ABILENE ENDODONTICS
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I, _____give Abilene Endodontics, PC permission to discuss treatment, fees, payment arrangements and insurance information with the following people:

Name	Relationship	Phone Number

If someone beside the patient is paying the bill please fill out the following:

Name	Relationship	Method of Payment	Amount Authorized

_____ _____ _____
Patient Signature D.O.B Date

_____ _____
Witness Signature Date