Alberta Health Services

Pre-Authorized Debit (PAD) Plan *(One-Time Debit)*

■ Use this form to authorize a *one time* debit from your account

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 ☐ Savings			

One Time Debit Details

☐ I/We authorize Alberta Health Services and the designated financial institution to debit the account specified for $ _____

☐ on the _____business day of _____ ,20_____

☐ before the _____business day of _____ ,20_____for the following reasons

PAD Category ☐ Personal PAD ☐ Business PAD ☐ Fund Transfer PAD

Please return the completed original form 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 1980 Station M Calgary AB T2P 4Z7

☐ 3rd Floor, 43 Michener Bend Red Deer AB T4P 0H6

☐ P.O. Box 1260, Station Main, Edmonton, AB T5J 2M8

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

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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 one time for the amount and reason stated on Side A.
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 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. 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)*

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