**Form A: Practice details**

*These details will be used to administer the service and by Webstar Health to set up an account for the practice on the Service Pact system.*

**One form is required for each practice (location) providing the service.**

A.1 Person completing these forms:

|  |  |
| --- | --- |
| **First name** |  |
| **Surname** |  |
| **Contact Telephone number** |  |
| **Email address** |  |

A2. Practice details:

|  |  |
| --- | --- |
| **Name of practice****(This is the trading name of the practice)** |  |
| **Address of practice** |  |
| **Postcode of practice** |  |
| **Telephone number of practice****(including STD)** |  |

A3. Please provide details of the person who will be taking day to day responsibility for this service at this practice and who can be contacted in the event of a service issue:

|  |  |
| --- | --- |
| **First name** |  |
| **Surname** |  |
| **Position** |  |
| **Telephone number** |  |
| **Email address** |  |

**Form B: Account information**

**One form is required for each practice (location) providing the service.**

1. Type of legal entity: Please complete **one** of the following rows for the practice

|  |  |
| --- | --- |
| Individual: |  |
| Write name above |
| Partnership: |  |
| Write name of partnership above |
| Limited Company: |  |
| Write name of Limited Company above |

Limited companies: For limited companies please complete the following information:

|  |  |
| --- | --- |
| **Registered Address****(including postcode)** |  |
| **Company Registration Number** |  |

Authorised signatory: Please provide details of the person who is authorised to sign the contract for the practice?

|  |  |
| --- | --- |
| **First name** |  |
| **Surname** |  |
| **Title / Position** |  |
| **Telephone number** |  |
| **Email address** |  |

**Form C: Payments made by the commissioner to the sub-contractor:**

*Payment will be made to the sub-contractor for the services provided by the directly into a bank account nominated by you.*

*Note: cheque payment is not possible.*

**One form is required for each practice (location) providing the service.**

C1. Please provide details of the person who will be responsible for receiving payment remittance advice. **Note – an email address is essential.**

|  |  |
| --- | --- |
| **First name** |  |
| **Surname** |  |
| **Position** |  |
| **Telephone number** |  |
| **Email address (essential)** |  |

C2. Bank Details: provide details of the bank account into which payment should be made

**Name(s) of Bank Account Holder(s):**

|  |
| --- |
|  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Bank/Building society account number:** |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Branch Sort Code:** |  |  | - |  |  | - |  |  |

|  |  |
| --- | --- |
| **Bank Name** |  |
| **Branch Name** |  |

**Please complete forms and return by email to: support@servicepact.co.uk**