



KELLER MEMORIAL FUND LETTER OF AGREEMENT TO PARTICIPATE

Date (MM/DD/Year): ____/____/____

Parent name(s) _____

Address: _____ City _____ Postal code _____

Dear _____:

The non-profit Keller Memorial Fund of the Kirkland Kiwanis Foundation is dedicated to helping children in our community obtain needed orthodontic care. We have created relationships with orthodontists and the University of Washington Department of Orthodontics to help ensure that your child obtains the orthodontic treatment that he/she requires.

Our understanding is that your orthodontist or the Department of Orthodontics at the University of Washington have discussed the care plan for your child. We have received your application for funding support from the Keller Memorial Fund of the Kirkland Kiwanis Foundation.

To make certain that there are no misunderstandings, the following defines the roles and responsibilities of each party:

Keller Memorial Fund

- The overall cost of treatment has been determined to be \$_____, of which the Keller Memorial Fund of the Kirkland Kiwanis Foundation has committed to pay directly to approved orthodontist the amount of \$_____ for partial payment for care. Payments will be made directly to your orthodontist’s office after treatment begins. Depending on the agreements you have made with your orthodontist, a second or third payment may be made at 12 months after treatment begins, and/or once treatment is completed.
- The Keller Memorial Fund is simply providing financial support to help cover the cost of orthodontic care. The treatment plan and execution, quality of care, follow-up, adjustments in treatments, and other direct care issues are handled between you and your orthodontist. The Keller Fund involvement is limited solely to providing financial assistance.
- Your orthodontist has agreed to provide the treatment he/she that is reviewed with you to address your child’s orthodontic issues. Your orthodontist is the person to contact with care issues and to whom you must maintain follow-up throughout the treatment period.
- Any change in orthodontist must be communicated to the Keller Memorial Fund.

Your child and family



Kiwanis

Kirkland Kiwanis Foundation Keller Orthodontic Fund

- Our understanding is that once treatments begin, you will make the agreed upon payments to your orthodontist's office promptly. Any problems with payment should be discussed with your orthodontist who will share this information with the Keller Memorial Fund.
- You and your family have also agreed to allow the use of your child's first name, photographs of your child's mouth and dentition at the start and conclusion of treatment. You or your orthodontist may provide other agreed to information to assist the Keller Memorial Fund in their efforts to raise money needed to help additional young people. A release form for the health protected information is enclosed. Please sign and return in the enclosed envelope.

We are very pleased to provide this assistance to your child and family. We look forward to hearing about how treatment is progressing. We at the Keller Memorial Fund of the Kirkland Kiwanis Foundation are hopeful that this treatment will have a very positive impact on your child's life.

Sincerely,

Tom Pendergrass, Secretary
Keller Memorial Fund
The Kirkland Kiwanis Foundation



Kirkland Kiwanis Foundation Keller Orthodontic Fund

**Authorization for Release of
Limited Medical Information and Oral Photographs**

The individual referred to below as "patient" has been approved by the Keller Memorial Fund of the Kirkland Kiwanis Foundation to receive financial assistance to obtain necessary orthodontic care.

As Parents and/or Guardians, we hereby authorize our treating orthodontist to release progress reports on the treatment plan and oral photographs to the Keller Memorial Fund of the Kirkland Kiwanis Foundation. The items to be released include our child's first name, birth date, oral photographs, and other relevant information that may assist the Kirkland Kiwanis Foundation in their fund-raising activities, including use of oral photographs in promotional brochures and/or on the KKF web site, brief case histories and other information without personally identifiable information that may be used is focused only on the fund raising to provide financial aid to future recipients.

Patient Name: _____

Signature: _____ Date: _____

Father/Guardian Name: _____

Mother/Guardian Name: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Family Street Address: _____

City: _____

Zip Code: _____

Phone Number: _____