Service Agreement and Consent for Care

Client Name: _____

Consent for Care:
I consent to receive care and services from Breakthrough Resources, in accordance with the home care plan of care developed with my input and consent, and in accordance with services authorized by my Payer, or in the case of managed care those services developed and authorized by my case worker.

Authorization for Payment of Services:
I authorize Breakthrough Resources, to bill for services provided to me and to receive payment from (check applicable payer source)

- ❑ Private pay hourly services
- ❑ Private pay live-in services
- ❑ Other _____

Private Pay Charges:

- ❑ Hourly charges for private pay home care service
  $_____ per hour
  - The minimum number of hours of service are _____
  - The agency charges time and one half when services are requested on holidays
  - 24 hours notice is required for cancellations of service hours to avoid a minimum change
- ❑ Charges for private pay live-in service

$_____ per 24 hour shift

- All live-in service requires a deposit of one week charges at the signing of this consent agreement. The amount of the deposit is $_____. The deposit will be applied to Breakthrough Resources Home Care Agency's, last invoice for service.
- The agency will charge time and one half when home care services are requested on agency holidays. The charge per hour will be $ _____.

The home care services provided to me by Breakthrough Resources will be in accordance with my needs, and the home care plan of care developed in consultation with me, or my representative. Breakthrough Resources Home Care Agency, will bill me on a twice monthly basis for any private pay services, or any co-payments required by agreement with my third party payer. I agree to pay all invoices with in ten (10) of receipt.

Payment and Overdue Accounts:
Fees for services rendered are payable upon receipt of invoice. Payment may be made by check, money order, cash or credit card. 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 10 days or more after the account becomes due at the rate of 1½% per month 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 $28.00 returned check fee will be charged. Checks are made payable to Breakthrough Resources.

Cancellations:
Cancellations may be made up to one (1) day in advance of a scheduled visit without charge. We reserve the right to charge for a scheduled visit if insufficient notice is not given.

Termination:
The "Agency" may terminate this agreement at any time upon written notice to the other party. The one exception is if staff is concern for staff safety. The "Client" may terminate this agreement upon notifying the agency. If either party terminates this Agreement, all fees due at time of termination will be due and payable by you immediately. The agency will immediately refund any prepaid fees.

Client Complaints:
Agency staff will listen attentively and courteously to complaints expressed by clients, or client representative, seek to clarify and understand the nature of client complaints, Encourage clients to contact the Administrator or designee regarding complaints that cannot be resolved by agency staff, Report complaints directly to the Administrator or designee.

The Administrator or designee will review all client and client representative complaints as they are received, Seek to clarify and discuss complaints with appropriate staff, contact the client or client representative to seek clarification regarding the complaint, initiate as soon as reasonable a problem solving process to resolve the complaint, evaluate and implement appropriate resolution actions as appropriate.

Problems will be reviewed within fourteen (14) business days of receiving a complaint and resolved within thirty (30) days. The Administrator of the Agency may request that complaints filed by clients and/or client representatives be document in writing.

Authorization to Release Information:
I consent to the release of information and/or disclosure of information by, and to, _____, to individuals acting in an official capacity as my home care agency representing governmental agencies or third party payers, or health care providers involved in my care. I also authorize the confidential release of my health care information in the case of a natural disaster to those whom may need that information to assist me.

Bill of Rights and Advanced Directives:

I acknowledge in signing this agreement that I have received the Breakthrough Resources Home Care Agency Client Bill of Rights. The Bill of Rights has been reviewed with me and I acknowledge understanding of my rights. I also acknowledge being given information on Advance Directives.

Client Signature or Representative Acting on Client's Behalf/Date

Breakthrough Resources Home Care Representative/Date