Security Agreement

This agreement is entered into by Forbes Rehab Services, Inc. (Forbes AAC) and the customer listed below. The agreement defines the terms of an equipment loan requested by the customer.

Generally, loans are granted either to a Speech-Language Pathologist (SLP) or an End User. SLPs can request equipment for: 1) Single-case evaluations with an end user; or 2) Long-term placements for ongoing usage in AAC-intensive settings. End Users can request equipment to fulfill trial requirements set forth by their funding source, or at the discretion of their evaluating SLP.

Regarding Loans to End Users:

1. **Purpose**: Loans are available to End Users to fulfill funding requirements for an in-home trial, or at the discretion of the evaluating SLP.
2. **Availability**: Loans are available on a first-come, first-serve basis and are subject to approval by Forbes AAC
3. **Duration**: Equipment is available for a 2-week period unless the End User's funding source requires a trial of a different length.
4. **Security**: The customer must submit a credit card number as security to this agreement.
5. **Required Documentation**: Forbes AAC must receive all required documents prior to issuing a confirmation on the booking.
6. **Return**: Loans to end users must be return shipped on or before the date specified on their order. A $250 late fee will be imposed on orders not return shipped by their due date.
7. **Damages**: The customer agrees that extensive damages or total loss of equipment are the financial responsibility of the customer.

Regarding Loans to Clinicians:

1. **Purpose**: Loaned equipment is for the purpose of assessments with end users who plan on procuring their own AAC device, pending a successful evaluation. The device is to stay with the clinician and not go home with the end user.
2. **Availability**: Loans are available on a first-come, first-serve basis and are subject to approval by Forbes AAC.
3. **Duration**: The duration of the loan is generally 2 weeks but can be ongoing for AAC intensive clinics.
4. **Consideration**: Forbes must approve all requests and will do so on a case-by-case basis.
5. **Review**: For long term loans in excess of 4 weeks, Clinician agrees to provide (upon request) data pertaining to the usage of the device. Typically, data will be requested every 4 weeks.
6. **Timely Responsiveness**: Clinician agrees to respond in a timely manner to requests pertaining to the order.
8. **Return**: The order must be return shipped on or before the date specified on the order; however, it is mutually understood that Forbes may require that the device be returned at any time. A $250 late fee will be assessed if the order is not returned on the due date or upon reasonable request; an additional $250 fee will be assessed on a weekly basis until the equipment has been returned.
7. **Damages**: Customer agrees that extensive damages or total loss of equipment are the financial responsibility of the customer.

The below signature indicates that you understand and agree to the Terms and Conditions and authorizes Forbes to charge the credit card on file for late or damaged equipment:

Facility name/Customer name: _____ Type of customers: ☐ End User ☐ SLP

ASHA License # (For SLPs): _____ Driver's License Number: _____

By signing this document, you are agreeing to the terms listed above:

Signed: _____ Date: _____

Important: Your order is drafted but not yet booked. Upon receipt of the required documents and approval by Forbes, you will be issued an order confirmation that includes ship dates for your order.

Forbes AAC
181 Illinois Ave. South
Mansfield, OH 44905

phone 419.589.7688
fax 419.589.5146

FORBES AAC

forbesaac.com

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Equipment requested: ProSlate 4D ☐ ProSlate 8D ☐ ProSlate10D ☐ WinSlate ☐ WinSlate with Enable Eyes ☐

Shipping Information:

Name:

Relationship to Client: ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other:

Street Address/Facility (if applicable):

City: State: Zip:

Preferred Phone: Alternate Phone: Email:

Billing Information:

The Guarantor is responsible for equipment. A credit card number is required to ensure timely and safe return of loaned equipment. No charges will be processed against the credit card unless the equipment is not returned on the specified date or the equipment is lost, stolen or damaged.

☐ Visa ☐ MC ☐ Disc Credit Card# Expiration Date: CVV2 Code:

Name on Card:

Address:

City: State: Zip:

Signature of Card Holder:

02/07/22

FORBES AAC
A trade name of Forbes Rehab Services, Inc.

Release of Information / Assignment of Benefits

Acceptance of Services

I understand that by signing this agreement, I authorize provision of products and/or services to me by FORBES REHAB SERVICES, INC. I also understand that the products and services provided are prescribed by my Physician and recommended by my Speech Language Pathologist and that it is necessary that I remain under the supervision of my attending physician during the course of my care.

Same or Similar Equipment

☐No ☐Yes If "Yes", name and purchase date of speech generating device or accessories _____ . If "No" is checked, I acknowledge that I have never received the same or similar speech generating device or accessories from another durable medical equipment (DME) provider. If I have selected "Yes" and the purchase date is less than 5 years ago, then I understand that my insurance carrier may not cover the above named equipment and I may be asked to execute an Advance Beneficiary Notice.

Release of Information

I hereby authorize release of any and all of my medical records and other information pertaining to my medical history, services rendered, or treatments received from my physician(s) or hospital(s) to FORBES REHAB SERVICES, INC., the Health Care Financing Administration, my insurance carrier(s), or other medical entity. In order to process insurance claims, I also hereby authorize FORBES REHAB SERVICES, INC. to furnish to an authorized distributor and/or the Health Care Financing Administration, my insurance carrier(s), or other medical entity, any medical history, services rendered, or treatment needed.

Assignment of Benefits

I authorize direct payment of insurance benefits by my insurance company, including Medicare if I am a Medicare Beneficiary, be made to FORBES REHAB SERVICES, INC. In the event that my insurance carrier does not accept "assignment of benefits", I understand that payments may be sent directly to me and that I am legally obligated to endorse and directly send such payments to FORBES REHAB SERVICES, INC. within 10 days of receipt, for payment of my bill.

