Self-Pay Rate Agreement

Disclaimer

I, the undersigned, understand:

I. Payment is due by me, the patient, or responsible party to Golden Victory Medical, LLC at time of service.
II. I have chosen not to use a third-party private insurance company's contracted agreement with Golden Victory Medical, LLC for reimbursement or provided services and accept full legal and financial ramifications, if any, for that choice.

I agree to maintain my credit card information securely on file with Golden Victory Medical, LLC. In providing them with my credit card information, I am giving Golden Victory Medical, LLC permission to automatically charge my credit card on file for the amounts listed above at the time of service. By signing this form, I authorize this agreement to remain in effect until the expiration of the credit card account and understand that I may revoke this authorization at any time by submitting a written request.

Printed Name of Patient: _____

Patient Signature: _____ Date: _____

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Card Type: [ ] Mastercard [ ] VISA [ ] Discover [ ] Amex [ ] Other
Cardholder Name (as shown on card):
Card Number:
Expiration Date (mm/yy): CVV:
Cardholder ZIP Code (from credit card billing address):

I authorize Golden Victory Medical to charge my credit card above for agreed upon purchases. I understand that my information will be saved to my Electronic Health Record (EHR) for future transactions on my account.

_____ _____

Signature Date

_____

Print Name