

## RENTAL EXTENSION AGREEMENT

## PATIENT INFORMATION:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Delivery comments: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (Month/Day/Year)

(for Patient identification purposes only)

Do any of the following apply?  No  Yes

- Patient is under the age of 18
- Patient has a legal guardian
- Patient has a personal representative

## EMERGENCY CONTACT:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

 Patient declined to provide emergency contact. (check if applicable)FINANCIALLY RESPONSIBLE PARTY: (REQUIRED IF: Patient is **under the age of 18** or if the patient has a **legal guardian or personal representative**)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

## STATEMENT OF CHARGES FOR EXTENSION Anticipated charges are as follows:

Commercial and Auto/PI	\$ _____/day	\$60 - Cash / \$70 - Commercial and Auto/PI - Mark <b>N/A</b> if using bundled rate.
Number of rental days	_____	
Total rental fee	\$ _____	The bundled rental rate is \$ _____ for _____ weeks. Rentals are all-inclusive (1 Control Unit, 1 Wrap and 1 Carry Bag). Should you need additional wraps, they can be added to your order at an additional cost of \$50.00 per wrap/week (additional wraps must also be listed on the prescription).
Deposit (if applicable)	\$ _____	This amount is to be paid by you upon delivery of the Product, and will be credited to the outstanding balance. This amount may be reimbursed to you in whole or in part according to the policy outlined below.
TOTAL AMOUNT DUE	\$ _____	Your insurance company may be billed this amount. (This does not apply to Cash/Self-Pay orders.)

## PATIENT or FINANCIALLY RESPONSIBLE PARTY SIGNATURE:

By signing below, I agree to the terms and fees set forth above and authorize CoolSystems, Inc. d/b/a Game Ready, to charge my credit card for the charges specified above.

Cardholder Name (print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Card Type (choose one):  Visa  Mastercard  Amex  Discover Last 4 Digits of Card Number: \_\_\_\_\_ Check #: \_\_\_\_\_

## PLEASE SUBMIT CHECK PAYMENTS TO:

CoolSystems, Inc.  
P.O. Box 39000  
Dept 34678  
San Francisco, CA 94139-0001

CoolSystems, Inc. Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(AGREEMENT CONTINUED ON BACK PAGE)

**NOTE:** The above charges may be subject to additional taxes in accordance with your city/state taxes for Durable Medical Equipment. Your local representative can assist you.

**PRESCRIBED EQUIPMENT:** CoolSystems, Inc., d/b/a Game Ready provides the Game Ready® Injury Treatment System which has been recommended and prescribed for you by your doctor. Accepting the doctor's recommendation is your choice, and by signing this Notice of Financial Responsibility and Assignment of Insurance Benefits, you agree to the terms set forth below.

**HEALTH INSURANCE CLAIMS - TERMS & CONDITIONS:** If you have insurance, CoolSystems may, at its discretion and as a courtesy to you, bill your insurance carrier for the total costs of renting this Product. Your insurance plan may or may not cover all of the cost of the use of the Product. In the event your insurance pays 100% of the billed charges or if the combined sum of payments made by both the insurance provider and you exceeds 100% of the total billed charges, including the payment of deductibles and share of cost percentages, CoolSystems will refund any such excess amount to you up to the amount previously paid by you. To the extent your insurance does not pay the charges for your use of the Product, you (or the undersigned) agree to be personally and fully responsible for payment of the charges set forth above. You bear ultimate financial responsibility for the charges, including personal injury cases, regardless of the outcome of litigation. In the event that the claim is denied, you (or the undersigned) agree to pay any unpaid balance, notwithstanding any appeal of such denial.

By signing below, the patient, the personal representative (if applicable), and the financially responsible party (if applicable), acknowledge financial responsibility for the rental of the Product and agree to the Terms and Conditions above.

**TO BE COMPLETED BY GAME READY REPRESENTATIVE:**

**ORIGINAL RENTAL INFORMATION:**

GAME READY RENTAL UNIT    Unit Serial Number: \_\_\_\_\_  
Original Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

**EXTENSION EQUIPMENT AND ACCESSORIES:**

GAME READY RENTAL UNIT    Unit Serial Number: \_\_\_\_\_

Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_ Number of Weeks: \_\_\_\_\_

<input type="checkbox"/> Ankle	<input type="checkbox"/> L	<input type="checkbox"/> XL	<input type="checkbox"/> Flexed Elbow	TRAUMATIC AMPUTEE	
<input type="checkbox"/> Articulated Knee			<input type="checkbox"/> Half Leg Boot	<input type="checkbox"/> Above-the-Knee	
<input type="checkbox"/> Back			<input type="checkbox"/> Full Leg Boot	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> C-T Spine			<input type="checkbox"/> Hand/Wrist	<input type="checkbox"/> Below-the-Knee	
<input type="checkbox"/> Cooling Vest			<input type="checkbox"/> Hip/Groin	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Cryo Cap			<input type="checkbox"/> Knee	<input type="checkbox"/> Utility	
<input type="checkbox"/> Elbow			<input type="checkbox"/> Shoulder	<input type="checkbox"/> Left	<input type="checkbox"/> Right
				<input type="checkbox"/> M	<input type="checkbox"/> L

**PAYMENT TYPE:**     Private Insurance     Patient Self Pay     Worker's Compensation     No Fault Auto  
                           TriCARE Active Duty Military     Veterans Affairs     Demo

CoolSystems, Inc. Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_