

# Harbor Dental Plan, LP

## General and Specialty Dental Provider Agreement

This agreement is entered into this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_. By signing I (we) am (are) licensed to practice dentistry in the state of Texas. This agreement is being made between the dental provider (hereafter referred to as “provider”) and Harbor Dental Plan, Inc., a Texas Limited Partnership (hereafter referred to as “Harbor Dental”). All providers are deemed to be independent contractors and this contract is not intended to create any form of employment status between Harbor Dental and provider. By signing below I (we) agree to be bound of all terms of this agreement as follows:

1. Will provide dental services to covered members using the same standards applicable to all other patients and without discrimination as covered by Federal and State laws.
2. Provider agrees to use the enclosed Procedure and Fee Schedule. General Dentists agree to a 25% discount off their usual and customary fee on any procedure not listed. Specialists agree to a 25% discount off their usual and customary fees. Specialists are Oral Surgeons, Periodontists, Prosthodontist, Pedodontists, Orthodontists and Endodontists as deemed eligible by the Texas State Board of Dental Examiners and accept these fees as the full fee allowed for charges to members of Harbor Dental.
3. Provider agrees that all payments for services rendered shall come solely from the member, and that the provider will not, under any circumstance, hold Harbor Dental liable for payment of any fees owed by member.
4. Harbor Dental will provide eligible members with an identification card containing members name, coverage type and expiration date. Provider agrees to be solely responsible to ensure membership status prior to initiation of any dental care.
5. Provider agrees to participate in the quality assessment and quality improvement program of Harbor Dental. These programs may include, but are not limited to, periodic on-site office reviews, credential verification of each provider, records request and records review. Each member, by virtue of their signed contract, has authorized Harbor Dental to review their dental records, if necessary, during any credentialing activity or in the case of a complaint resolution or quality of care issue.
6. Provider will carry malpractice insurance in an amount no less than \$100,000 per occurrence.
7. Each provider, covered by this agreement will maintain an active Texas Dental License. In the case of loss of the provider’s license, this agreement will terminate immediately upon such disclosure.
8. Provider agrees to notify Harbor Dental immediately upon loss of licensure.

9. The term of this agreement is continuous from the date of acceptance. Either party, with or without cause, may terminate this agreement with 60 days written notice. Provider, upon giving or receiving termination notice, shall continue to provide dental services to eligible members during the 60-day notification period. Provider agrees to complete any treatment in progress during the notification period, regardless of actual date of completion, and shall not seek additional payment from members or Harbor Dental.
10. Provider(s) and Harbor Dental agree to defend, indemnify and hold harmless the other party of this agreement from any claim, demand, liability, damage, loss, suit or judgment whether known or unknown, while this agreement is in effect and at any time thereafter. This shall include the officers, directors, agents and employees of each party.
11. This agreement will be accepted as written and constitutes the full and entire agreement. No oral changes will be accepted. All material changes to this contract will require written notification. All notices are required to be delivered by certified mail to the other parties accepted address of business.

**PROVIDER:**

**HARBOR DENTAL PLAN, LP.**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Signature of Agent of  
 Harbor Dental Plan, LP.  
 6300 W. Loop South, Suite 650  
 Bellaire, TX 77401  
 (800) 284-0822**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Specialty**

\_\_\_\_\_  
**Mailing address**

\_\_\_\_\_  
**City, State Zip**

\_\_\_\_\_  
**Date**