NDIS SERVICE AGREEMENT

OUR AUSTRALIAN MEDICAL SUPPLY

ABN: 46685982174
Provider: 4-LF95DKK
Tel: 0435 076 530

E-mail: info@australianmedicalsupply.com
Mail: PO Box 6041 Point-Cook Vic 3030

Send your form to:

*CompulsoryFieldsMustBe Completed

*Participant Name:	
*NDIS Number:	
*Date Of Birth:	
E-mail Address:	
Phone Number:	
Delivery Address:	
*Contact Who Orders:	☐ I Order For Myself ☐ Support Co-ordinator ☐ My Nominee
Contact Name:	
Contact Phone Number:	
Contact Email Address:	
*Who Arranges Payment Of Your Invoices?	☐ I Pay Myself ☐ Contact the NDIA For Me ☐ My Plan Manager
Plan Manager Company:	
Plan Manager Name:	

Plan Manager E-mail:	
Plan Manager Number:	
*Consent For NDIA To Exchange Information?	☐ Yes ☐ No

The Provider agrees to:

>Provide therequired support to satisfy the Participant's needs at the Participant's preferred time.

>Communicate openly and honestly in a timely manner.

>Treat the Participant with courtesy and respect.

>Listen to the Participant's feedback and resolve problems quickly.

>Protect the Participant's privacy and confdential information.

Responsibilities of Participant / Participant's representative

> Inform the Provider about how they wish the supports to be delivered to meet the Participant's needs.

>Give the Provider the required notice if the Participant needs to end the Service Agreement.

>Let the Provider know immediately if the Participant's NDIS plan is suspended or replaced by a new NDIS plan or the Participant ceases to be a Participant in the NDIS.

>To provide adequate information to the Provider so a service booking can be made and funds claimed whilst remaining under budget.

>To give consent for the NDIA to exchange information with the Provider

Payments

The Participant has nominated the NDIS to manage the funding for supports provided under this Service Agreement if selected above.

After providing those supports, Our Australian Medical Supply will claim payment for those supports from the NDIS.

If Our Australian Medical Supply is unable to claim the order amount from the NDIS, the Participant will be liable for the balance on the account.

Agreement Signatures

Participant or Participant's Representative	Provider's Representative
_____	_____
Signat ure	Signat ure
_____	_____
Name	Name
_____	_____
Date	Date