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

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

Signed:

181 Illinois Ave. South Mansfield, OH 44905



Date:



181 Illinois Ave. South Mansfield, OH 44905

phone 419.589.7688 fax 419.589.5146

Equipment reques	ted: ProSlate 6D	ProSlate 8D	ProSlate10D	WinSlate	WinSlate with Enable Eyes			
ProSlate 13D	ProSlate13 with EnableEyes							
Keyguard (specify the vocabulary and grid size):								
Shipping Information:								
Name:								
Relationship to C	lient: Spouse	Parent	Legal Guardian	Other:				
Street Address/Facility (if applicable):								
City:		State:		Zip:				
Preferred Phone	:	Alternate Ph	none:	Email:				

02/17/25



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 supe	ervision of my attending physician during the course of my care.	
Same or Similar Equipment No Yes If "Yes", name and purchase date of acknowledge that I have never received the sa (DME) provider. If I have selected "Yes" and the the above named equipment and I may be asked	me or similar speech generating device or accessories from another dur purchase date is less than 5 years ago, then I understand that my insura	rable medical equipment
treatments received from my physician(s) or ho carrier(s), or other medical entity. In order to pu	medical records and other information pertaining to my medical history, ospital(s) to FORBES REHAB SERVICES, INC., the Health Care Financing Acrocess insurance claims, I also hereby authorize FORBES REHAB SERVICE inancing Administration, my insurance carrier(s), or other medical entity	Iministration, my insurance S, INC. to furnish to an
REHAB SERVICES, INC. In the event that my insu	s by my insurance company, including Medicare if I am a Medicare Bene arance carrier does not accept "assignment of benefits", I understand the endorse and directly send such payments to FORBES REHAB SERVICES,	at payments may be sent
my insurance company, employer, or any other payment beyond 90 days of my receipt of items	EHAB SERVICES, INC. for all charges not covered by my insurance. I recombined third party payer refuses to pay the rental and/or purchase price(s) of the solution of the event that I have no insurance coverage or third party payer, the ement within 30 days of notification by FORBES REHAB SERVICES, INC. for	he above items, or delays that I will be responsible for
	ility based hospice care, skilled nursing care or hospital based care. I also enrollment in the above listed types of care, I assume full responsibility f CES, INC.	
	ommenced and prior to shipment of the order, will incur a cancellation to the promptly im payments received from the insurance provider(s) must be promptly	
	ng information as congrete inserts:	Please sign and date and
I acknowledge I have received the following		to Forbes AAC via fav
Forbes AAC Mission & Purpose Statement Client Complaint Procedure	Forbes AAC Contact Information JCAHO Information	at 419.589.5146, or email to:
Client Rights and Responsibilities	Forbes AAC General Warranty Information	Forbes AAC
HIPAA Privacy Practices Notice Availability of	Return Policy	181 Illinois Ave. South
Equipment	Operating Instructions and additional training materials	Mansfield, OH 44905
I ACKNOWLEDGE AND UNDERSTAND THE	ENTIRE CONTENTS OF THIS DOCUMENT AND REFERENCED DOC	UMENTS:
Client's Printed Name If the beneficiary is only able to sign by making a ma	Signature or Mark (X) of Client ark (X), a witness must enter his/her name and address below.	Date
Printed Name of Witness	Address of Witness	
	make a mark or signature, an authorized representative may sign on the benefir's name above and complete the following information, which we are required	=
Signed for the beneficiary by:Signed & Printed Name	of Representative Address of Representative	ve

Reason beneficiary cannot sign:

Date

Signed for the beneficiary by: ___

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

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

Assisting Speech Pathologist

Zip

State

Name Phone Date of Birth Address 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? 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 Alt Phone **Facility** Fax Address City State Zip **Email** Personal Advocate – This is an individual representing the client in a non-professional manner. Other Relationship to client: **Parent** Guardian Spouse Name Home Phone **Work Phone** Address City State Zip **Email** Professional Advocate (Optional) – This is an individual representing the client in a professional manner.

Case Manager

Home Phone

Work Phone

Email

Other

Forbes AAC

Name

City

Address

181 Illinois Ave. South Mansfield, OH 44905

Relationship to client:



1 of 3

email or FAX completed

Forbes Rehab Services, Inc.

181 Illinois Ave. South

Mansfield, OH 44905

fax 419.589.5146 funding@forbesaac.com

form to:

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

Physician Name Phone

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

Phone Name

Address Fax

State Zip City Policy holder date of birth

Policy Holder's SSN Social Security Number

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 State Zip City

2 of 3



181 Illinois Ave. South Mansfield, OH 44905





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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Forbes AAC

181 Illinois Ave. South Mansfield, OH 44905

phone 419.589.7688 fax 419.589.5146

