**FORD FAMILY DENTAL**

**PATIENT MEMBERSHIP PLAN**

**Enrollment Form**

The following Patient Membership Plan (attached) is provided for election by an eligible patient of Ford Family Dental. An eligible patient is one who is not covered by any type of insurance for dental care. An Eligible Patient (or if applicable their parent/legal guardian) may select from the plans offered below to be a participant in such plan.

On behalf of myself as the patient, or as the legal guardian on behalf of a minor or incompetent adult person, I represent that the participant identified below is an Eligible Patient. I have elected the plan identified by the checkmark in the associated box. The selected plan will be referred to as the “Plan”.

□ Children’s Plan □ Adult Basic □ Adult Premier □ Perio Program

**ATTESTATION OF PATIENT/PARENT OR LEGAL GUARDIAN ATTESTATION:**

**I understand that the Plan is not an insurance plan as that term is defined under state and federal law**. I understand that the Plan selected is for the identified participant only.

I represent by my signature below that I fully understand the criteria and eligibility requirements for the Plan and specifically the Plan I have selected above as provided for in the Terms and Conditions provided to me by Ford Family Dental. I further represent and warrant that the participant identified below is an Eligible Patient, and therefore eligible to enroll and participate in the Plan, and that I will assume responsibility for the payments required under the Plan I have selected for myself, or as the parent or legal guardian of a minor or incompetent person pursuant to the Terms and Conditions of the Plan.

**Payment in full for the selected Plan to Ford Family Dental, or the election to make monthly installment payments pursuant to the Terms and Conditions of the Plan is required upon signing this form to be enrolled in the Plan.**

NAME of Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of participant or parent or legal guardian

DATE of Enrollment: \_\_\_\_\_\_\_\_\_\_\_ [Completed by Ford Family Dental]

**TERMS AND CONDITIONS**

1. Payments. If payment is made in full, it can be submitted by cash, check, credit card (limited to the credit cards that we accept, for example Visa, Mastercard, etc.) If payments are made monthly, they are made by automatically deducted via ACH.
2. Length of Membership. All Membership plans are 12 months. Any refunds for extenuating circumstances (for example death of a member) will be at the discretion of Ford Family Dental and be at a prorated amount.
3. Cancellation. Patients may cancel their membership after 12 months during the Notice Renewal Period defined below without penalty to the patient. Ford Family Dental may cancel the plan less than 12 months due to non-payment.
4. Renewal Policy. The plan will automatically renew and a minimum of 30-day notice (“Notice Renewal Period”)will be given to the member/patient of such renewal.
5. Change in Terms. Any changes to the terms and conditions can be made at any time by Ford Family Dental with a minimum of a 30 day notice to member/patient prior to changes taking effect.
6. Routine X-Rays. These are x-rays that are routinely taken on the prophylaxis (“cleaning”) appointment. Routine x-rays are NOT additional x-rays taken for problem-focused issues for any type of appointment, including but not limited to emergency visits, office visits, prophylaxis appointments.