Financial Responsibility

I understand that I am responsible to FORBES REHAB SERVICES, INC. for all charges not covered by my insurance. I recognize that in the event that my insurance company, employer, or any other third party payer refuses to pay the rental and/or purchase price(s) of the above items, or delays payment beyond 90 days of my receipt of items, or in the event that I have no insurance coverage or third party payer, that I will be responsible for said payments and will make prompt reimbursement within 30 days of notification by FORBES REHAB SERVICES, INC. for all charges. THIS DOES NOT APPLY TO MEDICAID RECIPIENTS.

Medicare Recipients Only

I certify that I AM NOT receiving in home or facility based hospice care, skilled nursing care or hospital based care. I also understand that if the Medicare part B claim denies payment due to enrollment in the above listed types of care, I assume full responsibility for the cost of all equipment and services provided by FORBES REHAB SERVICES, INC.

Cancellation Policy

Order cancellations after billing services have commenced and prior to shipment of the order, will incur a cancellation fee calculated as the greater of 10% of the invoiced amount or $750. Any claim payments received from the insurance provider(s) must be promptly returned to Forbes Rehab Services for claim cancellation.

I acknowledge I have received the following information as separate inserts:

Forbes AAC Mission & Purpose Statement
Client Complaint Procedure
Client Rights and Responsibilities
HIPAA Privacy Practices Notice Availability of Equipment
Forbes AAC Contact Information
JCAHO Information
Forbes AAC General Warranty Information
Return Policy
Operating Instructions and additional training materials

Please sign and date and to Forbes AAC via fax at 419.589.5146, or email to:

Forbes AAC
181 Illinois Ave. South
Mansfield, OH 44905

I ACKNOWLEDGE AND UNDERSTAND THE ENTIRE CONTENTS OF THIS DOCUMENT AND REFERENCED DOCUMENTS:

Client's Printed Name _____ Signature or Mark (X) of Client _____ Date _____

If the beneficiary is only able to sign by making a mark (X), a witness must enter his/her name and address below.

Printed Name of Witness _____ Address of Witness _____

If the beneficiary is physically or mentally unable to make a mark or signature, an authorized representative may sign on the beneficiary's behalf. In this case, the representative should print the beneficiary's name above and complete the following information, which we are required to have on file.

Signed for the beneficiary by: _____ Signed & Printed Name of Representative _____ Address of Representative

Signed for the beneficiary by: _____ Reason beneficiary cannot sign: _____ Date _____

Client Information Form

This Client Information Form is used to facilitate the funding process through Forbes AAC, a trade name of Forbes Rehab Services. The information provided will be kept confidential. Please note that all requested information is necessary for Forbes Rehab Services to properly assist with the funding process. In order to ensure timely processing, please complete the ***entire*** Client Information Form. If you have any questions, please contact the Funding Department at 419.589.7866

email or **FAX completed form to:**

Forbes Rehab Services, Inc.
181 Illinois Ave. South
Mansfield, OH 44905
fax 419.589.5146
funding@forbesaac.com

Client Information – The client is the individual for which funding is being pursued.

Name Phone

Address Date of Birth

City State Zip SSN

Sex Male Female

Have you applied for or are you receiving in home or facility based hospice care, skilled nursing care or hospital based care?
No Yes

Have you ever owned a Speech Generating Device? No Yes, age of previous device

Place of Residence

Home Group Home Nursing Home Long Term Care Facility Other

Evaluating Speech Pathologist – This is the SLP that completes the Evaluation and Speech Evaluation Report.

Name Phone

Facility Alt Phone

Address Fax

City State Zip Email

Personal Advocate – This is an individual representing the client in a non-professional manner.

Relationship to client: Parent Guardian Spouse Other

Name Home Phone

Address Work Phone

City State Zip Email

Professional Advocate (Optional) – This is an individual representing the client in a professional manner.

Relationship to client: Assisting Speech Pathologist Case Manager Other

Name Home Phone

Address Work Phone

City State Zip Email

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Referring Physician Information – This is the medical doctor who is prescribing the equipment.

Physician Name | Phone | Fax

Funding Sources / Insurance Coverage – **BOTH Primary and Secondary insurance providers are required for funding. If both are not present at time of application it could significantly delay the funding approval process, and in many cases cause the process to start over. Both FRONT AND BACK of all cards need to be present to make sure the funding application is submitted correctly.**

Insurance Company Name

Policy Holder's Information - Primary

Name | Phone

Address | Fax

City | State | Zip | Policy holder date of birth

Social Security Number | Policy Holder's SSN

Name of Employer | Policy/Contract ID #

Group # | Policy Holder Relationship to Client

Insurance Company Name

Policy Holder's Information - Secondary

Name | Phone

Address | Fax

City | State | Zip | Policy holder date of birth

Social Security Number | Policy Holder's SSN

Name of Employer | Policy/Contract ID #

Group # | Policy Holder Relationship to Client

Delivery or Shipment Contact – This is the contact for shipment and delivery of equipment (PO boxes not allowed)

*Medicare requires equipment to be shipped to Client's Residence

☐ Client ☐ Evaluating SLP ☐ Personal Advocate ☐ Professional ☐ Other (list below)

Contact Name | Advocate Phone

Address | City | State | Zip

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Mansfield, OH 44905

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fax 419.589.5146

FORBES AAC
forbesaac.com

Email Updates – The email addresses listed below will be included in funding email updates. If this section is left blank, all email address associated with the funding packet will receive updates.

Name & Relationship to Client	Email
Name & Relationship to Client	Email
Name & Relationship to Client	Email

Notes –

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