American Pediatric Dental Group

American Dental Plan (ADP) – Recall Visits

The **American Dental Plan – Recall Visits** is a proprietary discount plan for patients with no dental insurance or for those who do not qualify for 3rd party financing. Patients pay a **fee of $125 per child for each dental visit** and the **benefits are valid for six (6) months** from the day the patient(s) is registered for the plan. The American Dental Plan is valid at any of our office locations.

The fee includes a single dental visit consisting of the following procedures: periodic oral evaluation (D0120), intraoral and panoramic dental radiographs (D0272, D0220, D0230, D0330), prophylaxis (D1120), fluoride application (D1208), and oral hygiene instructions (D1330). In addition, patients on our plan benefit from having a **35% discount** for any treatment recommended by the dentist. These include: sealants, fillings, stainless steel crowns, nerve treatments (pulpotomy/pulpectomy), extractions, space maintainers, and nitrous oxide ("laughing gas"). Items **excluded** from the *American Dental Plan – Recall Visits* are hospital/sedation fees and dental work that is referred to another specialist—for example, another pediatric dentist, oral surgeon, endodontist, general dentist, or orthodontist.

Special considerations: This plan may not be combined with benefits from an existing insurance policy and the fee may not be applied towards out-of-pocket fees of a new dental insurance policy. Once services are rendered, the fee is non-refundable.

Patient Registration Form

Today's Date: _____ **Fee (*per child*): $125**

Name of Children: Dates of Birth:

1. _____ 1. _____
2. _____ 2. _____
3. _____ 3. _____

Phone: _____ Email: _____

Address: _____ City: _____ State: _____ Zip Code: _____

I authorize American Pediatric Dental Group to charge my credit card $_____ for one (1) dental visit and six (6) months of benefits under the American Dental Plan (ADP). Plan expires on: _____.

Credit Card: O Visa O MasterCard O American Express O Discover
Cardholder Name: _____
Account Number: _____
Expiration Date: _____
CVV2 (3-digit number of Visa/MC; 4-digits on front of American Express): _____
Billing Address, City, State, Zip: _____
_____

SIGNATURE: _____ Date: _____

*I authorize **American Pediatric Dental Group** to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the discount plan described above, for the amount indicated above only, and is valid for one-time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company, so long as the transaction corresponds to the terms indicated in this form. Furthermore, I fully understand and agree that the account I am listing with you has sufficient funds to cover these charges. In the event that my account has insufficient funds and these charges or additional charges cause my account to exceed my credit limit, I understand that I am solely responsible for those overcharges.*

FOR OFFICE USE ONLY

☐ ID Verified by (this box must be checked by American Pediatric Dental Group personnel): _____