Smiles for Siouxland Savings Gold Plan

This Agreement is made between **Smiles for Siouxland** and our valued patient, _____ on this date, _____ for the purchase of the Smiles for Siouxland **Savings** Gold Plan.

The patient, _____understands the following:

1. The Smiles for Siouxland Savings Gold Plan is **NOT** insurance. It is a discount membership plan that gives the patient discounts on certain dental treatment.
2. Your treatment **MUST** be paid in full at the treatment date of service.
3. Non- refundable and cannot be pro-rated.
4. It is only for procedures done in our office, and does not include referrals to specialists.
5. This plan is only honored at Smiles for Siouxland, and cannot be used at any other dental office.

What does the Smiles for Siouxland Savings Gold Plan include?

1. **2** Exams per year
2. **2** Cleanings per year
3. Any necessary x-rays (excluding CBCT)
4. **20%** discount on procedures done in our office. (Excluding dental implants, orthodontics, & major surgeries). Consultations are free.

Fee for Smiles for Siouxland Savings Gold Plan:

1. Individual Plan- $299
2. Couple Plan- $575
3. Family Plan (3)- $752
4. Family Plan (4)- $917
5. Each additional- $110

I understand the above guidelines and limitations and agree to purchase the Smiles for Siouxland Savings Plan, which will be in effect for one year from this date.

Patient:_____ Date: _____

Office: _____ Date: _____

This plans Effective start date is January 1st 2018