

941-366-0801 | www.rightaccordhealth.com

Intent to Receive Service

This is to certify that on the following date, RIGHT ACCORD Home Health Care will begin delivering the below specified care services.

Person receiving car	e:			
Date of service:				
	Auto Debit ACH (Bank Account) Transfer –			
	Routing Number: Online By Mail – Addres			Account Number: s invoices must be sent:
With in 24 hours a N	lew Client Ag	reement will be em	ailed to:	
-	service. All f	urther invoices will		I to the above specified destination a weekly basis and will arrive no
Client/Responsible Payer:				Date:
Agency Representative:				Date: