ELIGIBILTY WAIVER

I,_______________________________ hereby certify that I am eligible for, _______________________________ effective _____________ through the present date.

I have chosen DR, REZA ALLAMEHZADEH or DR. ALIREZA GHAHRAMAN as the provider of my healthcare. I understand that if I am found ineligible, I am responsible for all costs incurred in the delivery of MEDICAL SERVICES to me and will pay these charges within 30 days of billing.

___________________________ ________________

Signature of patient or guardian Date