



Rental Agreement & Physician's Prescription for ArtAssist®...The Arterial Assist Device®

This agreement is between ACI Medical, LLC (hereafter called ACI) and the Renter of the equipment named below (hereafter called Renter). I/we agree as follows.

Renter's Name:	Telephone Number:	
Shipping Address:	City, State, Zip:	
Email Address:		
Credit Card #:	Exp. Date:	CVV#:
Name on Credit Card:		
Billing Address (If different from address above):		

Please (✓) check a Rental Plan:

Month-to-month Rental Plan

Renter agrees to rent the ArtAssist® Device (hereafter called ArtAssist or Device) from ACI using the credit card number provided above at the rental rate of \$700 for the first month (\$800 for bilateral type) and \$500 for each month thereafter, in one-month incremental payments, paid automatically in advance for each month, without prorating. The rental month starts on the date of delivery of the Device and continues to the same date of the following month. The Device must be picked up from Renter for immediate shipment to ACI by the last day of the rental month to avoid charges for the next month. Some states may be charged sales tax. Prices include ground shipping.

Type of ArtAssist® (for month-to-month rental plan): *Single Limb (Unilateral)* -OR- *Two Limbs (Bilateral)*

3-Month Rental Plan

Renter agrees to rent the ArtAssist Device from ACI using the credit card account provided above for \$1350 total, for three months rental, payable in advance. The rental period starts on the date of delivery of the Device and continues to the same date of the following third month. Renter may continue renting the Device for \$450 for each month thereafter, in one-month incremental payments, paid automatically in advance for each month, without prorating. The Device must be picked up from Renter for shipment to ACI by the last day of the rental period to avoid charges for the next month. Sales tax applies in some states. Price includes ground shipping.

The purchase price of the ArtAssist Device is \$5950.00 (bilateral). Renter may purchase the Device with 50% of all rental payments applied to the purchase price. Price includes ground shipping.

Renter agrees to notify ACI immediately if the credit card number provided above becomes invalid or is canceled or has insufficient credit limit for the next scheduled payment. Renter agrees to keep all packing materials and to use them to return the Device including accessories to ACI by using the return label sent with the Device. To arrange for pick-up of the Device, Renter will telephone ACI Medical customer service at the toll-free number **888-453-4356**. Components that are missing or damaged will be charged to the Renter.

Renter agrees to contact his/her physician immediately upon noticing any changes in skin condition at or near the sites of the cuff set, including but not limited to any rash, redness, blisters, etc. Renter agrees to look at the sites carefully before and after each use of the Device and to follow all instructions supplied with Device or as modified by Physician's prescription or instructions. Renter further agrees that the Device will not be used for any other person nor for any other purpose than as prescribed by the Physician. Renter also agrees to return the Device to ACI promptly after Physician orders discontinuation of its use.

Renter agrees to pay for all ACI's collection fees, costs and charges to settle any outstanding charges of account with ACI, including costs of repossession for nonpayment of rent. Renter agrees to allow ACI to pick-up or reposes the Device at ACI's sole discretion.

ACI Medical, LLC. • 1857 Diamond Street, San Marcos, CA 92078 USA

(T) 888.453.4356 • (F) 760.744.4401 • (E) info@acimedical.com • ArtAssist.com



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Proper use of the Device is to be monitored by Renter and Physician, and not by ACI. If the Device seems to be ineffective or causing problems, Renter agrees to consult with Physician. Renter agrees to rely upon Renter's Physician, and not ACI, for all advice concerning use of the Device. ACI only provides the Device to Renters who agree to have active and continuous follow-up care by properly licensed Physicians. Renter will call ACI Service Department at 888.453.4356 or the designated local representative if device malfunction is suspected.

No guarantees are made by ACI as the effectiveness of the Device. Renter agrees to hold ACI harmless from any liability concerning the use or effectiveness of the Device and Renter agrees that ACI is not responsible for improper use or for misuse of the Device. Any disagreement concerning this Agreement shall be construed under the laws of the State of California, County of San Diego.

NOTE: ACI Medical is NOT a Medicare provider. Renter understands that they must submit his or her own claim to Medicare or to their private insurance company and that ACI Medical does not accept assignment. Renter agrees to pay for these items or services even if Medicare or private insurance denies the claim. Renter understands that ACI is not a Medicare provider and has never been a Medicare provider. Renter understands prior to rental or purchase, that ACI Medical cannot submit a claim to Medicare or to private insurance companies on the Renter's behalf.

The signatures below signify that I/we have read and understand this agreement, and that I/we agree to be legally bound by it.

(Double click on signature box to add signature or print, sign, and date.)

X

ACI Medical Representative

X

Buyer

Print Name & Date

Print Name & Date

Physician's Prescription

This is a prescription for the ArtAssist® device, model AA-1000

Print Patient's Name

Patient's Telephone Number

Indication / Medical Necessity: Intermittent Claudication Rest Pain Tissue Loss Limb Salvage

Patient Instructions:

1. Apply to: Both Legs Right Leg Left Leg
2. Use one hour at a time (or _____ at a time)
3. Use three times per day (or _____ times a day)

Physician's Signature

Date

Physician's Telephone Number

Print Physician's Name

State

License

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