To Allergy & Asthma Consultants:

I am financially responsible for my adult child, ____,
(please print name)

who is a patient of AACMT. I would like to have financial matters handled in the following manner:

☐ Send any statements or bills to my child at his/her address;

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

____
(NAME – Please print)

____
(STREET ADDRESS)

____
(CITY, STATE, ZIP)

Signature of financially responsible person:____

Date:__________________________