**Caring Home Care, Inc.**
8198 Jog Road, Suite 204
Boynton Beach, FL 33472
Phone: 561-424-2477
Fax: 561-424-2478
Lic # 30211511

**Caring Home Care, Inc.**
1011 NW 51st Street, Suite 6
Ft Lauderdale, FL 33309
Phone: 954-318-0747
Fax: 954-318-0878
Lic # 30211170

**Caring Home Care, Inc.**
15455 W. Dixie Hwy, Unit A
N. Miami Beach, FL 33162
Phone: 305-947-7292
Fax: 305-947-7568
Lic # 30211130

# *Patient Consent and Service Agreement*

I or my authorized personal representative agrees to commence health care services with Caring Home Care, Inc. Services include but are not limited to my physician plan of treatment or services requested by me, personally, or by my authorized personal representative. I authorize Caring Home Care, Inc. to release any of my medical records and pertinent information concerning my care and hereby authorize Caring Home Care, Inc. to speak to my physician, family members, and my insurance carrier regarding my care. I acknowledge that I have received the Statement of Advanced Directives and the information has been discussed with me to my satisfaction.

I agree to the following services: ☐ HHA ☐ Homemaker ☐ Companion ☐ Respite ☐ RN/LPN

☐ I or my personal representative authorizes Caring Home Care, Inc. to accept an assignment of benefits, and receive payment on my behalf from insurance companies and/or third party payers.
I acknowledge that I will be personally responsible for all deductibles, copayments, or any charges not covered by my insurance company or third party payer. By signing a credit card authorization agreement, Caring Home Care, Inc. will automatically bill my credit card for any services not covered by a third party payer.

☐ As a Self-Pay patient, I will complete a credit card authorization agreement for weekly billing of health care services.

Daily Bill Rate: Live In _____ Hourly _____ Mileage _____

☐ As a Self-Pay patient, paying by personal check, I agree to provide a one week deposit for projected hours of service prior to the agreed start of care date.

☐ As a Medicaid recipient, I agree and accept the terms of services assigned under the contractual agreement between

Caring Home Care, Inc. and _____ .

In accordance with conditions of licensure, Caring Home Care, Inc. is providing you with the following information: As a licensed Nurse Registry in the state of Florida, Caring Home Care, Inc. abides by Title IV of the Civil Rights act of 1964. No person shall be denied care or employment because of race, color, creed, handicap or age.

I or my personal representative agrees to allow a Registered Nurse (RN) from Caring Home Care, Inc. to make periodic visits, as needed, to patient(s) home to assess the quality of care provided and may be billed as a separate fee. Caring Home Care, Inc. also provides a skilled nurse for an additional fee (per visit) at the request of the patient.

I and/or my personal representative will not attempt to solicit any of the caregivers employed by Caring Home Care, Inc. to work for me privately during the time of this agreement and for a period of 6 months after services have terminated. If I violate the agreement, I will pay a sum of $3,000 in liquidated damages to Caring Home Care, Inc.

***To report abuse, neglect or exploitation call 1-800-96-ABUSE. The hotline is available 24 hours daily***

Client Name: _____ Date: _____

Client/Personal Rep Guarantor Signature: _____

Client/Personal Rep Print Name: _____

Caring Home Care Rep Signature: _____ Date: _____