

PRINT, COMPLETE AND FAX
RENTAL AGREEMENT TERMS - VIENNA MEDICAL
2836 ENTERPRISE RD. SUITE 5 DEBARY, FL. 32713
386-753-1959 or toll free 800-489-8165 Fax 386-753-1949 or 866-602-2900

Responsible Party Name: _____ **Date:** _____

Address: _____

Phone #: _____ **Credit Card#** _____

Type: Visa___ M/C___ Discover___ **Expiration Date** _____

Drivers License # _____ **Exp. Date** _____

Start Date: _____ **End Date:** _____ **Number of days of rental** _____

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

PLEASE READ BEFORE SIGNING:

Terms: All items are rented on a weekly (7days) or (30 days) monthly basis excluding portable oxygen concentrators. Initial rental is due along with any other applicable charges and a \$300 Security Deposit before delivery can be made. . If an extension is needed we must have at least a 72 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 in home or is picked up and stops when the equipment is shipped out from your location or dropped off.

The Customer is responsible for replacement costs of damaged, missing or permanently stained rental equipment. WARNING: Florida statute 812.021 sub 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 Shenk Enterprises, LLC. d.b.a. Vienna Medical 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. Test and (or) 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 Shenk Enterprises, L.L.C. or Vienna Medical be liable to the Customer for any Incident or injury, indirect or consequential damages however caused, whether by negligence or otherwise relating to renting or using any medical equipment.

Indemnity – The Customer agrees to protect, indemnify and hold harmless Shenk Enterprises, L.L.C. 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.

Customer’s Signature: _____ **Date:** _____

Vienna Medical Representative: _____ **Date:** _____

PRIVATE OXYGEN RENTAL INTAKE

Phone: 1-800-489-8165

Fax: 386-753-1949

PATIENT INFORMATION

Date: _____ Intake Initials _____

Legal Patient Name: _____

D.O.B. _____ M ___ F ___ Ht: _____ Wt: _____

PERMANENT Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

SHIPPING Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

RESPONSIBLE PARTY/EMERGENCY CONTACT

Responsible Party Name: _____ Phone: _____

Emergency Contact (must be different than Responsible Party) _____

Phone: _____ Comments: _____

PHYSICIAN INFORMATION

****We must have the existing O2 prescription faxed to us prior to dispensing Oxygen****

You may call the physician and have him/her fax the order to 386-753-1949

Name: _____ Address: _____

City _____ State _____ Zip _____

Phone: _____ Fax _____

Patient's Diagnosis: _____ Liter Flow _____

RESPIRATORY EQUIPMENT SELECTION

- ___ Sequal ECLIPSE portable oxygen concentrator with 2 batteries and full set up.
- ___ Devilbiss IGO portable oxygen concentrator with 2 batteries and full set up.
- ___ LifeChoice portable oxygen concentrator with 2 batteries and full set up.
- ___ Invacare XPO2 portable oxygen concentrator with 2 batteries and full set up.
- ___ Inogen One portable oxygen concentrator with 2 batteries and full set up.
- ___ Invacare Solo portable oxygen concentrator with 2 batteries and full set up.

- ___ Extra portable oxygen conc. Batteries
- ___ HomeFill Full Oxygen System
- ___ Stationary Invacare Concentrator
- ___ E- Tanks
- ___ M-6 Portable tanks
- ___ M-9 Portable tanks

PRIVATE PAY RENTAL FEES AS OF 8-1-2010

Please check the rented items box to the left for your selections and initial at the bottom.

<u>ITEM:</u>	<u>Weekly</u>	<u>Monthly</u>
Stationary Oxygen Concentrators	\$55.00	\$140.00
Refillable Oxygen Homefill system	\$50.00	\$110.00
1 M6 Portable Oxygen Tank	\$22.00	\$28.00
E tank, regulator and Cart		\$20.00 (refill \$7.50)
CPAP Machine with Heat humidifier		\$100.00

Portable Oxygen Concent. w/2 batteries \$225.00(7 days) - \$25 each add. day

Portable Oxygen Concentrator extra batteries \$50.00(7 days) - \$8 each additional day

*Local customers may pick item up. For out of area customers additional shipping charges apply. Portable Oxygen Concentrators are \$75.00 round trip shipping charge for standard ground. For next day, 2 day service or other products shipping please call.

****IN ADDITION – PLEASE REMEMBER TO INSPECT YOUR UNIT AND ACCESSORIES UPON ARRIVAL TO ENSURE NO DAMAGE AND PROPER FUNCTION. SHOULD YOU HAVE ANY PROBLEMS PLEASE CONTACT US IMMEDIATELY. YOU ARE RESONSIBLE FOR ANY DAMAGE! PLEASE INSPECT. IN ADDITION, PLEASE REMEMBER IT IS RECOMMENDED THAT YOU SHOULD ALWAYS HAVE A MEANS OF EMERGENCY BACK UP OXYGEN. ELECTRONIC DEVICES CAN BREAK DOWN. ALWAYS HAVE A BACKUP PLAN.**

Deposit	<u>\$300 Refundable Deposit upon undamaged return of product</u>
Shipping	<u>\$75 round trip</u>
Unit Rental	_____
Battery Rental	_____
Other	_____

TOTAL \$ _____

Responsible Party Initials _____

Thank you for your business. All products are cleaned and tested for clinical use upon return. Should you have any questions, please call 1-800-489-8165

FAX COMPLETED FORMS TO 386-753-1949

Credit Card Authorization Form

Customer Name: _____

Card Holder Name: _____

I, _____, hereby authorize Shenk Enterprises, D.B.A. Vienna Medical, to charge my credit card for the amounts invoiced.

This charge is for the following products/services: _____

Amount to Charge \$ _____

AMERICAN EXPRESS / DISCOVER / VISA / MasterCard only

Credit Card Number: _____

Expiration Date: ____ / ____ SEC Code: _____

Credit Card Billing Address:

Street: _____

City: _____

State: _____

Zip Code: _____

Country: _____

Telephone: () _____

Fax: () _____

(a fax number or email is required)

Email: _____

Cardholder's Signature

Date

Your completion of this authorization form helps us to protect you, our valued Customers, from credit card fraud. Vienna Medical will keep all information entered on this form strictly confidential.

FAX COMPLETED FORM TO 386-753-1949