Co-payment Authorisation and Consent form

Your doctor has prescribed *botulinum toxin* (Botox, Dysport or Xeomin). Your medication is subsided by the Australian Commonwealth via the Pharmaceutical Benefits Scheme (PBS). You may be required to contribute to the cost of the medication (this is called a co-payment). This form is to get your consent and set up a payment method with you. (Please read, complete, and sign).

Name: . . . . . **DOB:** (DD/MM/YYYY) . . . . . .

Mobile: . . . . . **Email:** . . . . . .

Address . . . . . .

Suburb . . . . . **State** . . . . . **Postcode** . . . . . .

Please tick which (if any) healthcare card/s have been issued to you:

☐ Any type of Concession or DVA Card ☐ Safety Net Card

Consent

To enable your medication to be delivered to the clinic please read this carefully, sign, and provide your preferred payment method:

- I acknowledge and accept the PBS prescription co-payment terms included in this form.
- I understand that a co-payment is required by the Australian government as part of the PBS reimbursement scheme for prescription medications.
- I understand that co-payment is defined as a monetary contribution from the recipient of the medication of an amount of $31.60 for General medicare card holders or $7.70 for concession card holders, per prescription. This excludes private prescriptions.
- I consent to Integra Medical Group Pty Ltd (IMG) to act as my agent for the purposes of managing the ordering, and payment of my botulinum toxin medication.
- I understand that if I am eligible for the safety net rebate this will be handled as a refund.
- I give consent for IMG to pass my information to HPS Pharmacies to collect and store my information for the purposes of providing my medication, payment and accessing the Pharmaceutical Benefits Scheme on my behalf. This includes my script, name and contact information.

☐ Please **tick this box** and **sign below** to acknowledge you have read and agree to the above.

. . . .
Patient / Guardian Signature

. . . . . /. . . . . /. . . . .
Date

Payment Method

If you would like the clinic to enter the payment details for you, please fill in your preferred payment method below. If you would prefer to enter your payment details directly into BnTRx, please ask the clinic if you can scan the QR code and fill out an online version of this form instead.

Please be aware if we are unable to successfully process co-payment with the information provided, an invoice will be sent from the dispensing pharmacy.

Credit Card

Name _____

Card number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Expiry Date ___ / ___ CVV number ___ ___ ___

Direct Debit

Account Name _____

BSB ___ ___ ___ - ___ ___ ___

Account Number _____

By providing your bank account details and confirming this payment, you agree to this Direct Debit Request and the Direct Debit Request service agreement and authorise Stripe Payments Australia Pty Ltd ACN 160 180 343 Direct Debit User ID number 507156 (“Stripe”) to debit your account through the Bulk Electronic Clearing System (BECS) on behalf of Integra Medical Group (the "Merchant") for any amounts separately communicated to you by the Merchant. You certify that you are either an account holder or an authorised signatory on the account listed above.