SOUTH COUNTY Smiles Club

DIRECT AFFORDABLE CARE

membership form

401 783-1530 info@SmilesRI.com

Name: ______________________________ DOB: ____________

Address: ____

____

City: ______________________ State: ______ Zip Code: __________

Phone: ____

Email: ____

Membership Type (Please Circle): Annual $300/yr or Monthly $25/mo

*$99 Enrollment Fee applies to Monthly Payment Option

Credit Card Number: ______________________________________

Expiration Date: ____________________ Security Code: ____________________

I,______________________ authorize Dr. Joseph C. DiSano DDS to charge my Credit or Debit Card for my membership in the Smiles Club. I understand that there will be either an Annual Fee or a Monthly Fee with Enrollment Fee assessed based on the description above. I understand that my membership will automatically renew after one (1) year unless I fill out a cancellation form.

The total amount that will be charged to my Credit Card or Debit Card will be:

***$300** or **$399**

*please circle appropriate value

If for any reason my form of payment is no longer valid, it is my responsibility to call the office promptly to make arrangements for payment. It is also my responsibility to pay for any service charges that may apply for me missing payment.

Signature: ____

Date: ________________________