ABLE BIONICS USA

Bridging Bionics FOUNDATION

2019 PROGRAM PAYMENT FORM

All Clients:

Please complete the following information so we can update our client records.
We maintain client confidentiality for all information. Thank you.

Name: _____

Street Address: _____

_____

Mailing Address if different from Street Address: _____

_____

County of residence: _____
(For example: Pitkin County)

County of work: _____

Contact Phone: _____

Email Address: _____

Date of Birth: _____

US Citizen: Yes _____ No _____

Driver's License ID: _____ OR Other Government Issued ID: _____

Annual Client Program Fee Payment

The value of program services rendered to you is $500.00 and you are not entitled to claim a charitable contribution deduction for this amount. Scholarships are available upon request.

☐ I have enclosed a check for $500 for my annual program fee.

☐ Please charge my credit card $500 to cover the cost of my annual program fee.

☐ Please charge my credit card a monthly fee (to be determined per individual) until my $500 annual program fee has been met. We will call you to verify details.

Name: _____

Billing Address: _____

_____ Zip Code: _____

Credit Card: VISA _____ MASTERCARD _____ DISCOVER _____

CC #: _____

Expiration Date: _____ Security Code: _____

*** <u>All clients are required to complete a 2019 Waiver and update the Client Information Form and Medical Release if necessary.</u>**

If you are currently a client for the Able Bionics USA program and *you have had a change in your health condition or if you have a change in medications, please provide an update here:*

_____

_____

_____

_____

<u>Healthcare</u>

The following information is helpful for us to know, as the Able Bionics USA program is a charitably funded initiative. We recognize that Medicare/Medicaid and some insurance companies currently do not reimburse for Galileo Training Systems or exoskeleton therapy.

Do you have health insurance? _____ Yes _____ No

Name of Insurance: _____ Policy type: _____

Do you have Medicare/Medicaid? _____ Yes _____ No

1. *Medicare is a federal program that provides health coverage if you are 65 or older or have a severe disability, no matter your income.*
2. *Medicaid is a state and federal program that provides health coverage if you have a very low income.*

If you are eligible for both Medicare and Medicaid (dual eligibility), you can have both.

Name of person filling out application: _____

Relationship to Applicant: _____

Signature: _____ Date: _____

<u>Please mail this form to:</u> Bridging Bionics Foundation, PO Box 3766, Basalt, CO 81621