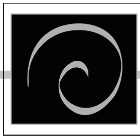

The Centeno-Schultz Clinic

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.

403 Summit Blvd, Suite 201 Broomfield, CO 80021 Phone: 303-429-6448 Fax: 303-429-6373 www.centenoschultzclinic.com

"The Pain Management Experts"