

DENTAL RETAINER AGREEMENT

Background

Mary-Stuart Gallian DMD is a Direct Primary Care dental practice (“DPC”), which delivers dental services at 3925 University Dr Fairfax 22030. In exchange for certain fees, the practice agrees to provide you with the services described in Appendix A on terms and conditions contained in this agreement (“Agreement”).

Definitions

1. Patient. In this Agreement, “Patient” means the persons for whom the Dentist shall provide care and treatment, and who have signed this agreement or are listed on the document attached as Appendix B, which is a part of this agreement.

2. Services. In this Agreement, “Services”, means the collection of services, offered to you by Mary-Stuart Gallian DMD in this Agreement. These Services are listed in Appendix A (1), which is attached and a part of this Agreement.

Agreement

3. NOTICE: THIS DENTAL RETAINER AGREEMENT DOES NOT CONSTITUTE INSURANCE, IS NOT A DENTAL PLAN THAT PROVIDES HEALTH INSURANCE COVERAGE FOR PURPOSES OF THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT AND COVERS ONLY LIMITED, ROUTINE HEALTH CARE SERVICES AS DEFINED IN THIS AGREEMENT.

4. Term. This Agreement will last until either party acknowledges a change. A change can either be a change in fees or if you decide to terminate.

5. Renewal. Memberships are valid for one calendar year (January 1 thru December 31). The program automatically renews every year on January 1 and can be cancelled with sixty (60) days written notice to the other party.

6. Termination. Regardless of anything written above, you have the right to cancel this agreement. Either party can end this agreement at any time by giving the other party sixty (60) days prior written notice by certified first class U.S. mail.

7. Payments and Refunds – Amount and Methods. In exchange for the Services (see Appendix A (1)), You agree to pay Mary-Stuart Gallian DMD, an annual fee in the amount that appears in Appendix C, which is attached and is part of this Agreement.

a) This annual fee is payable on a prorated basis when you sign the Agreement, and is due on the first business day of each calendar year thereafter.

b) The Parties agree that the required method of monthly or annual payment shall be by automatic payment, through a debit, Bank ACH or credit card.

c) If this Agreement is cancelled by either party before the Agreement ends, this plan is non-refundable. No refunds or premiums will be issued at any time if participant decides not to

utilize their dental membership. You do not receive a membership card; your plans effective dates are on file with the office.

8. This Is Not Health Insurance. Your signature on this clause of the Agreement acknowledges your understanding that this Agreement is not an insurance plan or a substitute for health insurance. You understand that this Agreement does not replace any existing or future health insurance or health plan coverage that you may carry. The Agreement does not include hospital services, dental specialists' services, or any services not personally provided by Mary-Stuart Gallian DMD or its employees. You acknowledge that the practice has advised you to obtain or keep in full force, health insurance that will cover you for healthcare not personally delivered by the practice, and for hospitalizations and catastrophic events.

9. Communications. The Patient acknowledges that although Mary-Stuart Gallian DMD shall comply with HIPAA privacy requirements, communications with the dentist using e-mail, facsimile, video chat, cell phone, texting, and other forms of electronic communication can never be absolutely guaranteed to be secure, private, or confidential methods of communications. As such, **Patient expressly waives the Dentist's obligation to guarantee confidentiality with respect to the above means of communication.** Patient further acknowledges that all such communications may become a part of the dental record.

By providing an e-mail address on the attached Appendix B and/or during online enrollment, the patient authorizes Mary-Stuart Gallian DMD, and its owners, employees and representatives to communicate with him/her by e-mail regarding the patient's "protected health information" (PHI).¹ The Patient further acknowledges that:

(a) E-mail is not necessarily a secure medium for sending or receiving PHI and, there is always a possibility that a third party may gain access;

(b) Although the Dentist will make all reasonable efforts to keep e-mail communications confidential and secure, neither the practice, nor the dentist can assure or guarantee the absolute confidentiality of e-mail communications;

(c) At the discretion of the Dentist, e-mail communications may be made a part of Patient's permanent dental record; and,

(d) You understand and agree that e-mail is not an appropriate means of communication in an emergency, for time-sensitive problems, or for disclosing sensitive information. In an emergency, or a situation that you could reasonably expect to develop into an emergency, you understand and agree to call 911 or the nearest emergency room, and follow the directions of emergency personnel.

(e) Email Usage. The dentist checks e-mail frequently on weekdays, during business hours. If you do not receive a response to an e-mail message by the next business day, you agree that you will contact the dentist by telephone or other means.

(f) Technical Failure. Neither Mary-Stuart Gallian DMD, nor the dentist will be liable for any loss, injury, or expense arising from a delay in responding to Patient, when that delay is caused by technical failure. Examples of technical failures (i) failures caused by an internet service provider, (ii) power outages, (iii) failure of electronic messaging software, or e-mail provider (iv) failure of the practice's computers or computer network, or faulty telephone or cable data transmission, (iv) any interception of e-mail communications by a third party which is

unauthorized by the practice; or (v) patient failure to comply with the guidelines for use of e-mail described in this Agreement.

10. Dentist Absence. From time to time, due to vacations, illness, or personal emergency, the dentist may be temporarily unavailable to provide the services referred to above in this paragraph one. In the event of the dentist's absence during usual clinic hours the name and telephone number of an appropriate provider for the Patient to contact will be made available.

