# Le Dentistry & Associates Membership Plan

## No Dental Benefits? We Have You Covered!

## Join our Membership Plan and **SAVE TODAY!**

Our Membership Plan provides the professional oral care you want at an affordable price! How can we do this? By offering the plan directly to you, we remove the cost and hassle of a middleman. We keep it simple, pass the savings to you, and focus on your oral care!

| Child Complete (13 and younger) | Adult Complete (14 and older) | Perio (14 and older) |
|---|---|---|
| **$299 / yr** | **$399 / yr** | **$499 / yr** |
| **Save $191!** | **Save $307!** | **Save $407!** |
| **Included Services** | **Included Services** | **Included Services** |
| 2 Professional cleanings | 2 Professional cleanings | 3 Perio maintenance |
| 2 Regular exams | 2 Regular exams | 3 Regular exams |
| 2 Fluoride treatments | 2 Oral screenings | 3 Oral screenings |
| Routine x-rays | Routine x-rays | Routine x-rays |
| 1 Emergency exam | 1 Emergency exam | 1 Emergency exam |

- Benefits start immediately. Join today, save today!
- Includes cleanings, exams and routine x-rays at no extra cost.
- Provides exclusive discounts off other procedures, like fillings.
- Provides 100% price transparency. You will never be surprised by treatment cost.
- There are no deductibles, waiting periods, annual maximums, preapprovals, or denials of claims.
- Membership runs for 12 months from the date you join.

# Stop by our front desk to learn more and sign up today!

## Coverage Begins on the Day You Register

Please fill out the form below.

First Name: _____
Last Name: _____
Address: _____
_____
Phone: _____
E-mail: _____
Date of Birth ____/____/____ Female | Male
S.S # _____

Dependent

First Name: _____
Last Name: _____
Address: _____
_____
Phone: _____
E-mail: _____
Date of Birth ____/____/____ Female | Male
S.S # _____

Enrollment Period
____/____/____ to ____/____/____

Signature (member & dependent)
_____ Date _____
_____ Date _____

MasterCard | Visa | Discover
Card # _____
Expiration Date: _____
CVW Code: _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Le Dentistry & Associates in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that Le Dentistry & Associates may at its discretion attempt to process the charge again within 30 days, and agree to an additional <insert $> charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.