**PATIENT SERVICE AGREEMENT**

Heart Ablaze Care, LLC.

Please review this agreement carefully, as it sets forth the understanding between you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (“Patient”) and\_\_\_\_\_\_Heart Ablaze Care LLC. \_\_\_\_\_\_ (“Agency”) regarding the services you have requested and we will provide for you. If you have any questions, concerns or issues about the content of this Agreement please contact us for clarification before signing it.

THIS AGREEMENT made this \_\_\_\_\_ day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (“Effective Date”) by and between\_\_\_\_\_\_\_\_\_\_Heart Ablaze Care LLC.\_\_\_\_\_\_\_\_\_\_\_\_ (Agency).

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Name of Patient and/or Responsible Person***

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***City State Zip***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***Home Phone Cell E-mail***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Emergency Contact (s) name and relationship Phone Alternate Phone***

(“Patient”) on the terms and conditions set out below:

1. **Term of Agreement**. The term of this agreement will start on the Effective Date, and will on an as-needed basis until the Agreement is terminated by either party, as provided hereunder.
2. **Services Requested**. We will provide the services (“Services”) requested and agreed upon in the Services Request Form and as set out in the Care Plan enclosed. The preferred day, time and duration of services will be mutually agreed upon by you and/or your representative and the agency. Service Invoices will be sent to provided e-mail and address
3. **Rates, Fees and Deposits**. We will provide the services at the following rates if there is not an authorization from your Long Term Care or Private Insurance Provider. If there is an insurance provider you will not have to worry about the rates below:

Patient has authorization: \_\_ Yes \_\_ No, if yes, please provide below:

Authorization #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient does not have authorization from insurance company. The following rates are:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| $ | 4hr. care | 6hr. care | 10hr. care | 12hr. care | 24hr. care |
| Weekday | $ | $ | $ | $ | $ |
| Holiday Pay  |  |  |  |  |  |

The minimum shift length is 4 hours. Weekends begin at 7pm on Friday and end at 7am Monday morning. Holidays are billed at 50% greater than the above or “time-and-a-half”. Designated holidays are Christmas Day, Thanksgiving Day, Memorial Day, July Fourth, New Year’s Day and Labor Day. If multiple service types or hours are requested, or if the service request changes, the rates may change accordingly. Rates for services are subject to review from time to time, but increases will be subject to at least a four-week advanced notice. To accommodate the rates you have been quoted, we will manage your care in such a way that the employee does not work more than 40 hours in any Monday through Sunday time sheet period. If you would like a given caregiver to be assigned to work when it means they will be accruing overtime pay (and they are willing to work the overtime), you will be charged time-and-a-half.

1. **Deposits.** A deposit equivalent to two week’s service charge will be expected upon execution of this contract before the start of services. The agreed total deposit is $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. The deposits are non-refundable. **\*\*\*No Deposit is expected if you have insurance with authorization.**
2. **Billing.** The caregiver will fill out a time sheet daily. At the end of the caregiver’s work week (Monday to Sunday), you will be expected to sign the time sheet as acceptance of the hours service delivered. Please sign it promptly so the caregiver can be paid promptly. After the start of services, invoices will be sent weekly of every (Monday) after completion of each service period. Any questions regarding time sheets or your invoice should be directed to our office.
3. **Payment and Overdue Accounts.** Fees for services rendered are payable upon receipt of invoice. Payment may be made by check, money order or credit card. It is Heart Ablaze Care’s policy not to accept checks endorsed over to the agency. All payments must be remitted to the address noted above; direct care workers are not permitted to accept payment. An account is considered overdue if not paid within 10 days of the billing date. Interest will be charged on account balances which remain unpaid for 5 days or more after the same becomes due at the rate of 1.5 % per month (18 % per annum), until paid. We reserve the right to discontinue providing services until the account is paid in full, including any additional charges and accrued interest. A $35.00 returned check fee will be charged. Checks are to be made payable to Heart Ablaze Care, LLC.

Payment Options:

 \_\_\_\_\_**Weekly Payment** The payment is once a week. The billing cycle is on every Monday of the week. The first (1) week payment shall be due at the time of signing Patient Service Agreement Form and considered as the advanced payment.

 \_\_\_\_\_**Daily Payment** The payment is due at the time service. The (1) day payment shall be due at the time of signing Patient Service Agreement Form and considered as the advanced payment.

1. **Cancellations.** Cancellations may be made up to 24 hours in advance of a scheduled visit without charge. We reserve the right to charge for a scheduled visit if insufficient notice is not given. In the event that a referred caregiver fails to arrive at the care recipient’s home, we will make every effort to find a replacement as quickly as possible. If a replacement is not found or if the caregiver alters the predetermined weekly schedule in some way, we will adjust the amount that you are billed accordingly.
2. **Termination.** Either “Patient” or “Agency” may terminate this agreement upon two (2) calendar-week’s written notice to the other party. If either party terminates this Agreement, all fees due at time of termination will be due and payable by you immediately. Exception to the two-week notice provision would include:

a. When care needs undergo a change which necessitates transfer to a higher level of care.

b. When there is documented non-compliance of the Care Plan or Service Agreement (including, non-payment of justified charges).

c. When the activities or circumstances in the home jeopardize the welfare and safety of the home care aide. Patient or patient’s representative shall have the right to appeal the discharge decision during the two week notice period and will be notified of this in the discharge statement. The Appeal panel will be led by the Director of Care Services and include both the Supervisor and Caregiver. The panel will review the patient file with the patient or patient’s representative. The Director of Care Services decision is final.

