PLAZA CENTRAL DENTISTS
MAROOCHYDORE

OUR FEES

Listed below is a summary of our fees for commonly carried out treatment for both our Standard (non-members) and Care Plan Members. You can still use your health fund to further reduce your costs on both our standard and member fees. Your savings begin immediately when you join our Care Plan for just $30/month which includes your new patient examination.

Description	Standard Non-Plan Fees	Care Plan Member Fees	Member Discount	Saving
Examination and X-rays				
New Patient Exam, Report, X-rays (up to 6)	$115	Included	70%	$80.45
Six Monthly Examinations	$46	Included	N/A	N/A
Additional X-rays (each)	$30.00	Included	N/A	N/A
Gum Care & Tooth Whitening				
Scale and Clean First Visit	$161.61	Included	N/A	N/A
Scale and Clean Second Visit	$161.61	Included	N/A	N/A
Home Tooth-whitening	$450.00	$360.00	20%	$90.00
Extractions				
Extraction	$210.00	$189.00	10%	$21.00
Root Canal Treatment				
Front Tooth	$812.50	$650.00	20%	$162.50
Back Tooth	$1312.50	$1050.00	20%	$262.50
Fillings Front Teeth				
One Surface	$166.67	$150.00	10%	$16.67
Two Surfaces	$200.00	$180.00	10%	$20.00
Three Surfaces	$233.33	$210.00	10%	$23.33
Fillings Back Teeth				
One Surface	$188.89	$170.00	10%	$18.89
Two Surfaces	$222.22	$200.00	10%	$22.22
Three Surfaces	$255.56	$230.00	10%	$25.56
Crown & Veneers				
Veneer (per tooth)	$1326.67	$995.00	25%	$331.67
Crown (per tooth)	$1326.67	$995.00	25%	$331.67

A detailed written treatment cost estimate will be provided at your examination visit

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MEDICAL / DENTAL HISTORY FORM

First Name: ______________ Last Name: ______________ Title: Dr / Mr / Miss / Ms

Date of Birth: ____/____/______ Your Occupation: ______________

Home Address: ______________

Suburb: ______________ State: ______________ Postcode: ______________

Home Phone: ______________ Mobile Phone: ______________ Work Phone: ______________

E-mail Address: ______________

Emergency Contact Name: ______________ Phone: ______________

Health Fund Provider: ______________ Membership Number: ______________

Medicare Number: ______________ Patient # on Card: ______________ Valid to: ______________

DVA Number (if applicable): ______________

PLEASE CIRCLE AND PROVIDE DETAILS:

1. Are you receiving any any medical treatment at present? YES / NO
   Details: ______________
2. Have you been in hospital during the past two years? YES / NO
   Details: ______________
3. Are you currently taking any prescribed or over the counter medication? YES / NO
   Details: ______________
4. Are you allergic to any medication, tablets or antibiotics? YES / NO
   Details: ______________
5. Have you had any prosthetic surgery? (e.g. heart valve, stents, knee or hip replacements? YES / NO
   Details: ______________
6. Are you currently pregnant or breastfeeding (Females Only) YES / NO
7. Do you smoke? YES / NO How many per day? ______________
8. Do you drink alcohol YES / NO Amount per day or week: ______________
9. Have you ever had or are receiving treatment for cancer? YES / NO
   Details: ______________

DO YOU HAVE OR EVER HAD, ANY OF THE FOLLOWING CONDITIONS?

Please circle YES or NO to each condition.

Heart condition YES / NO
Steroid therapy YES / NO
Rheumatic fever YES / NO
Epilepsy YES / NO
Asthma YES / NO
Diabetes YES / NO
Thyroid disease YES / NO
Depression YES / NO
Sinus trouble YES / NO

High blood pressure YES / NO
Kidney disease YES / NO
Excessive bleeding YES / NO
Stroke YES / NO
Cancer YES / NO
Tuberculosis YES / NO
Lung condition YES / NO
Blood disease YES / NO
Bisphosphonate meds YES / NO

Low blood pressure YES / NO
Prosthetic implant YES / NO
Cardiac pacemaker YES / NO
Digestive condition YES / NO
Liver Conditions YES / NO
Blood borne virus YES / NO
Bone disease YES / NO
Radiation therapy YES / NO
Arthritis YES / NO

