Agoura Hills DENTAL DESIGNS

# Smile Care Membership Plan

## Application

Fields marked * are required

## 1 Patient Information

Full Legal Name *

Date of Birth *

Phone Number *

Email Address *

Street Address *

City *

State *

ZIP Code *

## 2 Select Your Membership Plan

### Essential

**$35**

/month

**$360/yr — save $60**

- ✓ 2 Cleanings/year
- ✓ 2 Exams/year
- ✓ X-rays included
- ✓ 20% off services

### Complete

**$55**

/month

**$570/yr — save $90**

- ✓ 2 Cleanings/year
- ✓ 2 Exams + X-rays
- ✓ Fluoride treatment
- ✓ Emergency exam
- ✓ 25% off services

### Premier

**$75**

/month

**$780/yr — save $120**

- ✓ 2 Cleanings/year
- ✓ 2 Exams + CBCT
- ✓ Fluoride treatment
- ✓ 1 Whitening/yr
- ✓ Priority scheduling
- ✓ 25% off services

☐ Essential · $35/mo ☐ Complete · $55/mo ☐ Premier · $75/mo

Payment Frequency *

☐ Monthly ☐ **Annual (save up to $120/yr)**

Selected plan:

## 3 Payment Information

Payment Method *

☐ Credit Card ☐ Debit Card

Name on Card *

Card Number *

Expiration (MM/YY) *

CVV *

Billing ZIP *

## 4 Billing Address

☐ Same as patient address (if different, complete below)

Street Address

City

State

ZIP

## 5 Membership Terms & Disclosures

### Membership Terms

- NOT dental insurance — no claims filed.
- Fees due monthly or annually as selected.
- Non-refundable once benefits are used.
- Valid only at Agoura Hills Dental Designs.
- Cannot be combined with dental insurance.
- Missed payments may suspend benefits.

### Auto-Billing Authorization

- You authorize recurring charges to your card.
- Charges occur on your selected schedule.
- Cancel anytime if no benefits have been used.
- 30-day notice required after first benefit use.
- Confirmation email sent before each renewal.

### HIPAA Privacy Notice

- You acknowledge receipt of our Notice of Privacy Practices.
- You consent to use of PHI for treatment, payment, and operations.

## 6 Required Agreements

☐ I have read and agree to the Membership Terms & Conditions above.

☐ I authorize Agoura Hills Dental Designs to charge my payment method on the recurring schedule I selected.

☐ I acknowledge receipt of the HIPAA Notice of Privacy Practices and consent to its terms.

## 7 Patient Signature

By signing below I confirm all information is accurate and I agree to all terms above.

Date *

Patient Signature * (type full name or use e-signature tool)

FOR OFFICE USE ONLY:

NOTICE: This is NOT dental insurance. Benefits are non-transferable and cannot be combined with insurance.