



**APPLE SMILE CLUB
DENTAL SERVICE PLAN AGREEMENT**

1. Contact Information.

Patient Name: _____

Patient Address: _____

Additional Family Members added to Contract:

Patient Email: _____

Dentist Name: MICHAEL A. TWITCHELL, DMD

Dentist Location/Address: FAMILY DENTAL HEALTH

2543 LOCUST HILL ROAD

TAYLORS, SC 29687



2. **Term of Agreement.** This Prepaid Dental Service Program (the “Agreement”) by and between the Dentist and Patient shall be for a term of one (1) year commencing on the date of the last party to execute this Agreement (the “Term”), and shall automatically renew at the end of the Term for one month renewal terms (“Monthly Renewal Term(s)”) unless either party provides written notice to the other party of its intention to terminate the Agreement at least thirty (30) days before the end of the Term or the then current Monthly Renewal Term.

3. **Dental Services Provided by Dentist.** Dentist shall provide the following dental services (“Dental Services”) to the Patient in accordance with the terms of this Agreement:

- a) Oral examinations and routine cleaning of Patient’s teeth, but not more than two (2) per Term of twelve (12) months.
- b) Dental x-rays of Patient’s teeth necessary at the oral examinations and routine cleaning of teeth described in subsection a) above, including, bitewings, two (2) times per Term of twelve (12) months.
- c) Twenty (20%) percent discount on all other dental services provided by Dentist to Patient and not outlined in subsections a) through c) above, excluding any Orthodontic Services and take home dental products. For purposes of this Agreement, Orthodontic Services shall include active appliances, adjustments of the appliances, and any and all x-rays or oral examinations associated with the same.

The parties agree that the undersigned Dentist may delegate Dental Services to another qualified individually licensed dentist to perform the Dental Services, subject to the continued oversight and supervision of the undersigned Dentist.

4. **Fees for Services.** Patient agrees to pay Dentist in exchange for the Dental Services, a one-time nonrefundable joining fee of Seventy Five and 00/100 (\$75.00) Dollars (the “Membership Fee”) at the time of execution of this Agreement. Additionally, Patient shall pay to Dentist a one-time yearly payment of Two Hundred Ninety Nine and 88/100 (\$299.88) Dollars (the “Yearly Payment”), or monthly installments of Twenty Four and 99/100 (\$24.99) Dollars (the “Monthly Installment”) for twelve months, totaling the Yearly Payment. If Patient chooses to make Monthly Installments, the first Monthly Installment shall be due and payable at the time of execution of this Agreement along with the payment of the Membership Fee, the remaining Monthly Installments shall be paid to Dentist on the first (1st) day of every month thereafter, including each month during the Monthly Renewal Terms. The Patient may execute an Authorization Agreement for Direct Payments authorizing Dentist to charge a credit card or debit card designated by the Patient in the amount of the Monthly Installments, the form of such Authorization Agreement for Direct Payments is attached hereto as **Exhibit A**, and incorporated herein by reference (the “Authorization Agreement for Direct Payments Form”).



5. **Default and Termination.** Either party may terminate this Agreement upon written notice to the other party in the event of a material default under the terms of this Agreement. In the event of a material default, the breaching party shall have ten (10) business days from receipt of written notification of the default to cure such default to the reasonable satisfaction of the non-defaulting party before such termination shall become effective. Upon any termination by Dentist under this Section 5, all remaining Monthly Installments due after the date of such termination shall become immediately due and payable in full, and this Agreement and all rights and obligations created hereunder shall be deemed null and void and of no further force or effect.

6. **Relocation.** In the event Patient permanently relocates his or her principal residence more than sixty (60) miles from the office location of the Dentist, Patient may terminate this Agreement by providing written notice of such relocation to Dentist at least thirty (30) days before Patient's requested termination date of this Agreement (the "Termination Date"). Commencing on the Termination Date, this Agreement and all rights and obligations created hereunder shall be deemed null and void and of no further force or effect.

7. **Dentist's Termination.** Dentist reserves the right without the consent of the Patient to terminate this Agreement for any reason whatsoever, including, but not limited to, death or disability of the Dentist, sale of the dental practice where Dental Services under this Agreement are rendered, or relocation of the Dentist. Upon any termination by Dentist under this Section 7, all rights and obligations created hereunder shall be deemed null and void and of no further force or effect.

8. **Notices.** Any notice required or permitted to be given under this Agreement shall be given in writing and deemed given on the date it is sent by certified mail, postage prepaid, return receipt requested, to Dentist, at the address set forth above, and in the case of the Patient, at the address set forth above. In the event of any change in the address of Patient, it shall be the responsibility of Patient to notify Dentist in writing of such change(s) as set forth above.

9. **Entire Agreement.** This Agreement, including any schedules and exhibits attached hereto, contains the entire agreement between the parties and supersedes any prior or contemporaneous agreements between the parties. It may not be changed orally, but only by an agreement in writing, duly signed by the party against whom enforcement of any waiver, change, modification, extension, or discharge is sought; provided, however, Dentist retains the unilaterally right to change the terms of this Agreement after the end of the first Term.

10. **Not an Insurance Contract.** This is a direct contractual agreement for dental services between an individual dentist and an individual patient. The Dentist is contractually bound to personally provide the Dental Services.



11. **Governing Law.** This Agreement shall be governed and construed in accordance with the laws of the State of South Carolina without regard to conflict of law principles.

Dentist:

Print Name: Michael A Twitchell, DMD

Date: _____

Patient:

Print Name: _____

Date: _____

Parent/Guardian:

Print Name: _____

Relationship to Patient: _____

Date: _____



EXHIBIT A

Authorization Agreement for Direct Payments Form

Please complete the information below:

I _____ authorize FAMILY DENTAL HEALTH to charge my credit card
(full name)

indicated below on the _____ day of each month for payment of my Monthly Installment in the amount of \$24.99 per member for a total of \$_____ pursuant to that certain Prepaid Services Agreement by and between Michael A. Twitchell, DMD and _____.
Doctor Patient

Billing Address _____

Phone# _____

City, State, Zip _____

Email _____

- Visa MasterCard
 Amex Discover

Cardholder Name _____

Account Number _____

Exp. Date _____

V. Code _____

SIGNATURE _____

DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Family Dental Health in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.