1) year contract, starting from the date of signed contract between patient and Adam Carraway, DMD. The contract will renew automatically until patient or provider terminates with written notice. This savings plan has been designed as a courtesy to help meet the needs of our patients that do not have the benefit of dental insurance.

Annual Membership Benefits Include:

- Two (2) routine dental cleanings or periodontal maintenances (Adult or Child) per twelve (12) month term
- Three (3) dental examinations per twelve (12) month term
- X-rays (Adult - Four Bitewings, Child - Two Bitewings)
- X-rays (Adult & Child Two Periapicals)
- X-rays (One Panoramic X-ray)
- **Twenty percent (20%) courtesy discount** on all other services provided at Carraway Family and Cosmetic Dentistry. (Offer excludes bleaching and other retail dental products)

Cost:

- First family member = $299.00
- Second family member = $250.00
- Each additional family member = $199.00
- Payment of the above fees will be due in full when contract is signed
- No refunds will be given on unused services

Terms and Limitations:

- Full annual dues payment is expected at first visit
- Effective date is the day that you sign up, and renewal date is the same date every year
- This is an In-House Dental Savings Plan and is NOT dental insurance. It cannot be combined with any other dental insurance.
- This plan is good only for dental procedures performed at Carraway Family and Cosmetic Dentistry. Therefore, if you are referred to a specialist, they will NOT accept this savings plan.
- This plan is non-transferrable and non-refundable.
- Rates are subject to change annually
- This offer cannot be combined with any other offers
- This plan is for dental services only; retail products are not included.

Application for Dental Savings Plan

Guarantor Information

Name:_____ Email Address:_____

Address:_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

Additional Family Members:

Name(printed):_____ Date of Birth: _____

Name(printed):_____ Date of Birth: _____

Name(printed):_____ Date of Birth: _____

Name(printed):_____ Date of Birth: _____

Name(printed):_____ Date of Birth: _____

Annual Plan Cost

Individual		$299.00
2nd Family Member	$250.00	+ _____
Additional Family Member	$199.00 x ___	+ _____
Total Annual Cost:		= _____

Payment Type

Check #:_____

Credit Card (circle one): Visa Master Card Discover American Express

Card Number: _____ Exp. Date:_____ CVR Code:_____

I/ we have read and understand the above contract and agree to all terms.

Applicant's Signature: _____ Date: _____

Printed Name:_____

Adam Carraway, DMD: _____ Date: _____