

I wish to enroll in Dr. Colburn's VIP Dental Savings Program. This is a savings plan that cannot be used in conjunction with any insurance plans. This can only be used in this office. This program covers:

- Two routine exams and healthy cleanings per year
- Bitewing (cavity detecting) X-rays once per year
- Oral Cancer Screening once per year
- Fluoride treatments in conjunction with healthy cleanings for children under 14 years of age
- 20% discount on all other services provided in this office

The total fee for my Dental Savings Program is due upon signing of this agreement. This is an annual fee. My program is effective for one (1) year from this date. Payment of my portion of treatment is due on the date of service. Visa, MasterCard, Discover, American Express, and Care Credit are accepted for payment, but I may receive an additional 5% discount by paying cash. I would like to include the following people on my Dental Savings Program:

_____	_____
_____	_____
_____	_____
_____	_____

The total fee for my Dental Savings Program is as follows:

Self		\$350
Additional family members	_____ X \$350	_____
Total fee		_____

Patient Signature

Date

Financial Coordinator

Date