ALPHA OMEGA CLINIC AND CONSULTATION SERVICES
P: 301-767-1733 / F: 301-767-1743

7007 Bradley Blvd
Bethesda, MD 20817

3607-A Chain Bridge Rd
Fairfax, VA 22030

108 N. Payne St
Alexandria, VA 22314

5034 Dorsey Hall Dr, Ste 202
Ellicott City, MD 21042

CONSENT TO BILL A THIRD PARTY

I, ____
(Name)

____
(Client name if a minor)

____
(Relationship to the minor)

Authorize **ALPHA OMEGA CLINIC AND CONSULTATION SERVICES** to bill:

Name: ____

Address: ____

Phone: ____

As the person signing this consent, I understand that I am giving my permission for Alpha Omega Clinic and Consultation Services to bill the above named third party for services rendered. I also understand that I have the right to revoke this consent at any time. The person who receives the billing statements to which this consent pertains may not re-disclose them to anyone else without my separate written consent.

This authorization is valid **<u>one year</u>** from the date signed, or until (specify here) ______________

Signature of Client or Authorized Representative: _____________________________________

Date: ________________________________

Please return a copy of this request and the requested information to *Alpha Omega Clinic and Consultation Services* at the address or fax listed above.