CIROCCO
CENTER VALLEY
DENTAL CENTER

5280 Route 309
Center Valley, PA 18103
(610) 709-5599
SMILEHEALTHY.COM

JOIN TODAY

To expedite your membership on the Smile Healthy Dental Benefit Plan Call (610) 709-5599

MEMBERSHIP APPLICATION

Primary Member _____ Date of Birth_____/_____/_____ Gender ○M ○F

Address (Mailing) _____ City/State/Zip_____

Email _____ Phone _____

		Relationship	DOB	Gender
Additional Member	_____	○Spouse ○Child ○Other	_____/_____/_____	○M ○F
Additional Member	_____	○Spouse ○Child ○Other	_____/_____/_____	○M ○F

Dependent Name (Including spouse, domestic partner and children up to age 26)

Select Plan & Payment

☐ Single Plan $397/Year

☐ Dual Plan $697/Year

☐ Family of 3 Plan $997/Year

☐ Additional Family Member $197/Year

☐ Gap Coverage Plan $97/year (See #12 under Terms and conditions)

Method of Payment: Choose from Option A or B

☐ A ***Credit Card***

☐ I authorize that all initial membership fees will be charged to my credit card

☐ I authorize for automatic renewal on my annual enrollment date

☐ B ***Check made payable to*** CIROCCO DENTAL CENTER, PC

Terms & Conditions Signature authorization required

1. This Discount Plan is not insurance.
2. The enrollment fee includes a one year membership starting on the date this agreement is signed. The fee is due at the time the agreement is signed. The annual membership fee is non-refundable after 30 days even if you elect to end your membership part-way through the year, refund must be issued within 30 days of activation and prior to starting treatment.
3. The plan's fee schedule will remain unchanged during the year of membership.
4. Payment for services will be due at the time they are rendered unless prior financial arrangements were made. Accepted form of payment include cash, check, credit card and third party financing.
5. The plan excludes care that requires referral to a specialist for treatment. Upon such referrals you will be financial responsible for the the referred doctor's treatment fees. We have no jurisdiction over fees or practices of other offices.
6. Our normal fee schedule is subject to change without notice, usually once per calendar year.
7. Patients may continue to utilize our services as they have in the past as cash or insured patients without entering into a new agreement.
8. We reserve the right to refuse service and membership to anyone and for any reason if we believe that we are not a good fit for care.
9. Our goal is to improve your health by creating a better system for you to receive care and maintenance. We strive to provide our patients with quality care, current technology, superior dental materials and uncompromised care in a modern and comfortable environment with your best interest at the center of our professional relationship.
10. Accordingly, we ask that you are as committed to your health as we are as exhibited by your diligence toward your care.
11. You will not receive a membership card–your plan's effective date will be on file.
12. Gap coverage ***EXCLUSIVE*** to insured patients who have non-covered services with traditional PPO or indemnity insurance plans. This coverage ***EXCLUDES*** all diagnostic and preventative services normally covered with the complete individual plan or similar.

This signature authorization enrolls us in the plan selected for the individuals listed above.

Patient(s) Full Name(s)_____ DOB_____/_____/_____ Total Membership Fee_____

Signature (Primary)_____ Date _____/_____/_____

*Signature Acknowledges Terms and conditions above