DentiCare
PAYMENT SOLUTIONS

PRINT FORM CLEAR FORM

Dental Treatment
Direct Debit Request Payment Plan

CONSULTING DOCTOR & PRACTICE NAME

Consulting Doctor | Practice: **Cranbourne North Dental** | Provider ID: **148783**

1. RESPONSIBLE PARTY FOR PAYMENTS. *Indicates a MANDATORY FIELD

A Responsible Party must be an Australian citizen, employed, 18 years of age or older and not subject to bankruptcy or any debt agreements.

*Title | *First Name | *Last Name | *DOB (DD/MM/YY)

*Residential Address | *Mobile Phone Number

*Suburb | *Home Phone Number

*State | *Postcode | *Work Phone Number

*Email Address – required for statements and notifications | *ID No. (Medicare/Passport/Driver's Licence)

2. PATIENT DETAILS. *Indicates a MANDATORY FIELD

*First Name | *Last Name | *DOB (DD/MM/YY) | Practice Client ID No.

3. THE PAYMENT PLAN

Total Treatment Fee		Min 20% Deposit Paid to Practice		Payment Plan Amount		Number of Debits		Direct Debit Amount
$	−	$	=	$	÷		=	$

The **first Direct Debit Amount** will be debited on the _____ (DD/MM/YY) followed by the Direct Debit Amount above each

(please tick frequency): ☐ Week ☐ Fortnight ☐ Month.

I, the Responsible Party as detailed above, agree to the Payment Plan as set forth in Section 3. Please sign: _____

4. CHOOSE YOUR DIRECT DEBIT REQUEST PAYMENT METHOD

I/We, authorise and request Payment Advantage Pty Ltd T/A DentiCare Payment Solutions ABN 99 107 018 182, until further notice in writing, to arrange for my/our account as described in Schedule 1 or 2 specified below, provided that if no amount is specified, the account may be debited with any amounts which I/we must pay to you under the arrangements. Schedule 1 of this Direct Debit Request allows for Payment Advantage Pty Ltd T/A DentiCare Payment Solutions ABN 99 107 018 182 to debit the nominated amount as the Debit User specified in the Bulk Electronic Clearing System (CS2) under Debit User ID No. 317892.

☐ **Bank Account - Schedule 1**
$0.88 fee for bank account transactions

Account Holder Name (Please complete using CAPITAL LETTERS)

BSB Number | Account Number

Bank or Financial Institution

Signature on Nominated Account | Date of Signing (DD/MM/YY)

☐ **Credit or Debit Card - Schedule 2**
1.95% fee MasterCard & Visa transactions. 3.25% fee Amex transactions.

Name of Cardholder (Please complete using CAPITAL LETTERS)

Card Number (Visa, MasterCard or Amex)

Expiry Date (MM/YY)

Cardholder Signature | Date of Signing (DD/MM/YY)

ACKNOWLEDGEMENT: I/We have read the Direct Debit Request Service Agreement and the DentiCare DDR Payment Plan Terms & Conditions and agree to their terms and conditions. I/We authorise and request that this Direct Debit Request remain in force until cancelled, deferred, or otherwise altered in accordance with the Direct Debit Request Service Agreement. I/We confirm the bank account or credit card details as set out above are correct and this Direct Debit Request is signed by all the authorised signatories required by the financial institution where my/our account is held.

Cranbourne North Dental | 27 Linden Tree Way CRANBOURNE NORTH VIC 3977 | Ph: 03 5933 2766

PRACTICE USE ONLY
Submit this DDR Payment Plan & the signed Payment Plan Agreement to **payplans@denticarepayplans.com.au**