Please list any allergies you have (e.g latex, gluten etc): ______________________

Please detail any condition not listed here? ______________________

DENTAL HISTORY

1. When was your last dental examination carried out?
2. Have you ever been diagnosed with or been treated for gum disease? YES / NO
3. Are you currently experiencing pain or have a dental problem? YES / NO
   Details: ______________________
4. Are you nervous, anxious or ever had a bad experience at a dental visit? YES / NO
   Details: ______________________
5. Are you happy with the appearance of your teeth? YES / NO
   Details: ______________________
6. Do you want to discuss or find out more about any of the following:

PLEASE TICK:

☐ Replacement of Missing Teeth
☐ Cosmetic Appearance
☐ Removal of Wisdom Teeth
☐ Tooth Whitening
☐ Bad Breath
☐ Bleeding Gums
☐ Tooth Grinding/Clenching
☐ Dentures Implants
☐ Replacement of silver (mercury) fillings

All information we hold about you is strictly confidential and never shared with third parties without your explicit consent.

Patients Signature: ______________________

If under 18 years old:
Guardian Signature: ______________________ Print Name: ______________________

Date: ____/____/______

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Direct Debit Request Service Agreement

Please complete both pages of this form and return it to your dentist.

Practice details

Your dental practice name

Your dentist

Dental Care Membership Plan ☐ (please tick)

☐ Individual ☐ Couple ☐ Family (2 children) ☐ Child (please select a plan type)

Ongoing payment – this is what I agree to pay:

Total

$. monthly

Payment for Dental Care Membership Plan can be cancelled at any time. The first payment will incur a non-refundable $28.00 registration fee.

AND/OR

Treatment Membership Plan ☐ (please tick)

Total treatment cost remaining after deposit

$.

Treatment start date

/ /

Treatment end date

/ /

Ongoing payment – I agree to pay

$. weekly for

no. of instalments

After the commencement of your dental work, payments for the Treatment Membership Plan cannot be terminated unless the outstanding payment for the pro-rata amount of dental work completed to date is finalised. The first payment will incur a non-refundable $28.00 registration fee.

Acknowledgment: By signing and/or providing us with a valid instruction in respect to your Direct Debit Request, you have understood and agreed to the terms and conditions governing the debit arrangements between you and Dental Members Australia Pty Ltd (User ID 415095) as set out in this request and in your Direct Debit Request Service Agreement.

Name (please print)

Signature

Date

/ /

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Direct Debit Request Service Agreement

Please complete both pages of this form and return it to your dentist.

Your details

First name

Surname

Address

Suburb

State

Post code

Mobile

Home phone
(   )

Email address

You request and authorise **Dental Members Australia Pty Ltd** to arrange, through its own financial institution, a debit to your nominated account of any amount **Dental Members Australia Pty Ltd** has deemed payable by you. This debit or charge will be made through the Bulk Electronic Clearing System (BECS) from your account held at the financial institution you have nominated below and will be subject to the terms and conditions of the Direct Debit Request Service Agreement.

Please select your payment method below, providing either bank account OR credit card details.

Financial institution details of account to be debited

Financial institution name

Account name

BSB

Account number

Credit card

Type of card (please tick) ☐ Visa ☐ MasterCard ☐ Amex

Name on card

Credit card number

Expiry date

CVV number

Note all credit card/debit card transactions will incur a 1.9% surcharge.

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Direct Debit Request Service Agreement

The following is your Direct Debit Request Service Agreement with Dental Members Australia Pty Ltd. The agreement is designed to explain what your obligations are when undertaking a Direct Debit arrangement with us. It also details what our obligations are to you as your Direct Debit Provider.

We recommend you keep this agreement in a safe place for future reference. It forms part of the terms and conditions of your Direct Debit Request (DDR) and should be read in conjunction with your DDR form.

