Patient Treatment Plan and Consent Form

I, ___________________________________, understand that the following treatment is being recommended to me by Dr. _________________________________. Also, listed are the costs for that treatment and alternate options.

I understand that it will be my responsibility to follow home care instructions given as well as keeping all scheduled appointments. If I fail to call 48 hours in advance to cancel or reschedule my appointment or I fail to show up for two (2) visits, the privilege of having dental care free of charge or at reduced fees will be revoked immediately.

I also understand that the doctor will provide appropriate dental care to the best of his/her ability, but that there are no guarantees on treatment provided. I hereby release the doctor from an damages or claims arising from my treatment and I promise not to sue the doctor for any claims arising out of my treatment hereunder.

Treatment Plan (Please attach treatment plan on a separate sheet.)

Recommended Treatment	Estimated Lab Fee

Patient's Signature: ____ Date: __________________

Doctor's Signature: ____ Date: __________________

Smiles for Success approved: _______________________________________ Date: ________________

This agreement is valid for one year from signing date. This treatment place must be submitted to the SFS Board of directors for approval using this email address: board@secure.smilesforsuccess.org.

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