River City Dentistry, PC (Jason Allred, DMD)

rivercitydentistry.com rivercityoffice@gmail.com
737 N.Thornton St. Suite #A • Post Falls, ID 83854 (208)777-8668

River City Wellness Plan Contract

This is a contract agreement between River City Dentistry, Dr Donna Schau, and (patient name): * _____

to provided services as detailed under the guidelines of the plan.
All plan services must be carried out at the office of Dr Donna Schau at 737 N. Thornton St., Post Falls, ID 83854.

This agreement is effective as of: * _____ **This agreement expires as of: *** _____

The fees to enroll in this Wellness Plan are due in full at the time of enrollment. The enrollment fees are as follows: *

☐ Individual adult: $349/annually ☐ Individual child (under 13 years of age): $249/annually

*Please note: The Affordable Care Act defines pediatric dental insurance coverage as an essential health benefit. This contract does not eliminate the legal requirement that parents obtain dental insurance for children under the age of 18.

Please see the attached fee schedule for the specific fees on all procedures that are provided under this plan.

Guidelines:
. Treatment under this plan can only be provided at River City Dentistry, Donna Schau, DDS
. Enrollment starts the date the paperwork is received by our office AND the plan fees are paid in full.
. Benefits cover a 12-month period
. This program is a discount plan, not a dental insurance plan
. No refunds will be issued to patients who choose not to utilize the benefits, relocate or obtain dental insurance
. Two "no-show" or "late -cancel" (less than 24 hours notice) appointments will result in termination of the program for the individual with no refunds
. All payment for treatments that qualify under the plan are due in full at the time of service to qualify for the discount
. Plans and fees are subject to change annually; plan fees are guaranteed for 1 year
. Under the plan, children are defined as an individual under the age of 13

See attached fee schedule for covered servies.

Exclusions:
. This plan cannot be used in conjunction with any other dental insurance or discount
. This plan cannot be used for referrals to specialists or other medica/dental offices
. This plan cannot be used for claims made under automobile insurance or another 3rd party insurance
. This plan is non refundable nor transferrable
. Dental treatment under this plan is only valid for the 12-month period that you are enrolled in the plan. Enrollment fee must be paid in full on the day of enrollment
. The plan discount does not apply to medications, prescriptions, or supplies dispensed by our office.
. Treatment started prior to enrollment is not eligible for the plan
. Treatment completed more than 60 days after the termination date of the plan will not be eligible for discount
. Unused benefits will not be refunded or carried over to the next year

All services purchased under this agreement must be carried out during the dates specified above.

This agreement is terminable at will by written notice from the patient to River City Dentistry at 737 N. Thornton St., Post Falls ID 83854. Likewise, River City Dentistry may also terminate this agreement at will by written notice to the patient. If a party provides written notice of termination of this agreement, the provider shall refund to the patient all unearned fees in less than 30 days following the notice of termination.

This agreement may not be sold or transferred by the provider without the written consent of the patient and may be transferred only to another primary care provider.

This agreement does not provide health insurance coverage, including the minimal essential coverage required by applicable federal law. It provides only the services described herein. It is recommended that health insurance be obtained to cover medical services not provided for under this direct primary care agreement.

☐ * **I have read the above contract and agree to the terms and conditions of the contract.**

_____ _____
Patient Signature (or Guardian Signature & Relationship Date

_____ _____
Provider Signature Date

See attached fee schedule for covered servies.

Response Date: _____