

Advanced Dental Plan

WHAT IS THE ADVANCED DENTAL PLAN?

The ADVANCED DENTAL PLAN is an annual plan that has been developed to deliver quality dental care services to families like yours at prices that make sense for today's economy. Our office offers the convenience, comfort, and high-quality service, plus the individualized attention of private care.

WHERE ARE SERVICES OBTAINED?

Services for this plan are offered at our office only, located at 7000 Louetta Rd. in Spring, Texas.

HOW DO I RECEIVE CARE?

After your membership is effective simply call the dental office for an appointment. We have convenient office hours available Monday – Thursday.

WHO IS ELIGIBLE?

You, your spouse & any dependent children under the age of 19 or full time students up to age 26 years of age.

WHEN WILL BENEFITS BEGIN?

Benefits will begin immediately. Members are covered for 12 months.

WHAT IS THE ANNUAL COST

1 Member	\$475
2 Members	\$910
3 Members	\$1,325
4 Members	\$1,700
5 Members	\$1,997
6 or more Members	Consultation on fee

WHAT ARE THE BENEFITS?

The ADVANCED DENTAL PLAN provides teeth cleanings (up to 2 per year), examination (up to 2 per year) & x-rays **NO CHARGE**. Your membership in this plan also affords you a reduced fee schedule. However, unlike a conventional insurance plan there are no deductibles, no co-pays, and no yearly maximums. Additional comprehensive treatment or procedures are provided at **REDUCED** rates of **13% OFF**.

PATIENT PAYMENTS

All payments are made directly to the dental office. As treatment is performed payments are made at each appointment you should discuss all future payments and costs before future appointments are made. Interest free **PAYMENT PLANS** are available to cover

the cost of treatment for 6 or 12 months with approved credit (repayment length is based on amount of service).

EMERGENCY CARE

Eligible members and their eligible dependents may receive emergency exams including x-rays at **REDUCED** rates of **70%** and is available normal office hours. All procedures are provided at **REDUCED** rates of **13% OFF**. Any after-hours visits or procedures are at normal fees.

HOW TO JOIN

Fill out the attached enrollment form; include your check or your credit card information and the number of family members that will be joining the plan.

LIMITATIONS & EXCLUSIONS

1. Demonstrated non-compliance with the recommended course of treatment.
2. Services, which in the opinion of the attending dentist are neither necessary nor recommended for the patient's health.
3. Restorations, splints or other appliances used to increase vertical dimension or to restore occlusion.
4. Any service you are referred out of the office for; Periodontics, endodontics, and oral surgery as examples. Additional specialists required to be brought in the office such as a dental anesthesiologist for example.
5. Congenital malformations, except congenital anomaly of a tooth or teeth covered from birth.
6. Dispensing of drugs (whether supplied in or out of the dental office).
7. Hospital benefits for any other dental procedure.
8. Loss or theft of dentures, bridges or crowns.
9. Services for injuries or conditions, which are covered under Workers Compensation or Employer's Liability Laws.
10. Services that cannot be performed because of general health, physical or psychological limitations of the patient.
11. If patient should become covered by a traditional dental plan this plan becomes void.
12. If Periodontal Disease is present or we have a record of Periodontal Disease, any additional cleanings above the two per year (Periodontal Maintenance) is discounted by the regular rate of 13%.
13. Procedures performed after regular office hours are at normal fees.
14. Cannot be combined with any other office discount rates or special offers.

Advanced Dentistry of Spring
7000 Louetta Rd. Spring, Tx 77379
281-376-1214

Stephen Glass, DDS – General Dentist

Enrollment Form

Last Name _____ First _____ MI _____

Home Address _____

City _____ State _____ Zip _____

Main phone _____

Birthdate ____/____/____ Employer _____

List Covered Dependents

Name	Birthdate	Relationship

Payment Method:

Annual Payment (see attached table)

_____ Check Enclosed: \$ _____ (**Stephen D. Glass, DDS, PLLC**)

_____ Card # _____

Exp. Date ____/____ CVV code _____

Card Type (circle ONE): Visa/Mastercard/Discover/American Express

Signature: _____

Please read and sign below:

I understand the benefits, limitations, exclusions and requirements of the Advanced Dental Plan and I agree to the following:

1. For low operating costs of the plan and no administration fees, the plan is a paid on an annual basis.
2. Effective date is the day of processing payment.
3. There are no refunds and there is no obligation to renew after 12 months.
4. Fees for dental services are due when services are rendered.
5. Deposits are required to reserve time for long appointment and appointments with the specialist. Payment in full for ALL services is due at the time of the procedure.
6. **Failure to show for appointments and frequent late arrivals may revoke membership and there are no refunds.**
7. I understand this membership is not an insurance plan.
8. I agree to pay any and all costs in collecting all charges, including but not limited to attorney fees and court costs.

Printed Name of Plan Holder: _____

Signature: _____ **Date:** _____

Mail this form to:

**Advanced Dentistry of Spring
7000 Louetta Road
Spring, TX 77379**