Alberta Health Services

Pre-Authorized Debit (PAD) Plan - For Patients/Clients

- To authorize a *one time payment*, please complete Form 20301 instead of this form
- Use this form to authorize *reccurring monthly* payments or to cancel/update existing debit plans

This Request is for

☐ New debit plan
☐ Change to an existing debit plan
☐ Cancellation of existing debit plan

Patient/Client Information			
Name *(Last Name, First Name)*			Site
Address	City/Town	Province	Postal Code
Phone Number *(daytime)*	Phone Number *(cell)*	Patient/Client Reference Number *(if applicable)*	

Bank Account Information - Please include direct debit information or blank cheque marked "VOID"			
Name of Financial Institution (FI)	Account Number	Transit Number *(branch - 5 digits; FI - 3 digits)*	
Branch Address	City/Town	Prov	Postal Code
Type of Account ☐ Chequing ☐ Saving			

Pre-Authorized Debit Details

☐ Personal PAD ☐ Business PAD ☐ Funds Transfer PAD

Purpose of Pre-Authorized Debit *(Check all that apply)*

☐ Accommodation
☐ Laundry
☐ Parking
☐ Other *(specify)* ______________________________

☐ Regular monthly payments of $ _________ will be debited
☐ on the ________ business day of each month
☐ before the _______ business day of each month

☐ Variable monthly payments will be debited
☐ on the ________ business day of each month
☐ before the _______ business day of each month

Authorized Debit begins *(yyyy-Mon-dd)*	Final Payment Date, if applicable *(yyyy-Mon-dd)*

Please read/sign page 2 and return both pages to the Billing Cash and Collection Department responsible for your zone:

☐ 10th Floor North Tower, 10030 107 Street Edmonton AB T5J 3E4
☐ P.O. Box 1260 Station Main Edmonton AB T5J 2M8
☐ P.O. Box 1980 Station M Calgary AB T2P 4Z7
☐ 3rd Floor, 43 Michener Bend Red Deer AB T4P 0H6

The personal information collected by this form is collected under the authority of section 33(c) of the Freedom of Information and Protection of Privacy Act. If you have any questions about the collection of your personal information please contact the Manager of AHS Billing, Cash & Collections: by mail 10th Floor 10030 107 Street NW Edmonton AB, T5J 3E4 or by phone 1-844-735-0492

Alberta Health Services

Pre-Authorized Debit Plan

PAYOR'S PAD AGREEMENT - Terms and Conditions

1. I/We authorize Alberta Health Services and the designated financial institution to deduct from my/our account regular or variable monthly recurring payments.
2. **I/We have waived my/our right to receive pre-notification of the amount of the Pre-Authorized Debit and agreed that I/we do not need advance notice of the amount of PADs before the debit is processed.**
3. Alberta Health Services will obtain my/our authorization for any debits outside the scope of this agreement.
4. I/We understand that this authority is in effect until Alberta Health Services has received written notification from me/us of its change or termination. This notification must be received at the address below at least **ten (10) calendar days** before the next debit is scheduled.
5. I/We understand this authority will cancel without written notice if Alberta Health Services cancels the agreement.
6. Alberta Health Services may not assign this authorization, whether directly or indirectly, by operation of law, change of control or otherwise, without giving at least 10 days prior written notice to me/us.
7. Alberta Health Services may change monthly amounts with advance notification to the payors. New authorization is not required for such changes.
8. I/We have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to be reimbursed for any PAD that is not authorized or is not consistent with this PAD Agreement. For a Reimbursement Claim, or for more information on my/our recourse rights, I/we may contact my/our financial institution or visit www.payments.ca

Where the Payor's account agreement requires the signature of two or more signing authorities, the signatures of all such persons are required for the purposes of this Pre-Authorization Agreement.

Authorized Signature	Authorized Signature
Last Name *(print)*	Last Name *(print)*
First Name *(print)*	First Name *(print)*
Date *(yyyy-Mon-dd)*	Date *(yyyy-Mon-dd)*