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
HD Mobility Scooter/Power Chair:	$75.00	$250.00	$500.00
Ramp:		$50.00	$100.00
Lift Chair:		$125.00	$250.00
Premium Lift Chair:		$200.00	$400.00
Hospital Bed:		$150.00	$300.00
Over Bed Table:	$20.00	$40.00	
Wheelchair/Transport Chair	$15.00	$50.00	$100.00
HD Wheelchair/Transport Chair	$20.00	$75.00	$150.00
Walker	$10.00	$20.00	$40.00
Rollator	$15.00	$25.00	$50.00
Knee Scooter (up to 6 weeks):			$100.00
Oxygen Concentrator:		$75.00	$150.00
Portable Oxygen Concentrator:		$250.00	$500.00
Extra Battery:		$25.00	$50.00

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
After Hours	$50.00 nights, weekends and holidays

Rental Period: From: _____ To: _____

Retail Value: $_____

- **Rental items must be returned in the same condition prior to the rental. Any damages to the equipment or cleaning fees will be assessed and paid by the customer.**
- **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 customer's 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, delivery/pickup, and any recurring rental charges for the equipment.

Signature:_____ Date:_____