Application X-Ray

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | | |
| Address: |  | | |
| City/State/Zip: |  | | |
| Phone Number: |  | | |
| Email Address: |  | Initials |  |

***Your Email confirmation will be sent as soon as it is submitted***

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| XRAY |  |  | Expires | Amount |  |  |  | Expires | Amount |
| 1 Views | 4995 | 58.00 | 2 Mos |  | 6 Views | 4995 | 143.00 | 2 Mos |  |
| 2 Views | 4995 | 75.00 | 2 Mos |  | 7 Views | 4995 | 166.00 | 2 Mos |  |
| 3 Views | 4995 | 85.00 | 2 Mos |  | 8 Views | 4995 | 190.00 | 2 Mos |  |
| 4 Views | 4995 | 95.00 | 2 Mos |  | 9 Views | 4995 | 214.00 | 2 Mos |  |
| 5 Views | 4995 | 119.00 | 2 Mos |  | 10 Views | 4995 | 238.00 | 2 Mos |  |
| **Multiples** |  |  |  |  |  |  |  |  |  |

**Actual – Discount = Total**

|  |  |  |  |
| --- | --- | --- | --- |
| Screenings or Labs | Actual | Discount | Total |
|  |  |  |  |

*Brief Description/Notes:*

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|  |  |  |  |
| --- | --- | --- | --- |
| Receipt No. |  | Total: | $ |

I hereby release Havasu Community Health Foundation from all liability. If I do not personally obtain the results of this test, it is my responsibility to contact my physician for said results. This Agreement shall be effective the day it is signed by both parties and expires as posted next to the procedure. If I fail to complete my procedure by the expiration date, HCHF will consider my payment as a donation. I understand I will need to sign a new application and make an additional payment to utilize this program once it has expired. 90 cents of every dollar donated supports your charitable program of choice.

*Payment Method 5 CASH 5 CHECK 5 CREDIT5 SPLIT 5 OTHER*  Check No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Confirmation Code**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Participant/Caregiver Signature |  | Date |
|  |  |  |
| HCHF Representative |  | Date |