Air Liquide HEALTHCARE

Vital360 & Therapy Partnership Program

SLEEP SOLUTIONS

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

ALH Debtor ID | Office ID

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

Customer Authority

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

First Name | Middle Name | Last Name | DOB

Customer Details

Phone 1 (Home) | Phone 2 (Mobile) | Email

Address

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

Vital360 Program

Special Terms	Standard Value	Premium Value
Minimum Term	6 months	6 months
Daily Fee	$1	$3
PAP Mask Fee	$199	$199
Breakdown Service *(We will provide you with a replacement unit during the time your unit is being repaired)*	During Warranty Period	Life of PAP Machine

Office Use Only

ALH Debtor ID	Office ID

GOV Program

Item Description	Monthly Fee	Monthly Rental
	$4.56	

Vital360 Equipment

Vital360 Program (Tick one)	Item Description
Standard Value	
Premium Value	

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 (if I have selected the Vital360, Therapy Partnership Program or GOV) 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

ALH Debtor ID	Office ID

Policies & Agreements

Vital360 & TPP Agreement	au.healthcare.airliquide.com/therapy-partnership-program-agreement
Direct Debit Request Service Agreement	au.healthcare.airliquide.com/direct-debit-request-service-agreement
Connected Care Agreement	au.healthcare.airliquide.com/connected-care-agreement
CPAP/Bi-Level Orientation Checklist	au.healthcare.airliquide.com/orientation-checklist
Credit Reporting Policy	au.healthcare.airliquide.com/credit-reporting-policy
Privacy Policy	au.healthcare.airliquide.com/privacy-policy

Signature

Please carefully read the terms and conditions as set out in the Vital360 & Therapy Partnership Program Agreement, Direct Debit Request Service Agreement, Connected Care Agreement and Orientation Checklist (which form part of this agreement. Links to each of these documents are set out above.

If you have any general questions or concerns in relation to the terms and conditions in the above documents, please don't hesitate to discuss these with a member of our team. If you require guidance as to your individual legal rights under this agreement then we would encourage you to seek independent advice before proceeding.

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 Vital360 & 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 Direct Debit Request Service Agreement.

I have read, understood and agree to follow any guidance contained in 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