Financial Payment Form

Credit Card Form

Primary Financial Contact for Client

Name____

Relationship to client_______________________________ Email:_________________________________

Phone____

Preferred method of contact__________________________

Invoices

Send to: ____

Relationship to client____

Email:________________________________/ Fax: ___________________________________

Primary Credit Card Information

Cardholder's Name/ Corporate Name____(Exactly as on the card)

Cardholder's Billing Address ____
Street or PO Box City, State, and Zip Code

Card Number:__________________________________Expiration Date:_____/______ CVV:_____

Type of Credit Card: ○ VISA ○ MASTERCARD ○DISCOVER ○AMERICAN EXPRESS

Relationship to patient: SELF FAMILY FRIEND POA OTHER: _____

I authorize Preferred Gold to bill the above listed credit card in the amount of two weeks deposit. I understand that this initial charge and future charges may vary depending upon the actual services rendered.

I authorize Preferred Gold to bill the above credit card for the home health care services rendered as the rates agreed upon in the Private Service Agreement and Service Authorization. This authority is to remain in full force and effect until Preferred Gold has received notification, in writing, of patient's/designee's desire to terminate the agreement in such time and in such manner as to afford Preferred Gold a reasonable opportunity to act on it.

Card Holder Signature:_____________________________________ Date:________________________

DISCLAIMER: Preferred GOLD is a Private Pay service. We do not have any affiliation with Medicare or Medicaid, nor do we offer them as an option for payment.