SERVICE AUTHORIZATION

Patient's Name: _____

Start Date: _____ Start Time: _____ End Date: _____

Services to be provided:

RN Care Management Included - No Additional Charge

Private RN - Start of Care - $125/visit

Nurse Follow/ Revisit - $85/visit- Every 3 Months

Client Services	Hourly or Visit Rate	Frequency & Duration	Initialed
Escort	$135/flat 4 hours $32/additional hour		
Home Health Aide (HHA)	$29.00/hour Single $44.00/hour Mutual		
HHA Live-In Services	$400.00/day Single $520.00/day Mutual		
Skilled Nursing RN	$150.00/visit		
Nurse Medication Pre-Pour	$125/visit		
Shift Work RN	$95/hour		
Shift Work LPN	$65/hour		
RN Medical Escort	$140.00/hour $85.00/additional hour		
Travel Nursing	Domestic - $1800/day International -$2000/day		

Patient or authorized Patient Representative _____ Date_____

Witness _____ Date _____

Amount of Deposit for Services_____

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.

Financial Payment Form

ACH Authorization form

Please provide all required information listed below

Name of Bank: _____

Bank Address: _____

_____

Bank Account Number: _____

ABA Number: _____

(The ABA number is the 9 digits numbers on the left at the bottom of your check)

Account Type: ☐ Checking ☐ Savings

I hereby certify that I am the duly authorized account holder fully empowered to legally bind the above reference bank account. By signing as the account holder, I, hereby authorize Preferred Homecare of New York/ Preferred Gold, to initiate ACH debit entries to the financial account listed above.

AUTHORIZED ACCOUNT HOLDER TO WHOM INQUIREIES CONCERNING ACH TRANSFERS ARE TO BE DIRECTED:

Name: _____

Address: _____

Work Phone: _____ Cell:_____

E-mail Address: _____

Signature: _____ Date: _____

If using a checking account, please attach a copy of a void check to accelerate up the process.

Important: Please ensure that there will be sufficient funds in the account provided for the ACH withdrawal.