Alpine Dental Plan Application

I, _____, do hereby accept the following terms and conditions for the Alpine Dental Plan.

1. Payment of $120 per year is the charge for this plan and must be paid in full prior to any discounted rates.
2. My payment date is my renewal date if I wish to continue yearly on this plan.
3. This is NOT an insurance plan and I am responsible for all services performed.
4. Payment is due at the time of service.
5. If I am unable to pay in full, then I will be charged regular office fees and Finance Charges of 1%, determined monthly, on my entire balance until paid.
6. I will be given estimates prior to any procedures, upon request.
7. Additional costs may occur during treatment and I will be informed of these when they occur.
8. This plan is offered only through Alpine Dental Plan and cannot be combined with any other offers.
9. The plan is individual use only and is not transferrable to any other parties.

Patient Signature & Date

Office Manager Signature & Date

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