Tamara K. Abbett, D.D.S.

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Medford, OR 97504

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IN-OFFICE DENTAL PLAN

Name: ______________________________

Date: ________________________________

- ☐ I have opted for Plan 1 with 2 cleanings, exams, and routine radiographs as recommended during those hygiene visit s. (Annual cost $295)
- ☐ I have opted for Plan 2 with 4 cleanings, exams, and radiographs as recommended during those hygiene visits. (Annual cost $595)

My signature below and full payment of the annual charge for the in-office dental plan entitles me to these routine diagnostic and preventive services until________________________.

At that time, I may elect to subscribe for an additional year or revert to normal office fees.

- I understand that other services will have a courtesy discount of 10% with full payment at the time of service over the course of my enrollment.
- I understand that the usual 5% payment-at-time-of-service courtesy that is normally extended will not be available in addition to the 10% discount.
- Services may be recommended that I may choose to decline. I understand that the annual fee will not be adjusted or refunded if I elect to decline recommended diagnostic or preventive procedures.
- I understand that I must use the services within the membership year. Abbett & Associates will make every effort to help keep me on track, but if more than 2 appointments are broken (less than 24 hour notice), I will forfeit my pre-paid service.
- 1 understand that the following services are not included in the plan:
    - Implant services (after single implant)
    - Major reconstructive work will be discounted for the first $10,000, then will be charged at normal rates for work in excess of $10,000.

The office reserves the right to discontinue offering this plan at the conclusion of the one year period.

Signature :___________________________

Date: _______________________________