BROWN
FAMILY DENTISTRY
GROUP

DENTAL SAVINGS PLAN

An economical and sensible plan for individuals and families

YEARLY PLAN FEES:

PRICES VALID THROUGH 2021

NEW MEMBERS: $50 Application Fee

EXISTING MEMBERS: $25 Yearly Renewal Fee

*Must sign up for auto-renew or renew before expiration to receive $25 application fee.

OFFICE HOURS

Monday	8am- 5pm
Tuesday	8am- 5pm
Wednesday	7am- 5pm
Thursday	8am- 5pm
Friday	8am- 1pm

PLAN BENEFITS

- 20% off of preventive services (cleanings, exams, x-rays, and fluoride)
- 10% discount on additional services
- $250 off "clear aligner" therapy
- No yearly maximum
- No paperwork
- No deductibles
- No pre-authorization requirements
- No pre-existing limitations
- No waiting periods

1220 North Pleasantburg Dr.
Greenville, SC 29607

864.322.5051 browndentalcare.com

We've got you covered

No Insurance?
No Problem!

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LIMITATIONS & EXCLUSIONS

Discount plan cannot be used:

- in conjunction with other dental insurance or discount plans
- for services required due to a worker's compensation injury
- for referrals to specialists
- for hospitalization or hospital charges of any kind
- for cost of dental care which is covered by automobile or accident insurance
- for sedation
- for procedures requiring a referral to a specialist (which include some oral surgery, advanced periodontal services, some root canals, braces, dentures, and some partials

Guidelines:

Payment must be made the day that services are rendered and can be made with cash, check, or credit card. If no payment is made at the time of service, billing will be at the usual fee with no discount.

This plan is NON-REFUNDABLE and NON-TRANSFERABLE. No refunds will be issued at any time if the plan is not used.

NOTE: CareCredit or any other extended payment plan cannot be used when paying discounted fees.

APPLICATION

NAME:_____

ADDITIONAL MEMBER:_____

ADDITIONAL MEMBER:_____

ADDITIONAL MEMBER:_____

ADDITIONAL MEMBER:_____

ADDITIONAL MEMBER:_____

SELECT YOUR PLAN(S):

☐ NEW MEMBER ($50) ☐ EXISTING MEMBER ($25)

TOTAL COST:_____

METHOD OF PAYMENT:

☐ Cash ☐ Check ☐ Visa/MC/Disc

AUTO-RENEWAL:

I hearby authorize Brown Family Dentistry Group to charge the card on file ending in _____ on _____.

I understand that failure to renew before my plan expires will result in a renewal fee of $50, and that it is my responsibility to make changes to this agreement prior to the renewal date.

I have read and understand the plan details

SIGNATURE:_____

DATE:_____