



ABILENE ENDODONTICS

ROOT CANAL SPECIALISTS

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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 besides the patient is paying the bill please fill out the following:

Name	Relationship	Method of payment	Amount Authorized

Patient Signature

Date

Witness Signature

Date