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

GENESIS MD

Alaina D. Hallmark M.D.
Diplomate American Board of Family Medicine

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 15303 Huebner Rd. Bldg 7 San Antonio, TX. 78248 or the expiration date of this card.

_____
Cardholder's Printed Name

_____
Cardholder's Signature

15303 Huebner Rd. Bldg 7
San Antonio, TX 78248
P: 210-759-1420 F: 210-759-1404