LCOH DENTAL ADVANTAGE PLAN
Enrollment Form

Lower Columbia Oral Health

First Name: _____ Home Phone: _____

Last name: _____ Email Address: _____

Middle Initial: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

I wish to apply for the LCOH Dental Advantage Plan. I understand that all services under this program must be obtained at LCOH. I further understand that once my application has been processed my enrollment fee is non-refundable unless I request a refund in writing within the first 60 days and have not yet received discounted services. This plan does not apply to treatments previously started.

Signature: _____ Date: _____

This is not a replacement for dental insurance.

Discounts under this program shall not apply to any treatment started prior to enrollment or after membership expires, nor to any treatment plan in whole or part by insurance. No insurance benefits or other discount offers may be combined with this program. Annual memberships must be paid within 12 month membership period. All fees must be paid in full at the time of each treatment or when services are rendered.

A fee of $60.00 will be charged for skipped or cancelled appointments for non-emergent reasons more than two times in one calendar year without providing 24 hour notice.

This plan is non-transferable to other individuals.

Please fax the completed form to 360-578-1277, or email it to info@lcoh.net.