Albright Dental Practice
Dr. John H. Albright, D.D.S.
2804 Walbert Avenue
Allentown, PA 18104
610-821-8024 Fax 610-821-8084
jhalbrightdds@rcn.com

New Child In-House Dental Program Contract

(age 6 to 14 years old)

I, _____, agree to take advantage of the Albright Dental Practice Child's (age 6 to 14 years old) In-House Dental Program for my child, _____. I agree to pay the one-time only Program Set-Up Fee of $70.00 (seventy dollars) at time of contract signing. (This fee is adjusted to $35.00 (thirty-five dollars) if parent or guardian is a member.)

I understand that the Child Program price is $432.00 (four hundred thirty-two dollars) of which half, $216.00 (two hundred sixteen dollars), is do at time of contract signing. The balance will be broken up into 6 (six) monthly payments of $36.00 (thirty-six dollars) each to be **automatically applied to my credit card** ending in …_____ starting with the first day of the sixth month of my contract for the remainder of my contract year.

- ❖ I have been made aware that if my credit card is not able to be charged for any reason I will have a maximum of 14 (fourteen) days to submit another credit card to be kept on file for my child's program membership to remain in effect.

OR If I choose to pay the Child Program Fee Up-front in Full, an additional $25.00 (twenty-five dollars) will be deducted making the total cost $407.00 (four hundred seven dollars).

Child Program Includes:

- ➢ 1 New Patient Comprehensive Exam
- ➢ 1 Periodic Exam 6 mo. after Comprehensive Exam
- ➢ 2 Routine Cleanings per year
- ➢ Panoramic X-ray at Doctor/Guardian's Discretion
- ➢ 1 Emergency Exam per year
- ➢ 1 Periapical X-ray per year
- ➢ 2 Fluoride Treatments per year
- ➢ 15% Off All Other Dental Procedures

- The Term Year Under This Contract Starts on _____ and Ends on _____.
- I understand that I am responsible for making my child's appointments and keeping those appointments. If I must cancel an appointment, I will do everything within my power to give 48 (forty-eight) hour prior notice to Albright Dental Practice. (A fee will be charged for "no call, no show" missed appointments.)
- I understand that I am responsible to reschedule any missed or cancelled appointments. If I do not reschedule the appointment, it will not be carried over into the next year.
- I understand that this program is not transferrable to another family member.
- I understand that if I am referred to a specialist or other dental facility my membership will not apply any other practice or facility.
- I understand that all treatments are to be PAID IN FULL at each visit to keep the plan in effect.
- I understand that the annual enrollment fees are non-refundable.

Signed: _____ Dated: _____

ADP Employee Signature: _____ Dated: _____