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ABBETT & ASSOCIATES IN-OFFICE DENTAL BENEFIT & WELLNESS PROGRAM

Name: _____ Date: _____

I have opted for the GREEN PLAN with 2 routine cleanings, exams and routine radiographs as recommended during those hygiene visits. Annual cost \$385.

I have opted for the PURPLE PLAN with 4 periodontal maintenance treatments, exams and routine radiographs as recommended during those hygiene visits. Annual cost is \$820.

- I understand that other services will have a courtesy discount of 10% with full payment at the time of service over the course of my enrollment.
- I understand that the usual 5% payment at the time of service courtesy that is normally extended will not be available in addition to the 10% discount.
- Services may be recommended that I may choose to decline. I understand that the plan fee will not be adjusted or refunded if I elect to decline recommended diagnostic or preventive services.
- ***I understand that I must use the services within the plan year.***
- I understand that the following services are not included in either plan:
 - Implant services
 - Major reconstructive services will be discounted for the first \$10,000, any services in excess of \$10,000 will be charged at normal office fees.

Abbett & Associates reserves the right to discontinue offering this plan at the conclusion of the one year period.

My signature below and full payment of the annual fee for the in-office dental plan entitles me to these routine diagnostic and preventive services for 1 year from the beginning date of this plan.

The plan does not automatically renew, the best time for renewal is at your hygiene visit following the expiration of the prior plan.

If the plan is not renewed, normal office fees will apply and there will be no allowance to "back date" a plan.

Signature: _____ Date: _____