STAR CITY DENTAL SAVINGS PROGRAM

Select a program: ☐ Individual Child ☐ Single ☐ Dual ☐ Family

Please answer all questions or indicate "not applicable"

PERSONAL INFORMATION

First Name: ______________________ Last Name: ______________________

Birthday: ____

Mailing Address: ____

Street Address: ____

Home Phone: ______________________ Work Phone: ______________________

Cell Phone: ____

Email Address: ____

SPOUSE'S/PARTNER'S PERSONAL INFORMATION

First Name: ______________________ Last Name: ______________________

Birthday: ____

Cell Phone: ____

Email Address: ____

CHILDREN

First Name: ______________________ Last Name: ______________________

First Name: ______________________ Last Name: ______________________

First Name: ______________________ Last Name: ______________________

First Name: ______________________ Last Name: ______________________

First Name: ______________________ Last Name: ______________________

____

Member Signature Date

____

Parent or Guardian Signature (if child is under 18) Date

After the initial term of the one (1) year contract, this agreement shall be deemed renewed automatically each year for an additional one (1) year period, unless canceled via email or a phone call within thirty (30) days of the current term expiration date. You will receive an email 45 days and 30 days in advance of your contract end date. At that time, if you want to cancel your auto-enrollment, please respond to the email or call the clinic directly. If you forget to respond/cancel, we can refund you in full as long as no benefits have been used for that renewal period.

A recurring payment authorization form is required to be completed.

STAR CITY DENTAL SAVINGS PROGRAM

Star City Dental Savings Program is a **one (1) year contract**, starting from the date of the signed contract between the patient and Star City Dental. Our dental savings program is designed to provide access to affordable, quality dental care.

DENTAL BENEFITS INCLUDE:

- **Two Dental Prophylaxsis/Cleanings** (Adult Prophy, Perio Maintenance, or Child Prophy)
- **Two Exams: Comprehensive** (new patient), **Periodic** (recare), **Limited** (emergency)
- **Annual Radiographs** (Bitewings; Full Mouth Series or Panoramic Radiograph if necessary)
- **Two Fluoride Treatments**

ALL OTHER SERVICES OFFERED AT STAR CITY DENTAL ARE DISCOUNTED 15% OFF

COST:

- **Individual Child** (Age 13 and Younger) **= $315**
- **Single** (Age 14 and Older) **= $425**
- **Dual** (Married Couple) **= $750**
- **Family** (Three Members or More)
  - **1st Member = $375**
  - **2nd Member = $350**
  - **3rd Member = $325**
  - **Additonal Members = $300 each**

EXCLUSIONS AND LIMITATIONS:

- This contract is only for services performed by a staff member of Star City Dental.
- This contract does not replace, eliminate, or modify any other contract with Star City Dental.
- This contract does not give discounts on services already rendered.
- Family plans are limited to families of 3 people or more.
- Family members must live in the same household as the contract holder (unless attending college), are limited to immediate family members (parents and children), and are included in the family option up the age of 20.
- Maximum allowed discount off any single procedure is $500.
- Payment must be made at time of service.
- Cannot be used or combined with any other discount or promotion.
- No refunds of premiums will be issued at any time if participant decides not to utilize plan.

DENTAL SAVINGS PLAN AUTO-RENEWAL

AUTOMATIC PAYMENT DISCLOSURE

This form outlines your agreement with Star City Dental, in which you authorize us to process electronic payments from the credit card, debit card, or bank account provided below. You will be automatically charged the annual Dental Savings Plan contract renewal fee on the start date listed below. Payments will continue annually until the end date has been satisfied or your contract has been cancelled at your request. You will receive renewal information 45 days prior to your renewal date. If there are changes to the fees, you will be notified at this time. If you wish to cancel your contract, you must provide a written notification (30) days before to your current term renewal date. Please provide Star City Dental with a minimum 48 hour notice, should you need to edit a payment for any reason. If you are unable to fulfill the agreement, it will be your reasonability to contact Star City Dental to discuss alternate payment options. You will not receive any further correspondence from Star City Dental regarding these payments if your account remains in good standing. A receipt for payments completed will be available upon request.

Patient Name:

Last 4 digits of Card/Bank Account:

Renewal Start Date:

Plan Selected:

CHILD SINGLE ADULT DUAL FAMILY

*how many family members on plan:

Patient Signature (Parent/Guardian if under age of 18):

Date:

Card Holder/Bank Account Authorizing Signature:

Date: