



The Palisades Dentists

The Care Plan

Enrollment Form + Payment Authorization

Initial (Circle One: Verbal/Phone Consent, OR Self)

___ I elect to enroll in The Care Plan Membership (aka "The Plan") which covers basic/preventative care (as outlined in the informational Care Package and understand that I am responsible for any discounted treatment not covered under The Plan.

___ I understand that The Plan is administered by *calendar year*, and I have the option to renew each calendar year, or to revert back to Fee For Service treatment.

___ I understand that The Plan and traditional dental insurance are *mutually exclusive*.

*The Plan cannot be used in conjunction with traditional insurance

*The Palisades Dentists will NOT submit electronic claims IF I have a dental insurance plan AND am a member of The Care Plan

___ I can schedule my covered treatment under The Plan at any time interval (i.e. I can schedule my cleanings 2 months apart from one another—there is no limitation or exclusion period).

___ I must abide by the office's regular Cancellation Policy. Being a member of The Plan does not shelter me from incurring last minute cancellation fees (\$150/hr of scheduled treatment without a 72 hour notice).

Enrollment Fees (2023)

One-Time Enrollment	\$780 annually per member (adult or child)
Family Membership	10% off total amount if enrolling more than 1 individual

Name(s) of Member(s) Enrolling:

___ (Initial) I authorize a (circle ONE) one-time payment/recurring charge of _____ using the following payment method:

- Credit Card On File
- Online Invoice/Secured Payment Application (email)
- Cash or Check

Total # of members: _____ x \$780 = _____

(if 10% family discount, apply here) = _____

Total Enrollment 2023 = _____

Credit Card Information/Cardholder Name: _____

Billing Address: _____

CC Type: (Visa/MC/Amex/Discover) _____

CC number: _____

Exp. Date: _____ Security Code: _____

Printed Name: _____ Signature: _____ Date: _____