Abby Home Medical Rental Agreement

Name: ____ Cell Phone: ________________________

Address: ____

City: ____________________________ State: __________________ Zip Code:___________________

Email: _______________________________ Height:_______________ Weight:______________

Rental Equipment:		Daily	Weekly	Monthly
Mobility Scooter/Power Chair:		$50.00	$200.00	$400.00
Lift Chair:			$125.00	$250.00
Hospital Bed:			$125.00	$250.00
Over Bed Table:			$10.00	$25.00
Manual Wheelchair	Standard	$10.00	$40.00	$80.00
	Heavy Duty	$25.00	$50.00	$100.00
Transport Chair		$10.00	$40.00	$80.00
Rollator/Walker		$10.00	$20.00	$40.00
Knee Scooter:		$10.00	$40.00	$80.00
Oxygen Concentrator:			$50.00	$100.00
Portable Oxygen Concentrator:			$200.00	$400.00

Deposit:		
	Scooter, Powerchair, Lift Chair, Hospital Bed	$300.00
	Manual Wheelchair, Transport Chair, Knee Scooter	$100.00

Delivery & Setup	$50.00 within 25 miles of Abby Home Medical
	$75.00 between 26 and 50 miles of Abby Home Medical
Pickup	$50.00 within 25 miles of Abby Home Medical
	$75.00 between 26 and 50 miles of Abby Home Medical

Rental Period: From: _______________ To: _______________

Retail Value: $_____________

- The deposit will be refunded upon the return of the equipment. Rental items must be returned in the same condition prior to the rental. Any damages to the equipment or cleaning fees will be deducted from the deposit.
- Rental items must be returned within the agreed rental period. An automatic weekly/monthly withdrawal will occur until the Retail Value has been reached. It is the customers responsibility to return the equipment prior to the end of the rental period to prevent additional charges.

By signing this form, I have read the rental agreement and agree to the terms and conditions set forth herein. I agree to pay the rental, deposit, delivery/pickup, and any recurring rental charges for the equipment.

Signature:____ Date:______________________________