PAYMENT SOLUTIONS

Dental Treatment
Payment Plan Direct Debit Request

CONSULTING DOCTOR & CLINIC / PRACTICE

Consulting Doctor | Dr. | | Provider ID

1. RESPONSIBLE PARTY FOR PAYMENTS

A Responsible Party for Payments must be an Australian Citizen, be gainfully employed, 18 years of age or older and not subject to bankruptcy or debt agreements.

Title	First Name	Last Name	M/F	Date of Birth
				DD / MM / YYYY

Residential / Home Address

Suburb | State | Postcode

Active Email Address/Account – required for payment plan and payment activity statements

Phone Numbers

Mobile

Home ( )

Work ( )

ID Number Field Below Compulsory

ID

☐ Medicare Card, ☐ Passport or ☐ Driver's License Number

2. PATIENT DETAILS

First Name	Last Name	Patient DOB	M/F	Clinic/Practice Patient ID or Contract No
		DD / MM / YY		

3. THE PAYMENT PLAN

The **$39 Set Up Fee** and first **Direct Debit Amount** as detailed below will be debited on the ______/______/______ followed by the Direct Debit Amount each (please specify frequency with tick): ☐ Week or ☐ Fortnight or ☐ Month in the amounts detailed below.

$ **Total Treatment Fee** – $ **Deposit Amount** (Min 20% to be Paid to Practice) = $ **Payment Plan Amount** ÷ **No. of Debits** = $ **Direct Debit Amount**

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

4. DIRECT DEBIT REQUEST (DDR) & BANK ACCOUNT or CREDIT CARD/DEBIT DETAILS

I/We, as above Responsible Party, 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.

☐ SCHEDULE 1 - Via your **Bank Account**

Direct Debiting is not available on all accounts. If in doubt, please refer to your financial institution

Account in the Name(s) of

Name of Bank or Financial Institution | Branch/Suburb

BSB Number (full six digits) _ _ _ - _ _ _

Account Number

Bank Account Holders Signature | Signing Date DD / MM / YY

Bank Account Transactions Incur $0.88 Fee

☐ SCHEDULE 2 - Via your **Credit or Debit Card**

Accepted Cards: Visa, MasterCard & American Express

Card Number

Name on Card | Expiry Date MM / YY

Cardholder Signature

Signing Date DD / MM / YY

Accepted Cards: VISA, MasterCard, American Express

Credit & Debit Card Transactions Incur 2% Surcharge

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 the number of authorized signatories required by the financial institution where my/our account is held.

Provider ID	Provider to submit this DDR Payment Plan form & signed DDR Agreement to **payplans@denticarepayplans.com.au** or fax to **07 5503 1990**
	Direct Debit Request Payment Plan managed by Payment Advantage Pty Ltd T/A DentiCare Payment Solutions ABN 99 107 018 182 I Ph: 1300 633 472