The Centeno-Schultz Clinic

Guarantee of Payment – Consent Form

Patient Name: _____

I understand that the Centeno Schultz Clinic or Regenerative Sciences, Inc. will be submitting insurance claims on my behalf to my insurance carrier. **I am responsible for any copayments, coinsurance, deductibles and non-covered services** that are assessed as patient responsibility by my insurance carrier. I understand that payment for patient responsibility is **due from me upon receipt of notification.** If I have not paid the charges that are deemed my responsibility in 30 days, **I authorize the Centeno Schultz Clinic** to charge my credit or debit card. I understand that this payment information will be kept in a secured location separate from my medical records.

Patient Signature _____ **Date** _____

Credit Card Information

Card Type: ❒ Visa ❒ Mastercard ❒ Discover ❒ Amer. Express

Card Number: _____ Exp. _____

Name on Card: _____

Billing Address: _____

_____ Zip: _____

Cardholder Signature: _____ Date: _____

This payment arrangement will be valid for one year from today's date, and will need to be renewed annually.