11. Change of Law. If there is a change of any relevant law, regulation or rule, federal, state or local, which affects the terms of this Agreement, the parties agree to amend this Agreement to comply with the law.

12. Severability. If any part of this Agreement is considered legally invalid or unenforceable by a court of competent jurisdiction, that part will be amended to the extent necessary to be enforceable, and the remainder of the contract will stay in force as originally written.

13. Reimbursement for Services Rendered. If this Agreement is held to be invalid for any reason, and the practice is required to refund fees paid by you, you agree to pay the practice an amount equal to the fair market value of the dental services you received during the time period for which the refunded fees were paid.

14. Amendment. No amendment of this Agreement shall be binding on a party unless it is in writing and signed by all the parties, except for amendments made in compliance with Section 12 above.

15. Assignment. This Agreement, and any rights you may have under it, may not be assigned or transferred by you.

16. Legal Significance. You acknowledge that this Agreement is a legal document and gives the parties certain rights and responsibilities. You also acknowledge that you have had a reasonable time to seek legal advice regarding the Agreement and have either chosen not to do so or have done so and are satisfied with the terms and conditions of the Agreement.

17. Entire Agreement. This Agreement contains the entire agreement between the parties and replaces any earlier understandings and agreements whether they are written or oral.

18. No Waiver. In order to allow for the flexibility of certain terms of the Agreement, each party agrees that they may choose to delay or not to enforce the other party's requirement or duty under this agreement (for example notice periods, payment terms, etc.). Doing so will not constitute a waiver of that duty or responsibility. The party will have the right to enforce such terms again at any time.

19. Jurisdiction. This Agreement shall be governed and construed under the laws of the State of Virginia. All disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for Fairfax, Virginia.

20. Service. All written notices are deemed served if sent to the address of the party written above or appearing in Appendix B by certified first class U.S. mail.

APPENDIX A SERVICES

Dental Services. Dental & medical services under this agreement are those dental services that the Dentist is permitted to perform under the laws of the State of Virginia are consistent with dentist's training and experience, are usual and customary for a dentist to provide, and include the following:

Dental Membership Plan

- 2 Exams
- 2 Preventative Prophies
- 1 Fluoride Treatments (as needed)
- 2 Oral Cancer Exams
- 1 Advanced Oral Cancer Screening
- 1 Periodontal Screening
- 1 Wellness Digital Scan
- 4 Cavity Detecting X-Rays
- 2 Infection Detecting X-Rays (as needed)
- 1 Pano or Full Mouth Series (Every 3-5 Years)
- 15% Off Additional Treatments
- 15% Off Invisalign

Periodontal Membership Plan

- 4 Exams
- 4 Periodontal Maintenance
- 1 Fluoride Treatments
- 4 Oral Cancer Exams
- 1 Advanced Oral Cancer Screening
- 1 Periodontal Screening
- 1 Wellness Digital Scan
- 4-6 Cavity Detecting X-Rays
- 2 Infection Detecting X-Rays (as needed)
- 1 Pano or FMX (Every 3-5 Years)
- 15% Off Additional Treatments
- 15% Off Invisalign

1. Non-Dental, Personalized Services. Mary-Stuart Gallian DMD shall also provide patient with the following non-dental services ("Non-Dental Services"), which are complementary to our members in the course of care:

a. After Hours Access. Patient shall have direct telephone access to the dentist and/or the practice answering service seven (7) days per week.

b. E-Mail Access. Patient shall be given the practice's e-mail address to which non-urgent communications can be addressed. Such communications shall be dealt with by the dentist or staff member of Mary-Stuart Gallian DMD in a timely manner. Patient understands and agrees that email and the internet should never be used to access dental care in the event of an emergency, or any situation that Patient could reasonably expect may develop into an emergency.

Patient agrees that in such situations, when a patient cannot speak to the dentist immediately in person or by telephone, that patient shall call 911 or the nearest emergency medical assistance provider, and follow the directions of emergency medical personnel.

c. No Wait or Minimal Wait Appointments. Reasonable effort shall be made to assure that patient is seen by the dentist immediately upon arriving for a scheduled office visit or after only a minimal wait. Patients also agree to make reasonable effort to be on time.

Patient agrees that an understanding that their appointments are reserved times for them and must be maintained. Any missed appointments will be forfeited. Cancellation of an appointment requires minimum 48 hours' notice or appointment is forfeited.

d. Specialists Coordination. Practice and dentist shall coordinate with dental specialists to whom patient is referred to assist Patient in obtaining specialty care. Patient understands that fees paid under this Agreement do not include and do not cover specialist fees or fees due to any dental professional other than Mary-Stuart Gallian DMD staff.

APPENDIX B

PATIENT ENROLLMENT – DENTAL AGREEMENT FORM

Annual fees as set out in Appendix C shall apply to the following Patient(s), who by signing below agree to the terms and conditions of the Mary-Stuart Gallian DMD Dental Agreement Form.

*All patients must have a credit or debit card on file to cover the cost of membership & any incidentals not covered under the Agreement.

I certify that I have read, understand, and agree to the terms set forth in this Dental Agreement Form. I further certify that I have received a copy of this form.

APPENDIX C

MEMBERSHIP PRICE

Dental Membership:

Adult: \$499/Year

Child. \$449/Year

Periodontal Membership:

\$750/Year

SIGNATURE

Patient Signature

Printed Name

Date