

# SERVICE AGREEMENT

**Service Provider [Please Check One]**

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> <b>Caring People, Inc.</b><br>162-18 71 <sup>st</sup> Avenue<br>Fresh Meadows, NY 11365<br>(718) 425-4600 | <input type="checkbox"/> <b>Caring People of NJ, LLC</b><br>1169 Main Avenue<br>Clifton, NJ 07011<br>(973) 859-2700 | <input type="checkbox"/> <b>Caring People, LLC d/b/a<br/>Caring People of Palm Beach</b><br>15127 Jog Road, Ste. 201<br>Delray Beach, FL 33446<br>(561) 860-9200 | <input type="checkbox"/> <b>Caring People of Pompano<br/>Beach, LLC d/b/a Caring<br/>People of Broward</b><br>1000 W. McNab Road, Ste 321<br>Pompano Beach, FL 33069<br>(954) 861-6500 |
|--|---|--|--|

**Client Information**

First Name: \_\_\_\_\_  
 Last Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Start of Care Date: \_\_\_\_\_  
 Days Per Week: \_\_\_\_\_ Hours Per Day: \_\_\_\_\_ Live In: \_\_\_\_\_

**Payment Terms**

Hourly Rate: \_\_\_\_\_  
 Live In Rate: \_\_\_\_\_  
*\*Holiday Rates and Special Rates may apply-see Standard  
 Terms of Service*

**Method of Payment**

- Credit Card-complete attached authorization  
 ACH/EFT-complete attached authorization  
 Long Term Care Insurance  
 Policy Name: \_\_\_\_\_  
 Policy Number: \_\_\_\_\_

**1. Consent to Treatment and/or Service.** By entering into this Service Agreement the Service Provider indicated above (“Caring People”, “we” or “our”) agrees to provide and the patient (“I” or “you” ) voluntarily consents to receive home health treatment and/or service based upon the Plan of Care specifically tailored to my health and social needs.

**2. Terms of Payment**

**a. Invoices are payable upon receipt.** I have requested home health services from Caring People and understand that by making this request, I become fully financially responsible for any and all changes incurred in the course of the treatment authorized or services rendered. I understand that employee time sheets must be signed on a daily basis and at the end of the work week in order to confirm the hours/days of services rendered. I further understand that fees are due and payable as set forth herein. Invoices are prepared on a bi-weekly basis. We will charge your credit card or debit your bank account pursuant to the Electronic Funds Transfer (EFT) Authorization on the date the invoice is rendered. A finance charge of eighteen percent (18%) per annum will be charged on all invoices past due for 30 days from the date on the invoice. Should any balance be referred for collection, you further agree to pay all reasonable costs of collection including attorney’s fees, disbursements, court costs and interest. Caring People reserves the right to discharge any patient for nonpayment of charges upon (3) days written notice. If you should be discharged for nonpayment an assessment will be done and instructions provided for any needed ongoing care or treatment, including pain management.

**b. Fees.** The payment terms and rates set forth above are based upon our current fees for the type of services required based upon the Plan of Care prepared for you. Our invoices will include any disbursements made on your behalf such as travel, telephone, mailing and/or purchase of personal items on your behalf. Should your condition change necessitating a modification of the Plan of Care (such as a change from Live In to Hourly) or should we amend or adjust our billable rate schedule, you will be notified of the proposed rate modification in writing no less than seven (7) days before the new rates go into effect. In the case of an emergency regarding your care, we reserve the right to provide such information verbally to you.

**c. Holidays/Overtime.** All Overtime will be billed at a rate of 1.5 times the Hourly Rate or Live In Rate in effect at the time (the Overtime Rate). All services that exceed forty (40) hours per week for a specific employee will be charged to you at the Overtime Rate. When we provide services on New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day or Christmas Day, you will be charged the Overtime Rate. The holiday period is the twenty-four hour period that starts the evening before the holiday.

**d. Insurance.** I understand that Caring People only accepts assignment of certain select Long Term Care Insurance Policies. I have been advised that Caring People will not file Medicare claims on my behalf nor, initiate a claim with my Long Term Care Insurer. I understand that I am responsible to obtain and complete all appropriate paperwork from my insurance company. Moreover I understand that Caring People does not accept assignment of Medicaid benefits. I acknowledge that receipt of any pre-approval or pre-certification from my Insurance Company is not a guaranty of payment. I acknowledge that I am obligated to pay any sums due to Caring People that are not paid by my insurance company.

