



FawsonDentistry  
INTEGRITY • QUALITY • SERVICE

## LOYALTY SAVINGS PLAN – SERVICES AND LIMITATIONS

**\*PLAN IS EFFECTIVE FOR ONE CALENDAR YEAR STARTING FROM THE DATE OF ENROLLMENT**

### INCLUDED SERVICES

- Two complete exams with oral cancer screening
  - This will include an initial comprehensive exam and one periodic exam for new patients **-or-**
  - Two periodic exams for existing patients of record
- Necessary x-rays
  - This will include an intraoral complete series, bitewings, or periapical x-rays
- Two fluoride treatments
- Two cleanings
  - This will include two basic adult cleanings **-or-** two periodontal maintenance visits
- One emergency exam

### ADDITIONAL DISCOUNTS

- **15% discount** off the standard fee schedule for additional services when paid in full at time of service using cash, check, or credit card.
- **This discount will be reduced to 10% off the standard fee schedule if the enrollment fee or treatment is financed through a third party provider, such as Care Credit, due to merchant service charges.**

### PLAN LIMITATIONS AND EXCLUSIONS

- The plan is non-refundable. No refunds of the enrollment fee will be issued if the participant chooses not to utilize the Loyalty Savings Plan.
- The Loyalty Savings Plan may not be used in combination with another dental plan.
- The plan is only valid at Fawson Dentistry. The plan will not cover any portion of a specialist referral. This plan does not cover treatment which, in the opinion of the dentist, lies outside the realm of their capability.
- The plan cannot be used for treatment covered under Workmen's Compensation or Automobile Medical Claims.
- The plan does not cover hospital charges of any kind.
- **Panoramic, 3-D, or other specialty x-rays are not included in this plan**
- **Discount does not apply to \$99 Whitening for Life program**

Additional fees may be charged for any missed, cancelled, or broken appointments without 24 hours prior notice.

Fawson Dentistry reserves the right to refuse further treatment and to terminate the plan if the patient is non-compliant or if the patient's account becomes delinquent.

I, \_\_\_\_\_ hereby certify that I agree to the terms and conditions outlined above.

Signature \_\_\_\_\_ Date \_\_\_\_\_