

Shannon M. Coen D.M.D.

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Office Dental Discount Plan

Dr. Coen is offering a yearly in office Dental Discount Plan for her patients that do not have dental insurance coverage. This plan will help to decrease the out of pocket costs that patients can incur for cleanings, dental radiographs, and any dental treatment.

Annual Rate: \$150 per Adult per year

\$100 per Child per year (14 and under)

Examinations: All dental examinations including Periodic and Limited Exams are free with this plan.

Radiographs: All dental radiographs (x-rays) are free with this plan.

Cleanings: \$70 for Children and includes Fluoride treatment (14 and under)

\$80 for Prophylaxis (general cleaning) for Adults (14 and over)

\$90 for Periodontal Maintenance (cleaning after a deep cleaning)

Dental Treatment: 20% Discount on all in office Dental Treatments (Exclusion from this discount are Whitening and Invisalign).

Conditions of the In Office Dental Plan:

- The patient/guardian will need to sign and agree with the annual Office Dental Discount plan in order to receive these discounts.
- Failure to renew the annual payment and agreement will negate the discount on dental treatment.
- This plan is non-transferable to any other dental office and the annual fee is non-refundable. All payments for treatment are due at the time of service.
- If you have dental insurance and chose this plan you understand that Dr. Coen cannot bill your dental insurance for treatment covered under this plan during your time as a patient at this office.

Signature: _____ Date: _____

Agreement to Dr. Coen's Office Discount Plan:

I _____ agree to the above fees and discount for the following year (one year to the date on both forms). I have read over the details page and been allowed to ask questions about the plan. As long as I renew continuously every year I understand I will be locked into this fee schedule. Dr. Coen and her staff will attempt to contact me thirty (30) days before my renewal to let me know it is expiring. As long as I renew the plan within fourteen (14) days of my expiration dates I will be locked into the existing fees.

If I fail to renew my plan within fourteen (14) days of the expiration I understand that I will only be eligible for the new in office dental fees plan. If I chose to not to renew my plan for a period of time then I understand if I do chose to renew my plan I will be presented with the new fees that will apply if I chose to do so.

Renewal Contact Information:

Address: _____

Cell Phone: _____ Home Phone: _____

Other Phone: _____ E-mail: _____

PLEASE INTIAL ALL THAT APPLY BELOW:

_____ I am purchasing the plan for myself.

_____ I am purchasing the plan for the following Minor/Children. Please list names and birthdays below:

Signature: _____ Date: _____

Witness: _____