

**Albright Dental Practice**

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**New Adult In-House Dental Program Contract**

I, \_\_\_\_\_, agree to take advantage of the Albright Dental Practice In-House Dental Program for New Adult Patients. I agree to pay the one-time only Program Set-Up Fee of \$70.00 (seventy dollars) at time of contract signing.

I understand that the Adult Program (non-perio) price is \$492.00 (four hundred ninety-two dollars) of which half, \$246.00 (two hundred forty-six dollars), is do at time of contract signing. The balance will be broken up into 6 (six) monthly payments of \$41.00 (forty-one 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 program membership to remain in effect.

**OR** If I choose to pay the Adult Program Fee Up-front in Full, an additional \$32.00 (thirty-two dollars) will be deducted making the total cost \$460.00 (four hundred sixty dollars).

Adult Program (non-perio) includes:

- 1 New Patient Comprehensive Exam
- 1 Periodic Exam 6 mo. after Comprehensive Exam
- 2 Adult Cleanings per year
- 1 Set of Full Mouth X-rays
- 1 Emergency Exam per year
- 1 Periapical X-ray per year
- 1 Velscope Oral Cancer Screening
- 15% Off All Other Dental Procedures

- The Term Year Under This Contract Starts on \_\_\_\_\_ and Ends on \_\_\_\_\_.
- This contract is good for the first year of my enrollment as a new patient. Starting my second year, I understand that I will need to sign an established patient contract to continue getting further benefits.
- I understand that I am responsible for making my 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 to 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: \_\_\_\_\_