PATIENT LOYALTY PROGRAM APPLICATION

APPLICANT INFORMATION		
Name:		
Date of birth:	SSN:	Phone:
Current address:		
City:	State:	ZIP Code:

ADDITIONAL PROGRAM ENROLLEES		
Name:	Date of Birth:	Office Use Only:
Name:	Date of Birth:	Office Use Only:
Name:	Date of Birth:	Office Use Only:
Name:	Date of Birth:	Office Use Only:
Name:	Date of Birth:	Office Use Only:
Name:	Date of Birth:	Office Use Only:

PROGRAM INFORMATION	
Effective Date:	End Date:

I agree to pay $________ which includes two preventative care appointments (limited to all of the following options, administered two times at a maximum of two separate appointments: cleanings, exams, x-rays and fluoride treatment).

I also understand that I will be allowed to have **one** additional **limited exam** (15 minutes or less) and 1 additional problem-focused x-ray, as needed, throughout the plan contract.

I will also receive a 20% discount for any additional services provided within Dr. Wellborn's scope of care and that those charges are not included in the Patient Loyalty Program Fee listed above.

Should I require any dental treatment that Dr. Wellborn is not able to provide, I will need to seek my own payment and treatment options with the dental office performing the treatment and the fees paid above do not extend to any other dental office.

Any fees assessed for late or missed appointments will apply.

SOURCE OF PAYMENT		
Name on Card:		Exp Date: _ _ / _ _
Type of Card:	Card #:	VIN: _ _ _

AUTHORIZATION FOR PAYMENT AND MEMO OF UNDERSTANDING

_____I authorize my account to be charged with the entire fee indicated above at the effective date. I understand that this policy will be limited ONLY to the individuals listed above and paid for at the time of this contract.

_____I understand that Dr. Wellborn's office has a set fee schedule regarding the cost of services and the 20% discount applied to any additional restorative dental treatment will be off of the offices fee schedule. At any time, at my request, I am able to get information regarding the cost and length of treatment.

_____I understand that it is my responsibility to schedule any and all appointments for myself and my family within the service year. If I am unable or unwilling to schedule two appointments within the contract date, no refunds will be issued.

_____I understand that Dr. Wellborn guarantees the quality and workmanship he provides for 2 years on any restorative treatment. Should any dental care fail within 2 years based on workmanship or quality of materials, we will be happy to repair or replace that work at no cost to the patient.

Signature of applicant:	Date: