ALLERGY & ASTHMA
CONSULTANTS OF MONTANA
MICHAEL C. DICELLO, MD
CINDY K. FEDDES, FNP

FINANCIAL RESPONSIBILITY

To Allergy & Asthma Consultants:

I am assuming financially responsibility for the patient whose information is listed below.

Patient legal name: _____ DOB: _____

Relationship to Patient: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

I would like to have financial matters handled in the following manner:

☐ **Send any statements or bills to the patient at his/her address;**

☐ **Send any statements or bills to me at the following address:**

Name: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

I understand that this form means I will be held responsible for any and all medical bills for the aforementioned patient, until released from this responsibility at a time when the patient has a zero balance. I agree to pay all bills in a timely fashion, and will follow all the financial policies in place from AACMT, including the responsibility for any collection fees from past due balances.
If you have any questions, please do not hesitate to contact our billing department.

SIGNATURE OF FINANCIALLY RESPONSIBLE PARTY: _____

PRINTED NAME OF SIGNER _____ DATE_____