

JON BERNER MD

**Non-Custodial Third Party Guarantor Agreement**

Name of Guarantor: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home #: \_\_\_\_\_

Work #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

I, \_\_\_\_\_, the undersigned do hereby assume personal financial responsibility for services rendered by Jon Berner, MD, to the below referenced patient. I understand that payment is due upon receipt of invoice and that this guarantee of payment may only be revoked in writing by the guarantor for services rendered after the date in which the written revocation is received by Dr. Berner.

Unless specified below in writing this guarantee is effective for all services rendered as of:

Date of first appoint \_\_\_\_\_

OR

Other date as specified herein: \_\_\_\_\_

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Guarantor Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_