130 Court Street S. Vale, Oregon 97918
541-473-9166 Fax 541-473-9344

Viking Loyalty Program

For those without dental insurance, we offer a dental benefit package that works like insurance in our office. Dr. Atkinson has recognized that many of his loyal patients are without insurance. He wants to minimize the possibility of patients choosing less than excellent treatment due to the lack of financial subsidy provided by insurance. This plan has been developed to assist these patients by starting off on a more equal basis when compared to those with dental insurance.

Viking Loyalty Program includes: (in absence of periodontal disease)	**2 Regular 6 month Cleanings include:** (in absence of periodontal disease)	
2 Regular Prophy Cleanings	2 Regular Prophy Cleanings	$87 x 2= $174
1 Bitewing X-rays (4 films)	1 Bitewing X-rays (4 films)	$75
2 Full Oral Examinations	2 Full Oral Examinations	$47 x 2 = $94
2 Fluoride Applications	2 Fluoride Applications	$42 x 2= $84
1 Emergency Exam w/ Necessary X-rays	Complete Treatment Plan	
Diagnosis w/ Complete Treatment Plan	Oral Cancer Screening	
Intraoral Camera Exam		
Consultations		
Oral Cancer Screening		
Discount on all other services 15%		
*Cleaning excludes periodontal scaling and root planing		
$297.00 1st person in family		**$427.00 per person**

Annual Cost:
$297.00 1st person in family $257.00 2nd person in family $217.00 Each additional person
+ $75.00Additional for Periodontal Maintenance (Normally $176)

Advantages of our Viking Loyalty Program:

*No deductions *No waiting periods *No Exclusions
*Highest quality of care *No claims *State of the art facility

Provisions of our Viking Loyalty Program:

- Plan cannot be combined with other insurance plans, discounts or promotions
- The Patient Loyalty Program is not transferable
- Benefits are provided for one year from the date the plan is purchased
- Family is only persons living at the same address

I wish to enroll in the Viking Loyalty Program. I understand that dental services will be provided as described above.

Name ______________________________Signature:_________________________________ Date:_____________

For Office Use: Benefit Period Begins: ______/____/_20_____ Ends: ____/____/_20_____ **Total $ ____________**