1. **Agency’s Responsibilities**. \_\_Heart Ablaze Care, LLC.\_\_\_\_ responsibilities are outlined in “Rights and Responsibilities”.
2. **Patient’s Responsibilities**. Your responsibilities are outlined in the client handbook under “Rights and Responsibilities”.
3. **Light Housekeeping Defined**. The caregiver/employee is not required to provide a general housekeeping service. Typical “light” housekeeping tasks to be provided by the caregiver employee would include: tidying up of rooms in which the care recipient spends his/her time (bedroom, living room, kitchen), washing dishes after meals (wiping spills on sink or floor, “spot cleaning”), sweeping kitchen floor when needed, passing the vacuum in rooms used by care recipient, tidying bathrooms after use by care recipient (rinsing tub or shower after use, wiping spills on sink or floor). It is recommended that you hire an independent cleaning service for tasks such as scrubbing floors in kitchen and bathrooms, window or mirror washing, dusting behind and under furniture, drape cleaning and heavy laundry.
4. **Transportation.** Requested transportation services should be outlined in your Care Plan. A vehicle is not to be driven by the caregiver/employee without prior written authorization from the patient to the agency. \_\_Heart Ablaze Care, LLC.\_\_\_\_ insurance does not cover loss or damage caused by employees operating the patient’s owner or leased vehicle. The patient accepts full responsibility for any and all claims. If an employee of the Agency transports a patient in their own vehicle, company vehicle or the patient’s vehicle, the patient will release the Agency and/or that employee from all liability should an injury or accident occur. If the agency employee drives her/his own vehicle in order to perform services to the patient, the patient will be billed at $0.58 per mile (passed along in full to the caregiver). It is also your responsibility to pay for or reimburse the caregiver directly for any expenses incurred while providing services, such as tolls and parking, and the cost of food or entertainment undertaken as part of services. If the caregiver drives to your residence, a space safe from towing must be provided. If meters are to be used, then the caregiver must be allowed time to feed the meter at appropriate intervals. Such reimbursable expenses will be claimed by the caregiver and included in regular invoices.
5. **Private/Direct Hiring**. The overriding business relationship is strictly between you and \_\_\_\_Heart Ablaze Care, LLC.\_\_\_\_\_\_, and by agreeing to this proposal you are confirming to us that you will abstain from making or accepting any offers whereby any of the caregivers/employees we have referred to you would provide services other than as sanctioned by\_\_\_\_Heart Ablaze Care, LLC.\_\_\_\_\_ (whether you still have an ongoing relationship with\_Heart Ablaze Care, LLC.\_ or not) for a period of two years after the date of the final fee that you pay to us. If you violate this provision, you will immediately pay\_Heart Ablaze Care, LLC.\_ a sum of $10,000 for each affected individual/employee.
6. **Insurances.** We will maintain worker’s compensation insurance coverage for all full time caregivers/employees, and they will be bonded. In good faith, you agree to maintain homeowner’s insurance, medical insurance and/or other coverage as may be necessary to provide protection for the care recipient.
7. **Severe/Bad Weather**. In severe weather, we may determine it is not safe for our Home Care Workers to travel and provide services to your home that day and may have to cancel that day’s service. When this occurs we will notify you and reschedule. We appreciate your understanding regarding this matter.
8. **Services Provided**. The services that will be provided are:

\_\_ Personal Care \_\_ Respite \_\_ Adult Companion \_\_ Homemaker \_\_ Companion \_\_ Assistive Care \_\_ Private Duty Service \_\_ Personal Supports

**Hours or Frequency of Service**. \_\_\_\_\_ Hours/Units \_\_\_ Frequency (ex. 2hr per week for 2 weeks)

1. **Advance directives**.(*Please see your client handbook for more information on Advanced Directives.)*
2. **Indemnifying Clause.** The undersigned fully understands that the provider (a) is a non-medical provider, (b) is not licensed to preform medical services, and (c) undersigned, indemnifying, jointly, and severally hereby forever release and discharge, acquit, and forgive any and all claims, actions, suits, demands, liabilities, judgments, and proceedings both at law and in equity, arising from the beginning of time to the date of termination of this agreement with the Agency Provider such as caused directly by the negligent acts omissions by the above items and “Services” and the “agency’s caregivers” in which results to bodily injury or property damage. This lease shall be biding upon insured to benefit the parties, their successors, and assigns and personal representatives.
3. **Attorney Fee.** In any case of litigation, in preventing party the “Agency Provider” shall recover the cost and attorney’s fees arising from any lawsuits brought against the agency.

Your signature and /or your representative’s signature below indicate that you and/or your representative have read, understand and are in agreement with the terms and conditions of this Service Agreement.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Patient’s Representative Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency Authorized Signature and Position Date