



# Circle of Care

Sinai Health System

4211 Yonge Street, Suite 401  
Toronto, ON M2P 2A9

## Personal Pre-authorized Debit (PAD) Form

I authorize **Circle of Home Care Services (Toronto)** (“**Circle of Care**”) to charge my credit card monthly for regular or recurring payments, or payment of all charges arising under my account. I expressly waive any legislative or regulatory requirement for pre-notification of the amount to be charged to my credit card. Transaction dates that fall on a weekend or holiday will be processed the next business day.

Name: \_\_\_\_\_  
 Client ID: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I may revoke my authorization at any time, subject to providing written notice 5 business days before the next scheduled monthly payment.

Charges will be automatically withdrawn from the authorized credit card on a monthly basis, after invoices have been mailed out. All credit card information will be provided directly to Circle of Care over the telephone and will be stored on a secure website. I will notify Circle of Care if they are any disputes with charges or transactions that appear on the monthly invoice. After notification, Circle of Care will investigate the charges, and a credit will be issued if justified.

I have certain recourse rights if any charges processed do not comply with this agreement. For example, I have the right to receive reimbursement for any charge that is not authorized or is not consistent with this PAD agreement. I acknowledge that Circle of Care has advised me that I can obtain more information on my recourse rights by contacting my financial institution or visiting [www.cdnpay.ca](http://www.cdnpay.ca)

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

