Direct Debit Request (DDR)
Credit Card Direct Debit Request (CCDDR)

Air Liquide Healthcare PTY. LTD. **ABN 41 002 653 045**

ALH Debtor ID | Office ID

Customer Authority

I/We (Name of Customer/s giving the ☐ DDR* or ☐ CCDDR* - (*Tick which method)

First Name | Middle Name | Last Name | DOB

Employer Details

Employer Name

Contact Number

☐ Unemployed ☐ Retired

Details of the account to be debited

Name of the Financial Institution at which your account is held | Branch Name

Address of the Financial Institution | Post Code

Account Name | ABN/ARBN

BSB Number | Account number | Branch Name

Details of the card type to be debited

Please tick card type ☐ VISA ☐ Mastercard

Bank/Financial Institution

Card Holders Name

Credit Card Number | Expiry Date

Therapy Rental Program

Special Terms	Gold	Silver	Bronze
1. Minimum term of rental (Term)	18 months	6 months	1 month
2. Monthly rental	$80	$90	$100
3. One-off free mask	Yes	No	No
4. Free set-up appointment	Yes	Yes	Yes
5. Breakdown service (we will provide you with a replacement unit during the time your unit is being repaired)	Yes	Yes	Yes

Office Use Only

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Rental Equipment

Rental Package (Tick one)	Item Description	Monthly Admin Fee	Monthly Rental
Gold		$4.56	
Silver		$4.56	
Bronze		$4.56	
GOV ☐		$4.56	

Therapy Partnership Program Daily Fees

Item Code	Item Description	Daily Fee

Therapy Partnership Program Advance Fees

Item Code	Item Description	Advance Fee

Declaration

1. I/We, the Customer named herein, authorise and request Air Liquide Healthcare Pty Ltd to arrange for funds to be debited weekly (if I have selected the Therapy Partnership Program) or monthly (if I have selected the Therapy Rental Program) from my/our account at the Financial Institution identified above through the Bulk Electronic Clearing System (BECS) as per my Agreement with Air Liquide to commence therapy and the Direct Debit Service Request Agreement which I have read and understood.
2. I/we authorise Air Liquide Healthcare to verify my/our details as set out above with our/my Financial Institution.
3. I/we authorise our Financial Institution to release information to allow Air Liquide Healthcare to verify my/our signatures for the above mentioned account.

If in joint names, both signatures are required.

Signature | Date | Contact Number

Signature | Date | Contact Number

Please note Direct Debiting is not available on the full range of accounts; if in doubt, please refer to your Financial Institution.

Office Use Only

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Policy Agreements

Therapy Partnership Program Agreement	www.airliquidehealthcare.com.au/therapy-partnership-program-agreement
Direct Debit Request Service Agreement	www.airliquidehealthcare.com.au/direct-debit-request-service-agreement
Connected Care Agreement	www.airliquidehealthcare.com.au/connected-care-agreement
CPAP/Bi-Level Orientation Checklist	www.airliquidehealthcare.com.au/pap-orientation-checklist
Credit Reporting Policy	www.airliquidehealthcare.com.au/credit-reporting-policy
Privacy Policy	www.airliquidehealthcare.com.au/privacy-policy

Signature

To protect your own interests, please carefully read the terms and conditions as set out in the Therapy Partnership Program Agreement, Credit Card Direct Debit Request Service Agreement, Connected Care Agreement and Orientation Checklist included in this Agreement.

If you are uncertain as to your rights, then before agreeing to the terms, please seek independent advice. We are happy to discuss the terms of this Agreement.

- ☐ I acknowledge that I have been advised by Air Liquide Healthcare that the CPAP machine supplied to me has been set according to the prescription from my medical practitioner.
- ☐ I have read, understood and agree to the terms and conditions of the Therapy Partnership Program Agreement.
- ☐ I have read, understood and agree to Air Liquide Healthcare's Credit Reporting Policy and Privacy Policy and consent to the collection, use and disclosure of my personal information in accordance with the Privacy Policy
- ☐ I have read, understood and agree to the Credit Card Direct Debit Request Service Agreement.
- ☐ I have read, understood and agree to the CPAP/Bi-level Orientation Checklist.
- ☐ I have read, understood and consent to the Connected Care Agreement.
- ☐ I acknowledge that Air Liquide Healthcare has not made any claim or representation as to the effectiveness of the treatment prescribed by my physician(s). I acknowledge that Air Liquide Healthcare has informed me, and I agree that they will not assume any responsibility or liability for the success, failure, or effect of any treatments performed with the equipment.
- ☐ I consent to Air Liquide Healthcare providing my personal information to my medical practitioner/s, my insurer, or the paying government agency.
- ☐ I would like to receive updates from Air Liquide Healthcare Pty Ltd about products, services, promotions, special offers, news and events.

Signature | Date