**3. Non-Solicitation Agreement.** I agree that any time this Agreement is in effect and for a period of one hundred twenty (120) days from the termination of this Agreement by either party, I will not hire any employee or independent contractor of Caring People, on any basis whatsoever, nor will I directly or indirectly, solicit, induce, recruit or encourage any of Caring People's employees or independent contractors to leave their employment with Caring People. I acknowledge that a violation of this Non-Solicitation Agreement will damage Caring People and may result in Caring People bringing legal action against me seeking Liquidated Damages in the sum of \$15,000.00 for each employee wrongfully solicited as set forth herein, plus additional monetary damages as allowed by law and/or injunctive relief. In the event of a violation of this Non-Solicitation Agreement I agree to pay all of Caring People's attorney's fees, disbursements and costs resulting therefrom.

**4. Termination of Agreement by Patient.** You have the right to change or terminate service at any time. If you change or suspend service with less than twenty-four hours notice, you may be subject to incurring charges for the service scheduled during that twenty-four (24) hour period. Except in cases of emergency, all notices of change or notices terminating this Agreement should be in writing.

**5. Termination of Agreement by Caring People.** We reserve the right to terminate this Agreement for any cause upon (3) days written notice (except in cases of emergency). Termination may, but will not necessarily be based upon one or more of the following conditions in our sole determination:

- a. You no longer require our services based upon your health or social needs.
- b. Your home is no longer adequate for safe and effective care.
- c. You are no longer under the care of a physician who will verify diagnosis and assume responsibility for medical direction.
- d. Our fees for services rendered have not been paid as required herein.
- e. You no longer live in the geographic area serviced by us.
- f. Our personnel and resources are no longer adequate, available and/or suitable to accommodate your health and social needs.
- g. You and/or your family, representatives or caregivers fail to cooperate with us in any manner deemed necessary or prudent.
- h. In the event you cannot be left alone and there are no others who will remain responsible for your care during our absence or, if there are no others who can carry out requirements of the Emergency Care Plan.

**6. Valuables.** Our employees are not authorized to accept, have custody of or have the use of cash, credit or debit cards, bankcards, checks or other valuables belonging to you, without written approval in advance. Any and all suspicions of theft or misappropriation of valuables must be directed to Caring People in writing with proof of the allegations. We will not pay any claims, nor will credits be given for any such unauthorized use or misappropriation of valuables. We will refer such matters to our bonding company for final determination.



# CONSENT

**Service Provider** [Please Check One] any of which are referred to herein as “Caring People”.

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> <b>Caring People, Inc.</b><br>162-18 71 <sup>st</sup> Avenue<br>Fresh Meadows, NY 11365<br>(718) 425-4600 | <input type="checkbox"/> <b>Caring People of NJ, LLC</b><br>1169 Main Avenue<br>Clifton, NJ 07011<br>(973) 859-2700 | <input type="checkbox"/> <b>Caring People, LLC d/b/a<br/>Caring People of Palm Beach</b><br>15127 Jog Road, Ste. 201<br>Delray Beach, FL 33446<br>(561) 860-9200 | <input type="checkbox"/> <b>Caring People of Pompano<br/>Beach, LLC d/b/a Caring<br/>People of Broward</b><br>1000 W. McNab Road, Ste 321<br>Pompano Beach, FL 33069<br>(954) 861-6500 |
|--|---|--|--|

I hereby give Caring People my consent to use or disclose any protected health information to carry out my treatment, to obtain payment from insurance companies and for health care operations like quality reviews.

I further consent that protected health information may be received or released by Caring People by various means including but not limited to personal conversation, telephone, mail, e-mail or facsimile.

I have reviewed the Notice of Privacy Practices of Caring People prior to signing this Consent.

I understand that Caring People has the right to change their privacy practices.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand the Caring People is not required to agree to this request. If Caring People agrees to my requested restrictions, they must follow those restrictions.

I have not requested a restriction of how my protected health information is used.

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

\_\_\_\_\_  
Printed Name of Client

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

or

\_\_\_\_\_  
Printed Name of Client's  
Personal Representative

\_\_\_\_\_  
Personal Representative's Signature    Date

## ASSIGNMENT OF BENEFITS

**Service Provider** [Please Check One] any of which are referred to herein as “Caring People”.

- |  |   |  |  |
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|--|---|--|--|

**Client Information**

First Name: \_\_\_\_\_  
 Last Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_

**Long Term Care/Insurance Information**

Insurance Carrier: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_  
 Policy Number: \_\_\_\_\_  
 Claim Number: \_\_\_\_\_

**1. Long Term Care Insurance.** I understand that Caring People only accepts assignment of certain select Long Term Care Insurance Policies. I have been advised that Caring People will not file Medicare claims on my behalf nor, initiate a claim with my Long Term Care Insurer. Moreover, I understand that Caring People does not accept assignment of medicaid benefits. Acceptance of this Assignment of Benefits by Caring People and the receipt of any pre-approval or pre-certification from an Insurance Company is not a guaranty of payment. Payment for services rendered by Caring People is due at the time an invoice is rendered as set forth in the Service Agreement.

