Bach Medical Supply Client Intake

CSR:
Date: _____

ALL ITEMS MUST BE RETURNED CLEAN AND IN ACCEPTABLE CONDITION AS WHEN FIRST RENTED.

Full Name _____Date of Birth _____/_____/_____

Social Security # _____ (Required for ALL Rentals)

Home Address

_____

City _____ County _____ State _____ Zip _____

Home Phone _____Cell Phone_____ Work Phone_____

E-mail_____

Is Billing Address the same as Home Address? ☐YES ☐NO

IF NO, please fill out Billing Address _____City_____ State _____ Zip_____

Height____'____" Weight _____lbs Marital Status Married❑ Single❑ Other❑ Gender Male❑ Female❑

Emergency Contact: _____ Phone #:_____ Relationship: _____

Address _____ City _____ State _____ Zip _____

Person responsible for account if different from above:

Insured Name _____ Relationship _____Phone _____

Address

_____

Employer _____ Employer Phone

FOR MINORS AND DEPENDANTS

Parent Name _____

Address _____

City _____ State _____ Zip _____ Phone _____

Parent's Employer _____ Employer Phone _____

Parent's DOB _____ Parent's SSN_____

_____

PLEASE READ BEFORE SIGNING:

Terms: Items are rented on a weekly (7days) or (30 days) monthly basis. If an extension is needed we must have at least a 24 hour notice. An additional week or daily rate of rental begins the following day after your initial week of rental should it not be returned on scheduled date. ***Rental on equipment starts the day the equipment is received and stops when the equipment is returned or picked up***. We **do not** pro-rate any rental items. If an item is needed for a day or is returned early it will still be the same as the weekly or monthly rate.

The Customer is responsible for replacement costs of damaged, missing or permanently stained rental equipment.
WARNING: Missouri statute Section 578.150.1sub section 7 provides that failure to return rented equipment as agreed at time of rental is considered prima facie evidence of larceny and will be prosecuted. In the event Medidex, Inc. d.b.a. Bach Medical Supply institutes legal proceedings to recover missing property or damages arising from the contract, we will be able to recover Legal fees along with any additional costs to damaged equipment.
Repair Charges – **If returned equipment appears broken due to misuse, a test and repair charge of $50.00 may be charged for inspection, testing and minor repairs required to return the equipment to service**. This charge will be payable at the end of this agreement. If the equipment cannot be repaired, the customer will be notified and will be responsible for the designated replacement cost of the Equipment.
Limitation of Liability and Indemnity: Limitation of liability – In no event will Medidex, Inc. or Bach Medical Supply be liable to the Customer for any Incident or injury, indirect or consequential damages however caused, whether by negligence or otherwise.
Indemnity – The Customer agrees to protect, indemnify and hold harmless Medidex, Inc. from and against all claims, damages and costs including legal expenses arising out of Customer's use of the equipment.
I agree that I have been instructed on how to use the equipment and take full responsibility for the proper use and care of the equipment during the rental period so that it is returned in the same condition as when received.
I fully understand that I am responsible for any and all damages and therefore repair costs that may arise from use of the product during my rental period.

ITEM:		
WHEELCHAIRS	**Weekly**	**Monthly**
Standard Manual Wheelchair (250lbs)	$32.50	$65.00
Light weight Manual Wheelchair (250lbs)	$52.50	$105.00
Heavy Duty, Manual Wheelchair (350lbs)	$70.00	$140.00
Heavy Duty, Manual Wheelchair (450lbs)	$97.50	$195.00
Elevating Leg Rest for wheelchair	$17.50	$35.00
KNEE SCOOTERS		
Knee scooter	N/A	$85.00
HOSPITAL BEDS/ACCESSORIES		
Manual Hospital Beds	N/A	$195.00*
Semi Electric Hospital Beds	N/A	$225.00*
Trapeze (attached to hospital bed)	N/A	$40.00
Trapeze (freestanding)	N/A	$95.00
Over the Bed tables	N/A	$25.00
Patient Lift (hydraulic)	N/A	$195.00
Alternating pressure pump (**pad purchased separately**)	N/A	$45.00
RESPIRATORY ITEMS		
Suction pump (supplies are extra)	N/A	$50.00
Nebulizer Compressor (**supplies are extra**)	N/A	$25.00

***Hospital beds include delivery/pickup in Springfield**

_____Copy of CC _____Copy of DL (Employee Initials) Start Date of Rental: _____ End Date of Rental: _____

CONFIRMATION OF PRIVACY NOTICE (HIPAA)

I have received a copy of Bach Medical Supply's Privacy Notice which outlines how protected health information about me may be used and disclosed and how I can access this information. I certify that I have read the Privacy Notice, received a copy, and is the client, or is authorized as the client's general agent, to execute the above and accept its terms.

I authorize that Bach Medical Supply may contact me □ No □ Yes

Preferred method of contact: Cell □ Home Phone □ Work Phone □ E-mail □

Cell phone carrier (i.e. At&t) : _____

Person that we may share your confidential information with:

Name _____ **Relationship** _____

Address _____

City _____ **State** _____ **Zip** _____ **Phone** _____

My signature authorizes Bach Medical Supply and my physician to release any medical information about me to: Healthcare providers directly involved in my care; Bach Medical Supply personnel; Joint Commission surveyors; and third party payers to the extent that medical information is needed to process claims for payment for services provided.
You are ultimately responsible for any unpaid balances.

X_____ **X**_____

Customer/ Agent/ Parent Signature **Date**