RELEASE OF INFORMATION & PAYMENT

I authorize the release of any medical and/or other information necessary to process my medical and/or dental claims and authorize payment of medical benefits to Dr. Richard D. Walls.

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Patient's or Responsible Party's Signature

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Date

FINANCIAL STATEMENT

I understand I am ultimately responsible for the payment of the services rendered by Dr. Richard D. Walls to me and will also be responsible for any collection and/or attorney fees necessary to collect those fees.

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Patient's or Responsible Party's Signature

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Date