SAMPLE AGREEMENT FOR HOME HEALTH SERVICES

This agreement is made this _____ day of _____, _____, by and between _____("client") residing at _____ and _____, which is located at principal address _____. Now therefore in consideration of the promises and mutual covenants contained herein, the parties hereto, intending to be legally bound, agree as follows:

I. CONSENT FOR CARE/SERVICE TO BE PROVIDED

_____ agrees to provide nursing services and assistance to the Client consistent wit the medical plan prescribed by the Client's treating physician and accepted by the Client. The services will be provided in accordance with currently accepted methods of practice in the community and a practitioner with a current license and registration to practice in the State of _____. A representative of _____has explained my plan of care and all of my questions have been answered satisfactorily. I understand that I and/or my family/caregiver will receive instructions to assist with my care and that my care will therefore become my responsibility in the absence of _____ staff in my place of residence. I agree to notify my physician or others providing care of any adverse reactions or other significant events relating to my health.

II RELEASE OF INFORMATION

I hereby consent to and authorize _____ to disclose and release information contained in my clinical record to the health care providers involved in my care, third party payers, utilization review and professional standards review organizations, regulatory review entities and any other organizations, companies, community resources, etc, that may /will assist me to meet my home care and / or health needs.

III COMPENSATION FOR SERVICES

I certify that all information given by me to _____ is correct to the best of knowledge. I further understand that services provided to me by this organization will billed to the following:

1. My insurance company, please specify: Name of Insured
_____
Telephone No: _____
Contact Person: _____

2. Directly to my guarantor or me will be billed privately. Send billing to:
_____
_____

3. We are unable to verify coverage from your
4. insurance at this time of admission. I understand payment of benefits on my behalf by any and all third party payers.

IV ASSIGNMENTS OF BENEFITS

I hereby assign to _____ all insurance benefits and payments to which I entitled for services that are provided to me and I authorize provider to seek such benefits and payments on my behalf. It is understood that provider will bill insurers directly and that my assignment of benefits is ongoing and continuous unless cancelled by me in writing to insurer(s) providing a copy to the provider.

In considerations for services provided by _____, Client agrees to pay fees as follows:

A. FEE SCHEDULE Client shall pay for the services of _____ on an hourly basis according to a rate of time and a half if client request work on a holiday set forth by

_____. The hourly rate may be changed upon thirty (30) days written notice to the Client or legal representative. A billing statement will be provided to the Client each month and all fees charged are due within fifteen (15) days of receipt. If _____ payment is not received within 15 days you may be subject to interest accrual or late fees. Client shall provide a minimum of fourteen (14) days notice of any intent to discontinue the services of _____. _____ requires two (2) hours minimum notification prior to a scheduled visit. If notification is not given within stated time frame the Client agrees to pay a $ _____ cancellation fee.

B. TIME RECORDS _____ shall maintain time records. The Client shall promptly review and approve the time. Neglect by Client to review the time record will be considered an approval of the time submitted. Copies of time records may be provided upon request.

V LIMITATIONS OF LIABILITY

_____ is a nursing service providing direct nursing and personal care services by licensed and registered personnel to a Client in the home. _____ does not make legal or medical decisions for the Client and shall not be liable for any consequences accruing as a result of the legal or medical decisions made by the Clients, the client's legal representative or physician. Client hereby waives all claims against _____ for any damages or consequences of said legal or medical decisions.

In the event Client or Client's representative elect home care for the Client rather than care at a nursing or convalescent home which is contrary to the medical advice of Client's treating physician, _____ shall not be held responsible for any damages or the consequences of this decision.

VI LEGAL ATHORITY OF CLIENT

Please provide a copy of the following document(s):

Power of Attorney: Attorney in Fact: _____
Telephone No.: _____

Guardian: Name: _____
Authorizing Court: _____
Cause No.: _____

ADVANCE DIRECTIVE FOR HEALTH CARE

I have received an explanation and written information regarding advance directive from _____. I understand that is the policy of this organization to respect individual choice and to avoid discrimination based on whether or not I have an advance directive.

☐ I do not have an advance directive.

☐ I do have an advance directive.

VIII AUTHORIZATION FOR TRANSPORT

It is not the practice of _____ to provide transportation or services outside the residence of the Client. However, at the direction of Client or Client's legal representative, it may be necessary to transport Client, using Clients insured automobile, from Clients residence to _____. If client is unable to

provide an automobile, _____ employee may transport client in employees insured automobile and client will be charged $0.45 per mile to and from destination. _____ agrees to transport client to this destination only for said purpose. Client assumes al responsibility for any accident, injury or illness that may result from said instance away from residence and waives all claims against _____ and employee, occurring during said instance.

The undersigned hereby authorize _____ to transport client outside the residence.

Authorize Representative_____ Date _____

IX DEFAULT

In the event _____ engages an attorney for the recovery of any payments due under this agreement or for enforcement of any provision of this contract, Client and/or Guarantor agree to pay all cost and reasonable attorney's fees incurred by _____, whether or not a lawsuit is instituted.

NOTICE ABOUT PRIVACY

1. As a home patient, there are a few things that you need to know about our collection of our personal health care information.

- Federal and State governments oversee home health care to be sure that we furnish quality home health care services, and that you, in
- particular get quality home health care services. We need to ask you questions because we
- are required by law to collect health information to make sure that you get quality health care services.
- We will make your information anonymous. That

STATEMENT OF PATIENT PRIVACY RIGHTS

2. As a home health patient, you have the privacy rights listed below.

- You have the right to know why we need
- to ask you questions. We are required

1. You receive quality health care, and payment for Medicare and Medicaid patients is correct.

3. You have the right to have your personal health care information kept confidential. We keep anything we learn about you confidential. This means, only those who are legally authorized to know, or who have a medical need to know, will see your personal information.
4. You have the right to refuse to answer questions. We may need your help in collecting your health information. If you choose not to answer, we will fill in the information as best as we can. You do not have to answer every question to get services.
5. You have the right to look at your personal health information. We know how important it is that the information we collect about you is correct. If you think we made a mistake, ask us to correct it. If you are not satisfied with our response you can ask the Health Care Financing Administration, the federal Medicare and Medicaid agency, to correct your information.

X. ENTIRE AGREEMENT

I have received a copy and an explanation of the Patient/Client Rights and Responsibilities.

This admission agreement is applicable only to _____. I understand what I have read and what was explained to me and agree to the terms and conditions stated above.

XII. EFFECT OF AGREMENT

This agreement shall insure to the benefits and be binding on the parties and their heirs, legal representative, assignees, and successors of the parties.

In witness whereof, the parties have executed this agreement at _____, (State) _____ on the date written above.

HHA Hourly Rates: $ _____ per hour, 3 consecutive hours per day minimum. Registered Nurse Evaluation/Assessment $125.00 every 60 days. (This fee is waived if minimum of 9 hours per week is met.)

HH Visit Rate: $45.00 per visit, 3 visits minimum per week. Registered Nurse Evaluation/Assessment $125.00 every 6 days (this fee is waived if a minimum of 3 visits per week is met.

Day/Hours per Week _____

I hereby guarantee payment of all fees due for services provided to Client by _____ under the terms of the above agreement.

_____
Client or Clients Legal representative/Date

_____ Your company, title/Date