LOS ANGELES INTEGRATIVE GASTROENTEROLOGY & NUTRITION
Farshid Sam Rahbar, MD, FACP, ABIHM
"Whole-Person Approach to Digestive Care"
(310) 289-8000

Credit Card Authorization Form

I, _____ hereby request that any balance on my account be paid by the following credit card below.

_____

Signature Date

Method of Payment:

- ☐ **By authorizing the entity to charge my Payment/Credit Card as follows:**

Cardholder Name:	
Credit Card Number:	
Expiration Date:	
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.

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.

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

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