Direct Debit Request (DDR) Service Agreement & DentiCare Payment Plan Agreement

DentiCare PAYMENT SOLUTIONS

DIRECT DEBIT REQUEST SERVICE AGREEMENT

1. Payment Advantage Pty Ltd, t/a DentiCare Payment Solutions and/or DentiCare ABN 99 107 018 182 as Debit User (ID No. 317892) will initiate direct debit payments in the manner referred to within the DentiCare Direct Debit Request as per Section 3 The Payment Plan and Section 4 Direct Debit Request Schedule 1 or 2.
2. Debit payments will be made when due. DentiCare will not issue individual confirmation of payments made. Statements are available on request.
3. DentiCare will give you at least 14 days' written notice if DentiCare proposes to vary details of this arrangement, including the amount and frequency of payments.
4. If you wish to defer any payment or alter any of the details referred to in the Schedule or Payment Plan, then you must either contact DentiCare on 1300 633 472 or write to DentiCare at the following address: DentiCare PO Box 3156 Southport QLD 4215.
5. Any queries concerning debit payments or disputed debit payments must be directed to DentiCare as Debit User in the first instance.
6. Direct debiting is not available on the full range of accounts at all financial institutions. If in doubt, you should check with the financial institution before completing the Direct Debit Request.
7. You should ensure that the account details given in the Schedule are correct by checking them against a recent statement from the financial institution at which the account is held.
8. By signing this Direct Debit Request, you warrant and represent that you are duly authorised to request the debiting of payments from the account described in the Schedule.
9. The signature used for the Direct Debit Request must be identical to the signature used in connection with your nominated bank account and/or the primary cardholder of the credit card account.
10. It is your responsibility to have sufficient cleared funds available in the account to be debited to enable debit payments to be made in accordance with the Direct Debit Request.
11. If a debit payment falls due on any day which is not a banking business day, the debit payment will be made on the next banking business day. Monthly Direct Debits cannot be scheduled on the 29th, 30th or 31st.
12. If a debit payment is returned unpaid, DentiCare may charge you a fee for each unpaid item.
13. If you wish to cancel a Direct Debit Request or stop individual debit payments you must give at least 7 days written notice to DentiCare. This may be arranged by calling DentiCare on 1300 633 472.
14. Except where the account or banking service terms and conditions permit disclosure, and except to the extent that disclosure is necessary in order to process debit payments, investigate and resolve disputed transactions or is otherwise required or permitted by law, DentiCare will keep details of your account and debit payments confidential.

DENTICARE PAYMENT PLAN AGREEMENT

1. **By entering into a DentiCare DDR Payment Plan you acknowledge and agree that your scheduled direct debit payments and entire payment plan are affordable to you and remains your financial responsibility until the entire payment plan is paid in full.**
2. If a scheduled direct debit fails for any reason the failed scheduled direct debit payment will automatically be rescheduled and transacted within five banking business days, unless otherwise arranged with you by DentiCare or its agents.
3. If your financial institution rejects any of our attempts to debit your account, in accordance with your DDR Sections 3 & 4, an irrevocable reprocessing fee of up to $38.50 will be added to your payment plan and automatically debited from your account.
4. If your DentiCare Payment Plan account is in arrears greater than 90 days it shall be deemed in default and the total payment plan amount outstanding may become immediately payable. Legal and debt collection costs incurred by DentiCare or its agents in recovering outstanding debt or arrears or scheduled payments from you will be your responsibility and added to the amounts owed by you to DentiCare or its agents.
5. Under Part 3A of the Privacy Act a Responsible Party holding a DentiCare Payment Plan which is in default will be subject to a default listing with a credit reporting body such as Veda.
6. Under Part 3A of the Privacy Act we may contact a credit reporting body such as Veda to obtain a credit report about you.
7. Your information within your DentiCare Payment Plan is required to provide the DentiCare service. Your information may be disclosed to third parties relevant to your DentiCare Payment Plan and DentiCare's internal or external debt collection agencies where necessary.
8. In the event of a dispute relating to your treatment you and your chosen healthcare provider/s are required to provide DentiCare full details of your treatment relative to your DentiCare Payment Plan and you give consent to your chosen healthcare provider/s to disclose your information directly to DentiCare for the purpose of dispute resolution.
9. DentiCare will provide at least 14 days' notice of any changes to the terms and conditions of this DentiCare Payment Plan Agreement.
10. Any amendments or deferments of any of the debit arrangements as set out in Section 3 of the Direct Debit Request may result in additional fees and charges which you will be advised of at the time.
11. Evidence of your Age, Bankruptcy or Debt Agreement Status, Citizenship and Employment Status may be required from you at any time prior to or during your DentiCare Payment Plan. Failure to provide requested detail may result in the cancellation of your DentiCare Payment Plan.
12. DentiCare reserves the right to reject, suspend or cancel any Payment Plan at any time for breach of this agreement.

13. COMPLIANCE ACKNOWLEDGEMENT (Clause 13 of DentiCare Payment Plan Agreement Terms & Conditions)

By signing the Direct Debit Request as the Responsible Party for the Payment Plan you acknowledge & confirm that:

a) **You are providing accurate and valid details within your DentiCare Direct Debit Request Payment Plan.**
b) **You are an Australian Citizen residing permanently in Australia.**
c) **You are Employed and have Adequate Income to honour the scheduled payments as per your signed Payment Plan.**
d) **You are 18 years of age or older.**
e) **You are not subject to bankruptcy or any debt agreements.**

I, as the signing Responsible Party for Payments, agree to the DentiCare Direct Debit Request Service Agreement & Payment Plan Agreement

Name of Responsible Party for Payments	**Signature**	**Date of Signing (DD/MM/YY)**