Program Limitations and Exclusions

1. This plan cannot be combined with any other special offer or discount.
2. When Care Credit is used the amount of the discount will decrease by 10%.
3. Orthodontic services, including Invisalign, are not part of this dental plan.
4. Prophy (cleanings) by our office is defined as the removal of coronal plaque, calculus buildup and stains on the tooth above the gum line. Deeper cleanings or Scaling and Root Planing fall under a periodontal category and will be provided at the discounted rate.
5. For patients who require more than 2 cleanings per year, those cleanings will be provided at the discounted rate.
6. This plan is only good at O'Brien Dental. Therefore, if you are referred to a specialist, they will likely not offer the discount.
7. Yearly benefits are not carried over to the next year.
8. O'Brien Dental Your Choice Plan benefits cannot be transferred over to other family members.
9. Annual membership dues are non-refundable.
10. No refunds given if patient chooses not to use their dental plan.
11. The dental plan cannot be used in conjunction with a dental insurance policy or discount plan.
12. All payments are due at time of service to receive discount.
13. A 30 day notice must be made if one wishes to discontinue to plan for the new year.

Authorization

For monthly payments paid by credit card/debit card:
I give O'Brien Dental permission to bill my credit card account on a monthly basis throughout the end of the year. I understand that my policy will renew each year unless I provide a 30 day cancellation notification, and any unpaid premiums, declined credit cards, or declined draft funds will result in all insurance plan benefits becoming null and void. I understand that if I cancel my payments before the end of the year I will owe O'Brien Dental for the remaining amount of the contract and that my account may be charged accordingly.

Active Date:___________________________

Signature: ____ Date:

Name on Card:

Card Number:

Expiration Date: ______________________________ CVC: _________________________________

For automatic Bank Draft:

I authorize O'Brien Dental to draft the agreed amount from the financial institution listed below. I understand that my account will be drafted on the 1st of each month. I have the right to stop automatic payments from O'Brien Dental with reasonable notice made to O'Brien Dental, and I understand any unpaid premiums, declined credit cards, or declined draft funds will result in all insurance plan benefits becoming null and void. I understand that if I cancel my payments before the end of the year I will owe O'Brien Dental for the remaining amount of the contract and that my account may be charged accordingly.

Signature:____ Date:

Name of Bank as shown on check ____

Name shown on bank account ____
Bank Routing Number Bank Account Number