# Premier Dental Clinic Wellness Program

3825 Martin Way E #101
Olympia, WA 98506
360-456-7628

We are pleased to offer our in-house wellness program designed specifically for those without dental insurance.

With your payment, you will receive one each of the following treatments:

- Initial Comprehensive Exam or Periodic Exam only.
  Limited exams are not included, but will receive % discount.
- X-Rays: Full Series or 4-BW and any necessary PA's
- Prophylaxis (Basic Cleaning), if Scaling and Root Planing (Deep Cleaning) is required, there will be a surcharge to the patient of $25 for the first Quadrant. If additional quadrants of Scaling and Root Planing are required, each additional quadrant will be at 20% off our regular fees.
- Fluoride treatment
- Patient will receive at their next recall/cleaning appointment, one each of the following: Cleaning, Exam, Any necessary PA X-rays, and Fluoride. These Procedures are included as part of the Wellness Plan payment.
- The Wellness Plan will also allow the patient to receive a discount of 20% for any future services except for Orthodontics. If Orthodontics services are required, patient will receive a 10% discount off treatment.

Fee of $625.00 must be paid in full at the time of signing up for the Wellness Plan. The fee is non-refundable and cannot be exchanged, bartered, or transferred to others for use. Any unused treatment will expire one year from the sign up date, and cannot be rolled over. The Full Value of the Dental Wellness Program is up to $832.00 based on the patient coming in for Cleaning (2), Exam (2), X-rays (full series and any required PA's), Fluoride (2). The Dental Wellness Program is "NOT" dental insurance, and is not associated with any dental insurance company. This program cannot be used for patients who have other insurance, unless the primary insurance benefits have been exhausted. Cash payment discounts do not apply to services for patients on the Wellness Plan.

By signing below, I have agreed to the conditions above.

Patient/Guardian:________________________________ Date:___________________

Greenwood Family Dental Representative:_____________________________________