1237 S Val Vista Drive Mesa, AZ 85204
(480) 964-7449 (480) 627-0557 FAX

DENTIST AGREEMENT

The undersigned, being a licensed and practicing dentist in the state of Arizona ("Doctor") enters into the following agreement with the Crown Dental Plan Membership Group (tm) ("Plan"): 1237 S Val Vista Drive Mesa, AZ 85204. **(480) 964-7449.**

The Plan is a patient referral system through marketing and advertising set up to benefit both doctors and patients by referring patients to doctors who agree to provide services for fees at membership rates.

The Plan agrees to use reasonable efforts to advertise the doctor's services among its client base, and to refer or recommend clients to the doctor along with other plan affiliated doctors in the same geographic region, if any.

The doctor shall abide by the plans fee schedule (attached) for a continuous period until terminated by either party hereto.

Each patient enrolled in the Plan will be given a membership card by the Plan. The Doctor agrees to accept patients under the Plan only so long as the card has not expired, and only when the Doctor is the record dentist shown on the card. Treatment or services provided to a patient with an expired card or shown assigned to another doctor are not included under the Plan, even if treatment was begun under the Plan **.**

If a patient fails to pay his plan fee, his card and privileges shall be revoked. A patient may change his Doctor assignment as of the first day of any calendar month. Such revocation or change shall be made known to the doctor as soon as possible by the Plan. However, the doctor may choose to verify the current status of a patient with the Plan prior to treatment and charge.

The patient is solely responsible for payment of schedule of otherwise charged fees. **The Plan is not a guarantor or Insurer of the patient.**

Any question of eligibility, plan benefits or Doctor assignment shall be referred to the Plan. The decision of the Plan as to such matters is final and binding on the parties hereto.

The doctor agrees not to market competing dental plans to patients during the term of this agreement. List all locations to be included in our directory for marketing your practice below.

IF SIGNING AS AN INDIVIDUAL PRACTITIONER

_____
Dentist or Provider Signature **Date**

_____
Dentist or Providers name Please Print

IF SIGNING ON BEHALF OF A GROUP CORPORATION

_____
Authorized Signature **Date**

_____
Name or title of above Please Print

Location: 1 **Phone #**

Location: 2 **Phone#**

Location: 3 **Phone#**

Acceptance to be completed by Crown Dental

By _____ **Title** _____ **Date**_____ **DDS#** _____