LOS ANGELES INTEGRATIVE
Gastroenterology & Nutrition
Whole-Person Approach to Digestive Care

Third Party Billing & Guarantor Agreement

PATIENT:

I, _____ hereby request that any balance on my account be paid by the following individual or entity. I understand that if, for any reason, my balance is not paid in a timely manner, (see Payment Policy and Agreement) I will promptly pay any balance due upon receipt of statement or any other notification. I will also a provide driver's license or other proof of identification.

Signature **Date**

GUARANTOR:

(Relationship to Patient: _____)

I, _____ hereby acknowledge that the above-named patient has or will be receiving medical services from Dr. Rahbar and:

I agree to pay for the above patient's medical services, insurance deductible or co-payments, co-insurance or any unpaid prior balance at the time of the service and I hereby agree to pay such due amounts in one of the following manners. I do understand that in some instances, such as outpatient procedures, an advance payment may be requested. My telephone numbers and address for correspondence and receiving statements is also shown below. I will also provide driver's license or other proof of identification.

Signature **Date**

METHOD OF PAYMENT:

- ☐ **Check**
- ☐ **Cash (must be present at time of service)**
- ☐ **By authorizing the entity to charge my Payment/Credit Card as follows:**

Cardholder Name:	
Credit Card Number:	
Expiration Date:	

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Name of Credit Card:	
Card Security Code*:	

**The card security code is located on the back of the credit card and is typically a separate group of 3 digits to the right of the signature strip.*

Name of Guarantor	**Signature (Please sign above)**	**Date**	**Home Phone**
Street Address		**Apt/Unit #**	**Mobile Phone**
City	**State**	**Zip Code**	**Work Phone**

I have reviewed and agree to comply with this Agreement. My signature below also constitutes authorization to charge my credit card. I understand that I can cancel this Agreement or credit card authorization through a written notice to the doctor. In that case, I agree to pay for any balance due up to the date of such cancellation.

Signature **Date**