



# Healthy Smiles Program

We are excited to offer our Healthy Smiles Program for our patients who do not have dental insurance. Finances can often be a barrier for dental treatment and here at Jackson County Dental we want to remove that obstacle and allow everyone the opportunity to receive quality dental care. This program provides individual and families with a means to maintain oral health.

## Dental Services Include

Cleaning or Periodontal Maintenance (two per benefit year)	Routine X-Rays as needed (at recall apts)
In Office Fluoride Treatment (two per benefit year)	Examinations (two per benefit year)
Velscope/Oral Cancer Screening	Diagnosis
20% Discount on other Dental work needed per benefit Year	15% Discount on Orthodontic Services

## Annual Cost

- \$488 First family member (Cash or Check)
- \$423 Second family member (Cash or Check)
- \$397 Each additional family member (Cash or Check)

## Advantage of the Healthy Smiles Program

No Deductibles!	No Waiting Periods!	No Exclusions!
Highest Quality of Care!	State of the art facility and Technology!	No claims to file!

## Provisions of the Healthy Smiles Program

The cost of the Healthy Smiles Program is automatic savings for the first family member and compounds for each additional family member. This is a no lose program.

- **Payments are due the day services are rendered with either cash or checks.**
- Plan cannot be combined with other insurance plans, discount plans, or promotions.
- The Program is not transferable and non-refundable.
- Benefits are provided for one year from the first day of the month in which the patient is enrolled.
- Discounts only apply to services provided at this location. (Specialist and outside referrals are not included)
- To enroll you must pre-pay the above membership fees.
- **If a credit or debit card is used a 2.5% processing fee will be assessed for program fee and/or any related services.**
- Additional family members, if not a spouse, must be currently on the same account and under the age of 23.
- Additional family members must enroll within 6 months of the first family member to receive the reduced fee.

I \_\_\_\_\_ wish to enroll in the Healthy Smiles Program. I understand dental services will be provided as described above.

Signature \_\_\_\_\_ Self/Parent/ Legal Guardian      Date \_\_\_\_\_  
Witness \_\_\_\_\_      Date \_\_\_\_\_