

TREATMENT YOU NEED AT THE PRICES YOU CAN AFFORD

Our goal is to help you make dental visits more affordable so you can get the quality dental care you want and need. Our very own in-house dental discount plan will provide you with tremendous savings. This reduced-fee dental plan allows individuals or families to receive all the available dental services at Geaux Smiles for a percentage discount off the regular office fees. If you have recently lost your dental coverage or have never had dental coverage, this membership may be right for you.

MEMBERSHIP ANNUAL COST

MEMBER	\$300
SPOUSE	\$260
EACH ADDITIONAL FAMILY MEMBER	\$180

NOTE: Once the annual fee is paid and received for the membership program, you will be entitled to discounted fee dental services for 12 consecutive months. Starting on effective date, members, spouses and dependent children under age 19 or full-time students up to 23 years of age are eligible. Children may be members only as dependents or family members. **Your effective date is the day you sign up and your renewal date is the same date every year.**

SAVINGS

Membership includes the following services covered at 100%:

- **Examinations**
 - o 2 routine exams (once every 6 months)
- **Radiographs**
 - o Full mouth or PANO x-rays (once every 3 years)
 - o 4 bite-wings (once every 12 months)
- **Prophylaxis**
 - o 2 cleanings (twice per 12 months, separated by 6 months)
 - o 1 fluoride treatment for children (once per 12 months, under the age of 16)

All other dental services are offered at a 15% fee reduction off our normal fees. Discount does not apply to special offers, promotions or products.



TERMS AND LIMITATIONS OF THE PLAN

- This is a dental discount plan and is NOT dental insurance. It cannot be combined with any other dental insurance.
- Any failed cleaning and exam appointment will be counted toward a covered cleaning.
- We highly value all of our patients' and doctor's time. We request a minimum 24 hour notice to reschedule or cancel appointments. Otherwise, a \$25 cancellation fee will apply.
- Benefits are valid only at Geaux Smiles. Therefore, if you are referred to a specialist, they will NOT offer this discount.
- Should there be dental treatment needed following any type of injury where a lawsuit and therefore outside medical care, disability or workman's comp type insurances are involved, this discounted plan cannot be used.
- This plan is Non-Transferable – Family members cannot be substituted in for another family member.
- This is Non-Refundable – no refunds given if patient chooses not to use their dental plan.
- Rates are subject to change annually.
- Either party may terminate this agreement upon 30 days notice. In case of an early termination, the subscriber will be charged for all procedures completed during that period at regular fee and the account will be adjusted according.
- Payments for services are due at the time of service. If you choose to extend your payment for treatment by paying through CareCredit, the discount is reduced to 10% due to merchant fees. Annual membership fees cannot be paid with CareCredit.
- This offer cannot be combined with any other offers or special promotions.
- For orthodontic treatment, participant must remain a plan participant the entire duration of orthodontic treatment.
- Dental services only, products are not included.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND LIMITATIONS.

_____	_____	_____
Patient's name (please print)	Signature of patient, legal guardian, representative	Date
_____	_____	_____
Witness to signature		Date (Rev. 03/18)



APPLICATION FOR GEAUX SMILES DISCOUNT PLAN

Personal Information:

Name: _____ Email: _____
Address: _____
City: _____ State: _____ Zip: _____
Home (_____) _____ Work (_____) _____ Cell (_____) _____
Date of Birth: ____/____/____ Social Security Number: ____-____-____

Spouse's Information:

Name: _____ Email: _____
Address: _____
City: _____ State: _____ Zip: _____
Home (_____) _____ Work (_____) _____ Cell (_____) _____
Date of Birth: ____/____/____ Social Security Number: ____-____-____

Children's Information:

Name: _____ M / F Birthday _____
Name: _____ M / F Birthday _____
Name: _____ M / F Birthday _____
Name: _____ M / F Birthday _____
Name: _____ M / F Birthday _____

Plan Cost:

Individual		\$300	
Spouse	\$200	=	_____
Each Additional Family Member	\$175.00x	=	_____
Total Annual Cost			_____

Applicant's Signature: _____ Date: _____

Payment type:

Check Number: _____
Credit Card: Visa MasterCard Discover
Card Number: _____ Exp Date: _____
CVR Code: _____ Zip Code for Card Holder: _____
Card Signature: _____



Geaux Smiles Dental Discount Plan

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