DENTAL RETAINER AGREEMENT

Background

Haws Family Dentistry is a Direct Primary Care dental practice (“DPC”), which delivers dental services at 140 E 1000 S Suite 101 Brigham City Utah 84302. In exchange for certain fees, the practice agrees to provide you with the services described in Appendix A on terms and conditions contained in this agreement (“Agreement”).

Definitions

1. Patient. In this Agreement, “Patient” means the persons for whom the Dentist shall provide care, and who have signed this agreement or are listed on the document attached as
Appendix B, which is a part of this agreement.

2. Services. In this Agreement, “Services”, means the collection of services, offered to you by Haws Family Dentistry in this Agreement. These Services are listed in Appendix A(1), which is attached and a part of this Agreement.

Agreement

3. NOTICE: THIS MEDICAL RETAINER AGREEMENT DOES NOT CONSTITUTE INSURANCE, IS NOT A MEDICAL PLAN THAT PROVIDES HEALTH INSURANCE COVERAGE FOR PURPOSES OF THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT AND COVERS ONLY LIMITED, ROUTINE HEALTH CARE SERVICES AS DESIGNATED IN THIS
AGREEMENT.

4. Term. This Agreement will last for one (1) year, starting on the date this agreement is signed.

5. Renewal. The Agreement will automatically renew each year on the anniversary date of the agreement, unless either party cancels the Agreement by giving thirty (30) days prior written cancellation notice.

6. Termination. Regardless of anything written above, you always have the right to cancel this agreement. Either party can end this agreement at any time by giving the other party thirty (30) days prior written notice. If the patient cancels their plan they will be held liable for any fees associated with the services rendered.

7. Payments and Refunds – Amount and Methods. In exchange for the Services (see Appendix A(1)), You agree to pay Haws Family Dentistry, a monthly or annual fee in the amount that appears in Appendix C, which is attached and is part of this Agreement

a) This monthly or annual fee is payable on a prorated basis when you sign the Agreement, and is due on the fifteenth (15) (or on the day you signed up for annual plans) of each month or each year thereafter.

b) The Parties agree that the required method of monthly or annual payment shall be by automatic payment, through a debit, Bank ACH or credit card.

c) If this Agreement is canceled by either party before the Agreement ends, Haws Family Dentistry or its designee will review and settle your account as follows:

We will refund to you the unused portion of your fees on a per diem basis; or
If the value of the Services you received over the term of the Agreement exceeds the amount you paid in membership fees, you shall reimburse Haws Family Dentistry in an amount equal to the difference between the value of the services received and the amount you paid in membership fees over the term of the Agreement. The Parties agree that the value of the services is equal to the practice's usual and customary fee-for-service charges. A copy of these fees is available on request.

- If patient cancels the plan. Patient will be subject to full office fees not the discounted fee for any services.

8. This Is Not Health Insurance. Your signature on this clause of the Agreement acknowledges your understanding that this Agreement is not an insurance plan or a substitute for health insurance. You understand that this Agreement does not replace any existing or future health insurance or health plan coverage that you may carry. The Agreement does not include hospital services, dental specialists' services, or any services not personally provided by Haws Family Dentistry or its employees. You acknowledge that the practice has advised you to obtain or keep in full force, health insurance that will cover you for healthcare not personally delivered by the practice, and for hospitalizations and catastrophic events.

9. Communications. The Patient acknowledges that although Haws Family Dentistry shall comply with HIPAA privacy requirements, communications with the dentist using e-mail, facsimile, video chat, cell phone, texting, and other forms of electronic communication can never be absolutely guaranteed to be secure or confidential methods of communications. As such, Patient expressly waives the Dentist's obligation to guarantee confidentiality with respect to the above means of communication. Patient further acknowledges that all such communications may become a part of the medical record.

By providing an email address on the attached Appendix B and/or during online enrollment, the patient authorizes Haws Family Dentistry, and its owners, employees and representatives to communicate with him/her by email regarding the patient's "protected health information" (PHI).1 The Patient further acknowledges that:
(a) E-mail is not necessarily a secure medium for sending or receiving PHI and, there is always a possibility that a third party may gain access;

(b)Although the Physician will make all reasonable efforts to keep e-mail communications confidential and secure, neither the practice, nor the dentist can assure or guarantee the absolute confidentiality of email communications;

(c) At the discretion of the dentist, e-mail communications may be made a part of Patient's permanent medical record; and,

(d) You understand and agree that email is not an appropriate means of communication in an emergency, for time-sensitive problems, or for disclosing sensitive information. In an emergency, or a situation that you could reasonably expect to develop into an emergency, you understand and agree to call 911 or the nearest emergency room, and follow the directions of emergency personnel.

(e) Email Usage. The dentist checks e-mail frequently on weekdays, during business hours. If you do not receive a response to an e-mail message by the next business day, you agree that you will contact the dentist by telephone or other means.

(f) Technical Failure. Neither Haws Family Dentistry, nor the dentist will be liable for any loss, injury, or expense arising from a delay in responding to a Patient, when that delay is caused by technical failure. Examples of technical failures (i) failures caused by an internet service provider, (ii) power outages, (iii) failure of electronic messaging software, or e-mail provider (iv) failure of the practice's computers or computer network, or faulty telephone or cable data transmission, (iv) any interception of email communications by a third party which is unauthorized by the practice; or (v) patient failure to comply with the guidelines for use of e-mail described in this Agreement.