Definitions

account means the account held at *your financial institution* from which *we* are authorised to arrange for funds to be debited.

agreement means this Direct Debit Request Service Agreement between *you* and *us*.

banking day means a day other than a Saturday or a Sunday or a public holiday listed throughout Australia.

debit day means the day that payment by *you* to *us* is due.

debit payment means a particular transaction where a debit is made.

direct debit request means the Direct Debit Request between *us* and *you*.

us or ***we*** means Dental Members Australia Pty Ltd (the Debit User) *you* have authorised by signing a *Direct Debit Request*.

you means the customer who signed the *Direct Debit Request*.

your financial institution means the financial institution nominated by *you* on the *Direct Debit Request* at which the *account* is maintained.

1. Debiting your account

1.1 By signing a *Direct Debit Request*, *you* have authorised *us* to arrange for funds to be debited from *your account*. *You* should refer to the *Direct Debit Request* and this *agreement* for the terms of the arrangement between *us* and *you*.

1.2 *We* will only arrange for funds to be debited from *your account* as authorised in the *Direct Debit Request*.

1.3 If the *debit day* falls on a day that is not a *banking day*, *we* may direct *your financial institution* to debit *your account* on the *banking day* prior. If *you* are unsure about which day *your account* has or will be debited *you* should ask *your financial institution*.

2. Amendments by us

2.1 *We* may vary any details of this *agreement* or a *Direct Debit Request* at any time by giving *you* at least **fourteen (14) days** written notice.

2.2 The amount of *your debit payment* may be reduced by any lump sum payments made by *you*.

2.3 The amount of *your debit payment* may be reduced by any amounts paid by *your* Private Health Insurance rebate.

3. Amendments by you

3.1 *You* may change, stop or defer a debit payment, or terminate this agreement if *you* have not started *your* dental treatment by providing at least fourteen days (14 days) written notice in the form of a completed cancellation form. Cancellation forms will be available at *your* dental practice during business hours.

3.2 *You* may change, stop or defer a debit payment, or terminate this agreement if *you* have started *your* dental treatment by providing at least fourteen days (14 days) written notice in the form of a completed cancellation form. Cancellation forms will be available at *your* dental practice during *business hours*.

3.3 If *you* have started *your* dental treatment and terminate this agreement as provided for in clause 3.2, but the work the subject of the corresponding treatment plan has not been completed (e.g. patient transfers to another clinic), *you* remain liable for the balance amount payable for the work which has been completed, and agree that *debit payments* will continue until that balance has been paid. *You* may elect to pay the balance in a lump sum payment.

3.4 In no circumstances will a refund be available in the event of termination.

4. Your obligations

4.1 It is *your* responsibility to ensure that there are sufficient clear funds available in *your* account to allow a *debit payment* to be made in accordance with the *Direct Debit Request*.

4.2 If there are insufficient clear funds in *your account* to meet a *debit payment*:

(a) *you* may be charged a fee and/or interest by *your financial institution*;

(b) *you* will also incur a $30 dishonour fee by us; and

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(c) *you* must arrange for the *debit payment* to be made by another method or arrange for sufficient clear funds to be in *your account* by an agreed time so that *we* can process the *debit payment*. Contact your dental practice directly during *business hours* to arrange for the missed *debit payment* to be made by another method.

(d) if you have not arranged for the missed *debit payment* to be made before the next month's *debit payment* falls due, then the term of your Direct Debit Service Agreement will automatically be extended by the same time period.

4.3 In the event that your account remains in default, details of your account and the default will be passed to a debt collection agency for recovery. Any legal and/or debt collection costs incurred in recovering outstanding debts from you will be added to any amounts already outstanding.

4.4 *You* should regularly check *your* account statements to verify that the amounts debited from *your account* are correct.

4.5 It is *your* responsibility to ensure that you keep DMA informed of your current contact details.

5. Dispute

5.1 If you believe that there has been an error in debiting *your account*, *you* should notify us directly on info@dentalmembers.com.au and confirm that notice in writing with us as soon as possible at Unit 11/31 Springfield Lakes Boulevard, Springfield Lakes, Qld, 4300, so that we can resolve your query quickly. Alternatively you can take it up with your financial institution direct.

5.2 If *we* conclude as a result of our investigations that *your* account has been incorrectly debited we will respond to *your* query by arranging for your *financial institution* to adjust *your* account (including interest and charges) accordingly. We will also notify you in writing of the amount by which *your account* has been adjusted.

