CONCHO VALLEY ENDODONTICS
ROOT CANAL SPECIALISTS

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I, ________________________________give Concho Valley 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