WEST TEXAS ENDODONTICS
ROOT CANAL SPECIALISTS

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Stephen Rees DMD

I, _____give West Texas Endodontics 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