

Pablo J. Fonseca D.D.S., PA.

My Dentist in Miami

14277 SW 42nd Street
Miami, FL 33175
305-222-9219

40 SW 13th Street, Suite 103
Miami, FL 33130
305-222-9899

MY DENTIST IN MIAMI ADVANTAGE PLAN

Membership is active for twelve (12) months from the enrollment date and membership fees are non-refundable. My Dentist in Miami Advantage Plan is not an insurance plan. Discounts applied when services are provided to the patient. Discounts are not valid on any *sale or promotional items* or services. Discounts are not available on cosmetic or elective services. Program not valid with any other insurance and cannot be used for injuries covered under Worker’s Compensation or any other similar insurance.

Annual Membership for an individual is \$ 299 Adults / \$ 199 Children (Age 12 and under) or \$ 499 Family (up to 3 family members living in the same household) each additional person \$ 175 Adult / \$ 150 Child. Includes all fee discounts as described below plus **TWO NO-CHARGE regular cleanings (D1120, D1110) per enrollment year in the absence of periodontal disease.**

Benefits received under Advantage Plan are as follow:

<u>Treatment – ADA Code/ Description</u>	<u>Discount</u>
DIAGNOSTIC - D01000 – D0999	50 % Discount
PREVENTATIVE - D1000 – D99	50 % Discount
RESTORATIVE - D2000 – D2999	25 % Discount
ENDODONTICS - D3000 – D3999	25 % Discount
PERIODONTICS - D4000 – D4999	25 % Discount
PROSTHODONTICS - D5000 – D5999 (removable)	15 % Discount
PROSTHODONTICS - D6200 – D6999 (fixed)	15 % Discount
ORAL SURGERY - D7000 – D7999	15 % Discount
ORTHODONTICS - D8000 – D8999	10 % Discount

As the guarantor, I wish to enroll with a INDIVIDUAL or FAMILY - My Dentist in Miami Advantage Plan. I understand that this is not an insurance plan and cannot be used in conjunction with an insurance carrier. I understand that enrollment is effective _____ and expires within 12 months of the aforementioned date. *I further understand that the membership fee is non-refundable.*

Method of Payment: MasterCard Visa American Express Care Credit Cash

Guarantor Signature

Date

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MY DENTIST IN MIAMI ADVANTAGE PLAN ENROLLMENT FORM

Guarantor Last Name	First Name	Initial
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Mailing Address	City	State	Zip
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Phone Number	Social Security Number	Date of Birth
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Family Member #2

Last Name	First Name	Date of Birth
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Family Member #3

Last Name	First Name	Date of Birth
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Family Member #4

Last Name	First Name	Date of Birth
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Family Member #5

Last Name	First Name	Date of Birth
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Guarantor Signature

Date