**2. Assignment of Benefits.** I hereby assign all Long Term Care benefits to which I am entitled to Caring People and I direct my insurance carrier(s) to issue payment check(s) directly to Caring People. I understand that I am responsible for any amount not covered by insurance.

**3. Authorization to Release Information.** I hereby authorize Caring People to: (a) release any information necessary to insurance carriers regarding my illness and treatments; (b) process insurance claims generated in the course of services rendered; and (c) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. I authorize my insurance carrier(s) to release any insurance related information to Caring People as may be necessary to process such claims. This order will remain in effect until revoked by me in writing.

**4. Financial Responsibility.** I have requested home health services from Caring People and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized or services rendered. I further understand that fees are due and payable as set forth in the Service Agreement and agree to pay such charges incurred in full immediately upon presentation of an invoice. A photocopy of this assignment is to be considered as valid as the original.

\_\_\_\_\_  
Printed Name of Client's  
or

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Client's  
Personal Representative

\_\_\_\_\_  
Personal Representative's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Personal Representative Address

\_\_\_\_\_  
*A copy of the document authorizing the representation (Power of Attorney, Court Order Appointing Guardian, etc.) must be attached hereto and made a part hereof*

Caring People

By: \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Representative of Caring People

## GUARANTY OF PAYMENT

**Service Provider** [Please Check One] any of which are referred to herein as "Caring People".

- |  |   |  |  |
|--|---|--|--|
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|--|---|--|--|

**Client Information**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

**Guarantor Information**

Full Name: \_\_\_\_\_ Employer's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Employer's Telephone Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**1. GUARANTY:** By signing this guaranty, I guarantee to the Service Provider above named ("Caring People") that all sums due for services rendered to the above named Client pursuant to the Service Agreement, a copy of which I have been provided with, will be paid when it is due, no matter what may happen. This means that Caring People can demand payment from me if the Client fails to pay it in full for all of the monetary obligations contained in the Service Agreement. I also agree to be personally bound by the terms of the Non-Solicitation Agreement contained in the Service Agreement.

**2. RESPONSIBILITY:** I understand that I am responsible for payment of the full amount due to Caring People by the Client even if there are other Guarantors, this includes but is not limited to the finance charge of eighteen percent (18%) per annum charged on all invoices past due for 30 days from the date on the invoice. Caring People can demand payment from me without first (a) seeking payment from Client or (b) trying to collect from the Client's Long Term Care Insurance if any. Should any balance be referred for collection, I further agree to pay all reasonable costs of collection including attorney's fees, disbursements, court costs, interest and any other fees permitted by law.

**3. WAIVERS:** I HEREBY WAIVE ANY RIGHT TO REQUEST A TRIAL BY JURY IN ANY LITIGATION WITH RESPECT TO THIS GUARANTY. I REPRESENT THAT COUNSEL HAS BEEN CONSULTED SPECIFICALLY AS TO THIS WAIVER OR, THAT I HAVE SPECIFICALLY WAIVED THE RIGHT TO SEEK LEGAL ADVICE. I HEREBY WAIVE THE RIGHT TO INTERPOSE ANY COUNTERCLAIM OR OFFSET OF ANY NATURE IN ANY SUCH LITIGATION.

**4. NOTICES:** Caring People does not have to notify me, that any Obligation has not been paid. Caring People only has to notify me when when you wish me to make a payment under this Guaranty. Caring People does not have to notify me of any changes in the Service Agreement or in the fee schedule established therein.

**5. VALIDITY:** If any part of this guaranty is determined by a court to be invalid, the rest will remain in effect

**6. LAW:** This guaranty will be governed by the law of and constructed in accordance with the laws of the State of  **New York**,  **New Jersey**,  **Florida** and will be litigated in that State or in Federal Courts located within that State. Any litigation commenced in accordance with the laws of the State of New York will be instituted within the State of New York, any litigation commenced in accordance with the laws of the State of New Jersey will be instituted within Passic County, any litigation commenced in accordance with the laws of the State of Florida will be instituted within Broward or Palm Beach counties.

**7. HEIRS:** This guaranty will bind my heirs, executors, administrators, successors and assigns.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guarantor

\_\_\_\_\_  
Date