PATIENT NUMBER

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PATIENT'S NAME _____
Last First Initial Date

DATE	TREATMENT PLAN	FEE	ALTERNATE TREATMENT	FEE	PROB # ASGN

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RELEASE:
I accept the above treatment plan. I understand that because of unexpected circumstances, the treatment, the fees for treatment and/or the materials required as explained to me at this time, may require some changes after actual care has begun.

PATIENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

Form No. T201TP

TREATMENT PLAN