Using the Credit Card Authorization Form Provided By StatGo

StatGo provides this Credit Card Authorization form (CCAF) to assist you in collecting payments from private patients. If you complete the CCAF, StatGo will submit this information to a payment processor and attempt to obtain payment based on the information you have provided. Please try to complete the form in full and ensure that the credit card holder signs the authorization.

We will submit the charge via our credit card payment processing system for authorization and payment. After authorization and payment to StatGo we will forward payment to you via check or e-transfer.

Payments authorized and collected can be disputed by the Credit Card holder even after you have received payment. To minimize the likelihood of this occurrence please ensure the CCAF is completed in a clear legible manner and that the signature on the form matches the credit card holders signature on the back of the card.

In the case of disputed or reversed payments our payment processor will debit StatGo for the full amount in dispute. We will advise you of the change in status of the invoiced charges and request repayment of any funds already disbursed by StatGo to you relating to the CCFA payment request.

Governing Law and Jurisdiction Agreement

This agreement (“Agreement”) is entered into by and between
______________________________________ and _________________________________

[Name of patient] *[Physician] (collectively, the “Parties”)*

Governing Law

The Parties hereby agree that:

a) all aspects of the relationship between
____ and ____________________________

[Name of patient] *[Physician]*

(as well as her/his agents, delegates, employees, and any physicians and other independent healthcare practitioners providing medical or other healthcare and treatment to______________________, (or in association with_________________________),

[Name of patient] *[Physician]*

including without limitation any medical or other healthcare and treatment provided to _________________________________, and

[Name of patient]

b) the resolution of any and all disputes arising from or in connection with that relationship, including any disputes arising under or in connection with this Agreement, shall be governed by and construed in accordance with the laws of the province or territory of Alberta

Exclusive Jurisdiction

The Parties hereby acknowledge that the medical or other healthcare and treatment received by

______________________________________from _______________________________

[Name of patient] *[Physician]*

will be provided in the Province or territory of Alberta and that the Courts of Alberta shall have exclusive jurisdiction to hear any complaint, demand, claim, proceeding or cause of action, whatsoever arising from or in connection with that medical or other healthcare and treatment, or from any other aspect of the relationship between

______________________________________ and __________________________________

[Name of patient] *[Physician]*

____

Date

____

Name of patient [Please print]

____

Signature of patient / substitute decision-maker on behalf of patient

____

Name of physician [Please print]

____

Signature of physician

INVOICE

INVOICE #
INVOICE DATE
DUE DATE

StatGO Corporation
PO Box 4518, South Edmonton
Edmonton, Alberta T6E 4T7
GST 79529 7290 RT0001

To:

Description		Amount
Patient: Date of Service: Services Provided by: Hospital Facility:		
Processing Fee		$95
GST		$4.75
Total Due CAD		

Please make payment to

If you have any questions concerning this invoice, contact StatGo Admin at 1.800.516.0818 or support@statgo.ca

Thank you for your business. Please note there will be a 1.5% interest rate charge per month on late invoices.

CREDIT CARD AUTHORIZATION

Sign and complete this form to authorize Statgo Corp to make charge your credit card listed below. **By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date**.

SERVICES PROVIDED

Patient's Surname: Patient's First Name:

Service/Procedure Description:

Total Fee: Service/Procedure Date:

CREDIT CARD AUTHORIZATION

I hereby authorize StatGo Corp as an agent of to charge
$____________________CND to the credit card below for the services described above
on or after___________________________.

☐ Visa ☐ Mastercard ☐ American Express

Card Number: ____

Expiration Date:___________________ Security Code (CVV code) on back of card: __________

Name as it appears on card:____

Billing Address for Credit Card:
Address: ____
City:____________________ Province/State: __________________
Country:___________________ Postal/Zip: ______________________

SIGNATURE: _____________________________________ DATE:______________________________

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

INVOICE REMITTANCE ADVICE

Please return this advice with payment. Thank you

INVOICE #

INVOICE DATE:

PHYSICIAN NAME:

PATIENT NAME:

CLAIM POLICY NUMBER: ______________________________
(if applicable)

CHEQUE NUMBER:

NEED A RECEIPT?
O Mail to home address
O Email to: ________________________

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