Kenyon HomeCare Consulting

Smarter Solutions.
Better Outcomes.

Washington

Client Electronic File Forms Skilled Home Health

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CLIENT CHART FORMS

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INTAKE FORM

Date: _____

Client Name: _____ Phone: _____

Address: _____

Date of Birth: _____ Age: _____ SSN: _____

Services requested: _____

_____

_____

_____

_____

_____

_____

Start date: _____

Medical diagnosis: _____

_____

_____

_____

_____

_____

_____

Physician: _____ Phone: _____

Contact name: _____ Phone: _____

Referral source/person: _____ Phone: _____

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CLIENT SERVICES AGREEMENT

Client Name: _____ Client Number: _____

CLIENT RIGHTS AND RESPONSIBILITIES

I understand and have received the list of my rights and responsibilities: _____

(Client Initials)

CONSENT FOR CARE

I consent to receive care from [AGENCY NAME] as outlined in the plan of care and other services agreed to by [AGENCY NAME] and me.

Services available through [AGENCY NAME]	Services to be provided to you:
Home Care Aide	☐ Home Care Aide
Homemaker	☐ Homemaker
Transportation	☐ Transportation
Live-in	☐ Live-in
Respite Care	☐ Respite Care
	☐ Other: _____

PAYMENT

I agree I am to pay all invoices within 14 days of receipt of the bill and a late charge of 12% may be assessed to bills that are later than 30 days. I am liable for all charges, collection costs, and attorney fees regardless of the payor. I understand I am responsible for all charges. Further, I authorize payment directly to [AGENCY NAME] of any insurance benefits payable to me for services provided and covered by my insurance plan.

BILL RATE AND DEPOSIT

The bill rate for Caregiver services is $ _____ an hour/day. This rate is subject to change with a 30-day notice.

I agree to pay $ _____upon signing of this agreement (cash, credit card, or check). This deposit for services will be applied to the last invoice for services.

HOLIDAYS

Holidays are Thanksgiving Day, Christmas Day, are New Year's Day. You will be reminded of each holiday prior to the holiday. If you decide to have services on a holiday, you will be billed at a rate of one and one half for services provided starting at 7am of the holiday until 7am of the following day.

SERVICE INTERRUPTION

I understand, from time to time, there may be an interruption of services due to circumstances that are unavoidable. [AGENCY NAME] will make every effort to staff the shift and will notify me if they are unable to do so. During those times, I agree to provide or arrange for back-up care.

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Release of Liability

I release and hold harmless [AGENCY NAME], its agents and employees from any and all liability arising from transporting me in my vehicle or the employee vehicle, or agent of [AGENCY NAME]**. I accept transportation at my own risk**. If transportation is provided in the employee car, I agree to pay 40 cents per mile, which will be billed with my monthly statement.

Telephone Use

I understand that my health care workers will be required to call in and out on my phone. I authorize all health care workers attached to [AGENCY NAME] to use my phone for business related calls.

Hiring of Agency Name Employees

I understand that **I will not solicit or accept a solicitation from an employee or attempt to hire an employee of [AGENCY NAME]** for a period of 120 days following completion of services to me. Further, if I hire the employee before the 120 days I will immediately pay [AGENCY NAME] the sum of $5,000.00.

Termination

I understand I may cancel a shift or terminate this agreement with a four-hour notice. [AGENCY NAME] may terminate this agreement by providing a 72-hour notice. I understand that any cancellation with less than four hours' notice will be billed at the full shift fee.

Advanced Directives

I have received and reviewed the Advanced Directives Information statement. _____

(Client Initials)

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