A Foundation of the
American Association of Women Dentists

Treatment Plan

Note: **THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S DENTAL RECORD**

Please submit this form prior to treatment. Only pre-approved lab costs will be reimbursed.

I, ________________________________, understand that the following treatment is being

recommended to me by Dr. ________________________________.

Also listed are costs for that treatment and alternative 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 if 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 and the Smiles for Success Foundation from any damages or claims arising form my treatment and I promise not to sue the doctor for any claims arising out of my treatment hereunder.

Smiles for Success reimburses lab bills up to $1,500 to volunteers who are members of the AAWD, and up to $1,000 to volunteers who are non-members.

Recommended Treatment	Usual and customary fee	Estimated Lab Fee

Patient's Signature: ________________________________ **Date:** ____________________

Doctor's Signature: ________________________________ **Date:** ____________________

Smiles for Success Board approved Yes ☐ **No** ☐ **Date:** ____________________

This agreement is valid for one year form signing date.

Smiles for Success Foundation • 216 W. Jackson Blvd., Suite 625 • Chicago, IL 60606
Phone (800) 920-2293 • Fax (312) 750-1203 • info@smilesforsuccess.org • www.smilesforsuccess.org