5.3 If *we* conclude as a result of our investigations that *your account* has not been incorrectly debited *we* will respond to *your* query by providing *you* with reasons and any evidence for this finding in writing.

6. Accounts

6.1 *You* should check:

(a) with *your financial institution* whether direct debiting is available from *your account* as direct debiting is not available on all accounts offered by financial institutions.

(b) *your* account details which *you* have provided to *us* are correct by checking them against a recent *account* statement; and

with *your financial institution* before completing the *Direct Debit Request* if you have any queries about how to complete the *Direct Debit Request*.

7. Confidentiality

7.1 *We* will keep any information (including *your account* details) in *your Direct Debit Request* confidential. *We* will make reasonable efforts to keep any such information that *we* have about *you* secure and to ensure that any of *our* employees or agents who have access to information about *you* do not make any unauthorised use, modification, reproduction or disclosure of that information.

7.2 *We* will only disclose information that *we* have about *you*:

(a) to the extent specifically required by law; or

for the purposes of this *agreement* (including disclosing information in connection with any query or claim).

8. Notice

8.1 If *you* wish to notify *us* in writing about anything relating to this *agreement, you* should write to:

Dental Members Australia
Unit 11/31 Springfield Lakes Blvd
Springfield Lakes
QLD 4300

or email: **info@dentalmembers.com.au**

8.2 *We* will notify *you* by sending a notice in the ordinary post to the address *you* have given *us* in the *Direct Debit Request*.

8.3 Any notice will be deemed to have been received on the third *banking day* after posting.

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TERMS AND CONDITIONS

Plaza Central Dentists Maroochydore, aim to do our very best to fulfil the needs, expectations and wishes of our clients.

We work in good faith to provide our clients with the best possible care keeping within our 'Scope of Practice' as defined by our governing body the Dental Board of Australia (DBA) and the Australian Health Practitioners Regulation Authority (APHRA).

We adhere to strict guidelines for the provision of dental care, professional ethics and work within our level of training, experience and expertise without misleading our clients. Your rights as a clients are outlined in our Charter of Patient Rights and full copy of the Terms and Conditions of our Care Plan are available at the practice.

Terms and Conditions - "Love your Smile" Promotions

1. All of our services are regulated by our governing body the Dental Board of Australia and the Australian Health Practitioners Regulation Authority.

2 We are legally required to carry out a comprehensive examination of the teeth, gums and supporting tissue prior to providing our clients with any course of routine, complex or cosmetic dental treatment.

3. All of our "Love Your Smile" promotions on our website, social media or print are subject to:

3.1. Clients agreeing to undergo a full comprehensive clinical examination to ensure that the advertised promotionis clinically necessary, in our clients' best interest and will not cause harm or suffering.

3.2. Plaza Central Dentists Maroochydore providing clients with a detailed written treatment plan, advantages and disadvantages of the advertised promotion and their associated costs including any prerequisite treatment that may need to be carried out and its associated costs.

3.3. Plaza Central Dentists Maroochydore being given informed consent by clients either verbally or in writing to carry out treatment. It is the responsibility of the client to ensure that they have had all their questions answered, understood the advantages and disadvantages of any advertised promotion and have had the time to consider all their options. Clients have the right to change their mind.

3.4. All our fees for treatment are correct at the time of printing. Any quotes provided for treatment are valid for 6 months. Clients have the right to change their minds or cancel an accepted promotion prior to treatment by providing us with at least 48 hours' notice. No refunds are given if a comprehensive examinations has already been carried out. A copy of our Financial Policy is available at the practice.

4. We reserve the right to refuse to carry out any advertised or promoted offer if it is deemed to be clinically unnecessary, not in our clients' best interest or after a clinical examination has been carried out and it is found that a client is unsuitable for the promoted.

5. In keeping with our governing bodies standards on advertising, our 'Love Your Smile" promotions do not have an expiry date but are subject to the conditions set out above and may be changed or withdrawn at any time.

6. Any promotions or offers on our website, social media or in print may be subject to joining the practice as a Care Plan Member and/or agreeing to a comprehensive examination for which there may be a fee (a guide to our fees is available at the practice on request).