STATGO
INTELLIGENT MEDICAL BILLING

INVOICE

Att: StatGo Corp.
P.O. Box 45030
RPO Brentwood
Calgary, AB Canada T2L 1Y4

INVOICE DATE
01-Jul-2018

TO: Name of patient
Enter Patient Address Here

Description	Amount
Patient: Name of patient DOB: Date of birth Date of Service: 01-Jul-2018	
Services Provided by:	
Description of Services Provided: 1. Pre-anesthetic evaluation prior to surgical procedure. 2. Anesthesia services for	
Processing fee:	$ 50
Total Due in Canadian Dollars.....	$ 50

Payment by: Credit Card ☐ Please complete Credit Card Authorization Form

Other Method ☐ Make all cheques payable to StatGo Corp.

Payment is due upon receipt.

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

STATGO
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CREDIT CARD AUTHORIZATION

FOR ANESTHESIA SERVICES PROVIDED NOT COVERED BY ALBERTA HEALTH INSURANCE PLAN

Sign and complete this form to authorize StatGo Corp to make a one time debit to 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.**

ANESTHESIA SERVICES PROVIDED

Patient's Name: Name of patient

Service/Procedure Description:

_____

_

Total Fee: $ $ 50 Service/Procedure Date: 01-Jul-2018

CREDIT CARD AUTHORIZATION

I hereby authorize **StatGo Corp** as an agent of Dr. _____ to charge

$_____**CND** to the credit card below for the anesthesia 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 01-Jul-2018

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.

PO Box 45030, Brentwood, Calgary, Alberta Canada T2L 1Y4
Tel. 1.800.516.0818 Fax 403.800.9010
www.statgo.ca

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 infomration 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 recived payment. To minimize the likelyhood of this occurance 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 fulll 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 Name of patient _____ and
[Name of patient]

_____ (collectively, the "Parties").
[Physician]

Governing Law

The Parties hereby agree that:

a) all aspects of the relationship between Name of patient _____ and
[Name of patient]

_____ (as well as her/his agents, delegates, employees, and any
[Physician]

physicians and other independent healthcare practitioners providing medical or other healthcare and treatment to Name of patient _____, or in association with _____),
[Name of patient] *[Physician]*

including without limitation any medical or other healthcare and treatment provided to Name of patient _____, 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 _____
[Province or territory]

(other than conflict of laws rules) and the laws of Canada applicable therein.

Exclusive Jurisdiction

The Parties hereby acknowledge that the medical or other healthcare and treatment received by Name of patient _____ from _____ will be provided in the
[Name of patient] *[Physician]*

province or territory of Alberta _____, and that the Courts of Alberta _____
[Province or territory] *[Province or territory]*

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 Name of patient _____ and _____.
[Name of patient] *[Physician].*

Date: 01-Jul-2018 _____

Name of patient _____ _____

Name of patient *[Please print]* Signature of patient / substitute decision-maker on behalf of patient

Date: 01-Jul-2018 _____

_____ _____

Name of physician *[Please print]* Signature of physician