Juanita H. Sprute M.D.
Diplomate American Board of Family Medicine

GENESIS MD

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HSA/FSA PAYMENT AUTHORIZATION

Patient Name:_____

Account Number:_____

Date:_____

I authorize Genesis MD to charge the credit card listed for balances not paid by my insurance company. These fees may include deductibles, non-covered services, co-insurance and any other fees that my insurance company considers to be 'patient responsibility.' If there are no funds available on my card, I understand that I will be billed for any remaining balances.

I understand that this authorization is valid until I cancel, in writing, to Genesis MD at 9647 Huebner Rd. San Antonio, TX 78240 or the expiration date of this card.

_____
Cardholder's Printed Name

_____
Cardholder's Signature