ESCORT SERVICE AUTHORIZATION

Patient's Name: _____

Client Services	Hourly or Visit Rate	Frequency & Duration	Total	Initialed
Escort	$135/flat 4 hours $32/additional hour			

Services to be provided: **Start Date: _____ Start Time: _____**

Primary Financial Contact for Client

Name_____

Relationship to client_____ Email:_____

Phone_____

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 credit card for the home health care/Escort services rendered as the rates agreed upon in the 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.