# CORONA FAMILY DENTAL

# DENTAL DISCOUNT PROGRAM

1. **This program is not insurance**. Therefore, this program does not meet any federal or state requirements for healthcare minimum coverage. It is *only* applicable to Corona Family Dental services and goods provided to our patients in Florida.

2. ***Term of Agreement***: This Agreement is effective immediately following our execution of this Agreement and you paying all subject fees. The Agreement will continue subject to the terms and conditions in this Agreement.

3. ***Termination of Agreement***: Either you or the Practice can terminate this Agreement upon thirty days' notice. This Agreement will automatically terminate if you fail to pay the any fees.

4. ***Payment*****:** You agree to timely pay the fee for participation in the Program as required in this Agreement. The fee may be modified by the Practice upon ninety days' notice to you.

5. ***Services & Goods***: You will receive a discount on our goods and services as set forth on our webpage at: www.coronafamilydental.com That fee schedule discount is considered incorporated into this Agreement. The fee schedule will reference goods and services that are EXCLUDED from the discount. The fee schedule may be modified upon ninety days' notice to you. This discount may not be applied to any goods or services provided under or related to a government program. This discount does not apply to any goods or services supplied by another person or entity. Any stated fees are the minimum fees.

6. ***Patient Affirmations***: You agree that you will not submit or attempt to submit any bill for services or goods to a government or government sponsored program. You affirm that you have been honest about your health and dental issues with the Practice's dentist.

7. ***Your Information/Contact information***:

   Full Name: _____

   Address:_____

   _____

   Telephone Number: (  ) _____-_____

   Email address:_____

8. ***Program Participation***: The Program will <u>*only*</u> apply to persons you list in this section. Omitting an individual will mean the individual will <u>not</u> be eligible for discounts. It you do not provide complete and accurate information, the discount will not be available to you or the person listed.

Are you seeking:

Participation only for you: Yes / No

Participation for your family (you, your spouse and children only): Yes / No

You are requesting participation in this Program by the following persons who are related to you by blood or marriage and reside in your home. Family participation *only* includes you, your spouse and your children.

A. Your Full Name:_____

   Date of birth:_____

B. Spouse Full Name: _____

   Date of Birth:_____

C. Child Full Name:_____

   Date of Birth:_____

D. Child Full Name:_____

   Date of Birth:_____

E. Child Full Name:_____

   Date of Birth:_____

9. ***Assignment***: Neither Party may assign or transfer any of its rights, duties, or obligations under this Agreement, in whole or in part, without the prior written consent of the other Party. The Practice may assign this Agreement to another dental practice that purchases the practice or the practice's assets.

10. ***Government Rulings or Opinions***: This Agreement may be immediately terminated by Practice if in its reasonable opinion the government has issued an advisory, opinion or finding that this Program may be or would be illegal.

11. ***Voluntary Agreement***: You agree that you are free to participate or not in this Program. If you were to reject participation or terminate this Agreement (other than whiling owing fees), those

decisions will not affect the Practice's treatment of you or your ability to be a patient of the Practice. You understand that you are free to not participate in this Program.

12. ***Amendment***: This Agreement and its referenced materials (including website) set forth the entire Agreement with respect to the subject matter and supersedes all prior agreements, oral or written, and all other communications between the parties relating to this matter. Except as described in this Agreement, this Agreement may not be amended or modified except by mutual written agreement signed by both parties.

13. ***Force Majure***: Neither party shall be responsible or liable for any failure or delay in the performance of all or part of this Agreement, directly or indirectly, due to circumstances beyond its control, including, but not limited to, an act of God, acts of the federal or Florida government, pandemic, executive orders of a government official, epidemics, travel restrictions, health crises, quarantines, riots, war, strike, labor or product shortages.

14. ***Fee***: Based on the participation listed by you in #8, your annual fee is currently $_____. You understand that if you fail to pay timely, then your participation will immediately terminate. If the Practice allows you to re-instate participation, the Practice may request that you pay a reasonable administrative fee of $99 for re-instatement. The Practice is not required to agree to re-instatement. The fee is due and one time and cannot be made in payments.

15. ***Scheduling***: This Program does not promise to schedule patients except as can be accommodated in the general operations of the Practice.

16. ***Governing Law/ Venue***: This Agreement has been entered into in the State of Florida and shall be construed and interpreted in accordance with, and shall be governed by, the laws of the State of Florida. Any suit, action or proceeding with respect to or arising out of this Agreement shall have as its venue, **Sarasota and Manatee** County Florida, and shall be litigated solely in the state and federal courts with jurisdiction over **Sarasota and Manatee** County, Florida. Company hereby consents to the personal jurisdiction of such courts and waives any objection that such venue is inconvenient or improper.

17. This Agreement is made for the sole and exclusive benefit of you and Corona Family Dental, and is not intended to benefit any other third party. No other party may claim any right or benefit or seek to enforce any term or provision of this Agreement.

18. You agree that you may cancel in writing within the first thirty days of signing this Agreement and receive a refund. If you cancel, then you will not be entitled to any discounts. This

cancelation must be delivered to the office you signed up at: Corona Family Dental at Sarasota East: 8282 Bee Ridge Road Sarasota, FL 34241. Corona Family Dental at Spring Forest 10940 State Route 70 unit 102 Bradenton, FL 34202. Your cancelation will be subject to an administrative fee of $25.

19. THE PATIENT AND ANY OTHER PERSON RESPONSIBLE FOR PAYMENT HAS A RIGHT TO REFUSE TO PAY, CANCEL PAYMENT, OR BE REIMBURSED FOR PAYMENT FOR ANY OTHER SERVICE, EXAMINATION, OR TREATMENT THAT IS PERFORMED AS A RESULT OF AND WITHIN 72 HOURS OF RESPONDING TO AN ADVERTISEMENT FOR THIS DISCOUNTED FEE CORONA CARE.

Print Name:_____

Signature:_____ Date:_____