Asheville Smile Center

Ultimate Dental Savings Club

This agreement between **Asheville Smile Center (Dentist)** and _____ _____ **(Patient)** is established on _____ _____, 20____ and will expire on _____ _____, 20____. For this period of 12 months, Asheville Smile center is pleased to include the following benefits for the annual membership fee (specified below):

- ✓ **Two complete basic professional cleanings (not including periodontal treatment).**
- ✓ **Two complete exams (new patient and/or periodic) by doctor during the hygiene visits.**
- ✓ **One complete annual required x-ray series (bitewings or full mouth series only).**
- ✓ **Unlimited Emergency Exams and Problem Focused X-Rays**
- ✓ **<u>10% Savings</u> on all non-elective general dentistry procedures, including treatments for periodontal disease, fillings, crowns, bridges, etc.**
- ✓ **<u>10% Savings</u> on all purely elective cosmetic dentistry procedures, including Six Month Smiles, Invisalign and porcelain veneers (minimum of 4 teeth).**
- ✓ **No maximums, no waiting periods, no exclusions, no red tape.**
- ✓ **<u>10% Savings</u> on all dental products.**

Savings based on payment in full. Savings with other payment methods, such as financing, less 5%.

<u>Total Value: Minimum $830 to Unlimited</u>, depending on savings on dentistry.

The annual fee to become a member of the Ultimate Dental Savings Club is Patient's choice of:

_____ **Option #1: 1 payment of $350 (save $50)**

_____ **Option #2: 4 consecutive monthly payments of $100 (total of $400)**

_____ **Option #3: Periodontal Maintenance Cleaning Plan add on $125 (total $500)**
Includes: 4 routine periodontal cleanings

Patient agrees to:

- Attend all scheduled appointments at the scheduled times.
- Give minimum 2 business days notice for rescheduling appointments.
- Comply reasonably with Dentist's clinical recommendations.
- Make on-time payments (maximum savings achieved by paying in full).
- Refer friends, family, coworkers, and neighbors when pleased with our quality and services.

Patient's Signature: _____ Date:_____