CHRISTINA P. MASON, DDS, INC

Smile&Save™ Club

UNCOMPLICATE YOUR CARE

Patient Registration Form

Patient Information

First and Last Name: _____ M.I. _____

Address: _____ City, State, Zip: _____

Mobile phone: _____ Other: _____ Date of Birth: _____

Email: _____

Membership Level Selection - Please Check Your Selection

Smile&Save™ Platinum Member	Smile&Save™ Gold Member	Smile&Save™ Silver Member
• *Four* cleanings per year (periodontal cleaning included) • $500 off Invisalign alignment • 20% off non-lab related treatment • 15% off lab-related treatment • *Four* flouride treatments per year • Any necessary X-rays • Yearly examination	• *Two* cleanings per year (periodontal cleaning included) • 20% off non-lab related treatment • 15% off lab-related treatment • *Two* flouride treatments per year • Any necessary X-rays once per year • Yearly examination	• *Two* preventative cleanings 15% off lab and non-lab treatment • *Two* flouride treatments per year • Any necessary X—rays once per year • Yearly examination
☐ $699 - Individual member	☐ $499 - Individual member	☐ $349 - Individual member
$649/each additional member Additional members: ☐1 ☐2 ☐3 ☐4 ☐ ____	$449/each additional member Additional members: ☐1 ☐2 ☐3 ☐4 ☐ ____	$299/each additional member Additional members: ☐1 ☐2 ☐3 ☐4 ☐ ____

Information for Additional Members

First & Last Name: _____ Date of Birth: _____

Same Address? ☐ Yes ☐ No Address if different: _____

City, State, Zip: _____ Phone: _____

Email: _____

First & Last Name: _____ Date of Birth: _____

Same Address? ☐ Yes ☐ No Address if different: _____

City, State, Zip: _____ Phone: _____

Email: _____

First & Last Name: _____ Date of Birth: _____

Same Address? ☐ Yes ☐ No Address if different: _____

City, State, Zip: _____ Phone: _____

Email: _____

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Payment Information

Method of payment: ☐ Cash ☐ Check ☐ Credit/Debit Card

Card provider ☐ Visa ☐ MasterCard ☐ Discover

Card number_____ Expiry _____

Name on the card: _____

Terms, Conditions, and Exclusions of Membership

The 12 month membership fee is due upon joining. Membership will become effective upon receipt of fees, with no waiting period. It is the sole responsibility of the Member to maximize their benefits by arranging all appointments within the 12 month membership period If the appointments are not used, the member will not be entitled to a refund. Appointments included with your membership are not transferrable to another patient or extended beyond your membership expiration date. Renewal payment is due the beginning of the same month each year. The anniversary month of your membership is the month you originally joined, regardless of when payment is received. ALL MEMBERSHIP PLANS ARE NON-REFUNDABLE AND NONTRANSFERABLE.

Discounts under your membership do not apply to any treatment that was done prior to joining. The membership treatment discounts exclude sleep studies and sleep appliances. The membership treatment discounts exclude treatments directly related to Disclusion Time Reduction and Neural Occlusion.

Our membership is NOT a dental insurance plan, and can only be used at Christina P. Mason, DDS, Inc, for treatment provided by Dr. Mason or her staff. The plan cannot be combined with any other discount, offer, coupon, insurance, or outside financing plan such as CareCredit. The membership cannot be used for hospitalization or hospital charges of any kind and cannot be used for services for injuries covered under worker's compensation. The plan cannot be used for treatment, which in sole opinion of Dr. Mason, lies outside the realm of her expertise. The plan cannot be used for referrals to specialists and is not transferable for discounts at a specialist's office. It cannot be used for costs of dental care which is covered under automobile or medical insurance. Payment for service is due when service is rendered. Discounts under your membership do not apply to any treatment prior to joining. Discounts under your membership cannot be used for any family member on your account unless they have also paid a membership fee.

If I _____ choose not to pay at the time of service, I am responsible and will pay the customary fees for such services. I acknowledge that I am financially responsible for payment, in full, at time of services to take advantage of the savings being offered with my membership. If I do not pay, in full, at time of services I understand that I will be required to pay the customary fees for the services delivered regardless of my membership status. Furthermore, I understand the benefits, terms, conditions, exclusions, and disclaimers of membership.

_____ _____

Patient Signature *Date*

_____ _____

Witness Signature *Date*