



The Centeno-Schultz Clinic

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## GUARANTEE OF PAYMENT CONSENT FORM

TODAY'S DATE \_\_\_\_\_

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.

Signature of Patient \_\_\_\_\_

CARD TYPE: CREDIT \_\_\_\_ DEBIT \_\_\_\_

MASTER CARD \_\_\_\_ VISA \_\_\_\_ DISCOVER \_\_\_\_

CARD HOLDER NAME  
AS IT APPEARS ON THE CARD \_\_\_\_\_

CARD NUMBER \_\_\_\_\_

EXPIRATION DATE \_\_\_\_\_

CARD HOLDER SIGNATURE \_\_\_\_\_

CARDHOLDER ZIP CODE \_\_\_\_\_

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