2025

SMILES BENEFIT AGREEMENT

As a member of the Smiles Benefit Program, you will benefit from reductions in fees for professional services provided for you at Cannon Falls Smiles. Upon payment of membership fees, you are agreeing to the following terms:

1. This is not dental insurance or health insurance and should not replace health insurance.
2. The Smiles Benefit Program cannot be used in conjunction with any other benefit/insurance program.
3. Annual membership begins at the time of payment and is good for a period of 1 year.
4. This program is assigned to individual patients and may not be assigned, sold, or transferred under any circumstances.
5. Membership in the Smiles Benefit Program allows you access to reduced fees and is not to be considered insurance. No claims to insurance companies or providers will be made.
6. The Smiles Benefit Program may only be used for services provided by Cannon Falls Smiles, 411 West Main Street, Cannon Falls, MN.
7. Children between 8-16 will be covered at the reduced fees only if an adult family member is also enrolled in the plan.
8. This agreement does not include Ortho services (ex. Invisalign or ortho appliances)

TERMS OF THE AGREEMENT

I agree to pay the amount listed for the plan listed below per 12 months and will receive 100% coverage.

Adult 2	**Child 2**	**Adult 3**	**Adult 4**
2 Routine cleanings	2 Routine cleanings	3 Routine cleanings	4 Routine cleanings
2 Exams	2 Exams	2 Exams	2 Exams
1 Diagnostic x-ray set	1 Diagnostic x-ray set	1 Diagnostic x-ray set	1 Diagnostic x-ray set
2 Fluoride treatments	2 Fluoride treatments	2 Fluoride treatments	2 Fluoride treatments
Cost per year = $400	Cost per year = $256*	Cost per year = $462	Cost per year = $524
	*Requires 1 adult		
Qty =	Qty =	Qty =	Qty =

In addition to the preventive services list above, the member will receive a 15% discount on other restorative (ex. Fillings, Crowns) and preventive services when payment (cash, check, credit card) for these services is made in full on the day of service.

By signing this agreement, you have agreed to the terms of membership as outlined. This fee is non-refundable.

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Patient's (or Legal Guardian's) Signature Printed Name Date