Caregiver Pro Homecare, Inc.
12201 Liberty Ave, 2FL, Richmond Hill, NY 11419
Phone:(718)-504-8054 Fax:(866)220-5663

SERVICES CONSENT/STATEMENT OF SERVICES AND CHARGES
RELEASE OF INFORMATION/ACKNOWLEDGEMENT

Client: _____

( ) I authorize the staff to provide services, as requested by myself/representative and ordered by my physician. Services provided by Caregiver Pro Homecare, Inc. may include nursing, home health aide, personal care aide, social worker, dietician/nutritionist, physical therapist, speech therapist, occupational therapist, audiologist, respiratory therapist, homemaker, and housekeeper.

( ) The services provided by Caregiver Pro Homecare, Inc. will have been explained to me and I understand that I may refuse treatment within the confines of the law after being informed of the consequences of my action.

( ) I give my consent and authorization for release of medical information to Caregiver Pro Homecare, Inc. by physician and other health care provider facilities.

( ) I authorize Caregiver Pro Homecare, Inc. and other licensing/regulatory bodies to periodically examine my medical record for the purpose of checking compliance to the applicable rules, regulations, and standards.

( ) I understand that it would be prudent and in my best interest to establish a Home Health Service Plan of Care in the event of an emergency such as a fire, hurricane, severe snowstorm, or other natural disaster. Therefore, I hereby grant Caregiver Pro Homecare, Inc. permission to reveal to any governmental agency, supplemental provider agency, community volunteer service, or any other providers of services, medical records regarding my nursing care, except where otherwise prohibited by law. I further understand this would be done as necessary, upon request, in order to ensure a safe and effective emergency preparedness plan of care.

( ) I acknowledge receiving verbal and written information concerning my **Rights and Responsibilities** as a home care client and the **NYS Proxy Law/Advance Directives.** In addition the agency has provided a *written procedure for submitting complaints and concerns, and directions regarding contacting the agency after hours, on weekends, and holidays.*

Service	Frequency	Hourly Fee	Weekend/Holiday Fee	Expected Insurance Coverage	Patient's Financial Responsibility
PCA / HHA		N/A	N/A	100%	0%

* See Agency's Rate/Fee Sheet

( ) I agree that I (or my representative) shall be directly responsible for payment for all home care services provided according to this service agreement. I understand that the invoices are rendered weekly and payable upon receipt. Late payments over 30 days will result in a 1.5% late fee charge per month.

( ) I agree to pay a sum of $2500.00 in damages to reimburse Caregiver Pro Homecare, Inc. for the cost of recruiting, hiring, and training, if I directly employ an employee of the company that has provided services within six months of services.

Client/Representative Signature: _____ Date: _____