Staley Dental Arts Dental Savings Plan

The perfect solution for your basic dental health!

Staley Dental Savings Plan is an annual reduced fee dental plan that allows individuals and families to receive quality, high tech, caring service that our practice provides at a reduced rate.

If you are not covered by any dental insurance, you and your spouse, as well as children under the age of 14 or full time students up to age 23 are eligible.

PLAN BENEFITS

- 3 EXAMS A YEAR
- 2 CLEANINGS A YEAR.
- 2 FLUORIDE TREATMENTS A YEAR
- FREE XRAYS AS NEEDED
- 25% OFF ALL DENTAL PROCEDURES

*EXCLUDES TEETH WHITENING AND ORTHODONTICS

PLAN COST:

INDIVIDUAL - $20.00 MONTHLY

TWO PEOPLE - $35.00 MONTHLY

FAMILY PLAN - $60.00 MONTHLY
INCLUDES 2 ADULTS / 2 CHILDREN
CHILDREN AGE 13 AND UNDER

ADD AN ADULT $20.00/MONTH
ADD A CHILD $12.00/MONTH

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Contact Us to get started today!
816-605-0034
www.staleydentalarts.com
office@staleydentalarts.com

PAYMENT DETAILS

CREDIT CARD PAYMENTS ONLY

CHARGES RUN ON THE 3RD FRIDAY OF EACH MONTH

VISA, MASTERCARD, DISCOVER

CARD # ______________________________

Name on Card __________________________

EXP ________ CVV __________

LIMITATIONS, RULES & EXCLUSIONS

There is no waiting period. Benefits begin immediately upon enrollment with payment. 1st month may be prorated.

*Members must remain in the plan for 12 months.

*Payments will continue indefinitely after the initial 12 months, unless notified by the patient to stop payments.

*Children may only be members as dependents of adult members. Payments by Credit Card will be processed on the 2nd Friday of each month.

*All fees for treatment are due at the time of service.

*Rules, limitations and exclusions are subject to change without notice

*No Refunds are issued.

Does not apply to:

* Services not performed at this office.

*Loss or theft of any dental appliance.

*Services that are to be covered by another type of insurance.

*Services that are provided without cost to the member.

Terms: I understand the benefits, limitations, exclusions and requirements of The Staley Dental Savings Plan and I agree to the following: I will remain in the plan and pay membership fees for a minimum of 12 months. Fees are non-refundable. Fees for dental services are due as rendered.

LAST NAME ____________________ FIRST _________________ MI ____ DOB _______ PHONE _______________

HOME ADDRESS _______________________________________ CITY ______________ STATE ___ ZIP ________

LIST DEPENDENTS	DOB	RELATIONSHIP
________________________________	____________	_______________________________
________________________________	____________	_______________________________
________________________________	____________	_______________________________

SIGNATURE _________________________________ DATE ___________