Diamond
MEDICAL EQUIPMENT & SUPPLY, INC.

300 South Rodney Parham
Ste 16
Little Rock, AR 72205
501-225-3106
Info@diamondmedical-ar.com

MEDICAL EQUIPMENT RENTAL AGREEMENT

Name of Renter: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone # _____ Email: _____

Patient Info (Person using the equipment):

Name: Pennie Lewis _____ DOB: ___/___/___

Height: ____ FT ____ IN ____ Current Weight: ____ lbs

Equipment Rented? _____Rate: $_____/Week or Month

SN#_____ Date of rental: _____ Est date of return: _____

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize ***DIAMOND MEDICAL EQUIPMENT AND SUPPLY*** to charge my credit card automatically if item is not returned by the date listed above for agreed upon rental price. I understand that my information will be saved to file for future transactions on my account. I agree to return the above listed equipment in the same condition as it was received. Diamond Medical shall NOT be responsible or liable for any loss or damages. Renter assumes all risk and liability for any loss, damage or injury, including death, to persons or property of Renter, Patient, or others arising out of the use or operation of the medical equipment.

_____ _____

Customer Signature Date