

Hospital Bed Hire Form

Patient Information:

- Full Name: _____
 - Date of Birth: _____
 - Gender: _____
 - Address: _____
 - City: _____
 - State/Province: _____
 - ZIP/Postal Code: _____
 - Phone Number: _____
 - Email Address: _____
-

Bed Rental Information:

- Type of Bed Required (check one):
 - Standard Hospital Bed
 - Adjustable Hospital Bed
-

Rental Duration:

- Start Date of Rental: _____
 - End Date (if known): _____
 - Total Duration (in months): _____
-

Delivery Details:

- Delivery Address (if different from above): _____
 - Preferred Delivery Date and Time: _____
 - Contact Person for Delivery (if different from patient): _____
 - Phone Number of Contact Person (if applicable): _____
 - Transport Fee: 350 ZAR (to be paid before delivery)
-

Billing Information:

- Billing Address (if different from patient's address): _____
- Name of Responsible Party for Payment (if applicable): _____
- Phone Number of Billing Contact: _____
- Email Address for Billing: _____

Payment Terms:

1. A deposit of R500, one month's rental, and the R350 transport fee must be paid upfront before the bed is delivered.
2. The monthly rental charge will be billed at the start of each rental period.

Terms and Conditions:

1. The bed is for temporary use only, and all rental charges will be applied based on the rental duration (monthly).
2. The patient or responsible party is responsible for the bed's safe usage and return in the same condition as it was delivered.
3. Any damages or missing equipment will be charged accordingly.
4. A deposit (if applicable) will be required at the time of rental.
5. Rental charges are billed on a monthly basis and are due at the start of each rental period.
6. **Banking Details for Payment:**
 - o **Account Name:** AY Saul
 - o **Bank Name:** ABSA
 - o **Account Number:** 4115946537
 - o **Branch Code:** 632005
 - o **Reference:** Patient's Surname

Signature:

- **Patient's or Responsible Party's Signature:** _____

- **Date:** _____