STATGO
INTELLIGENT MEDICAL BILLING

INVOICE

INVOICE #
INVOICE DATE
DUE DATE

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

To:

POLICY NUMBER: N/A

Description		Amount
Patient: Date of Service: Services Provided by: Hospital Facility:		
Processing Fee		$95.00
GST		$4.75
Total Due CAD		

Please make payment to 0

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

FOR EMERGENCY SERVICES PROVIDED
NOT COVERED BY ALBERTA HEALTH INSURANCE PLAN

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: $0.00 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.

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INVOICE REMITTANCE ADVICE

Please return this advice with payment. Thank you

INVOICE # 0

INVOICE DATE:

PHYSICIAN NAME: 0

PATIENT NAME: 0

CLAIM POLICY NUMBER:
(if applicable) _____

CHEQUE NUMBER: _____

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