DR. RYAN J. GREENE
3811 Fairview Drive, Anderson IN 46013

GREENE ENDODONTICS

I understand that all charges are my responsibility to pay, regardless of insurance coverage. I shall be responsible for all fees incurred for service provided to me and my dependents. I further acknowledge I will be responsible for reasonable collection fees, attorney fees and court costs incurred in any attempt by provider to collect amounts I may owe. I authorize payment of medical benefits to the above name provider. I authorize release of medical information to may insurance carrier for claim processing purposes and to any collection agency or attorney.

_____ _____

Patient's Signature Date

_____ _____

Patient's Name Printed Witness (Optional)