FREESTATE AMBULANCE

The Industry Leader In Timely, Compassionate, and Reliable Transportation

PAYMENT FORM

SERVICE
DATE SCHEDULED: _____ **QUOTED PRICE:** _____ **CALL TAKER:** _____

Patient name: _____ Social Security # _____

☐ Round Trip ☐ One Way ☐ Several Destinations Vehicle Operator: _____

Pick Up Location/Address: _____ ☐ also return location

Drop Off Location/Address: _____

3rd Location/Address (If applies): _____

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home: _____ Work: _____ Cell: _____

PAYMENT RECEIVED: ☐ YES ☐ NO **AMOUNT PAID**: **$**_____

☐ **CASH** Other Payment Arrangements per _____Date: _____ Time: _____ * Note Below

☐ **CREDIT CARD #** _____-_____-_____-_____-_____, Exp. Date:_____, Pin:_____

Name on CC: _____ □ **VISA** □ **MC** □ **AM-EXPRESS**

☐ **CHECK #**_____ Driver's License: State_____ DL # _____ Exp. Date: _____

Revised 2/26/2014