BOS DENTAL

Periodontal Savings Plan

Patient Name: ____

I am enrolling in Bos Dental's Periodontal Savings Plan. The cost of the plan is $615 per year and coverage will end 1 calendar year from the date signed. This is a 50% savings off the regular cost. During the year the plan is in effect, I am eligible for the following treatments at no additional cost.

- 3 Periodontal Maintenance cleanings
- 1 Comprehensive ***New Patient*** Evaluation
- 2 Annual Recall Evaluations
- 1 Emergency Evaluation (problem focused exam)
- 1 Full Mouth Set of Radiographs (every 3-5 years)
- 2 or 4 Bite-Wing Radiographs (cavity checking x-rays), 2 Anterior Radiographs
- Any other Radiographs required at Included Evaluations
- 3 Fluoride Treatments

In addition to the included care listed above, the plan provides a **15%** discount for all other dental care. This cannot be combined with Care Credit. Examples include (but are not limited to):

- Fillings
- Crowns
- Extractions
- Treatment of Active Periodontal Disease/Scaling & Root Planning
- Implants
- Partials and Dentures
- Any additional cleanings outside of the 3 Periodontal Cleanings.

By signing below, I state that I have read the above benefit plan and I agree to its terms. I understand that $615 is due at the time of activation of the plan and that fees must be paid at the time of service to receive the 15% discount.

Signature of Patient/Guardian: ____

Date Signed: _____________________________

Date Expires: _____________________________

Staff Initials: _________