10. Dentist Absence. From time to time, due to vacations, illness, or personal emergencies, the dentist may be temporarily unavailable to provide the services referred to above in this paragraph one. In the event of the dentist's absence during usual clinic hours, Patients will be given the name and telephone number of an appropriate provider for the Patient to contact.

11. Change of Law. If there is a change of any relevant law, regulation or rule, federal, state or local, which affects the terms of this Agreement, the parties agree to amend this Agreement to comply with the law.

12. Severability. If any part of this Agreement is considered legally invalid or unenforceable by a court of competent jurisdiction, that part will be amended to the extent necessary to be enforceable, and the remainder of the contract will stay in force as originally written.

13. Reimbursement for Services Rendered. If this Agreement is held to be invalid for any reason, and the practice is required to refund fees paid by you, you agree to pay the practice an amount equal to the fair market value of the medical services you received during the time period for which the refunded fees were paid. See (7c).

14. Amendment. No amendment of this Agreement shall be binding on a party unless it is in writing and signed by all the parties. Except for amendments made in compliance with Section 12 above.

15. Assignment. This Agreement, and any rights you may have under it, may not be assigned or transferred by you.

16. Legal Significance. You acknowledge that this Agreement is a legal document and gives the parties certain rights and responsibilities. You also acknowledge that you have had a reasonable time to seek legal advice regarding the Agreement and have either chosen not to do so or have done so and are satisfied with the terms and conditions of the Agreement.

17. Entire Agreement. This Agreement contains the entire agreement between the parties and replaces any earlier understandings and agreements whether they are written or oral.

18. No Waiver. In order to allow for the flexibility of certain terms of the Agreement, each party agrees that they may choose to delay or not to enforce the other party's requirement or duty under this agreement (for example notice periods, payment terms, etc.). Doing so will not constitute a waiver of that duty or responsibility. The party will have the right to enforce such terms again at any time.

19. Jurisdiction. This Agreement shall be governed and construed under the laws of the State of Utah. All disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for Brigham City, Utah.

20. Service. All written notices are deemed served if sent to the address of the party written above or appearing in Appendix B by first class U.S. mail.

APPENDIX A SERVICES

Dental Services. Dental & medical services under this agreement are those medical services that the Dentist is permitted to perform under the laws of the State of Utah are consistent with dentist's training and experience, are usual and customary for a dental physician to provide, and include the following:

List of Benefits:

(Child/Adult Plans)
2 Exams
2 Basic Cleanings
2 Fluoride Treatments
2 Oral Cancer Screenings
2 Periodontal Screenings

Routine X-Rays (including pano when needed)
15% OFF Additional treatment
$500.00 OFF Orthodontic Treatment

OR

(Perio Plan)
2 Exams
3 Perio Cleanings
2 Fluoride Treatments
2 Oral Cancer Screenings
2 Periodontal Screenings
Routine X-Rays (including pano when needed)
15% OFF Additional treatment
$500.00 OFF Orthodontic Treatment

OR

(20, 30, 40 Botox Plans)
units of Botox
$11.00 a unit each additional unit
Botox can be administered every 3 months (*4 Times Per Year*)

OR

(Filler Plan)
1 Syringe of Filler every 6 months
Savings of $70.00

*All Plans are subject to a “Use it or Lose it” agreement. If patient does not take advantage of the intended services within their year contract, the services will not roll over to the following year.

Non-Medical, Personalized Services.

Haws Family Dentistry shall also provide patient with the following non-medical services (“Non-Medical Services”), which are complementary to our members in the course of care:

a. E-Mail Access. Patients shall be given the practice’s e-mail address to which non-urgent communications can be addressed. Such communications shall be dealt with by the dentist or staff member of Haws Family Dentistry in a timely manner. Patient understands and agrees that email and the internet should never be used to access medical care in the event of an emergency, or any situation that Patient could reasonably expect may develop into an emergency.

Patients agree that in such situations, when a patient cannot contact the dentist or other dental providers, that patient shall call 911 or the nearest emergency medical assistance provider, and follow the directions of emergency medical personnel in extreme emergency cases.

b. Patient is subject to any fees associated with missed appointments, cancelations, or late fees per office policies.

c. Specialists Coordination. Practice and dentist shall coordinate with medical specialists to whom the patient is referred to assist Patient in obtaining specialty care. Patients understand that fees paid under this Agreement do not include and do not cover specialist fees or fees due to any medical professional other than Haws Family Dentistry staff.

APPENDIX B
PATIENT ENROLLMENT – MEDICAL AGREEMENT FORM

Annual and monthly fees as set out in Appendix C shall apply to the following Patient(s), who by signing below agree to the terms and conditions of the Haws Family Dentistry Medical Agreement Form.

*All patients must have a credit or debit card on file to cover the cost of membership & any incidentals not covered under the Agreement.

I certify that I have read, understand, and agree to the terms set forth in this Medical Agreement Form. I further certify that I have received a copy of this form.

APPENDIX C

MEMBERSHIP PRICE:

Basic plan: $30.00 Monthly/$325.00 yearly
Perio Plan: $51.00 Monthly/$582.00 yearly
Botox 20:$73.00 Monthly
Botox 30: $110.00 Monthly
Botox 40: $147.00 Monthly
Filler Membership: $92.00 Monthly

*Additional Office Fees, not included in the membership outline, that may be incurred are not covered in these pricings and are to be paid at the time of service.

SIGNATURE

_____
Patient Signature

_____
Printed Name

_____
Date

Office Use:
*Please note, we are not attorneys, and we recommend having the Dental Retainer Agreement reviewed by a legal source you trust.