



2575 Spruce Street
Boulder CO 80302
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Guarantee of Payment Consent Form

Patient Name: _____
Last First Middle Initial

I understand that my insurance will be billed for each visit and then I will be billed by Spruce Street Internal Medicine for any deductible or coinsurance due. I have fourteen days to pay.

I AUTHORIZE SPRUCE STREET INTERNAL MEDICINE to charge my payment card for the balance due if I have not *PAID OR CONTACTED* Spruce Street Internal Medicine for payment arrangements.

Card Holder Name

Card Holder Signature

Card Number

Expiration Date

Card Type:

MasterCard

Visa

28 November 2011