RIGHT ACCORD
Private Duty-Home Health Care
1960 South Tamiami Trail Venice, FL 34293
941.366.0801| www.rightaccordhealth.com

SERVICE AGREEMENT for _____ (Client Name)

This agreement sets forth the terms of our engagement and the nature of our services to be provided and your responsibilities in connection with such services.

RIGHT ACCORD is a provider of non-medical, in-home caregiver and companion care to the elderly who require assistance with their daily living activities. You wish to engage us to provide a caregiver at your home during prescribed times mutually agreed upon in advance to perform certain tasks as more fully described below:

* Personal Care (bathing, grooming, etc)	* Medication Reminders	* Meal preparation
* Light housekeeping	* Laundry	* Shopping / Errands
* Homemaker / Companionship	Others:	Skilled Nursing

AGREED RATE

Our fees are based on the amount of **hours/days** worked plus out-of-pocket expenses. The agreed rate for the type of care requested will be **$**_____ per **hour or $**_____ **per packaged shift.** Live In shifts are billed per 24-hour daily rate according to Fee Schedule. Hourly rate automatically applies if caregiver not able to have enough rest for 12 hours at night.

If you choose to send the caregiver home before the end of the shift, please note the **FULL** shift will be charged for unless prior arrangement has been made. **PLEASE NOTE: Observed holidays, overtime and couples care are charged at time and a half.** We have the absolute right, without limitation or penalty; to stop all work in the event there are disputes and/or delinquent fees due us.

Service requirement: ☐ **Personal Care** ☐ **Homemaker/Companionship**

Commencement date: _____ **Amount of hours per visit:** _____ **times per week** _____

	MON	TUES	WED	THURS	FRI	SAT	SUN
Requested time							

Please provide adequate notice to RIGHT ACCORD should you need to change, increase or decrease these days/hours.

SERVICE DEPOSIT

In order to begin work and place a qualified caregiver in your home, we will require a service deposit of **$**_____. This deposit represents an estimate of our fees for the first **week** of service to you. This deposit will be held until service's are no longer required, at which time this amount will be refundable and credited against any unpaid invoices or fees due to us. Please note that an additional deposit will be required if services are changed to increase the hours.

BILLING

Weekly invoices will be sent to you both for services rendered and for costs incurred on your behalf.
The amounts shown on these invoices shall be due and payable within15 days from the date of the invoice.
Billing will be for the agreed amount of hours/days as shown above. You will be notified when rates are changed.
Overdue accounts after 30 days will be subject to interest and collection.

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NON-SOLICITATION AGREEMENT

You hereby agree not to privately or directly hire, solicit or request transfer with another home care provider any caregiver under the employ of Right Accord for at least one year after the employee leave the employ of Right Accord. In the event that you breach the terms of this agreement, you agree to pay the sum of $15,000.00 to RIGHT ACCORD. This is a fair amount for the significant investment of time

and money to hire, train caregivers and maintain clients. Additionally, you agree to accept full employer responsibility for said caregiver. You further agree to indemnify and hold RIGHT ACCORD harmless, its officers and employees from any liability resulting from your chosen arrangement. In addition, you will be responsible for any costs, damages and legal fees arising from this case.

TRANSPORTATION

You authorize the use of your automobile, if applicable, for errands and incidental transportation in connection with our caregiver services. If you are the driver, you agree to carry insurance and a valid driver's license. We agree that our caregivers will be appropriately insured and licensed.
Additionally, a mileage fee of fifty-eight cents (.585 cents per mile) will be added to your invoice if caregiver will be driving their own vehicle to use for your care.

CANCELLATION OF SERVICES

Either party may cancel this Agreement at any time with **72 Hours** advance notice to the other party in writing. This does not apply to emergency medical situations such as hospitalization. If services are interrupted in any way for vacations etc., you agree to give us two weeks notice.

We appreciate the opportunity to be of service to you and look forward to a long-lasting relationship. The foregoing is in accordance with our understanding and we hereby agree to its terms and conditions.

By: _____ _____
Agency Representative Signature **Client or Representative Signature**

Date: _____ Client**/Representative Name (Print)**_____

Deposit amount received $ _____ Initials: _____ Date: _____
Check # _____ Cash $ _____

PERSONAL GUARANTY (CLIENT /CLIENT REPRESENTATIVE)

I,_____,SSN - _____, residing at _____
_____ hereby personally guaranty the payment of all obligations to RIGHTACCORD Private Duty-Home Health Care.