COOLICAN FAMILY DENTAL

2019 IN-HOUSE MEMBERSHIP PLAN

A special offer for our patients without dental insurance!

EXAMINATIONS	
New PT Comprehensive Exam	100%
Periodic Exam	100%
Limited Exam	100%
RADIOGRAPHS	
Full Mouth X-rays	100%
Panoramic X-ray	100%
Bitewings X-rays	100%
Periapical X-rays	100%
PREVENTATIVE	
Adult Cleaning	100%
Child Cleaning	100%
Periodontal Maintenance	100%
Fluoride Treatment	100%
ADDITIONAL SERVICES	
Any Service Not Listed Above	15%

FREQUENCIES PER YEAR

- Up to **TWO** (2) Routine Dental Exams (D0120)
- **ONE** (1) New Patient Comprehensive Exam (if needed) (D0150/D0180)
- Up to **FOUR** (4) Cavity Detecting X-rays (D0274)
- **TWO** (2) Healthy Mouth Cleanings (D1110/01120)

  or **TWO** (2) Periodontal Maintenances (D4910)
- **TWO** (2) Fluoride Treatments (D1206)
- **ONE** (1) Emergency Exam (D0140)
- **UNLIMITED** Individual X-rays As Needed (D0220)
- **ONE** (1) Panorex X-ray or Full Mouth Series X-ray (D0210/D0330)
- **ONE** (1) Identafi Oral Cancer Screening Procedure (D0431)
- **15% DISCOUNT** for ALL Procedures Not Listed Above

COOLICAN FAMILY DENTAL
803 S. Main Street • Scranton, PA 18504
P: (570) 343 – 8166 F: (570) 983 – 2888
www.coolicandental.com

Terms and Limitations

- ❖ This is a Dental Discount Plan and is NOT Dental Insurance. This plan cannot be combined with any other Dental Insurance.
- ❖ This Membership Plan is only valid at Coolican Family Dental; therefore, if you are referred to a specialist, they will not offer this discount.
- ❖ This Plan is Non-Transferrable – Family members cannot be substituted in for another family member. However, discounted yearly fees are available to enroll additional family members. All family members do not need to start term on the same date.
- ❖ Annual Membership Plan fees are Non-Refundable – No Refunds will be given if patient chooses not to use their Membership Plan. The included services do not carry over from one contract term to the next.
- ❖ Rates are subject to change. Annual renewal fee is subject to current rate and may be more or less than initial fee.
- ❖ Annual Membership Dental Plan renews automatically. A 30-day written notice is necessary to cancel term and not renew.
- ❖ Payments for services are due at the time of service or will be billed at the usual and customary fees.
- ❖ Periodontal Maintenance is prescribed Three (3) or Four (4) times a year - this program covers visits #1 and #3.
- ❖ Additional visits will qualify for discount of 15%.
    - ❖ 15 % Discount not applicable if payment is made using Care-Credit/Lending Club.
- ❖ Membership and procedure fees cannot be combined with any other offer or promotion.
- ❖ Should there be a dental treatment needed following any type of injury where a lawsuit and therefore outside medical, care, disability or workman's comp type insurances are involved, the discounted plan cannot be used.

2018 Membership Plan Annual Investment:

First Adult/Subscriber	_____________ $449.00	______________________________ Patient Name
Second Adult/Dependent	_____________ $399.00	______________________________ Patient Name
Eligible Child	_____________ $295.00	______________________________ Patient Name
Total Investment	**$ ____________**	

Patient/Subscriber Signature: ____ Date: _______________

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2018 MEMBERSHIP PLAN AUTOMATIC PAYMENT AGREEMENT

I, ____, authorize John P. Coolican, DMD
Patient Name

Inc. to charge my Credit Card or Bank Account below for $_________________ beginning on
Annual Fee

____________ every year for the In-House Dental Membership Plan.
Date

☐ **CREDIT CARD**

Cardholder's Name: ____

Credit Card Number: ____

Expiration Date: _____/_____ CVC Code: _________ Billing Zip Code: ______________

☐ **CHECKING ACCOUNT**

Name on Account: ________________________ Bank Name: _______________________________

Routing #: _________________________ Checking Acct #: ________________________________

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the merchant in writing of any changes in my account information or termination of this authorization at least 30 days prior to the next billing date.

If the above noted payment date falls on a weekend or holiday, I understand that the payments may be executed on the next business day.

For ACH debits to my checking account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF), I understand that the merchant may at its discretion attempt to process the charge again within 30 days and agree to an additional $25.00 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment.

I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank; so long as the transactions correspond to the terms indicated in this authorization form.

Patient/Subscriber Signature: ______________________________________ Date: ______________