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 $399/yr or Monthly $33.25/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.

If for any reason my form of payment is no longer valid, it is my responsibility to call the office promptly to make arrangements for payment.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: _____