



2024 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/Eagle County/Garfield 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: _____



*** All clients are required to complete a 2023 Waiver and update the Client Information Form and Medical Release if necessary.**

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

Healthcare

The following information is helpful for us to know, as the BBF 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: _____

**Please email this form to: Amanda@bridgingbionics.org
OR mail to Bridging Bionics Foundation, PO Box 3766, Basalt, CO 81621**

BRIDGING BIONICS FOUNDATION is an IRS designated 501(c)(3) public charity: EIN# 46-2182977
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www.bridgingbionics.org